

CAIRO + FIVE: REVIEWING PROGRESS FOR WOMEN FIVE YEARS AFTER THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT

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In 1994, 184 United Nations Member States met in Cairo to consider the broad issues of and interrelationships between population, sustained economic growth and sustainable development, and advances in the health, education, economic status and empowerment of women. The consensus reached at this meeting was expressed as a 20-year Programme of Action. In 1999, over 170 government delegations and about 200 non-governmental organizations met again to discuss progress and obstacles, and to decide on steps for further implementation of this International Programme of Action. Referred to as the ICPD (International Conference on Population and Development) Plus Five, this review showed that the ICPD Programme of Action has resulted in significant changes in health policies and programmes in a number of countries. Challenges to overcome and examples of failure were also noted during this review. This article reports the results of the ICPD Plus Five review with a particular focus on women's health.

INTRODUCTION

When 184 United Nations Member States came together five years ago at the International Conference on Population and Development ("ICPD") in Cairo, they forged what commentators everywhere described as a "remarkable consensus". With strong support from women's groups and non-governmental organizations ("NGOs") from around the world, these governments agreed to a sweeping 20-year Programme of Action¹ ("POA") that places the health and rights of women at the centre of population and development programmes. As an international consensus document, the Programme of Action has great significance and authority.

The POA was, and still is, innovative in many ways. It recognizes the interrelationships between consumption and production patterns, economic development, access to education, population growth, demographic structure and environmental degradation. It emphasizes the importance of empowering women and ensuring gender equality and equity. It asserts the reciprocal relation between rights, that is, that respect for human rights is a prerequisite for the enjoyment of the highest attainable standard of health, and conversely, that the right to control every aspect of one's health and sexuality forms an important basis for the enjoyment of other rights. It puts aside demographic targets to focus on the needs and rights of individual women and men, and promotes a comprehensive reproductive health approach. It recognizes that men must take responsibility for their sexual behaviour, and that their full involvement in reproductive health and child rearing is crucial. It addresses the need to provide adolescents with appropriate information and services, and includes important commitments to reduce infant and child

mortality.

But the ICPD Programme of Action also deserves notice because it has had significant impact on health policies and programmes in a number of countries. Many women's groups around the world have been able to use it effectively to lobby their governments for new legislation or programmes in matters of health and rights. While there are still many challenges to overcome and examples of failure, the ICPD was clearly a watershed.

The importance of the ICPD Programme of Action was made clear at the five-year review of implementation of the POA (called ICPD Plus Five), which took place at the United Nations between March and July 1999. Over 170 government delegations and about 200 NGOs gathered in New York to discuss progress and obstacles, and to decide on concrete steps for further implementation. ICPD Plus Five showed that the ICPD has changed the international discourse on matters of population. "Reproductive health" and "reproductive rights" are now part of the language of diplomacy. Even the governments that opposed the ICPD Programme of Action in 1994, turned, at ICPD Plus Five, into staunch defenders of every word contained in the POA, quoting it chapter and verse throughout the negotiations as the new standard.

ICPD Plus Five highlighted many examples of success at the national level. Some less encouraging statistics were also brought to the world's attention in the areas of maternal mortality, HIV/AIDS and sexually transmitted diseases ("STDs"), and violence against women. But, once again, the international consensus upheld the 1994 Programme of Action. And, in spite of vocal opposition to "new language" by the same small group of conservative states that had opposed the 1994 consensus, governments were able to reach progressive new agreements on important issues such as abortion, HIV/AIDS, maternal mortality and contraception.

The discussion that follows highlights what the ICPD Programme of Action means for women's health, including examples of successes, failures and challenges from various in-country experiences; presents the results of the ICPD Plus Five review of the implementation of the Programme of Action; and outlines the next steps. But before engaging in this discussion, we will briefly analyze the legal nature of the ICPD Programme of Action as a consensus document and its relation to international law.

THE ICPD PROGRAMME OF ACTION AND INTERNATIONAL LAW

While not a treaty with legally binding provisions, the ICPD Programme of Action is nevertheless a valuable international consensus document. It is the result of intergovernmental negotiations at the highest level, and was agreed to by 179 states. As such, it is an important tool for understanding and interpreting international law in the fields of health and rights, particularly those of women.

The ICPD Programme of Action states at the outset that the principles behind its provisions are to be found in existing international treaties - instruments such as the International Covenant on Civil and Political Rights ("ICCPR"), the International Covenant on Economic, Social and Cultural Rights ("ICESCR"), the Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW"), and the Convention on the Rights of the Child ("CRC"). The ICPD Programme of Action also states that respect for and promotion of human rights must be a key feature of population and development programmes: "While the International Conference on

Population and Development does not create any new international human rights, it affirms the application of universally recognized human rights standards to all aspects of population programmes."²

With respect to the right to health, principle 8 of the Programme of Action reiterates article 12(1) of the ICESCR.³ It goes on to include the principle stated in article 16(e) of CEDAW regarding the right to decide freely and responsibly on the number and spacing of children,⁴ but recognizes that this right does not belong solely to men and women in the context of marriage, but should more appropriately be recognized for "couples and individuals":

Principle 8. Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.

[emphasis added]

The Programme of Action then details what the right to health means with respect to reproductive and sexual health:

7.2. 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. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

7.3. Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination,

coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

[emphasis added]

Other human rights provisions can also be argued to underlie the understanding of the highest attainable standard of sexual and reproductive health that was developed at the ICPD. For example, the right to liberty and security of the person⁵ obviously forms the basis for the recognition that coercion and violence have no place in health policies and programming.⁶ Similarly, the right to security of the person generates the commitment to end female genital mutilation,⁷ and to ensure that legal abortion is safe.⁸ Rebecca Cook⁹ has argued persuasively that the right to life¹⁰ forms the basis for the commitment to reduce maternal mortality.¹¹

Article 12 of CEDAW, which mandates elimination of discrimination against women in the field of health care, underlies the agreement to remove all legal, medical, clinical and regulatory barriers to family planning services" - examples of which include laws or policies that require women requesting health services to obtain the authorization of their husbands. Article 13(1) of the CRC acknowledges the right of the child to seek, receive and impart information and ideas of all kinds. This can be argued to provide the basis for the requirement that adolescents have access to information on reproductive health, STDs and HIV/AIDS, family planning and sexual abuse.¹³

In 1995, the Committee on the Elimination of Discrimination Against Women - the treaty body charged with reviewing states' compliance to CEDAW - decided that it would also monitor implementation of the ICPD Programme of Action with respect to women's human rights. At the same time, it decided it would use elements of the Programme of Action to set standards to determine whether states are complying with their human rights obligations to eliminate discrimination against women in the field of health.¹⁴ Further, in preparing its General Recommendation number 24 on Women and Health adopted at its 20th session in February 1999, the Committee stated that it expressly took into account the ICPD Programme of Action, as well as the Programme of Action of the 1993 World Conference on Human Rights, and the Platform for Action of the 1995 Fourth World Conference on Women.¹⁵

In the field of health, we would argue that the ICPD Programme of Action can therefore be best understood as an authoritative, but not binding, interpretation of international law.

WHAT THE ICPD PROGRAMME OF ACTION MEANS FOR WOMEN'S HEALTH: EXAMPLES OF SUCCESS, DIFFICULTIES, OBSTACLES

Perhaps the most striking aspect of the ICPD Programme of Action is precisely the attention it devotes to the issue of women's health, and in particular to their reproductive and sexual health. One must remember that, before 1994, the sight of international diplomats tackling issues such as sexuality, abortion, female genital mutilation, violence against women and reproductive tract infections ("RTIs") was far from commonplace. This neglect of women's health changed dramatically at ICPD, and the issues were taken up and extended in Beijing a year later at the Fourth World Conference on Women. While the POA addresses many dimensions of women's health, we will discuss five of these in particular.

First, the Programme of Action marks a paradigm shift in international agreements on population. Previous agreements at the Conferences on Population in Bucharest (1974) and Mexico City (1984) had focused on the threat of population "explosion" and the need to set demographic targets to limit growth. This, in turn, had led to a focus on contraception without much regard for other aspects of reproductive health, and an almost complete lack of discussion of sexuality or gender discrimination. In a number of countries, demographic targets had led to coercion in family planning and incentives for health providers to recruit clients for contraceptive services or sterilization.

In Cairo, the international community took a very different approach, emphasizing an understanding of reproductive health as indivisible from issues of equality, empowerment and rights. It also placed the health and rights of women at the centre of the agreement, with the understanding that, when women are empowered and have access to health services, education and income, they make childbearing decisions that correspond to their desires and needs and are rational for society. The international community expressly rejected the use of incentives and targets in family planning services.¹⁶ Moreover, the move away from the demographic paradigm towards a reproductive health approach makes the POA relevant for all countries, and not only for those facing rapid population growth.

Second, the consequence of these changes in outlook was the agreement that family planning programmes should not stand alone, but become part of fully integrated reproductive health services within the primary health care system. States agreed that reproductive health care should be made available to all individuals of appropriate ages as soon as possible and no later than the year 2015.¹⁷ They decided that reproductive health care in the context of primary health care should include, among other services and in addition to family planning: education and services for all stages of pregnancy and delivery; prevention and treatment of infertility; safe abortion services in cases where it is legal, and management of the consequences of abortion for all women who experience them; treatment of RTIs and STDs; and information, education and counselling on human sexuality and responsible parenthood. States also agreed that effective referral for treatment should always be available. The integrated reproductive health approach means that contraception, rather than being offered in a "vertical" program, is to be only one element of the services offered to meet the overall health needs of the client. For example, health providers should not recommend intrauterine devices ("IUDs") without considering the

likelihood that family planning clients may be at risk of STDs, and they should also offer advice on prevention of STDs, use of barrier methods such as the male and female condoms, testing and treatment.

Third, the requirement that birth control services and information be provided without coercion, and that women and men be allowed to make reproductive decisions freely and responsibly, means that quality of care and respect for patients must become priorities. In the case of family planning services, for example, this means that full information must be given to clients about the advantages and disadvantages of various contraceptive methods, and that a full range of safe and effective methods must be offered. In different cultural and social contexts, this will obviously call for different approaches - more time might be needed to discuss benefits and side effects and answer questions in contexts where clients are not already aware of modern methods, are less educated, or are reluctant to challenge the authority of health providers. In this respect, the Programme of Action also emphasizes the importance of involving clients in the design, implementation and evaluation of reproductive health programming, and of establishing partnerships between governments and NGOs to define policies, provide services and monitor and evaluate them.¹⁸

Fourth, the POA recognizes the urgent need to reduce maternal mortality and morbidity. Paragraph 8.21 of the Programme of Action calls for a reduction of maternal mortality levels to one-half the 1990 levels by the year 2000. Targets were set for countries with intermediate levels of mortality (maternal mortality rates should be below 100 per 100,000 live births by 2005, and below 60 per 100,000 live births by 2015) and for countries with the highest levels of maternal mortality (rates below 125 per 100,000 live births by 2005, and below 75 per 100,000 live births by 2015).¹⁹ Further, all countries (including developed ones) agreed to reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem, and agreed that "disparities in maternal mortality within countries and between geographic regions, socio-economic and ethnic groups should be narrowed".²⁰

Fifth, given the 80,000 maternal deaths and millions of injuries and illnesses caused by clandestine and illegal abortions every year, states recognized unsafe abortion as a major public health concern.²¹ States did not go as far as calling for access to safe abortion services in all cases, but they agreed that, in circumstances where it is not against the law, abortion should be performed in safe conditions. Moreover, they agreed that in all cases, women should have access to quality services for the management of complications arising from abortion (whether performed legally or not).

In spite of these progressive commitments to women's health, the Programme of Action has shortcomings, which can perhaps be explained by the necessity to reconcile the diverse views and values of the governments present in Cairo. The POA commitments are prefaced by a "sovereignty clause" which provides that the "implementation of the recommendations contained in the Programme of Action is the sovereign right of each country...". The Programme of Action's main paragraph on abortion²² does not call for the legalization of abortion. Women had to wait until the Fourth World Conference on Women in Beijing a year later for governments to agree even to *consider* reviewing laws that impose criminal penalties on women who have undergone an illegal abortion.²³ Finally, the Programme of Action discusses the concept of sexual health only briefly. Moreover, paragraph 7.2 of the ICPD POA describes sexual health as an aspect of reproductive health, when it is reproductive health that is obviously an aspect of

sexual health.

The commitments contained in the Programme of Action have been taken up by countries to varying degrees since 1994. While there is no comprehensive survey of all countries' compliance with ICPD commitments, many national or regional assessments have been conducted. The following are three examples of very large countries with different cultures and family planning histories.

India, which had used centralized demographic and contraception targets since the late 1960s, dropped them in 1996 as a result of the ICPD. The focus of India's reproductive health program is now decentralized community needs assessment, with greater emphasis placed on maternal and child care and prevention of STDs and HIV/AIDS in addition to family planning. Observers note, however, that both the attitudes and skills of health providers are slow to change to address issues of quality of care. The package of reproductive health services remains limited and still does not address the needs of adolescents and men. Indian women's health NGOs, although strong and well organized, are rarely consulted by government in spite of the ICPD commitment to establishing partnerships. But, while much remains to be done, this major change in philosophy in India's reproductive health programmes is considered promising.²⁴

Brazil had already developed a Comprehensive Women's Health Care programme in the mid-1980s, thanks to the important role played by the women's movement. Nevertheless, the ICPD Programme of Action has had an undeniably positive impact. A National Commission on Population and Development, which includes representatives of the women's movement, was created in 1995 to undertake ICPD follow-up. Among many progressive measures taken after 1994, a new curriculum for sex education in schools was designed by the Ministry of Education, and the Program for Adolescent Health was reinforced. The National Campaign to Prevent Sexual Exploitation was expanded, and legal measures to protect youth against sexual and other abuse were greatly strengthened. Abortion services in public hospitals in cases where abortion is legal, which used to be unavailable, are now provided in at least 13 hospitals in seven cities.²⁵ The humanization of medical care for abortion and its complications is also a noteworthy achievement. Further, the Brazilian government has issued regulations on surgical sterilization to prevent abuses, while recognizing voluntary sterilization as an acceptable procedure for reimbursement by the Unified Health System. Still, there are many challenges left, including reducing maternal mortality (220 for every 100,000 live births) and the high rates of caesarean section (between 35 and 45 per cent of all births²⁶), as well as making male responsibility in sexuality and reproduction a reality.²⁷

In Nigeria, since the ICPD, local NGOs have been instrumental in establishing a National Guidelines Task Force on sexuality education for adolescents. In 1996, the Task Force, which included more than 15 Nigerian NGOs as well as representatives of government, international agencies and academic institutions, produced a set of guidelines for comprehensive sexuality education.²⁸ The National Council on Education is now pursuing the means for integrating sexual and reproductive health education in school curriculum at the national level. The federal Ministry of Health, in cooperation with NGOs, has recently developed a strategy to implement the reproductive health component of the National Adolescent Health Policy. This is particularly important in the context of Nigeria, where 63 per cent of young women have experienced sexual intercourse by age 18,²⁹ and HIV/AIDS among adolescents has taken on epidemic proportions.

ICPD PLUS FIVE

The UN's ICPD Plus Five review held in New York in March and June 1999 highlighted these and other examples of progress at the national level. The review, however, also brought alarming facts to the world's attention. Worldwide, maternal mortality remains high, especially in Sub-Saharan Africa and Asia: 600,000 women die every year, and some 18 million are left disabled or chronically ill, due to preventable complications of pregnancy and childbirth. The World Health Organization ("WHO") estimates that 330 million new STD infections occur annually, at least half of these among young people. HIV/AIDS accounts for six million new infections every year, increasingly affecting women, babies and young people. Sexual violence is endemic and lethal, both within and outside marriage. At least 150 million women who want to limit their childbearing do not yet use contraception.

Moreover, the financial contributions to implement the Programme of Action have not been sufficient, whether from external donors or from national governments. While the ICPD POA estimated that, by the year 2000, \$17 billion U.S. a year would have to be spent on reproductive health programming (including on HIV/AIDS) in developing countries and countries with "economies in transition" (the former Soviet bloc), it is projected that only \$10 billion U.S. will in fact be available.³⁰

At ICPD Plus Five, governments agreed on priority actions for the 15 years remaining in the 20-year ICPD agenda and reached four major additional agreements on sexual and reproductive health, including new benchmark indicators. They also reiterated their commitment to provide the financial resources for the implementation of the Programme of Action and to reverse the decline in development assistance.³¹

First, with respect to indicators, the ICPD Plus Five document states that the goal of access to universal sexual and reproductive health set out in paragraph 7.6 of the POA should be measured not by a single indicator - contraceptive use - as in the past, but by monitoring three fundamental aspects of health together, namely, contraception, maternal mortality, and STD and HIV/AIDS.³² For all three aspects, states agreed to the following specific goals.

Regarding contraception, they agreed to close the "gap between contraceptive use and the proportion of individuals expressing the desire to space or limit their families" by at least 50 per cent by 2005, 75 per cent by 2010, and 100 per cent by 2050 (sic).³³

With respect to maternal mortality, states recognized the importance of providing emergency obstetric care, and of having skilled attendants³⁴ present at birth to treat complications and refer women for emergency care. In countries where maternal mortality is very high, states agreed that skilled attendants should assist at least 40 per cent of all births by 2005; 50 per cent by 2010; and 60 per cent by 2015. Globally, skilled attendants should assist 80 per cent of all births by 2005; 85 per cent of all births by 2010; and 90 per cent of all births by 2015.³⁵

Regarding HIV/AIDS, states reiterated the importance of prevention and management of all RTIs, and of promoting barrier methods (condoms and microbicides,³⁶ if available) to prevent infection. States agreed that young people (15-24 years old) should be given specific attention - by 2005, at least 90 per cent, and by 2010, at least 95 per cent, of young people should have access to the necessary information, education and services. This includes access to "preventive

methods such as female and male condoms, voluntary testing, counseling and follow-up". The HIV infection rates in young people should be a benchmark indicator, "with the goal of ensuring that by 2005 prevalence in this age group is reduced globally, and by 25 percent in the most affected countries, and that by 2010 prevalence in this age group is reduced globally by 25 percent".³⁷ In paragraph 40 of the ICPD Plus Five document, states also agreed that the work of relevant United Nations bodies (including, presumably, treaty bodies) on indicators for the promotion and protection of the human rights of women should incorporate issues related to sexual and reproductive health - thus, arguably, validating the approach taken by the Committee on the Elimination of Discrimination Against Women since 1995.

Second, recognizing that the HIV/AIDS pandemic is far more serious than had been understood in 1994, the ICPD Plus Five document urges governments to enact legislation to prevent discrimination against people living with HIV/AIDS and those vulnerable to HIV infection so as to ensure that they are not denied information to prevent further transmission, and are able to access treatment and care. The document calls on governments, where feasible, to make anti-retroviral drugs available to women during and after pregnancy as part of their ongoing treatment against HIV/AIDS, and to provide counselling so that mothers living with HIV/AIDS can make free and informed decisions about breastfeeding.³⁸

Third, turning to the issue of abortion, the ICPD Plus Five document details what should be done to ensure that legal abortion services are safe by stating that "...in circumstances where abortion is not against the law, health systems should train and equip health service providers and take other measures to ensure that such abortion is safe and accessible".³⁹ While this provision might seem self-evident, agreement on a paragraph of this kind had not been possible in Cairo in 1994, nor in Beijing in 1995. This provision, initially put forward by the Brazilian delegation with the active support of other Latin American countries, met considerable opposition from the Vatican, Nicaragua, Argentina and conservative Muslim states. After much discussion, the Muslim states joined the consensus, and the Vatican, Nicaragua and Argentina had to submit a reservation to the paragraph. It was perhaps the most dramatic, and certainly one of the most intensely debated, agreements.

Fourth, governments agreed to mobilize resources to provide the widest possible range of contraceptive methods, including *new options and underutilized methods*.⁴⁰ This particular agreement is meant to refer to underutilized methods such as emergency contraceptive pills,⁴¹ female condoms and vasectomy, and new methods such as microbicides. Emergency contraception is not explicitly mentioned in the ICPD Plus Five document, however, at the insistence of the Vatican and a few of their supporters. The Vatican is opposed to emergency contraception even though the WHO recognizes emergency contraceptive pills as a safe means of preventing unwanted pregnancy, and has concluded that emergency contraceptive pills cannot interrupt a pregnancy and are thus not a form of abortion.⁴²

It is worth mentioning that ICPD Plus Five also witnessed a heated debate on adolescents' right to sexual and reproductive health information and services. Despite pressure by a handful of conservative states, delegations successfully resisted calls to subordinate the rights of adolescents to the rights of parents. Rather, the document protects the balance between the two sets of rights achieved in Cairo in 1994. Governments also agreed to provide sexuality education at all levels of schooling, and expressly recognized the importance of addressing adolescents' needs for education, income-generating opportunities and vocational training.⁴³

NEXT STEPS

ICPD Plus Five reached important agreements that many thought could not be achieved. As in Cairo, NGOs, and in particular women's health advocates, mobilized to ensure that the ICPD Plus Five document not only reaffirmed the Programme of Action, but also specified concrete steps for action.

To achieve the goals of the ICPD Programme of Action and the ICPD Plus Five document, action is now needed both at the international and national levels. At the international level, the gains of ICPD and ICPD Plus Five need to be protected and extended at the upcoming five-year review of implementation of the Platform for Action of the Fourth World Conference on Women ("FWCW"). Particular care should be taken to protect the provisions of the FWCW Platform for Action which recognize that the human rights of women include their right to control their sexuality ("sexual rights"),⁴⁴ and which call on states to consider reviewing laws that contain punitive measures against women who have undergone illegal abortions⁴⁵ - provisions likely to be attacked by fundamentalist forces. At the same time, United Nations treaty bodies must actively integrate the standards set in the POA and at ICPD Plus Five in their monitoring of the human rights of women. On the issue of resources, the mechanisms outlined in the ICPD Plus Five document to increase funding for health, such as reduction of the external debt of the poorest countries and debt swaps for investments in health, should be given priority consideration.

At the national level, where government expenditures are too often shaped by military interests and corruption, more pressure needs to be brought to bear on decision makers. Budgetary allocations must give priority to developing the effective and accessible health systems required to meet the goals of the ICPD and ICPD Plus Five. Women's health activists, who have in many countries been the main advocates for reproductive health, need to be joined by other concerned activists - health professionals, lawyers and researchers - in pressing for a redefinition of priorities, better programmes and new laws. Lawyers, in particular, should push for changes in the legislation and regulations that currently impede women's access to health services. In the context of the health sector reforms which most countries are now experiencing, making reproductive and sexual health a priority is both equitable and sensible. The world agreed on this course of action at the ICPD and ICPD Plus Five. Now is the time to act.⁴⁶

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¹ United Nations, *Report of the International Conference on Population and Development*, Document A/Conf. 171/13, New York, 1994. This document may be found at <gopher://gopher.undp.org:70/00/ungophers/popin/icpd/conference/offeng/poa.txt>.

² Paragraph 1.15, ICPD POA.

³ Article 12(1) of the ICESCR provides that "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."

⁴ Article 16(e) of CEDAW provides:

States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

⁵ Article 9(1), ICCPR.

⁶ See para. 7.3, ICPD POA, above.

⁷ Paragraphs 4.22 and 7.40, *ibid.*

⁸ Paragraph 8.25, *ibid.*

⁹ R.J. Cook, "Women's Health and Human Rights", World Health Organization [hereinafter WHO], 1994, pp. 10, 23; R.J. Cook, "Human Rights Law and Safe Motherhood" (1998) 5 European Journal of Health Law, 357-75. The overwhelming majority of maternal deaths worldwide are preventable with existing knowledge and technology.

¹⁰ Article 6(1), ICCPR.

¹¹ Paragraph 8.32, ICPD POA.

¹² Paragraph 7.20, *ibid.*

¹³ Paragraphs 7.45, 7.46 and 7.47, *ibid.*

¹⁴ United Nations, *Committee on the Elimination of Discrimination Against Women* (14th session), Document A/50/38, 31, New York, May 1995, which can be found at <www.un.org/womenwatch/daw/cedaw>.

¹⁵ United Nations, *Vienna Declaration and Programme of Action*, Document A/Conf. 157/23, New York, 1993; United Nations, *Report of the Fourth World Conference on Women*, Document A/Conf. 177/20. New York, 1995. Both these documents can be found at <www.un.org/womenwatch/confer/index.html>.

¹⁶ Paragraphs 7.3, 7.12 and 7.22, ICPD POA.

¹⁷ Paragraph 7.6, *ibid.*

¹⁸ Paragraphs 7.7, 7.0, 7.47, 15.8, 15.9 and 16.10, *ibid.*

¹⁹ Maternal mortality is 6 per 100,000 live births in Canada, and 12 per 100,000 live births in the United States.

²⁰ Paragraph 8.21, ICPD POA.

²¹ Paragraph 8.25, *ibid.*

²² *Ibid.*

²³ Paragraph 106(k) of the Platform for Action, *Report of the Fourth World Conference on Women, supra*, note 15.

²⁴ "From Contraceptive Targets to Reproductive Health: India's Family Planning Programme After Cairo", in Health, Empowerment, Rights and Accountability [hereinafter HERA], *Confounding the Critics: Cairo, Five Years On*, Conference Report, Cocoyoc, November 1998, pp. 68-74.

²⁵ A. Germain and T. Kim, *Expanding Access to Safe Abortion: Strategies for Action*, IWHC, 1998, p. 8.

²⁶ Latin American and Caribbean Women's Health Network, *The Cairo Consensus: Women Exercising Citizenship Through Monitoring*, LACWHN's Review of Five Latin American Countries -Brazil/Chile/Columbia/Nicaragua/Peru, 1998, p. 35; Brazilian Demographic and Health Survey, 1996. By way of comparison, the caesarean section rate is 19 per cent in Canada, and 24 per cent in the United States. WHO considers that rates above 15 per cent are medically unnecessary. The high Brazilian rates are attributable to poor medical practices and the fact that, until recently, tubal ligation was not reimbursed by state health insurance. This, combined with restrictions on the availability of certain types of contraceptives, created incentives to have sterilization performed at the same time as a caesarean section. See A. Germain and J. Ordway, *Population Control and Women's Health: Balancing the Scales*, IWHC, 1989, p. 6.

²⁷ *The Cairo Consensus: Women Exercising Citizenship Through Monitoring*, LACWHN's Review of Five Latin American Countries, *ibid.*, p. 42. 10 *Journal of Women's Health and Law*

²⁸ Action Health Incorporated, *Guidelines for Comprehensive Sexuality Education in Nigeria*, National Guidelines Task Force, Lagos, 1996.

²⁹ Action Health Incorporated, "Growing Up: A Newsletter for Young People", (Vol. 7, No. 1) March 1999.

³⁰ *Draft Report of the Secretary General for the Special Session of the General Assembly Containing Proposals for Key Actions for Further Implementation of the Programme of Action of the International Conference on Population and Development*, February 25, 1999, Document E/CN.9/1999/PC/4, available at <www.unfpa.org>

³¹ United Nations, *Report of the Ad Hoc Committee of the Whole of the Twenty-first Special Session of the General Assembly*, Document A/S-21/5/Add.1, July 1, 1999 ("ICPD Plus Five Document"), which can be found at <www.unfpa.org>.

³² Paragraph 53, ICPD Plus Five Document.

³³ Paragraph 58, ICPD Plus Five Document.

³⁴ Skilled attendants are defined by WHO as "trained midwives, nurses, nurse/midwives or doctors who have completed a set course of study and are registered or legally licensed to practice"

(WHO/FIGO/International Confederation of Midwives, "Definition of the Midwife", 1992). Skilled attendants are qualified to provide preventive care to pregnant women, detect abnormal conditions in mothers and infants, assist women through labour and delivery and prescribe essential drugs. When delivery complications arise, these attendants - especially those working at the community level - need to be able to carry out emergency measures if medical help is absent, and get medical assistance or refer women to an appropriate medical facility. Traditional birth attendants, including those who have been trained, are not defined as skilled attendants. See *The Safe Motherhood Action Agenda: Priorities for the Next Decade*, Report of the Safe Motherhood Technical Consultation, October 18-23, 1997, Colombo, Sri Lanka, pp. 2935; see also <www.safemotherhood.org>.

³⁵ Paragraph 64, ICPD Plus Five Document.

³⁶ Microbicides are substances that women can apply in the vagina before intercourse to protect themselves against STDs alone or, depending on the product, against both pregnancy and STDs, including HIV/AIDS. Microbicides are still at the testing stage.

³⁷ Paragraph 70, ICPD Plus Five Document.

³⁸ Paragraphs 67, 69 and 70, *ibid.*

³⁹ Paragraph 63iii, *ibid.*

⁴⁰ Paragraph 57(a), *ibid.*

⁴¹ Defined by WHO as increased doses of oral contraceptive pills (either ethinylestradiol and levonorgestrel combined, or levonorgestrel only) taken within 72 hours of unprotected intercourse to prevent an unwanted pregnancy. Emergency contraceptive pills have been shown to inhibit or delay ovulation. They may also act to prevent fertilization or implantation, but the evidence is inconclusive. WHO, *Emergency Contraception, A Guide For Service Delivery*, 1998, pp. 19-20.

⁴² WHO, *Emergency Contraception*, *ibid.*, p. 20.

⁴³ Paragraphs 21(b), 35(b) and 73 to 75, ICPD Plus Five Document.

⁴⁴ Paragraph 96 of the Platform for Action, *Report of the Fourth World Conference on Women*, *supra*, note 15.

⁴⁵ Paragraph 106(k) of the Platform for Action, *ibid.*

⁴⁶ For more information about the ICPD and ICPD Plus Five, see A. Germain and R. Kyte, *The Cairo Consensus: The Right Agenda for the Right Time*, International Women's Health Coalition, 1995; United Nations Population Fund Website at <www.unfpa.org>; the International Women's Health Coalition Website at <www.iwhc.org>; and the HERA Website at <www.iwhc.org/hera/index.htm>.