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INTEGRATION OF THE HUMAN RIGHTS OF WOMEN AND THE GENDER PERSPECTIVE

VIOLENCE AGAINST WOMEN

Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, in accordance with Commission on Human Rights resolution 1997/44

Addendum

Policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women

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Introduction

1. The present report examines policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women. Many forms of violence against women result in violations of women's reproductive rights because such violence often imperils their reproductive capacities and/or prevents them from exercising reproductive and sexual choices. Similarly, many reproductive rights violations constitute violence against women per se, defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".[1] Inadequate levels of knowledge about human sexuality and inappropriate or inadequate reproductive health information and services, culturally-imbedded discrimination against women and girls, and limits on women's control over their own sexual and reproductive lives all contribute to violations of women's reproductive health.

2. While such practices may be sanctioned by moral or community codes,[2] they nonetheless violate a woman's fundamental right to reproductive health and may constitute violence against women. Reproductive rights are a fundamental and integral part of women's human rights, and, as such, are enshrined in international standards that transcend cultural, traditional and societal norms.

I. INTERNATIONAL LEGAL FRAMEWORK

3. As defined and recognized by Governments at the International Conference on Population and Development ("ICPD") in 1994, reproductive health entails that people have the ability 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 definition is "the right of men and women to be informed and to have access to safe, effective, affordable and acceptable 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".[3]

4. Reproductive rights rest on recognition of the basic right of all couples and individuals to have the information and means to decide freely and responsibly the number, spacing and timing of their children, and the right to attain the highest standard of sexual and reproductive health, free of discrimination, coercion and violence. The Platform for Action adopted at the 1995 Fourth World Conference on Women further recognizes that "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". [4]

5. The right to reproductive health implicates the right to sexuality and sexual autonomy. While sexual and reproductive health rights are linked, they are not coterminus. Underscoring the recognition in the Cairo Programme of Action of the right to have a satisfying and safe sex life, paragraph 96 of

the Beijing Platform for Action states that, “the human rights of women include the 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”. Sexual rights include the right to information, based upon which one can make informed decisions about sexuality; the rights to dignity, to privacy and to physical, mental and moral integrity in realizing a sexual choice; and the right to the highest standard of sexual health. [5]

6. Reproductive and sexual health rights under international human rights law derive from a number of separate human rights. The Convention on the Elimination of All Forms of Discrimination against Women (“CEDAW Convention”) recognizes that the ability of a woman to control her own fertility is fundamental to her full enjoyment of the full range of human rights to which she is entitled. In this vein, article 12 provides for equality in access to health care, including family planning, 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.

7. The CEDAW Convention also contains several provisions that, in addressing the exploitation of women, are relevant to women’s reproductive health. For instance, article 6 requires States to take all appropriate measures to suppress all forms of trafficking and exploitation of prostitution, while article 16.2 requires States to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.

8. Recognized as customary international law, the fundamental human rights to be free from torture, to be free from gender discrimination and the inherent right to life, are directly applicable to the issue of violence against women and women’s reproductive health. [6] In addition to these basic norms, international human rights law contains non-discrimination provisions crucial to the realization of women’s human rights, including, for example, the right to modify customs that discriminate against women. [7]

9. Working to further the goals of the CEDAW Convention, the Committee on the Elimination of Discrimination against Women (CEDAW) has focused particularly on ending discrimination against women in national AIDS strategies and has called on States parties to give special attention to the subordinate position of women in some societies which makes them especially vulnerable to HIV infection. [8] Together with the Sub-Commission on Prevention of Discrimination and Protection of Minorities, the Committee has paid special attention to the area of traditional practices harmful to the health of women. Such practices include, but are not limited to, female genital mutilation, dangerous birth practices and son preference. The Committee has called on States parties to take appropriate measures to eradicate the practice of female genital mutilation, which could include the introduction of appropriate educational and training programmes and seminars, the development of national health policies aimed at eradicating female genital mutilation in public health facilities, and the provision of support to national organizations working for these goals. [9]

10. The world conferences have helped to articulate the legal framework and policy goals for the enforcement of women's right to reproductive health. For instance, with respect to the question of abuse by health workers, the ICPD Programme of Action urges Governments at all levels "to institute systems of monitoring and evaluation of user-centred services with a view to detecting, preventing and controlling abuses by family-planning managers and providers and to ensure a continuing improvement in the quality of services" (para. 7.17). To this end, Governments should ensure conformity to human rights and to ethical and professional standards in the delivery of family planning and related reproductive health services aimed at ensuring responsible, voluntary and informed consent.

11. The Beijing Platform for Action, in turn, urges Governments to "ensure that all health services and workers conform to human rights and to ethical, professional and gender-sensitive standards in the delivery of women's health services aimed at ensuring responsible, voluntary and informed consent; encourage the development, implementation and dissemination of codes of ethics guided by existing international codes of medical ethics as well as ethical principles that govern other health professionals" (para. 106 (g)). Moreover, recognizing that confidentiality and accessibility of information are critical to the realization of women's reproductive rights, the Platform for Action directs Governments to "redesign health information, services and training for health workers so that they are gender-sensitive and reflect the user's ... right to privacy and confidentiality" (para. 106 (f)).

12. The world conferences on human rights and women's rights have also addressed specific practices violative of women's human rights, which directly impact women's reproductive health. For instance, the Beijing Platform for Action declared that "any harmful aspect of ... traditional, customary or modern practices that violates the rights of women should be prohibited and eliminated" (para. 224).

13. Other relevant practices specifically addressed in world conference documents include gender-based violence and all forms of sexual harassment and exploitation, child marriages and female genital mutilation. [10] The Beijing Platform for Action also addressed the problems of early pregnancy associated with child marriage, urging Governments "to enact and strictly enforce laws concerning the minimum legal age of consent and the minimum age of marriage and raise the minimum age for marriage where necessary" (para. 274).

14. Moreover, in order to facilitate the realization of women's human rights, the World Conference on Human Rights stressed the importance of "working towards the ... eradication of any conflicts which may arise between the rights of women and the harmful effects of certain traditional or customary practices, cultural prejudices and religious extremism" (VDPA, Part II, para. 38).

II. GENERAL FINDINGS

A. Reproductive health consequences of violence against women

15. Serious violations of a woman's right to reproductive health can result from practices that themselves constitute violence against women. Examined below are the reproductive health consequences that result from rape, domestic violence, female genital mutilation, early marriages and early childbearing, sex-selective abortions, female infanticide, and trafficking and forced prostitution. Each of these practices jeopardizes women's reproductive freedom and rights. The following forms of violence may have devastating physical and psychological health consequences. States have an obligation to address violence against women by enacting and effectively implementing and enforcing laws prohibiting and punishing all forms of such violence as well as by enacting policies and programmes to avert its commission. Numerous international instruments have recognized State responsibility in this regard.

1. Rape

16. As the Special Rapporteur has pointed out, rape as the ultimate violent and degrading act of sexual violence, constitutes "an intrusion into the most private and intimate parts of a woman's body, as well as an assault on the core of her self". [11] While rape commonly occurs as a manifestation of extreme sexual violence against individual women, rape is increasingly used as a weapon of war, political repression, or ethnic cleansing.

17. United Nations and other sources have documented numerous cases of rape in the context of armed conflict. During the conflict in the former Yugoslavia, for example, tens of thousands of Muslim women were held in "rape camps" where they were raped repeatedly and forced to bear children against their will. Genocidal rape, often followed by murder, was carried out against even larger numbers of Tutsi women during the 1994 conflict in Rwanda. During the recent riots in Indonesia in May 1998, there was widespread rape of ethnic Chinese women. Rape may be used to make women "unmarriageable" in the communities in which they live. Rape may be used not only to punish the victim, but also to punish male family members, who are often forced to witness the act.

18. Rape committed as a part of political repression is prohibited under international law as torture or cruel, inhuman or degrading treatment. The International Covenant on Civil and Political Rights and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment both promote the dignity and physical integrity of the person and prohibit torture and cruel, inhuman, or degrading treatment. The Convention on the Elimination of All Forms of Discrimination against Women has also been interpreted by CEDAW to prohibit all forms of violence against women, including rape. Finally, the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women also specifically prohibits rape and other forms of violence.

19. Numerous international authorities have also recognized rape as a form of torture when rape is used to punish, coerce or intimidate, and is performed by State agents or with their acquiescence. Moreover, rape committed as a

weapon of war is explicitly prohibited under international humanitarian law governing both international and internal conflicts. The Rome Statute of the International Criminal Court (the ICC Statute) explicitly defines, for the first time under international humanitarian law, rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization and other forms of sexual violence as both crimes against humanity and war crimes.[12] The ICC Statute places rape and other sexual violence on par with serious international crimes and rejects previous references under earlier humanitarian law treaties to sexual violence as exclusively "crimes against honour" and "outrages upon personal dignity" rather than violence.

20. Whatever the motive, rape may have a devastating effect on a woman's reproductive health. Often, the physical and psychological harm caused by rape temporarily or permanently affects women's sexual and reproductive autonomy and has lasting reproductive health consequences for the victims. Globally, the physical consequences of rape and sexual violence account for approximately 5 per cent of disease among women.[13] Numerous surveys done in the United States indicate that up to 30 per cent of women who are raped acquire a sexually transmitted disease (STD) as a result. Rape victims are at a higher risk of STDs, such as AIDS, gonorrhoea, syphilis, genital herpes and chlamydia, as well as the long-term health consequences of STDs such as pelvic inflammatory disease and cervical cancer. Women biologically are more vulnerable to acquiring STDs and the consequences are more serious and life-threatening for women than for men. Further, they are exposed to the risk of unwanted pregnancy.

21. Rape can also cause profound emotional trauma that manifests itself in depression, inability to concentrate, sleep and eating disorders, feelings of anger, humiliation and self-blame, as well as severe sexual problems, including problems of arousal, fear of sex, and decreased sexual functioning. The adult pregnancy rate associated with rape is estimated to be 4.7 per cent.[14] For a woman impregnated by rape, abortion may be legally denied, practically obstructed or unacceptable to the woman herself on religious or cultural grounds, thus compounding the woman's physical and emotional trauma with a constant physical reminder of her rape.

2. Domestic violence

22. Domestic violence can have serious repercussions for women's reproductive health, particularly where the battered woman is pregnant. Studies indicate that domestic violence directly affects women's use of family planning and contraception. This dynamic is exemplified by the case of M, a married Ugandan mother who was beaten by her husband for not producing more children, and further beaten when her husband discovered that she was using contraceptives.[15] In a survey of women in Texas, more than 12 per cent of the 1,539 respondents had been sexually abused by a current or former male partner after the age of 18. Of these 187 women, 12.3 per cent reported that they had been prevented from using birth control, and 10.7 per cent stated that they had been forced to get pregnant against their will.[16]

23. Sexuality and reproduction is one of many ways in which batterers seek to exercise power and control over battered women. In exercising their reproductive rights and seeking reproductive health services, battered women

often risk their physical and psychological safety, making them vulnerable to increased violence. Battered women have gone to great lengths to prevent unwanted pregnancies by their abusers when their access to contraceptives has been limited, in some cases resorting to clandestine and unsafe abortions.

24. The battering may escalate during and immediately after pregnancy, resulting in severe health problems for both the mother and the baby. Interviews with battered women in Santiago indicated, for example, that for 40 per cent of these women, the battering increased during pregnancy. Studies further indicate that in Malaysia, 68 per cent of battered women were pregnant, [17] while in the United States, 25 per cent of battered women are beaten during pregnancy. In addition to the physical injury resulting from the battery, battering during pregnancy can result in premature labour, miscarriages, recurrent vaginal infections, delivery of premature or low-birth-weight infants with reduced chances for survival, sexual dysfunction, fear of sex, and sexually transmitted diseases. Because pregnancy may be the only time when some women come into regular contact with health-care providers, prenatal care visits may provide a good opportunity to screen for physical violence.

3. Trafficking/forced prostitution

25. Each year, thousands of young girls and women all over the world are trafficked into forced prostitution. They may be abducted or lured by traffickers with promises of higher-paying jobs than they can find locally, only to be sold to a brothel owner and forced into prostitution. Using a combination of threats, physical force, illegal confinement and debt bondage, brothel owners prevent escape or negotiation by these women

26. Unable to negotiate the terms of sex, women trafficked into forced prostitution find themselves increasingly exposed to serious health risks, including sexually transmitted diseases. These women have virtually no say in whether or not to service a particular customer, how many customers to accept in a given day, condom use, or the type of sex. [18] Preliminary medical research suggests that the younger the girl, the more susceptible she may be to HIV because the mucous membrane of the genital tract, being thinner than that of a grown woman, serves as a less efficient barrier to viruses. In many cases, brothels restrict the use of condoms, as clients are willing to pay higher rates for unprotected sex. Sexual intercourse with multiple clients can lead to painful vaginal bruises and abrasions, which increases the women's exposure to STDs. Moreover, subjected, in effect, to multiple rapes, these women suffer serious psychological consequences from their repeated victimization.

27. Apart from the risk of infection through sexual intercourse with numerous clients, the increasing use of contraceptive injections in brothels puts these women at further risk of disease, as brothel owners often use the same, possibly contaminated, needle multiple times. The contraction of AIDS could lead to death, and other STDs contracted by these women may ultimately leave them infertile. In cultures in which the primary purpose of marriage is procreation, infertility can render these women unmarriageable, as can pre-marital sex or perceived promiscuity. Shunned by their communities as a result, these women may be forced to return to prostitution in order to

support themselves, thus continuing the vicious cycle of sexual servitude. Reports also indicate that there have been cases of forced sterilization of brothel inmates, hysterectomies during abortion being the most typical.

4. Cultural practices

28. Some cultures that place a high value on women's sexual and reproductive capacities seek to control these capacities through practices that violate women's reproductive rights and constitute violence against women. Blind adherence to these practices, lack of information and education regarding their health consequences, and State inaction with respect to their elimination all contribute to the perpetuation of these practices, with harmful consequences for women's reproductive health.

29. The Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the Declaration on the Elimination of Violence against Women, and the Beijing Declaration and Platform for Action all require States to refrain from invoking any custom, tradition, or religious consideration to justify cultural practices that constitute violence against women and violations of women's reproductive health. The following analysis examines ways in which States' failure to meet this requirement has led to severe, adverse health consequences violative of women's reproductive rights.

(a) Female genital mutilation

30. Female genital mutilation (FGM) has been recognized by the Special Rapporteur as a form of violence against women. Female genital mutilation is the act of partially or totally removing the external female genitalia. It is estimated that 130 million women worldwide have undergone FGM, and that nearly 2 million undergo the procedure every year.[19] Female genital mutilation is practised in approximately 40 countries, primarily in East and West Africa, countries in the Arabian Peninsula, and in Asia. An increasing number among immigrant communities in Australia, Canada, Europe and the United States of America also practise this custom. The frequency and extent of the mutilation varies from country to country.

31. Female genital mutilation results from patriarchal power structures that legitimize the need to control women's lives. The practice "arises from the stereotypical perception that women are the principal guardians of a community's sexual morality and also the primary initiators of unchastity".[20] Female genital mutilation curtails women's sexual expression in order to ensure women's chastity. In some cultures, FGM is considered necessary for the best interest of the girl, in that it prepares the girl for the pain of childbirth. The symbolic significance marks the girl's rite of passage into womanhood and the acceptance of her responsibilities towards her future husband and her community, thus improving her "marriageability".

32. The ritual significance of the practice often masks the devastating physical and psychological effects it has on the woman. Traditionally performed by birth attendants who use crude and unhygienic instruments, the "operation" creates a serious risk of local and systemic infections, abscesses, ulcers, delayed healing, septicaemia, tetanus and gangrene.

Short-term complications can include severe pain and haemorrhage that can lead to shock or even death, while long-term complications can include urine retention, resulting in repeated urinary infections; obstruction of menstrual flow, leading to frequent reproductive tract infections and infertility; and prolonged and obstructed labour.[21] Furthermore, FGM can result in psychological problems such as chronic anxiety and depression. The cycle of pain continues when cutting and restitching is carried out to accommodate sexual intimacy and childbirth.

33. Because the procedure can render sexual intercourse extremely painful, FGM fulfils the social goal of suppressing women's sexual desire. A major study in Egypt has suggested that, in communities where FGM is practised, women's sexuality is affected by both the degree to which the inhibition of sexual expressions are internalized through socialization, as well as by the type of FGM operation women undergo.[22] Girls are taught to inhibit their sexuality in preparation for marriage because of the social value that requires "respectable" women to not appear "lustful".[23] Studies also suggest that circumcised women living outside of communities where FGM is practised may have problems developing their sexual identity.[24]

34. The practice of female circumcision has been condemned as a violation of the rights of women and girls. Female genital mutilation affects women's enjoyment of their lives and reproductive health in a manner that denies liberty and security to women, and subjects them, usually at a young age, to physical violence and serious health problems. In an effort to prevent such violations, the ICPD Programme of Action urges Governments to prohibit FGM where it is practised and to give "vigorous support to efforts among non-governmental and community organizations and religious organizations to eliminate such practices" (paras. 4.22, 5.5 and 7.40).

35. The Beijing Declaration and Platform for Action emphasizes the importance of education to aid understanding of the health consequences of the practice. Numerous African countries, including Ghana, Burkina Faso, Egypt and the Gambia, as well as some countries with significant African immigrant populations, such as the United Kingdom, Sweden, France, Australia and the United States, have criminalized the practice. The ineffectiveness of such laws in decreasing the prevalence of FGM attests to the need for Governments to engage in education and community outreach efforts aimed at addressing the deeply ingrained cultural attitudes that continue to foster the practice in the face of the potential criminal penalties. Moreover, there is a need to address the medicalization of FGM. In many urban areas of Africa and the Middle East, FGM is increasingly practised by trained health personnel. The procedure is done by personnel working at hospitals and health centres and include those trained by international non-governmental organizations.

(b) Child marriages and early childbearing

36. Though declining in frequency, child marriage remains a serious problem in many countries. In Nigeria, a quarter of all women are married by the age of 14, one half by the age of 16 and three quarters by the age of 18. In Botswana, 28 per cent of women who have ever been pregnant were pregnant before reaching the age of 18. In Jamaica, one third of all births are to

adolescent mothers, while in Peru, Colombia and El Salvador 13 per cent or 14 per cent of women between 15 and 19 are already mothers.[25]

37. Based on the view that virginity is essential in a bride, in some societies, girls are married off at a young age, often to much older men. As a result of the early marriages, these young girls are traumatized by adult sex and are forced to bear children before their bodies are fully mature. A number of human rights treaties require that marriage be entered into with the free consent of men and women of full age. A young bride lacks the maturity and knowledge to consent not only to the marriage itself, but also to the sexual acts she would be forced to engage in once married. Moreover, laws and policies allowing for a lower age of marriage for women stereotypes women as childbearing machines and denies them equal standing with men with respect to their right to consent to marriage.

38. Early marriage can lead to early childbearing and frequent pregnancies, resulting in physical stress for the young mother and underweight babies, which in turn accounts for the high infant mortality rates in regions where early marriages are the norm. It is estimated that without obstetric care, women who give birth before they reach the age of 18 are three times as likely to die in childbirth as women aged 20-29 under similar circumstances.[26] Prolonged or obstructed labour due to underdeveloped pelvic bones can cause vesico-vaginal (VVF) or recto-vaginal fistula (RVF), or the tearing of the walls between the vagina and the bladder or the rectum. If left untreated, this condition can cause a woman to leak urine and faeces. This condition usually results in infertility. In many cases, VVF victims are abandoned by their husbands and, in some cases, forced into prostitution to support themselves. Moreover, the lengthening of a woman's reproductive period caused by early marriage can have other adverse effects on her health, including malnutrition.

(c) Sex-selective abortion/female infanticide

39. A cultural preference for sons can result in violence against female foetuses and girl children. In many cultures, a son is considered an asset to the family as it is he who carries the lineage forward, whereas a daughter is considered a social and economic burden to the family. These pressures compel pregnant women to resort to sex-selective abortions to abort female foetuses. In communities in which women do not have access to sex-selective abortions – for example, where the amniocentesis or sonogram technology necessary to detect the sex of the foetus is lacking, or where abortion is prohibited – women and men may resort to female infanticide to avoid having to raise a daughter.

40. Critical to the effectiveness of government policies undertaken to address sex-selective abortions and female infanticide is a comprehensive understanding of the cultural attitudes that promote the practice. For instance, studies indicate that failure of the "cradle scheme" used in certain regions in India – under which mothers can leave unwanted female infants in their cradles, to be given to other families – is attributable to strong views regarding caste and community. In these regions, parents might prefer the death of the foetus or infant over the thought of their child growing up with people of another community or caste.

41. The strong preference for sons can leave women vulnerable to abuse by unscrupulous health-care workers. In Haryana, India, for example, more than 50 per cent of the 80 doctors in town make money from sex determination tests and abortions, and 50 per cent of the ultrasound tests are carried out by ultrasound operators with no special training. The ultrasound tests may be carried out as early as the second month of pregnancy – when it is impossible to detect the sex of the foetus – pronounced as female and aborted.

42. Sex-selective abortions and female infanticide can have an adverse impact on the reproductive health of future generations of women in the community. The sex ratio of the population may gradually become tilted against females, and result in burdening the available fewer number of women to produce the required number of children to sustain the community.

43. Both the ICDP Programme of Action and the Beijing Declaration and Programme for Action call for the elimination of all forms of discrimination against the girl child and the root causes of the harmful and unethical practices of female infanticide and prenatal sex selection.

B. Violence within the context of reproductive health policy

44. Violence against women may occur within the context of reproductive health policy. Violence and violations of women's reproductive health may result either from direct State action, via harmful reproductive policies, or from State failure to meet its core obligations to promote the empowerment of women. Direct State action violative of women's reproductive rights can be found, for example, in government regulation of population size, which can violate the liberty and security of the person if the regulation results in compelled sterilization and coerced abortion or in criminal sanctions against contraception, voluntary sterilization and abortion. State failure to meet its core obligations, on the other hand, can be found, for example, in a failure to effectively implement laws prohibiting FGM, or a failure to set a minimum legal age for marriage. This failure to empower women thus leaves women vulnerable to the numerous forms of violence perpetrated by private individuals and institutions.

45. Within the context of reproductive health policy, reports indicate that State policies contribute to violence against women, manifested in forced abortions, forced sterilization and contraception, coerced pregnancy, and unsafe abortions. Potentially – if not actually – resulting in the death of the victim, all of these practices violate a woman's right to life. Indeed, the World Health Organization estimates that 75,000 women a year die from excessive bleeding or infection caused by unsafe abortions alone. Forced abortions, forced contraception, coerced pregnancy and unsafe abortions each constitute violations of a woman's physical integrity and security of person. In cases, where, for instance, government officials utilize physical force and/or detain women in order to force them to undergo these procedures, these practices may amount to torture and cruel, inhuman and degrading treatment.

46. Governmental neglect of preventable causes of violence against women also constitutes an affront to women's human rights. In order to be truly universal, international human rights law must be applied both to require States to take effective preventive and curative measures with regard to

violence against women, and to afford women themselves the capacity to achieve their own empowerment, security and self-determination. Specifically, international human rights treaties require States to take measures to ensure women's rights, including women's rights to be free, through their empowerment, from all forms of discrimination and violence; to achieve their rights to liberty and security; and to have access to health care, including health information and education, and social services necessary to treat and prevent victimization by all forms of violence.[27]

47. Implicit in the promotion of these rights is the State's obligation to act with due diligence to prevent, investigate, and punish violations. States whose Governments leave private violations of human rights unaddressed breach their duty under international law to protect human rights. States must also facilitate realization of these rights by employing governmental means to afford individuals the full benefit of human rights, including taking appropriate legislative, administrative, judicial, budgetary, economic and other measures to achieve women's full realization of their human rights.[28]

1. Violations resulting from direct State action

48. Examined below are State policies that deny women their dignity and right to self-determination by diminishing their capacity to make reproductive choices according to their own wishes and life circumstances. The denial of these rights can lead to devastating health consequences – in many cases, compromising a woman's right to life and security of person.

(a) Forced abortions

49. State policies that encourage or sanction forced abortions violate a woman's right to physical integrity and security of person, and the rights of women to control their reproductive capacities. State policies aimed at controlling population growth can result in coerced abortions.

50. China's one-child policy demonstrates this linkage between reproductive health policy and violence. Through this policy the Chinese Government restricts the number of children a married couple may have, and, at times, violently enforces this policy through forced abortions. Under the one-child policy, single women and migrant women unable to return to their home regions are subject to compulsory abortions. Family planning officials in China allegedly employ intimidation and violence to carry out the policy, sometimes removing women from their homes in the middle of the night to force them to have abortions. Former family planning officials reported having detained women who were pregnant with "out-of-plan" children in storerooms and offices for as long as necessary to "persuade" them to have an abortion. Once a woman relented, the official would escort her to the hospital and wait until the doctor could provide the official with a signed statement documenting that the abortion had been performed. Relatives of those attempting to avoid forced abortion are also subject to detention and ill-treatment.

(b) Forced sterilization

51. A severe violation of women's reproductive rights, forced sterilization is a method of medical control of a woman's fertility without the consent of a

woman. Essentially involving the battery of a woman – violating her physical integrity and security – forced sterilization constitutes violence against women. Amnesty International has condemned such actions as amounting to cruel, inhuman and degrading treatment of detainees or restricted persons by government officials.

52. In countries where there is widespread sterilization of women for contraceptive purposes, many women either do not sign the consent form or are not aware that they are consenting to be sterilized. Most are not informed about the irreversible nature of the operation or of alternative contraceptive methods. When discussing contraceptive methods, health care workers often pressure women to undergo sterilization. Reports indicate that in Peru, in an effort to meet Government-imposed sterilization quotas that offer promotions and cash incentives, State health workers promise women gifts of food and clothing if they agree to undergo sterilization. In so doing, these health workers take advantage of poor rural women, many of whom are illiterate and speak only indigenous Indian languages. Women who refuse to consent to sterilization face threats that their food and milk programmes will be terminated. Those coerced into undergoing sterilization are reportedly then operated upon under unsanitary conditions.

53. In China, forced sterilization has been carried out by or at the instigation of family planning officials against women who are detained, restricted, or forcibly taken from their homes to have the operation. Official family planning reports and regulations indicate the use of forced sterilization. For example, a 1993 county report by family planning officials in Jiangsi Province stated that "[w]omen who should be subjected to contraception and sterilization measures will have to comply". Reports also indicate that despite the assurances by the State Family Planning Commission that "coercion is not permitted", there has been no indication of sanctions being taken against officials who perpetrate such violations.

(c) Forced contraception/provision of unsafe or inappropriate methods of contraception

54. The manner in which contraceptive methods are delivered may result in a denial of a woman's right to bear children or may punish her for exercising that right. [29] For instance, certain policies, such as those recently passed by the United States Government, which base welfare funding on the number of children a woman has, in effect penalize women on welfare for having babies, and thereby limit a woman's right to decide the number of children she wants to bear. Some Governments use less subtle means to force women to use contraception.

55. Contraception may be coerced or forced by virtue of a refusal by health workers to remove contraceptive devices. For instance, because Norplant must be surgically inserted and removed, a woman who wishes to have the device removed can find herself at the mercy of health workers. In Bangladesh, only 15 per cent of women with Norplant were even aware that Norplant could be removed on request. Moreover, those who attempted to request removal after suffering serious side effects were routinely denied, and even subject to verbal abuse. In the United States, African-American women in rural Georgia reported that Government-funded Medicaid would pay for Norplant implants but

would only remove them for “medical reasons”. Yet, when various women complained of continuous bleeding, headaches, massive hair loss and heart palpitations, the local medical authorities considered these “inconveniences” rather than medical problems. If women had these implants removed before the end of two years, they would have to pay $300 to reimburse the State for the cost of insertion. [30]

56. Forced contraception may also be used to punish women criminal offenders. For example, Norplant is used to punish female offenders and women who use drugs during their pregnancy – even where there is no connection between the punishment and the crime – thereby punishing the woman not for her illegal use of drugs, but for her reproductive capacity. Indeed, research has revealed that drug-addicted women who are pregnant receive harsher sentences than drug-addicted women who are not pregnant. In the United States, courts have offered low-income female offenders release on probation in exchange for their consent to long-acting contraceptive implants. [31] These practices send the disturbing message that certain groups in society do not deserve to procreate.

(d) Denial of contraception/coercive pregnancy

57. While forced sterilization is a form of violence within the context of reproductive health, so is the restriction on and prohibition of access to voluntary contraception. Acts deliberately restraining women from using contraception or from having an abortion constitute violence against women by subjecting women to excessive pregnancies and childbearing against their will, resulting in increased and preventable risks of maternal mortality and morbidity. According to the International Planned Parenthood Federation, in a number of countries in French-speaking Africa, for example, a 1920 French law punishing the advertising, sale and distribution of contraception as well as “incitement to abortion” remains on the books, chilling the free exercise of reproductive choice.

58. Social pressures, combined with the threat of domestic violence, may result in restrictions on a woman’s ability to exercise reproductive and sexual autonomy. A woman’s ability to bear children is linked to the continuity of families, clans and social groups, and, as such, has been the object of regulation by families, religious institutions and governmental authorities. The importance of procreation to a particular community can put enormous pressure on women to bear children. The social stigma attached to the use of birth control – i.e. the implication that a woman who uses birth control must be promiscuous, or the belief that birth control is an affront to her partner’s masculinity – may also serve, in effect, to limit women’s access to birth control.

(e) Abortion

59. In countries where abortion is illegal or where safe abortions are unavailable, women suffer serious health consequences, even death. Women with unwanted pregnancies are forced to resort to life-threatening procedures when an abortion performed under appropriate conditions would otherwise be safe.

60. Of countries with populations greater than 1 million, 52 countries permit abortion to save the life of a woman, 23 to preserve physical health, 20 to preserve mental health, 6 for economic and social reasons and 49 on request. [32] Many countries such as Austria, France, Italy, the Netherlands and Canada have enacted liberal abortion laws, which are consistent with women's right to liberty, health, life and security. However, countries such as Chile, Nepal and El Salvador consider abortion criminal. For example, the El Salvador Penal Code, which entered into effect in January 1998, considers abortion a "crime relating to the life of a human being in formation", and eliminates all exceptional circumstances in which abortion was previously allowed and increases the penalties for abortion. [33] In Germany, the State can discipline women and even use criminal sanctions to require women to bring their unwanted pregnancies to term. [34]

61. WHO estimates that there are approximately 40 million abortions annually, of which 26 to 31 million are legal and 20 million are illegal and thus unsafe. [35] Women of financial means may have access to safe abortions while poor women must resort to clandestine abortions in extremely unsafe conditions. Even where abortions are legal, the scarcity of available facilities and the potentially prohibitive cost of legal abortions may compel women to seek clandestine abortions by untrained practitioners utilizing crude abortion methods.

62. The difficulties associated with obtaining an abortion in India, where abortion is legal, is demonstrative of these problems. In India, only 1,800 of the 20,000 primary health centres have Medical Termination of Pregnancy facilities. Moreover, government authorities insist on a sterilization procedure after the abortion, and while abortion is technically free of charge, the charges incurred for blood, saline and drugs, in addition to the cost of bribing hospital employees, cause women to seek the services of illegal practitioners. Women with unwanted pregnancies are forced to rely on low-cost alternatives which are often undertaken by untrained practitioners under unsanitary conditions.

63. Not only is there an urgent need for safe and affordable abortion, but there is also a need for assurances that the abortions will be kept confidential, especially given the stigma associated with abortion in certain cultures. Protests and even death threats by anti-choice extremists, such as those belonging to "Operation Rescue" in the United States of America, pose another serious obstacle to obtaining safe abortions. The efforts of anti-choice extremists are not limited to local clinics, but threaten to render inaccessible abortions abroad. For example, the "global gag rule", which has been introduced and narrowly defeated in the United States Congress during each of the past four legislative sessions, would prohibit any overseas non-governmental organization or multilateral organization from receiving United States funds if that organization uses its own funding to provide abortion-related services or engage in pro-choice lobbying efforts. If passed, such legislation would obstruct crucial dialogue among policy makers and non-governmental organizations on the issue of how to combat unsafe abortion and how to respond to violence against women, which may require provision for abortions in, for example, cases of rape.

64. The unavailability of safe, confidential and affordable abortion services can have severe consequences for women with unwanted pregnancies. Nearly 20,000 Indian women die every year due to unsafe abortions.[36] Attempts to induce abortion through the use of herbs or roots through the vaginal route, the injection of acid-like fluids into the womb, the use of caustic soda, arsenic and double doses of contraceptive pills, and the insertion of surgical probes, plant stems, wires and toothpicks have harmful reproductive health consequences and may fail to result in successful abortions.

65. Crude abortions can have serious health complications, including allergic reactions, death by kidney or respiratory collapse due to highly toxic fluids, or even death. WHO estimates that, globally, 75,000 women die from excessive bleeding or infection caused by unsafe abortions every year. A far greater number contract infections that cause fever, pain and, in many cases, infertility – which can be devastating in cultures where a woman's worth depends on her ability to produce children, particularly sons. Most women who undergo an unsafe abortion require some form of subsequent health care, yet most developing country health systems do not provide emergency medical care for women suffering from abortion complications and, as a result, treatment is often delayed and ineffective, with life-threatening consequences.

2. Violations resulting from State failure to meet minimum core obligations

66. Just as direct State action can result in violence against women, a State's inaction or failure to meet minimum core obligations can result in further violence against women. Government failure to take positive measures to ensure access to appropriate health-care services that enable women to safely deliver their infants as well as to safely abort unwanted pregnancies may constitute a violation of a woman's right to life, in addition to the violation of her reproductive rights. Along the same lines, government failure to provide conditions that enable women to control their fertility and childbearing, as well as to bring voluntary pregnancies to term, constitutes a violation of a woman's right to security of the person.

(a) Failure to provide comprehensive health services

(i) Government funding for research into women's reproductive health issues

67. The key to the development of effective policies addressing a minimum core of obligations is a showing by the State that it has based its reproductive policies on reliable data regarding the incidence and severity of diseases and conditions hazardous to women's reproductive health, and on the availability and cost effectiveness of preventive and curative measures. As underscored in the Beijing Platform for Action (para. 109 (h)),

> "[Governments should] (h) Provide financial and institutional support for research on safe, effective, affordable and acceptable methods and technologies for the reproductive and sexual health of women and men, including more safe, effective, affordable and acceptable

methods for the regulation of fertility, including natural family planning for both sexes, methods to protect against HIV/AIDS and other sexually transmitted diseases and simple and inexpensive methods of diagnosing such diseases, among others ...".

68. All too often, State policies derive from the perceived moral requirements of the community, or even the needs and priorities of the health profession, rather than a careful epidemiological and social assessment of women's health needs. As a result institutions dedicated to promoting women's reproductive health lack adequate access to scientific resources to contribute to the understanding of factors relating to reproductive health and to expand reproductive choice. Research into the prevention, detection and treatment of mammary, cervical and uterine tumors would significantly improve women's morbidity and mortality rates, as these three diseases account for almost half the deaths caused by malignant tumors in women aged between 15 and 64.

(ii) Maternal mortality

69. Government failure to prevent maternal mortality compromises a woman's right to life and her right to security of person. In spite of information from the international Safe Motherhood initiative demonstrating the preventability of pregnancy-related deaths, many States fail to take the necessary steps to reduce maternal mortality.

70. Maternal deaths are deaths among women who are pregnant or who have been pregnant during the previous 42 days.[37] The risks and complications related to pregnancy and childbirth are among the leading causes of maternal deaths. Most maternal deaths are preventable. While some countries have taken steps to reduce maternal mortality,[38] it is estimated that over 585,000 deaths occur among women of reproductive age due to preventable complications in pregnancy, childbirth, or unsafe abortions. These are not mere misfortunes or unavoidable natural disadvantages of pregnancy but rather preventable injustices that Governments are obliged to remedy through their political, health and legal systems.[39] Ninety-nine per cent of these deaths happen in developing countries. Of these, South Asian countries contribute the highest number of maternal deaths, followed by African countries and Latin American countries. One in every 10,000 women dies in Northern Europe compared to 1 in 21 women in Africa.[40] A woman's lifetime risk of dying from pregnancy-related complications or during childbirth is 1 in 48 in the developing world, versus 1 in 1,800 in the developed world.[41]

71. Both the ICPD Programme of Action (para. 8.21) and the Beijing Platform for Action (para. 106(i)) urge Governments to reduce maternal mortality by one half of their 1990 levels by the year 2000, and to cut the levels by an additional one half between the years 2000 and 2015. However, as the target date nears, maternal deaths remain a common occurrence. The most common causes for the great number of maternal deaths are the woman's age, spacing of pregnancies, and the desirability of the pregnancy. The woman's health, dietary needs, financial resources and her unequal status in society, and the resulting poor schooling and early marriage of girls, are also relevant factors, as is the lack of adequate training for health care workers in the

areas of prenatal care, delivery and post-partum care. Moreover, cultural and religious beliefs may serve to mask the incidence of maternal deaths that could be prevented by inexpensive and available interventions.

72. Broad-ranging social and economic reforms have had an adverse effect on maternal mortality. In the Latin American and Caribbean region, structural adjustment policies during the 1980s and early 1990s and health care reform resulted in a shift from the Government as a key provider of health services to a promoter of either private or public general health insurance. This has had an adverse impact on the ability of low-income groups – especially rural and indigenous people – to gain access to health care services.[42] As a result, rural and urban clinics do not have the facilities to perform Caesarean operations or to treat other complicated births. The staff lack training in family planning methods, and the nurse-to-patient and doctor-to-patient ratios are very high. Even where adequate medical facilities exist, the cost of these services can be prohibitive. With respect to the Asian region, the recent economic crisis has had an impact on maternal care. [43]

(iii) Non-provision of contraceptive information

73. A failure of Governments and service providers to recognize a woman's right to control her fertility may translate into a failure to provide accurate and objective information regarding the full range of contraceptive methods. Non-provision of contraception and contraceptive advice may also result from discrimination in the delivery of health services. In some societies, contraceptive advice is not given to unmarried persons or adolescents. Even where a woman is married, in the absence of authorization by her husband or male partner, she may be denied access to reproductive health services and health services more generally.

74. Because husbands often take little or no responsibility for contraception and vasectomy is rarely mentioned or considered as a contraceptive measure, women must act to control their fertility in order to preserve their own health. Most women have some idea about contraceptive methods, be they traditional ways or modern methods. However, misinformation and fears of the ill effects of contraceptive methods on the health and the ability to bear children often deter women from using them.

75. The unmet need for family-planning services is substantial. It is estimated that 350 million out of 747 million married women of reproductive age are not using contraceptives. One hundred million would prefer to space their next birth or not have any more children. Twenty-five per cent would prefer to delay or avoid pregnancy.[44] In China contraceptive use is prevalent (91 per cent), but knowledge of how contraceptive methods work and are used is limited. The story of a newlywed Chinese girl who was not using contraception even though she did not want a child provides a telling account. When asked why she did not use contraception, she replied,

> "I read in a journal that recently married couples would not get pregnant because the successful meeting of mature sperm and egg takes over 48 hours. We are newly married and have sexual intercourse almost

> every night. I thought that with old and new sperm eating each other, none of them would survive more than 48 hours. Therefore, I thought no pregnancy would happen." [45]

76. In order to provide full recognition of a woman's right to reproductive autonomy, reproductive health care must provide complete and impartial information regarding the full range of contraceptive methods and reproductive health issues generally.

(b) Failure to address physical and psychological violence perpetrated by health care providers

77. In some countries, physical and psychological violence against women of low socio-economic status occurs in public health facilities. These violations are often ignored or inadequately addressed by administrative and judicial authorities. A recent report documents numerous cases in Peru of physical and psychological violence against women who use public reproductive health services, including rape, assault, and numerous forms of verbal abuse. For example, María testified that:

> "the doctor made me enter and didn't let my sister or my father come in and told the nurse to stay outside. Then he told me to take off my clothes, my pants and blouse, and to lay down on the table. There I was without clothes. Then the doctor told me: 'So you are pregnant? Who could you have been with?' I felt him put his fingers in my private parts. He was hurting me a lot, and then I realized that both his hands were on my waist and he was thrusting himself into me and hurting me. He was abusing me. I was scared and he told me that 'that is how it is'. Then I pushed him away and started to cry, he told me that I had nothing wrong with me and to put on my clothes." [46]

78. Even in the relatively few cases in which women were willing to file formal complaints, health officials and the judicial system failed to provide adequate remedies to the victims. Such violations are clearly extreme examples of government failure to meet core obligations to provide comprehensive and quality reproductive health care services to all women, regardless of their social and economic status in their societies.

III. RECOMMENDATIONS

79. States should ratify all international human rights instruments. States should withdraw any reservations to these instruments, particularly those regarding the human rights of women.

80. States must ensure that the foremost concern in the formulation and implementation of reproductive health and family planning programmes is respect for the individual rights of women.

81. States should create and promote a process of cross-sectoral and interdisciplinary collaboration, focusing on training and capacity-building for treaty bodies, agencies and non-governmental organizations on the issue of women's reproductive and sexual health.

82. States must exercise due diligence to prevent violence against women in order to protect their human rights, including, among others, specific laws to combat rape, domestic violence, trafficking and forced prostitution, female genital mutilation, sex-selective abortions and female infanticide.

83. States should pass and enforce a minimum legal age limit for marriages. States must undertake training programmes to sensitize health workers providing reproductive health services – including those who work in antenatal clinics, maternity services and family planning services – to the possibility of gender violence among their clients.

84. States should take all measures necessary to eradicate discrimination and violence against women who use public health care services, and to guarantee institutional settings in which women's human rights are respected.

85. States should provide increased education to health workers and ensure easy availability of information about the human rights implications of reproductive health, including State obligations under international law.

86. States should provide training to health workers in women's reproductive rights, including training with respect to how to identify violations during physical examinations, as well as how to provide appropriate intervention information.

87. States should implement training programmes to provide those who work in minority communities with linguistic and cultural training sensitive to the differences of their clientele.

88. States must take appropriate measures to monitor reproductive health services and ensure that these services are offered without any form of discrimination, coercion or violence, and that information disseminated by health workers is comprehensive and objective.

89. States should provide financial and institutional support for the creation of support groups, shelters, crisis centres with counselling and legal assistance, and women-only police stations with trained workers and 24-hour hotlines.

90. States should provide financial and institutional support for research on safe and effective methods for the regulation of fertility, protection against sexually transmitted diseases, including HIV/AIDS, and confidential testing and diagnosis of STDs.

91. States should provide financial and institutional support for research into the prevention, detection and treatment of illnesses associated with women's reproductive health, particularly those with the highest indicators of maternal mortality and morbidity.

92. States should engage in systematic research and collection of data with respect to the incidence of violations of women's reproductive and sexual health, and use such data to inform future State policies that impact women's rights to reproductive and sexual health.

93. States should provide financial and technical support for organizations and institutions dedicated to promoting women's reproductive and sexual health, and engage in collaborative relationships with such institutions and organizations in the formulation of government reproductive health policies.

Notes

1/ Article 1 of the Declaration on the Elimination of Violence against Women, proclaimed by the General Assembly by its resolution 1998/104 of 20 December 1993.

2/ Harmful Traditional Practices Affecting the Health of Women and Children, Fact Sheet No. 23, United Nations, Geneva, 1995.

3/ Programme of Action of the International Conference on Population and Development, para. 7.2. In Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. 1, resolution 1, annex.

4/ Platform for Action of the Fourth World Conference on Women, para. 96. In Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995 (United Nations document, Sales No. E.96.IV.13), chap. I, resolution 1, annex I.

5/ Yasmin Tambiah, "Sexuality and human rights", in Margaret Schuler, From Basic Needs to Basic Rights, 1995, p. 37.

6/ Freedom from torture is reflected, inter alia, in article 7 of the Universal Declaration of Human Rights, article 7 of the International Covenant on Civil and Political Rights, and article 37 of the Convention on the Rights of the Child; freedom from gender discrimination is reflected, inter alia, in article 2 of the Universal Declaration of Human Rights, article 2.2 of the International Covenant on Economic, Social and Cultural Rights, article 2.1 of the International Covenant on Civil and Political Rights, article 3 of the Convention on the Elimination of All Forms of Discrimination against Women; the right to life is reflected, inter alia, in article 3 of the Universal Declaration of Human Rights, article 6 of the International Covenant on Civil and Political Rights, article 6 of the Convention on the Rights of the Child.

7/ Convention on the Elimination of All Forms of Discrimination against Women, article 2 (f) and (g) and article 5 (a); Convention on the Rights of the Child, article 24.3.

8/ General Recommendation No. 15, adopted by the Committee on the Elimination of All Forms of Discrimination against Women (ninth session, 1990) (see A/45/38).

9/ General Recommendation No. 14, adopted by the Committee on the Elimination of All Forms of Discrimination against Women (ninth session, 1990). Ibid.

10/ Vienna Declaration and Programme of Action (VDPA) adopted by the World Conference on Human Rights (A/CONF.157/23), Part I, para. 18 and Part II, para. 49; ICPD Programme of Action, para. 5.5.

11/ Diana Scully and Joseph Marolla, "Riding the bull at Gilley's: Convicted rapists describe the rewards of rape", in Pauline B. Bart and Eileen Geil Moran (eds.), Violence Against Women: The Bloody Footprints, 1993, p. 42. Cited in E/CN.4/1997/47, para. 19.

12/ Rome Statute of the International Criminal Court, adopted by the United Nations Diplomatic Conference of Plenipotentiaries on the Establishment of an International Criminal Court on 17 July 1998 (A/CONF.183/9), arts. 7 and 8.

13/ International Family Planning Perspective, vol. 22, No. 3, September 1996, p. 118. Rebecca J. Cook and Mahmoud F. Fathalla, "Advancing Reproductive Rights Beyond Cairo and Beijing".

14/ Centers for Disease Control, National Center for Injury Prevention and Control, Rape Fact Sheet.

15/ L. Heise, J. Pitanguy and A. Germaine, "Violence Against Women: The Hidden Health Burden". World Bank Discussion Papers, 1994, p. 10.

16/ Ibid.

17/ Rashida A. Abdullah, Gender Based Violence as a Health Issue: The Situation and Challenges to the Women's Health Movement in Asia and the Pacific, 1997.

18/ Human Rights Watch, Rape for Profit: Trafficking of Nepali Girls and Women to India's Brothels, p. 66.

19/ Center for Reproductive Law and Policy, "Reproductive Freedom in Focus - Legislation on Female Genital Mutilation in the United States", October 1997, p. 2.

20/ Rebecca J. Cook, "International Protection of Women's Reproductive Rights", New York University Journal of International Law and Politics, vol. 24, Winter 1992, No. 2, p. 682.

21/ Center for Reproductive Law and Policy, "Women's Reproductive Rights in Mexico: A Shadow Report", December 1997, p. 24 (prepared for the Eighteenth Session of the Committee on the Elimination of All Forms of Discrimination against Women).

22/ Supra note 19.

23/ Abdel Halim, "Female Circumcision and the Case of Sudan", p. 253, in Margaret Schuler, From Basic Needs to Basic Rights, 1995.

24/ Ibid.

25/ Center for Reproductive Law and Policy, “Women of the World: Laws and Policies Affecting Their Reproductive Lives - Latin America and the Caribbean”, 1997, p. 13.

26/ Supra note 13 p. 117.

27/ Rebecca J. Cook, “Violence Against Women: Enforcing and Improving Legal Measures” (paper presented at the WHO/Federation of Gynaecology and Obstetrics (FIGO) Pre-Congress Workshop on the Elimination of Violence Against Women: In Search of Solutions, WHO Regional Office, Copenhagen, 30-31 July 1997).

28/ Ibid.

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30/ Internation Reproductive Rights Research Action Group, Statement and recommendations, prepared in response to Special Rapporteur's request for comments, September 1998, p. 14.

31/ Jeff Goldliar, “The Sterilization of Women with an Intellectual Disability”, University of Tasmania Law Review, 1990-91, p. 10.

32/ Centre for Reproductive Law and Policy, The World's Abortion Laws, 1998.

33/ Supra note 25, p. 98.

34/ Supra note 20, p. 705.

35/ Nafis Sadik, The State of World Population 1995, United Nations Population Fund, p. 47.

36/ “The Double Death Syndrome”, India Today, 31 August 1996.

37/ Supra note 20, p. 646.

38/ Mexico, Ethiopia, South Africa, Argentina, Bolivia and Guatemala have implemented strategies to train rural midwives, provide protection to women during pregnancy and breastfeeding, train health professionals and educate women on the risks of pregnancy.

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40/ International Solidarity Network, “Women's Reproductive Rights in Muslim Communities and Countries”, 1994, p. 47.

41/ Population Reference Bureau, “Making Pregnancy and Childbirth Safer”, Washington, D.C.

42/ Supra note 19, p. 10.

43/ Asia-Pacific Regional Consultation with the United Nations Special Rapporteur on Violence against Women, Colombo, 11-12 August 1998.

44/ Cook and Fathalla, supra note 13, p. 119.

45/ Reproductive Health Matters - Promoting Safer Sex, Number 5, May 1995, p. 96.

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