Abstract

This article explores the scope of an international human right to reproductive health care. Given the immediate obligations imposed by human rights treaties upon governments to insure a minimum core content of this right, the article proposes a specific definitional content of a minimum package of reproductive health information and services that governments must provide. In identifying this minimum content, reference is made to the Programme of Action of the International Conference on Population and Development and to various recommendations of the World Health Organization—two international sources of consensus and/or expertise on reproductive health. The article further proposes that certain statistical indicators and particular types of government actions be incorporated into government reporting requirements and monitored by the human rights community. By proposing definitional content and monitoring standards related to the international right to reproductive health care, the article seeks to promote international accountability, national initiatives and, ultimately, optimal attainment of reproductive health for women.

Este artículo explora el alcance del derecho humano internacional al cuidado de la salud de la reproducción. Dadas las obligaciones inmediatas impuestas por los tratados de los derechos humanos sobre los gobiernos para asegurar el mínimo contenido de este derecho, el artículo propone un contenido específico de un paquete mínimo de información sobre la salud de la reproducción y los servicios que los gobiernos deben de proveer. Al identificar este mínimo contenido, se hace referencia al Programa de Acción de la Conferencia Internacional sobre Demografía y Desarrollo y a las varias recomendaciones de la Organización Mundial de la Salud — las dos fuentes internacionales de concenso y/o experiencia sobre la salud de la reproducción. El artículo propone además que ciertos indicadores estadísticos y tipos particulares de acciones gubernamentales deben de incorporarse en los requerimientos de los reportes al gobierno y ser monitoreados por la comunidad de los derechos humanos. Al proponer un contenido definido y estándares de monitoreo relacionados al derecho internacional de los cuidados a la salud de la reproducción, el artículo buscar el promover responsabilidad internacional, iniciativas nacionales y, ultimadamente, el óptimo logro de la salud de la reproducción para la mujer.

Cet article examine le champ d'un droit international de l'homme aux soins dans le domaine de la santé liée à la reproduction. Compte tenu des obligations actuelles imposées aux gouvernements par les traités des droits de l'homme pour assurer le respect du concept élémentaire de ce droit, l'article propose la définition d'un shéma de base représentant les informations et services de santé dans le domaine de la reproduction que les gouvernements doivent au minimum assurer. En identifiant ce contenu minimum, référence est faite au Programme d'Action de la Conférence Internationale sur la Population et le Développement et aux diverses recommendations de l'Organisation Mondiale de la Santé—deux sources internationales de consensus et/ou d'expertise dans le domaine de la santé liée à la reproduction. L'article propose, également, que certains indicateurs statistiques et certains types d'actions gouvernementales soient inclus dans les rapports gouvernementaux et controlés par la communauté des droits de l'homme. En proposant la définition d' un contenu et des indicateurs de suivi du droit international dans le domaine du soin et de la reproduction, l'article cherche à promouvoir des garanties internationales, des initiatives nationales et enfin la réalisation optimale de la santé des femmes dans le domaine de la reproduction.

An International Human Right To Reproductive Health Care: Toward Definition And Accountability

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The international feminist campaign for reproductive health[1] is premised on the principle that "women, *both* as individuals *and* in their collective organizational forms and community identities, [must be able] to determine their own reproductive and sexual lives in conditions of optimum health and economic and social well-being."[2] The concept is both unprecedented and unrealized.

This article explores the applicability of the monitoring and enforcement processes of the international human rights system to the goal of promoting reproductive health. Although numerous factors affect the reproductive health of women, one of the core causes of poor reproductive health is a severe lack of affordable, accessible, quality reproductive health care.[3] Thus, this article seeks to articulate the extent to which international human rights law requires governments to provide reproductive health information and services. To enhance enforceability of women-centered human rights norms, we focus on a pragmatic inquiry: irrespective of national resource limitations and differences, what is the minimum package

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of reproductive health care that governments must provide immediately? We do not attempt to discuss the broad, long-term reproductive health-related goals that women seek to achieve within the human rights framework, and that governments also have a responsibility—albeit a more progressive one—to realize.

Part I presents the factual backdrop for claims of a human right to reproductive health care. Part II reviews the textual bases for a right to reproductive health care. Part III explores the scope and "minimum core content" of this right. Part IV discusses standards by which to monitor governmental obligations to ensure reproductive health care, and Part V sets forth a conclusion.

Part I. The Facts

There is widespread consensus that women lack control over their sexual and reproductive lives[4] and that the overall quality of reproductive health care is poor.[5] An estimated 60 to 100 million women in the world are considered "missing" because of health and other social disadvantages.[6] Half of the world's burden of disease is attributable to communicable diseases, maternal and perinatal causes, and nutritional disorders,[7] but women—particularly women in low-income nations—bear a larger proportion of this disease burden than men.[8] In the area of reproductive health, women bear an even greater share of the disease burden.[9] Overall morbidity and mortality for women from sexually transmitted diseases (STDs), excluding HIV/AIDS, is over 4.5 times that of men[10] and STDs have more serious sequelae in women.[11] As to HIV/AIDS, worldwide prevalence of the disease is increasing primarily amongst women.[12] Finally, the World Health Organization (WHO) estimates that, annually, more than 500,000 women die from complications related to pregnancy, including from unsafe abortion.[13] Indeed, in some areas of the world, a woman's lifetime risk for maternal mortality is as high as one in 20.[14]

In attempting to strengthen governmental legal responsibility for inadequacies in reproductive health care that contribute to the poor health status of women, it is useful to understand the role that governments around the world already play in meeting health needs. In virtually every nation

in the world, government is a key player in the health sector. One indication of this is the extent of public expenditure for health care. In 1990, estimated global health expenditures amounted to over $1,700 billion.[15] Of this amount, governments spent more than $1,000 billion, or nearly 60 percent of the global budget.[16] Of the $170 billion spent on health in countries in Africa, Asia and Latin America, governments spent 50 percent of the total amount—2 percent of these regions' gross national product (GNP).[17] In industrialized nations, where total health expenditure was almost $1,500 billion, governments spent just over $900 billion, or 60 percent of the total health budget— more than 5 percent of GNP.[18] In addition, governments regulate and implement policy initiatives for the health sector. Despite governmental involvement in health, more than one billion people—almost all in low-income nations—do not have access to even the most basic health care services.[19]

Global data on the involvement of governments in services that comprise reproductive health care is difficult to obtain. To date, most governmental involvement in such services has been in the form of family planning programs, which in numerous countries have been provided pursuant to a national population policy. Over half of all low- and middle-income nations have adopted comprehensive national population policies.[20]

Family planning services are currently subsidized by national governments in approximately 130 countries.[21] In 1990, total annual expenditure for family planning in low- and middle-income nations was more than $4 billion, or approximately $1 to $1.25 per capita for such regions.[22] Worldwide, "over 80 percent of all contraceptive users receive their supplies and services from public sector programs."[23] Yet, only 60 percent of people in low-and middle-income countries have access to *any* family planning methods.[24] It is estimated that approximately 100 million women in all such nations (excluding China) have an unmet need for contraception.[25] The need for other reproductive health services is equally urgent. Current annual expenditures on AIDS prevention in low- and middle-income nations, in which 85 percent of all infections occur, is less than $200 million per year.[26] It is estimated that comprehensive AIDS and STD prevention services for all such

nations would cost at least 10 times more than is currently being spent.[27]

Against this backdrop of significant but inadequate governmental expenditures and women's poor reproductive health status, can governments be held responsible for violating or failing to fulfill a human right to reproductive health care?

Part II. Major Sources of Women's Right to Reproductive Health Care [28]

Reproductive health care, together with certain aspects of reproductive choice, are within the scope of international human rights treaties.[29] These documents support a right to health which — if the principle that "women's rights are human rights"[30] means anything — must be understood to encompass a right to reproductive health. Moreover, human rights treaties also guarantee a right to certain specific health services.

Although health was first articulated as a human right in the Universal Declaration of Human Rights,[31] a more detailed articulation of this right is set forth in Article 12 of the Covenant on Economic, Social and Cultural Rights:[32]

> 1. The States' Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> 2. The steps to be taken by the States' Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child; ...
>
> d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.[33]

The Convention on the Elimination of All Forms of Discrimination Against Women also addresses aspects of women's right to health.[34] Article 10(h) requires States parties to provide equal access to "educational information to help to ensure the health and well-being of families, including information and advice on family planning." In addition,

Article 12 prohibits discrimination "in the field of health care," ensures equal "access to health care services including family planning" and requires states to:

> ...ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.[35]

The International Convention on the Elimination of All Forms of Racial Discrimination[36] and the Convention on the Rights of the Child[37] also guarantee a right to health. The right to health contained in the Race Convention establishes a principle of racial equality regarding the right to "public health."[38] The Children's Convention concerns the right to health of persons under the age of 18 (or who have not attained majority).[39] Specific measures include ensuring the health of children by requiring that states provide pregnant women with the health services necessary for safe delivery, and by implicitly recognizing that adolescents also have reproductive health care needs.[40]

Thus, the right to health is an explicit human right. The Economic Covenant states a broad right to health, while other treaties focus on the rights of specific groups—women, racial minorities and children. Together, these provisions form the international legal basis for women's right to reproductive health care. Logically and factually, reproductive health is a subset of health. Moreover, human rights principles of non-discrimination require the application of all treaty obligations regarding health care to ensure equally the reproductive health care services especially needed by women. But the articulations of a right to health and reproductive health leave us a long way from implementation of this international human right.[41]

Part III. The Scope of Women's Right to Reproductive Health Care

Notwithstanding clear textual support in international treaties for a right to reproductive health care, efforts to monitor and enforce state compliance with this right have been severely hampered by the absence of definitional specificity.[42] The right to health, though drafted to ensure the

"highest attainable" standard of health, must be considered to have a "minimum core content."[43] "Each [economic, social and cultural] right must...give rise to an absolute minimum entitlement, in the absence of which a state party is to be considered in violation of its obligations."[44] But each right also has a broader scope that is subject to progressive realization. In this section, we draw upon several international sources to propose a scope and minimum core content to a right to reproductive health care.

An exploration of the core content of a right to reproductive health care should commence with an examination of the right to health itself. The WHO Constitution has defined health as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity."[45] WHO's definition of health has, however, been criticized by some commentators as being too vague, at least for the purpose of supplying content to international legal texts.[46]

International organizations and scholars have made several attempts to provide content to the right to health.[47] Thus, there appears to be general agreement that the right to health excludes the guarantee of perfect health to all[48] and that the right to health is tantamount to a "right to health protection."[49] This "right to health protection" has two components: "a right to health care and a right to healthy conditions."[50] So, too, the right to reproductive health can be regarded as including a right to the pre-conditions necessary to secure reproductive health and a right to reproductive health care. Although a "minimum core content" must ultimately be developed for both elements, this article focuses only on health care.

A. A Minimum Core Package of Reproductive Health Care

In seeking to define with some specificity a minimum reproductive health package of required information and services, we turn both to recognized sources of international governmental consensus and to recommendations of appropriate multilateral agencies. In the case of reproductive health care, therefore, we look to the Programme of Action of the International Conference on Population and Development (ICPD Programme),[51] and to documents and reports produced by WHO. The ICPD Programme provides a rich source of in-

ternationally agreed upon principles regarding core elements of reproductive health care and family planning services. Although the ICPD Programme is not technically a binding source of international law, it can nevertheless contribute to the task of analyzing the minimum core content of the right to reproductive health care.[52]

The ICPD Programme is notable for its endorsement of a "new comprehensive concept of reproductive health."[53]

> Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.[54]

The ICPD Programme also attempts to define the scope of health services necessary to achieve reproductive health.

> [R]eproductive 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....[55]

The ICPD Programme contributes to a discussion of the content of reproductive health care by attempting to delineate the types of health care services that "should" be provided.

> Reproductive health care in the context of primary health care should, *inter alia*, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery care, and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and management of the consequences of abortion; treatment of reproductive tract infections, sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood.[56]

The document regards reproductive health care as a constellation of services and contributes to discussions of the scope of reproductive health care. Although it does not make recommendations regarding components of a minimum package of reproductive health care, the ICPD Programme reflects international consensus regarding the more important elements of a core reproductive health care package.

The ICPD Programme addresses family planning in some detail. Without specifying the precise content of family planning services,[57] Paragraph 7.12 states generally that the aim of such programs "must be" to enable couples to make informed, free and responsible reproductive choices and to "make available a full range of safe and effective methods." The ICPD Programme also focuses on the manner in which services are to be provided. The document states that "[t]he principle of informed free choice is essential to the long-term success of family-planning programmes"[58] and requires governments to "secure conformity to human rights and to ethical and professional standards in the delivery of family planning and related reproductive health services..."[59]

Another primary concern of the ICPD Programme is reduction of maternal mortality and enhancement of safe motherhood.[60] The document recommends that reproductive health services seeking to achieve these objectives should include "education on safe motherhood, prenatal care that is focused and effective, maternal nutrition programmes, adequate delivery assistance that...provides for obstetric emergencies; referral services for pregnancy, childbirth and abortion complications; post-natal care and family planning."[61]

The ICPD Programme also emphasizes actions to prevent and provide treatment for STDs, particularly HIV/AIDS.[62] The document recommends that reproductive health programs increase efforts to detect and treat STDs and provide information, education and counselling regarding all STDs, including HIV/AIDS. Promotion and distribution of condoms is also recommended.

WHO is another source of international expertise regarding reproductive health care. Although WHO's definition of reproductive health is similar to that contained within the ICPD Programme,[63] WHO has specifically sought to iden-

tify a "minimum" level of reproductive health services.

> A reproductive health package must include, as a minimum, components of family planning, STD prevention and management and safe motherhood. A cluster of interventions for safe motherhood must be at the centre of any reproductive health strategy.[64]

In terms of family planning, WHO envisages services that not only provide information and education but also ensure "universal access to a full range of safe and reliable [family planning] methods."[65] Such services are to be linked to more general reproductive health services and to account for the health impact of unsafe abortions. Although WHO maintains that "abortion should not be promoted as a method of family planning,"[66] it recommends that health consequences of and complications arising from unsafe abortion be managed. WHO reaffirms that women should have "access to high quality [abortion services] and affordable counselling and services."[67] Basic STD services are to include condom distribution, information and education, referrals, diagnosis, and treatment. WHO has also designed a "Mother-Baby Package" as the core of safe motherhood services. The Mother-Baby package includes diverse services such as the prevention of unwanted pregnancy, pre-natal care, community-based care for normal deliveries, obstetric first aid, immunizations, and treatment of syphilis and other common infections.

Thus, WHO's basic minimum reproductive health package has three clear elements: family planning; STD and safe motherhood services together with information and counseling; and education on all aspects of reproductive health. This package coincides with priority services and information identified in the ICPD Programme, thereby providing an important guide to the scope and minimum core content of reproductive health care.

B. Quality Care: A Crucial Element of Minimum Services

Quality care lies at the core of the international women's health and rights agenda.[68] In large part this is because international donor concern about the global "population problem" has resulted in single-minded support for family planning programs that have failed to adopt a reproductive health

care approach.[69] It is widely perceived, at least by women, that family planning services are driven by a demographic concern for population control rather than by a desire to subsidize quality women's reproductive health care.[70] This concern for population control is seen as playing a causal role in global incidents of coercion and neglect of quality health care standards.[71] It is therefore crucial that even the minimum core content of reproductive health services reflect a concern with quality care.[72]

Experts in international family planning have developed a six-part framework for assessing the quality component in such services.[73] "These six elements reflect *six aspects of services that clients experience as critical.*"[74] These elements are: (1) choice of methods (referring to the number and variability of contraceptive methods); (2) information given to clients during service that "enables clients to choose and employ contraception with satisfaction and technical competence;" (3) technical competence (referring to clinical technique, observance of protocols, use of aseptic techniques, etc.); (4) interpersonal relations during the provision of service; (5) mechanisms to encourage continuity of care or follow up; and (6) appropriate constellation of services (referring to the provision of family planning in a reproductive health care context).[75] The fact that the ICPD Programme endorses many of these criteria for assessing quality and states that governments "must" significantly improve quality of care in the delivery of family planning,[76] would seem to indicate international consensus on the importance of insuring at least minimum quality health care.

The prospect of incorporating concerns with quality care into the minimum core content of the right to reproductive health care services is a difficult one. First, there is an inherent incompatibility between the use of quantitative statistical measures as indicators of human rights compliance and the qualitative aspects of health care.[77] Second, there are inherent tensions between the principle of universality in the international context and certain, more locally variable, indicators of quality in health care.[78] Moreover, as a general matter, high medical standards are difficult to universalize and to reconcile with a "minimum core content" approach, while extremely low standards may jeopardize the health of

individuals and "trivialize the special stigma behind the label `human rights viol[ation]'."[79] Finally, some indicators of quality readily lend themselves to statistical reporting (e.g., the education level of professional staff), while many others require surveys, interviews and observations to be assessed accurately. As one commentator has observed, "[m]easuring quality is not as straightforward as measuring quantity...[and] is likely to continue to depend primarily on periodic special efforts at data collection."[80]

Due to the necessity of resource-intensive operational research to measure some aspects of quality, therefore, it may be unrealistic to monitor certain aspects of quality of care.[81] Notwithstanding these difficulties, it remains crucial to develop indicators of quality reproductive health care appropriate for human rights analysis.[82]

Part IV. Monitoring Governments' Immediate Obligations for the Right to Reproductive Health Care[83]

Even with greater definition of the scope and minimum content of a right to reproductive health care, questions regarding the nature of government obligations and measures for its compliance remain. In analyzing the obligations imposed on States parties by various human rights instruments, commentators have identified two principal types: obligations of result and obligations of conduct.[84] An obligation of result refers primarily to the outcome of state behavior. An obligation of conduct is concerned with behavior a state should either engage in or abstain from. Such obligations often specify the means by which States parties are to achieve their obligations of result.

Although all obligations cannot be easily distinguished into these categories, such classifications are useful in reviewing obligations imposed by human rights treaties. This section focuses only upon those aspects of a right to reproductive health care that governments that have ratified the relevant treaties are required to ensure immediately.

A. Governmental Obligations for a Right to Reproductive Health Care

For the purposes of this article, the key immediate obligation of result under human rights law is the responsibility of governments to ensure minimum essential levels of a right

to reproductive health in a non-discriminatory manner.[85] Together with the Women's Convention, the Economic Covenant provides the primary legal basis for this claim. Seen as possessing "a dynamic relationship"[86] with all other provisions of the Economic Covenant, Article 2 imposes an obligation upon States parties to "achieve progressively" the right to health set forth in Article 12.[87] Article 2(1) reflects a recognition that full realization of economic, social and cultural rights is not likely to occur quickly or easily.[88]

Nonetheless, the Economic Committee has stated that "*a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every state party.*"[89] Although inadequate resources may prevent a state from being immediately obligated to fully realize the right to health, it is generally believed that there is nevertheless an immediate obligation to ensure "minimum essential levels" of health.[90]

The Economic Covenant requires States parties immediately to guarantee, at the very least, a minimal core content of reproductive health care to women. As discussed in Part III, this minimum package of care includes services relating to family planning, STDs, and safe motherhood, together with minimal compliance with quality of care standards and provision of basic information about reproductive health.

The other treaties discussed in Part II immediately obligate States parties to provide those aspects of reproductive health care that are explicitly stated in their text.[91] In addition, a critical immediate obligation of result with respect to the right to health is the prohibition against discrimination contained in human rights treaties.[92] For example, the Economic Covenant requires that the right to health be exercised without "discrimination of any kind" based on factors such as race, color, sex, language, property, social origin, birth, or other status.[93]

Human rights treaties also impose immediate obligations of conduct upon States parties with respect to a right to reproductive health. These instruments do not, however, specify the manner in which states should act. Hence, Article 2 of the Economic Covenant obligates states to take "all appro-

priate means, including particularly the adoption of legislative means."[94] Moreover, States parties are required to act both "individually and through international assistance and cooperation."[95] Other measures—including administrative, educational, financial and social—are also "appropriate" and important.[96] Similarly, the Women's Convention requires states to give legal effect to the obligations it imposes by, *inter alia*, incorporating relevant principles into their national constitutions and by adopting appropriate legislation.[97] States parties thus enjoy discretion in their choice of implementing measures.

B. Monitoring Governmental Obligations

Although States parties' obligations are easily outlined, the creation of a global accountability framework is more challenging. One of the most difficult questions is: by which standards and measures should government compliance be assessed?

The standards by which to monitor government responsibility for a right to reproductive health care will depend upon the nature of the obligation imposed. Because an obligation of result is primarily concerned with the outcome of state behavior, compliance with such obligations can be attempted by use of statistical indicators. Obligations of conduct, on the other hand, are concerned either with a behavior a state should follow or from which it must abstain. Traditional statistical indicators do not adequately reflect the measures a state may or may not have taken towards a specific required objective. Monitoring obligations of conduct therefore requires a focus on the actions taken or to be taken by governments to comply with their international legal obligations.[98]

1. Obligations of Result: Monitoring via Indicators

One means of determining whether States parties have fulfilled their obligation to provide minimum and specified reproductive health services in a non-discriminatory manner is by the use of indicators. Indicators are statistical data attempting to numerically describe the "prevailing circumstance at a given place at a given point in time."[99] These indi-

cators, generally selected from the body of data collected by national governments, are utilized both by domestic and international agencies to assess and compare conditions between nations as well as across geographic and temporal lines within nations.[100] The United Nations Research Institute for Social Development (UNRISD) has identified seven criteria for selection of indicators: availability of data; comparability; quality of data; validity of indicator; discriminative power; balance and avoidance of duplication; and conceptual significance.[101]

But there are many problems with using indicators. Some common concerns are the difficulty of discerning universally applicable indicators, accounting for cultural factors, potential manipulation of statistical data,[102] and their "essentially quantitative" nature.[103] Moreover, effective monitoring requires the use and development of indicators that governments may not currently collect or report upon. Such data collection is often expensive and difficult to obtain.[104] Also, meaningful cross-country comparisons of socio-economic rights are difficult. Given the enormous variation in economic resources and conditions, it can be difficult to make meaningful comparisons regarding compliance with, or progress toward, human rights norms. Finally, unless an indicator is disaggregated by appropriate sub-groups, it is unlikely to present a full human rights picture.

Nevertheless, in an effort to improve compliance with human rights principles, committees responsible for monitoring human rights at the United Nations have attempted to document the status, or progress toward realization, of certain rights by the use of indicators. The Economic Committee already requests States parties to provide data in their reports on the following reproductive health-related indicators: infant mortality rate; proportion of pregnant women having access to trained personnel during pregnancy and/or delivery; and maternal mortality rate.[105] In addition, the Committee on the Elimination of Discrimination Against Women (CEDAW) requests States parties to provide them with information regarding: "the existence of special services for women—for example in connection with their reproductive function—and the access to prenatal and post-natal care;" mortality and morbidity rates of mothers and children; the

average number of live births per woman; the number of abortions performed annually; and the number of teenage pregnancies and the age of such pregnant women.[106] It is important to note that none of the reproductive health-related indicators mentioned above specifically address certain components of what we have defined as minimum core content of the right to reproductive health care.

Given the various components of the minimal reproductive health package proposed in this paper, additional indicators need to be developed to monitor compliance with a right to reproductive health care. Although public health statistics and human rights indicators are not one and the same, it is useful to begin by looking at health-related indicators already developed by WHO.

WHO proposed four categories of general health care indicators: health policy indicators; social and economic indicators; provision of health care indicators; and health status indicators (including quality of life).[107] Its criteria for these indicators were that they must be valid, objective, sensitive, and specific.[108] The only reproductive health-related indicators initially proposed by WHO were maternal and infant mortality rates.[109] More recently, WHO has sought information on such indicators for "all identifiable subgroups"—sex, urban and rural areas, geographical/administrative subdivisions and defined socio-economic groups.[110]

Moreover, WHO has also developed indicators specifically relating to maternal health.[111] These include: annual numbers of maternal deaths and maternal mortality ratio; proportion of women attended at least once during pregnancy by trained personnel; proportion of births attended by trained health personnel; proportion of complicated obstetric cases managed at specified facilities; and Cesearian sections as a percentage of all births in the population.[112]

There is an urgent need to develop other indicators that can be used to reflect progress on other aspects of the minimum core content of the right to reproductive health care. Attention should be turned to issues such as family planning, STDs (including HIV/AIDS), quality of care, and the provision of information. For example, important family planning indicators might include: geographic distribution of family planning providers relative to population density; rates of

unmet need for family planning services; rates of usage of different types of contraception; prevalence of infertility; proportion of family planning providers that offer the minimum reproductive health package proposed in this paper; and numbers and categories of medical professionals providing family planning. STD-related indicators would include: general incidence of STDs; prevalence of different types of STDs (including HIV/AIDS); access to diagnosis and treatment of STDs; and proximity of medical personnel trained in STD diagnosis, prevention and treatment.[113] All such data should be disaggregated, where appropriate, by sex, race, age, marital status, socio-economic group, and geographic lines.[114]

Indicators for assessing quality in reproductive health care can also be developed. Examples of quality of care indicators that could realistically be collected by governments through imposition of reporting requirements and without on-the-ground operational research include: education, training, and date of last retraining of clinical staff; availability of clean toilet and running water facilities at the health care delivery site; gender breakdown of staff by staff function; presence of equipment needed to sterilize implements up to clinical standards for the procedure performed at each service location; and degree of privacy afforded to clients during interviews or examinations.

Because a right to reproductive health care involves government action in a variety of areas, indicators regarding the above specific aspects of reproductive health and reproductive health care should be complemented by those relating to government policy regarding general health and reproductive health. Examples include: health expenditure as a percentage of GNP; reproductive health expenditure as a percentage of total health expenditure; categories of reproductive health expenditure; and cost of various reproductive health services.

2. Obligations of Conduct: Monitoring Government Action

To ensure mandatory minimum and specified reproductive health services in a non-discriminatory setting, states must do more than mobilize or re-allocate resources. Governments must legislate, regulate, and take other appropriate actions to enhance and guarantee a right to reproductive health care. In short, they must adopt and enforce laws and policies

that implement access to minimum services for all.[115] They must also refrain from actions that violate the right by undermining access to the minimum required reproductive health care. Thus, the potential range of government action in this area is vast.

Laws and policies can regulate and allocate resources to ensure availability of the minimum package of reproductive health services and information. Under such legal and policy authority, governments should require that training in all aspects of family planning, STD and safe motherhood information and services be part of the curriculum of all formal educational institutions in the health care and public health fields. Governments should provide subsidies for training traditional or other health workers already practicing in the field. Further, governments should provide incentives for medical establishments to engage in creative ways of ensuring quality, reaching low-income groups, and making the most with the least resources, by funding and monitoring demonstration projects concerned principally with meeting minimum core reproductive health care needs. Governments should take steps to ensure that all provider sites have access to the drugs, devices, and equipment necessary for providing the minimum package of reproductive health care.

Governments should also establish gender-sensitive, rights-protective mechanisms for enhancing women's general status and for providing consumers of the minimum package of reproductive health care with meaningful redress for abuses or misinformation. Governments should pass laws protecting women's free and voluntary choice among a selection of fertility regulation methods (including contraception and abortion)[116] as well as clients' rights to informed consent and confidentiality in family planning, STD, and pregnancy-related treatment. Governments should require development of basic informational material on "patients' rights" and on the risks and benefits of all medical procedures within the minimum reproductive health care package. They also should require health workers to be trained to provide information and referral related to issues in reproductive health that go beyond the minimum services provided. Schools should be required to provide basic reproductive health information.

Finally, laws can ensure reproductive health care by re-

moving barriers, such as the legal requirements of spousal consent for abortion, sterilization, and other procedures. Legal restrictions or prohibitions on minimum services should be lifted. Population policies focused on demographic targets to the exclusion of the rights and health of clients should be revised. Restrictions, if not medically necessary, limiting who can provide a service or where it can be provided should be removed.

Part V. Conclusion

The right to reproductive health care is an international human right. Although this paper discusses only immediate obligations of States parties to ensure at least a minimum core package of reproductive health care, international instruments also require States parties to provide a broader range of reproductive health services over time and to take immediate steps towards full realization of the guarantee of the highest attainable standard of health. Yet, there is a stark disparity between the obligations assumed by ratifying governments and their actions at the national level. Millions of people lack access to even basic health care and minimal reproductive health information and services.

The failure of governments to ensure reproductive health care is often attributed to economic limitations and to a lack of political will concerning women's status. Thus, the transformation of international legal obligations into conduct and results at the national level remains a significant challenge. National enforcement of an international human right to reproductive health care will depend upon a diversity of factors such as the nature, power and accessibility of the national legal system, political concern with reproductive health, and the existence of strong non-governmental sectors—such as women's groups and medical groups—that advocate for policy change in this area.

But recognition of an international right to reproductive health care provides a firm legal basis from which to demand national implementation. Further, international reporting and monitoring aspects of the human rights system afford an opportunity to expose governmental neglect of the health needs of women both to national and global approbation. Thus, full recognition and monitoring of a right to reproductive health

care, together with articulation of an immediate governmental obligation to provide a specified minimum package of information and services, will, we hope, contribute to national change. One day, attainment of optimal reproductive health and true reproductive autonomy for women will be a reality.

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References

1. See generally G. Sen and C. Grown, *Development, Crises, and Alternative Visions: Third World Women's Perspectives* (1987); J.S. Jaquette, *The Women's Movement in Latin America: Feminism and the Transition to Democracy* (1989); A. Germain and J. Ordway, *Population Control and Women's Health: Balancing the Scales*, (International Women's Health Coalition, in cooperation with the Overseas Development Council), June 1989.
2. S. Correa and R. Petchesky, "Reproductive and Sexual Rights: A Feminist Perspective," in Sen, Germain and Chen, (eds.), *Population Policies Reconsidered: Health, Empowerment and Rights* (Cambridge, Mass.: Harvard University Press, 1994)pp. 107,109 (emphasis in original).
3. The term "reproductive health care" is used here to denote the medical, public health, and related services and information necessary to maximize the reproductive health of individuals.
4. C. Garcia-Moreno and A. Claro, "Challenges from the Women's Health Movement: Women's Rights Versus Population Control," in Sen, et al., see note 2, pp. 47, 52-54.
5. See generally I. Aitken and L. Reichenbach, "Reproductive and Sexual Health Services: Expanding Access and Enhancing Quality," in Sen, et al., see note 2, pp. 177, 183.
6. M. F. Fathalla, "Reproductive Health in the World: Two Decades of Progress and the Challenge Ahead," in *Reproductive Health: A Key to a Brighter Future* 17 (Geneva: World Health Organization, 1992), (citing A.J., Coale, "Excess Female Mortality and the Balance of the Sexes in the Corporation: An Estimate of the Number of Missing Females," in *Population and Development Review* 17(1991):517-523).
7. The World Bank, *World Development Report 1993: Investing in Health* (New York: Oxford University Press, 1993) pp.66.
8. *Id.*, p. 66.
9. World Health Organization, *Achieving Reproductive Health for All: The Role of WHO*, 7 (Geneva: World Health Organization, 1995), ("reproductive ill-health accounts for over 30 percent of the overall burden of disease and disability among women, compared with only 12 percent for men"). For a discussion of the inadequacies of reproductive health care, see generally Khattab, A.S. Hind, *The Silent Endurance: Social Conditions of Women's Reproductive Health in Rural Egypt*, (Cairo, UNICEF/ Population Council, 1992); R. Dixon-Mueller and J. Wasserheit, *The Culture of Silence: Reproductive Tract Infections Among Women in the Third World*, (New York: International Women's Health Coalition, 1991).

10. *World Development Report 1993*, see note 7, p. 115. It should be noted that reproductive tract infections ("RTIs"), a term encompassing STDs as well as endogenous infections such as yeast or bacterial vaginosis and infections resulting from medical procedures such as abortion or insertion of intrauterine devices, are a very common cause of morbidity among women in poorer countries. J. Wasserheit, "The Significance and Scope of Reproductive Tract Infections Among Third World Women," *International Journal of Gynecology. Obstet.*, supp. 3(1989):145-168.
11. This is in part because they are less detectable and receive later treatment than in men. Health consequences include cervical cancer, infertility, ectopic pregnancy, poor birth outcomes, and chronic pelvic pain. Population Action International, *Preventing AIDS and STDs: Priorities of Family Planning Programs* (May 1995):3; Fathalla, see note 6, p. 13.
12. World Health Organization, Global Program on AIDS, *The HIV/AIDS Pandemic: 1993 Overview*, 5,18 (Geneva: World Health Organization, 1994).
13. Fathalla, see note 6, p. 9.
14. *Id.* One study has indicated that health care delivery systems bear some responsibility for these high rates of maternal mortality. T.K. Sundari, "The Untold Story: How the Health Care Systems in Developing Countries Contribute to Maternal Mortality," in *International Journal of Health Care Services,* 22(1992): 513-528.
15. *World Development Report 1993*, see note 7, p. 52.
16. *Id.*
17. *Id.*
18. *Id.* Table A.9, p. 210. In higher-income nations the annual expenditure on health is $1,340 per capita compared to $41 per capita in the remainder of the world. Total annual health expenditure on a per capita basis ranges from $24 in Sub-Saharan Africa to $21 in India, $11 in China, $77 in the Middle East and $105 in Latin America and the Caribbean.
19. United Nations Development Program, *Human Development Report 1994,* 135 (Table 2) (New York: United Nations, 1994).
20. L. S. Ashford, "New Perspectives on Population: Lessons from Cairo," *Population Bulletin* 50 (Washington, D.C.: Population Reference Bureau, Inc., 1995):1, 9.
21. *Id.*
22. The World Bank, *Effective Family Planning Programs* 31 (Washington, D.C.: The World Bank, 1990).
23. J. A. Ross and E. Frankenberg, *Findings From Two Decades of Family Planning Research* 16 (1993).
24. United Nations, *World Population Trends and Policies: 1987 Monitoring Report* (New York: United Nations, 1988) para. 338, p. 97.
25. J. Bongaarts, "The KAP Gap and the Unmet Need for Contraception," in *Population and Development Review* 17(1991): 293, 312. See also Steven W. Sinding, J. Ross, and G. Rosenfield, *Seeking Common Ground: Demographic Goals and Individual Choice*, 12 Population Reference Bureau (May 1994).
26. *World Development Report 1993,* see note 7, p. 100.
27. *Id.* p. 101.
28. This section of the article does not discuss regional human rights instruments. See, e.g., Article 16 of the African Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/Rev. 5, *reprinted in* 21 I.L.M. 59 (1982); Articles XI, XXIX and XXXV of the American Declaration of the Rights and Duties of Man, approved by the Ninth International Conference of American States, Bogota, Colombia, March 30 to May 2, 1948. Resolution XXX, Pan American Union, Final Act of the Ninth Conference of American States, 38-45 (Washington, D.C., 1948).

29. See, e.g., R.J. Cook, *Women's Health and Human Rights*, (Geneva: WHO, 1994); L.P. Freedman and S.L. Isaacs, "Human Rights and Reproductive Choice," *Studies in Family Planning* 24 (Jan./Feb. 1993):18; R.J. Cook, "International Protection of Women's Reproductive Rights," *N.Y.U. Journal of International Law & Policy* 24(1992): 645; B.E. Hernandez, "To Bear or Not to Bear: Reproductive Freedom as an International Human Right," *Brooklyn Journal of International Law* 17(1991): 309; B. Stark, "International Human Rights and Family Planning: A Modest Proposal," *Denver Journal of International Law and Policy* 18(1989): 59.
30. See C. Bunch, "Women's Rights as Human Rights," in *Gender Violence: A Development and Human Rights Issue*, (Center For Women's Global Leadership, 1991).
31. G.A. Res. 217 A (III), U.N. Doc. A/810, at 71 (1948), *reprinted in* Centre for Human Rights, Geneva, (ed.), *Human Rights: A Compilation of International Instruments*, Sales No. E. 93. XIV.1 (Vol. I, Part I), (New York: United Nations, 1993). See Article 25 of the *Universal Declaration of Human Rights.*
32. G.A. Res. 2200, U.N. GAOR, 21st Sess., supp. No. 16, at 49, U.N. Doc. A/6316 (1966) (*entry into force January 3, 1976*) [hereinafter *Economic Covenant*]. As of December 31, 1994, this treaty has been ratified by 131 states. United Nations, *Multilateral Treaties Deposited With the Secretary-General*, U.N. Doc. ST/LEG/SER.E/13, at 107 (31 December 1994) [hereinafter *Multilateral Treaties*]. An earlier broad statement of the right to health is contained in the preamble to the Constitution of the World Health Organization [hereinafter WHO]. WHO, "Constitution of The World Health Organization," in *Basic Documents* (14th Edition, 1994, adopted in July 22, 1946).
33. Article 12(2) of the Economic Covenant has been characterized by commentators as attempting to establish goals in the form of statistical indicators and risk-groups. See H.L. Fuenzalida-Puelma and S. Scholle Connor, (eds.), "Summary and Analysis," *The Right To Health In The Americas: A Comparative Constitutional Study* 601 (Washington, D.C.: Pan American Health Organization, 1989); P. Alston, "The United Nations' Specialized Agencies and the Implementation of the International Covenant on Economic, Social and Cultural Rights," *Columbia Journal of Transnational Law* 18 (1979):79.
34. G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entry into force September 3, 1981*) [hereinafter Women's Convention], reprinted in *Human Rights: A Compilation of International Instruments*, see note 31, p. 150. As of December 31, 1994, this treaty has been ratified by 138 states. *Multilateral Treaties*, see note 32, p. 161. For a general discussion of the focus on non-discrimination in the Women's Convention, see N. Kaufman Hevener, "An Analysis of Gender Based Treaty Law: Contemporary Developments in Historical Perspective," *Human Rights Quarterly* 8(1986):70.
35. See Articles 12(1) and (2) of the Women's Convention. Article 14(2)(b) requires States parties, on a basis of equality of men and women, to ensure rural women the right of "access to adequate health care facilities, including information, counseling and services in family planning." Article 16 sets forth rights relating to sexual autonomy, child custody and property ownership within the context of marriage.
36. G.A. Res. 2106 A (XX) (*entry into force January 4, 1969*), 660 UNTS 195, [hereinafter "Race Convention"], reprinted in *Human Rights: A Compilation of International Instruments*, see note 31, p. 66. As of December 31, 1994, this treaty has been ratified by 142 states. *Multilateral Treaties*, see note 32, p. 91.

37. G.A. Res. 44/25, U.N. GAOR, 44th Sess., U.N. Doc. A/44/736 (1989) (*entry into force September 2, 1990*) [hereinafter "Children's Convention"] reprinted in *Human Rights: A Compilation of International Instruments*, see note 31, p. 174. As of December 31, 1994, this treaty has been ratified by 168 States. *Multilateral Treaties*, see note 32, p. 191.
38. See Race Convention, note 36, Article 5. The term "public health" differs somewhat from "health." The mandate of public health is to "assure the conditions in which people can be healthy." Institute of Medicine, *Future of Public Health*, (Washington, D.C.: National Academy Press, 1988).
39. See Children's Convention, note 37, Article 1. See generally I. Prieto, "International Child Health and Women's Reproductive Rights," *New York Law School Journal of International Comparative Law* 14 (1993):143.
40. Children's Convention, see note 37, Article 24.
41. See T. C. Van Boven, "The Right to Health," in R. Dupuy, (ed.), *The Right to Health as a Human Right - Workshop, The Hague Academy of International Law and the United Nations University* 54 (The Netherlands: Sijthoff & Noordhoff, Alphen aan den Rijn, 1979).
42. See A.R. Chapman, *Monitoring Women's Right to Health Under the International Covenant on Economic, Social and Cultural Rights*, p. 5 (unpublished paper under the auspices of The Science and Human Rights Program, American Association for the Advancement of Science, November 10, 1994) (describing efforts of an expert seminar convened by the U.N. Centre for Human Rights in 1993 to develop indicators for monitoring compliance with economic, social and cultural rights).
43. P. Alston, "Out of the Abyss: The Challenges Confronting the New U.N. Committee on Economic, Social and Cultural Rights," *Human Rights Quarterly* 9(1987): 332, 352.
44. *Id.*, p. 353.
45. WHO, *Constitution*, see note 32, p. 1; see also Fuenzalida-Puelma & Connor, "Summary and Analysis," see note 33, p. 597.
46. *Id.*
47. See V. Leary, "The Right to Health in International Human Rights Law," *Health and Human Rights* 1(1994): 24; Fuenzalida-Puelma & Connor, see note 33; R. Dupuy, see note 41; Committee on Economic, Social and Cultural Rights, "Report on the Eighth and Ninth Sessions," U.N. Doc. E/1994/23 Supp. No. 3 (1993).
48. R. Roemer, "The Right to Health Care," in Fuenzalida-Puelma & Connor, see note 33, pp. 17-23.
49. Fuenzalida-Puelma & Connor, "Summary and Analysis," see note 33, p. 598.
50. *Id.*, p. 600.
51. See United Nations, "Report of The International Conference on Population and Development," A/CONF.171/13, 18 October 1994. 178 states and regional economic integration organizations were represented at this conference.
52. The endorsement by the United Nations General Assembly of the ICPD Programme somewhat increases its legal significance. See G.A. Res. A/RES/49/120, U.N. GAOR, 29th Sess., [hereinafter "Cairo Resolution"]; see generally *Restatement (Third) of the Foreign Relations Law of the United States* §103, Comment c. The Cairo Resolution affirmed that "[g]overnments should commit themselves at the highest political level to achieving its goals and objectives." *Id.*, p. 3. It emphasized "the need for follow-up activities" and, in deciding on the role of the United Nations General Assembly in the follow-up, included a commitment to "monitor, review and assess the implementation of the Programme . . . at the national, regional and international levels." *Id.*, p. 5. To the extent

that such a resolution reflects international endorsement of a principle and/or practice, it can be used to evidence, interpret or define that standard. See Sir G. Fitzmaurice, "The Future of International Law and of the International Legal System in the Circumstances of Today," *Livre du Centenaire: 1873-1973* 196, 269 (1973) (resolutions can "constitute material influencing the content of law") (emphasis in original).
53. ICPD Programme, see note 52, at Paragraph 1.8 of the ICPD Programme. The ICPD Programme also endorses "reproductive rights," the right to health and other related rights. See Principle 8 and Paragraph 7.3 of the ICPD Programme.
54. *Id.* at Paragraph 7.2.
55. *Id.*
56. *Id.* at Paragraph 7.6. As to abortion, paragraph 8.25 states that while abortion should not be "promoted as a method of family planning," unsafe abortions should be recognized as a public health problem and attempts should be made to eliminate the need for abortion and the need for post-abortion counselling and to ensure safe abortion to the extent it is legal.
57. *Id.* at Paragraphs 7.12 to 7.26.
58. *Id.* at Paragraph 7.12.
59. *Id.* at Paragraph 7.17.
60. *Id.* at Paragraphs 8.19 to 8.27. For a fuller discussion of the health services necessary to promote safe motherhood, see A. Starrs, (ed.), "Preventing the Tragedy of Maternal Deaths: A Report on The International Safe Motherhood Conference," pp. 27-38 (Co-sponsored by the World Bank, WHO and the UN Fund for Population Activities in Nairobi, Kenya, February 1987).
61. ICPD Programme, see note 52, at Paragraph 8.22. But the document stops short of recommending the need to ensure access to abortion. See note 56.
62. *Id.* at Paragraphs 7.27 to 7.33 and Paragraphs 8.28 to 8.35.
63. WHO, "Maternal and Child Health and Family Planning: Quality of Care. A Conceptual and Strategic Framework for Reproductive Health," (Report by the Director-General), p. 3, EB95/28, 13 January 1995 [hereinafter "Maternal and Child Health"].
64. *Id.*, p. 5. See also T. Türmen, *Reproductive Health: WHO's Role in a Global Strategy* 16,19 (Report to a Meeting on the Development and Delivery of Reproductive Health in the Context of Primary Health Care sponsored by the World Health Organization, Division of Family Health, Geneva, 23-24 March 1995) (identifying family planning, STD, and safe motherhood as reproductive health care priorities).
65. *Id.*
66. *Id.*, p. 6.
67. *Id.*
68. *E.g.*, A. Germain, S. Nowrojee and H.H. Pyne, "Setting a New Agenda: Sexual and Reproductive Health and Rights," Sen et al., see note 2, pp. 27, 30; D. Rogow, "Quality of Care in International Family Planning: A Feminist Contribution," (unpublished paper presented to a meeting sponsored by the International Women's Health Coalition and The Population Council, entitled "The Contraceptive Development Process and Quality of Care in Reproductive Health Services," New York City, October 8-9, 1986).
69. See generally R. Dixon-Mueller, *Population Policy and Women's Rights*, (Westport, Conn.; Praeger, 1993); Germain and Ordway, see note 1.
70. See C. Garcia-Moreno and A. Claro, "Challenges from the Women's Health Movement: Women's Rights Versus Population Control," in Sen

et al., see note 2, p. 47; A. Jain, "Walking the Walk: Reproductive Health and Family Planning Programs," in *Reproductive Health Approach to Family Planning* 78, (presentations from a panel at the USAID Cooperating Agencies Meeting compiled by the Population Council, February 25, 1994).
71. See, e.g, T.K. Sundari, "Women and the Politics of Development in India," *Reproductive Health Matters* 1:29 (May 1993).
72. J. Bruce, "Fundamental Elements of the Quality of Care: A Simple Framework," *Studies in Family Planning* 21(March/April 1990):61; *Id.*, p. 62. Referring only to family planning services, several commentators recently stated that access to family planning services is widely understood to be a human right; I. Askew, B. Mensch and A. Adewuyi, "Indicators for Measuring the Quality of Family Planning Services in Nigeria," *Studies in Family Planning* 25(September/October 1994):268, 269.
73. J. Bruce, see note 72. See also S. Kumar, A. Jain and J. Bruce, "Assessing Quality of Family Planning Services in Developing Countries," *The Population Council, Program Division Working Papers No. 2* (October 1989) [hereinafter "Kumar et al., Assessing Quality in Developing Countries"].
74. J. Bruce, see note 72, p. 63 (emphasis in original). As women themselves express their desired "scope and priorities for reproductive health care," the most prominent components of quality care are: "women's own needs as individuals should dominate as the service-giving goal; a broader spectrum of women's reproductive health needs should be met (information about sexuality, the introduction of diagnosis and treatment of STDs, and clinical attention to other gynecological ailments); and service providers should consult [with women] more closely when designing all aspects of care." J. Bruce, "Women's Interests: How Can Family Planning Managers Respond?," in A. Jain, (ed.), *Managing Quality of Care in Population Programs* 40 (West Hartford, Conn.: Kumarian Press, 1992).
75. J. Bruce, see note 72, pp. 63-64. These elements were initially intended to set the standards necessary for expressing the judgment about "whether quality is good or bad." *Id.*, p. 62. Indeed, the creators of the quality of care framework have explicitly declined to participate in the setting of standards that would be applicable to all programs. See A. Jain, J. Bruce and B. Mensch, "Setting Standards of Quality in Family Planning Programs," *Studies in Family Planning* 23(November/December 1992):392.
76. ICPD Programme, see note 52, at Paragraph 7.23.
77. A driving force behind the push for a focus on the quality of care has been a concern over the distortion of quality and health concerns wreaked by an exclusive focus on quantitative measures of program performance such as: acceptance rate, continuation rate, couple years of protection ("CYP") and contraceptive prevalence rate ("CPR"). See A. Jain and J. Bruce, "A Reproductive Health Approach to the Objectives and Assessment of Family Planning Programs," in Sen et al., see note 2, pp. 193-209. Jain and Bruce suggest an alternate index for assessing program performance, nicknamed the "HARI index" (Helping Individuals to Achieve their Reproductive Intentions). *Id.*,
p. 200.
78. Some aspects of quality have no objective or universally applicable standard of measurement. They necessarily vary depending on local circumstances. Thus, appropriate services may include voluntary HIV testing in a relatively high HIV infection area; basic manual breast exams in an area with unusually high prevalence rates of breast cancer; or immunization referral where immunization levels are low. But these services may or may not be considered a universal core element of quality care. Moreover, elements of some medical protocols (e.g., particular tests required

before certain contraceptive methods may be obtained) may be characterized as "medical barriers," see J. D. Shelton, M. A. Angle and R. A. Jacobstein, "Medical Barriers to Access to Family Planning," *The Lancet* 340 (1992):1334, in one context and as crucial requirements of quality care in another, see generally J. Cottingham and S. Mehta, "Medical Barriers to Contraceptive Use," *Reproductive Health Matters* 19(1993):97.

79. K. Roth, "Domestic Violence as an International Human Rights Issue," in R. J. Cook, (ed.), *Human Rights of Women: National and International Perspectives* (Philadelphia: University of Pennsylvania Press, 1994):326, 321. In short, it is crucial that poor conditions that are simply poor because they occur in low-income countries not be viewed as synonymous with human rights violations. See note 90.

80. *Report of the Subcommittee on Quality Indicators in Family Planning Service Delivery* at 4-5 (submitted to the Agency for International Development's Task Force on Standardization of Family Planning Program Performance Indicators, October 1990) [hereinafter "*The Report*"].

81. For example, indicators such as providers' understanding of clients' backgrounds, providers' biases and protection of clients' modesty require "situation analysis" to assess accurately. See Kumar et al., see note 73, pp. 15-17, 23-24. Situation analysis is a "diagnosis of strengths and weaknesses of family planning subsystems and quality of care at a representative sample of SDPs [service delivery programs] using both interviews of staff and clients and observations...." R. Miller, I. Askew and A. Fisher, "Situation Analysis Studies as a Means of Identifying and Solving Service Delivery Problems: The Development and Evolution of the Family Planning Situation Analysis Methodology, in The Population Council, *Africa Operations Research and Technical Assistance Project, Proceedings of End-of-Project Conference* (4-7 October 1993) p. 66 [hereinafter "Development and Evolution"].

82. For a discussion of possible quality of care indicators, see discussion in Part IV (B) *infra*.

83. This section discusses only the obligations imposed upon States parties pursuant to specified international human rights treaties. We do not examine the customary international law jurisprudence regarding state responsibility. For a discussion of this topic, see I. Brownlie, "State Responsibility, Part I," (Oxford: Clarendon Press, 1993); P. Allott, "State Responsibility and the Unmaking of International Law," *Harvard International Law Journal* 29(1988):1; "International Law Commission," 2 *Year Book of the International Law Commission*, U.N. Doc. A/CN.4/SER.A/1975/Add.1 (1986). (EDITOR'S NOTE: For further discussion of governmental obligations concerning women's right to health, see D. Sullivan, this volume).

84. "Summary Record of the Twenty-Ninth Session" [1977] 1 *Year Book of the International Law Commission* 214-233, U.N. Doc. A/CN.4/SER.A/1977; G. S. Goodwill-Gill, "Obligations of Conduct and Result," in Philip Alston and Katarina Tomasevski,(eds.), *The Right to Food*, (Boston: Martinus Nijhoff Publishers, 1984).

85. Although governments also have an immediate obligation to take "steps" to fulfill guarantees beyond the minimum, we focus primarily on the immediate obligation to provide at least a minimum package of information and services in the here and now.

86. Committee on Economic, Social and Cultural Rights [*hereinafter* "Economic Committee"], "General Comment No. 3. The Nature of State Parties Obligations," in *Report on the Fifth Session*, Economic and Social Council, E/1991/23, E/C.12/1990/8, Supplement No. 3 (26 November-14 December 1990):83.

87. Article 2 is regarded as imposing a hybrid mixture of obligations of conduct and of result. P. Alston and G. Quinn, "The Nature and Scope of State Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights," *Human Rights Quarterly* 9 (1987):156, 185.
88. See generally D.M. Trubek, "Economic, Social, and Cultural Rights in the Third World: Human Rights Law and Human Needs Programs," in T. Meron, (ed.), *Human Rights in International Law: Legal and Policy Issues* 205 (Oxford: Clarendon Press, 1984):213-217; L. B. Sohn, "The New International Law: Protection of the Rights of Individuals Rather than States," *American U. Law Review* 32(1982):1-64; *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, U.N. Doc. E/CN.4/1987/17, Annex, *reprinted in Human Rights Quarterly* 9(1987):122-135 [hereinafter "Limburg Principles"].
89. Economic Committee, "Report on the Fifth Session," see note 86, paragraph 10, p. 86.
90. For a state to "be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations." *Id.*, paragraph 10, p.86.
91. See Article 12(2) of the *Economic Covenant* (reduction of infant mortality and conditions assuring medical services), see note 32; Article 12(2) of the *Women's Convention* (family planning services in connection with pregnancy), see note 34; Article 24(2) of the *Children's Convention*, see note 37.
92. Article 1 of the *Women's Convention*, see note 34; Article 1 of the Race Convention, see note 36; Article 2(2) of the *Children's Convention*, see note 37.
93. *Economic Covenant* at Article 2(2); but see Article 2(3) (discussing "developing country" treatment of "non-nationals"). Also UN Commission on Human Rights, *Non-Discrimination in the Field of Health*, preamble, Resolution 1989/11 (March 2, 1989).
94. *Economic Covenant*, see note 32, Article 2(1).
95. *Id.*
96. *Economic Committee*, "Report on the Fifth Session," see note 86, paragraph 7, p. 85.
97. *Women's Convention* see note 34, Articles 2(a), 2(b), 2(e), 2(f), 2(g) and 5(a). See also *Race Convention*, see note 36, Articles 2(1)(c), 2(1)(d), 2(2) & 7 and *Children's Convention*, see note 37, Articles 3(2), 3(3) and 4.
98. Note that although in the section above we have addressed only immediate obligations, the monitoring standards discussed in this section are applicable to all — immediate and progressive — government obligations.
99. D. Turk, *The New International Economic Order and the Promotion of Human Rights* 3-4, U.N. Doc. E/CN.4/Sub.2/1990/19 (6 July 1990) [hereinafter *"The New International Order"*].
100. E.g., WHO, *Development of Indicators for Monitoring Progress Towards Health for All by The Year 2000* [hereinafter "By the Year 2000"] 13-14 (1981).
101. Turk, *The New International Order*, see note 99, pp. 4-5.
102. D. Turk, *The Realization of Economic, Social and Cultural Rights* 4-5, U.N. Doc. E/CN.4/Sub.2/1991/17 (18 July 1991); see also *id.*, pp. 4-5,10 (listing several recurring themes identified by UNRISD through several case studies).
103. Turk, see note 99, p. 9.
104. D. McGranahan, E. Pizarro and C. Richard, *Measurement and Analy-*

sis of Socio-Economic Development 9 (Geneva: United Nations Research Institute for Social Development, 1985).
105. United Nations Centre for Human Rights and United Nations Institute for Training and Research, *Manual on Human Rights Reporting Under Six Major International Human Rights Instruments* (New York: United Nations, Sales No. E.91.XIV.I, 1991):64.
106. *Id.*, p. 168.
107. *By The Year 2000,* see note 100, p. 7.
108. *Id.*, p. 12. *"More will be gained by selecting a small number of relevant indicators for which a country can obtain the information within its resources than by aiming at comprehensiveness." Id.*, p. 17 (emphasis in original).
109. *Id.*, p. 18.
110. WHO, *Seminar on Appropriate Indicators to Measure Achievements in the Progressive Realization of Economic, Social and Cultural Rights* 4, HR/GENEVA/ 1993/SEM/BP.19 (25-29 January 1993).
111. WHO, *Indicators to Monitor Maternal Health Goals: Report of a Technical Working Group,* WHO/FHE/MSM/94.14 (1993).
112. *Id.*
113. See, for example, second periodic reports submitted by States parties to the Covenant containing rights covered by Articles 10 to 12, in accordance with the second stage of the programme established by the Economic and Social Council in its resolution 1988 (LV), Addendum 24, Denmark, UN Doc.E/C.12/1988/4 of 10 February 1988, paragraph 130.
114. As to indicators related to the provision of basic reproductive health-related information, it would be unrealistic to propose statistical indicators for the desired "result", that is, an informed populace. However, the "conduct" required can be measured and is discussed below.
115. See generally M. I. Roemer, *National Health Systems of the World. Volume 1. The Countries* 72, (Oxford University Press, 1991).
116. Hence, the *Women's Committee* requests States parties to provide them with information regarding the legal regulation of abortion, its legality and the enforcement of the law, including any sanctions imposed, and any court cases registered in this regard. United Nations, *Manual on Human Rights Reporting,* see note 105, p. 168.