A central challenge in developing reproductive health strategies is giving real meaning to the right of couples and individuals to determine, freely and responsibly, the number and spacing of their children. This article places the right of reproductive choice in legal and historical contexts, highlights salient issues that arise in trying to formulate international standards for its enforcement, and examines two particularly thorny issues: the tension between demographic priorities and reproductive choice and the tension between international standards and local custom/religion. The article calls on health professionals to participate actively in the elaboration of reproductive rights, both through their immediate work in the health-care field and through involvement in the international policymaking process that will take place in three upcoming international conferences. (STUDIES IN FAMILY PLANNING 1993; 24, 1: 18–30)

Reproductive health strategies are built around a core insight that is at once simple and deeply revolutionary: that women as full, thinking, feeling personalities, shaped by the particular social, economic, and cultural conditions in which each of them lives, are central to their own reproduction. Thus, health policies and programs cannot treat reproduction as mere mechanics, as isolated biological events of conception and birth; rather they must treat it as a lifelong process inextricably linked to the status and roles of women in their homes and societies. That insight is simple because every woman—whether she is rich or poor, from North or South, married or unmarried, multiparous or childless, religious or atheist—knows it to be true from her own life experience. Yet it is revolutionary because it challenges some fundamental, often unrecognized, assumptions about women that underlie four decades of mixed experience in the population and maternal-child health fields.

In the last five to ten years, several major international organizations and influential actors in the population and health fields have taken up the call for comprehensive reproductive health strategies, and have begun to elaborate what this will entail in theory and in fact (for example, Germain, 1987; Bruce, 1987 and 1990; Fathalla, 1987 and 1991; Sai and Nassim, 1989; Barzelatto and Hempel, 1991). Almost invariably, discussions of reproductive health strategies acknowledge the close connections between health and law, and include as a basic tenet the importance of reproductive choice as a universal human right. But if the commitment to reproductive choice is to mean anything in practice—if it is to be a principle of law that influences the way that policymakers and service providers operate—we will need to examine much more closely what we really mean by an individual human right to reproductive choice, freedom, or autonomy in a world as demographically complex and culturally diverse as ours.

While international lawyers and human rights theorists grapple with the many difficult jurisprudential issues involved in elaborating a practice of reproductive rights as human rights, the international health community can and must play a central role in the overall process. For in this, as in so many other areas, changes in law are a necessary but not sufficient condition for improvement in the quality of people’s lives. We begin, therefore, by identifying several basic principles that have emerged from the evolving field of reproductive health and showing how they connect law to health. Then we attempt to put the issue of international reproductive rights into historical and legal context and to frame some of the most critical questions that arise. After focusing on the tension between demographic priorities and reproductive choice that has plagued so much of the dis-

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discussion about reproductive rights at the international level, we address the equally important problem of the tension between international legal standards and local law, custom, and religion.

Basic Principles

Three basic principles can be distilled from what several commentators have called “women-centered” approaches to reproductive health (Barzelatto and Hempel, 1991; Toro, 1989). Each has important implications for the analysis of the connections between law and health.

First, a women-centered approach to reproductive health is fundamentally about trusting women. For when all the rhetoric is stripped away, the key to improving reproductive health is women’s autonomy—enabling women to take control over their reproductive lives by entrusting to them both the authority to make decisions about reproduction and the ability to make those decisions based on access to adequate information and appropriate services. Perhaps this, the commitment to women’s autonomy, is the value that can transcend political borders and cultural divides. These essential qualities of respect, of dignity, and of control have been shown again and again to be linked to improved health, and to the reproductive decisionmaking that leads to reduced fertility as well (Mason, 1988). Law provides one of the primary tools for conceptualizing, promoting, and protecting women’s autonomy. Reproductive rights are the legal categories generally used to express the principle that women, and men as well, are entitled to control their reproductive lives.

Second, a women-centered approach means understanding and addressing reproductive health in the way women experience it: not as a series of isolated biomedical phenomena, but as an integral part of everyday life. Such a reconceptualization of health and illness helps to uncover the many ways that law relates to health. For one, it focuses attention on the relationship between providers and patients. For example, a growing body of work on informed consent and the quality of care in family planning programs has shown that law and ethics can and should influence the ways health care is organized and services are sought and provided (Bruce, 1990; Cook and Maine, 1987).

Perhaps more important, law helps shape the social world in which women live. Family law, for example, regulates relationships between men and women through its rules about marriage, divorce, sexuality, intrahousehold economics, and responsibilities for children—all of which have a significant influence on reproductive health. The reconceptualization of health that animates reproductive health strategies brings men back into the picture: Once reproductive health is understood to involve more than just the biological workings of a woman’s womb, the concept must, almost by definition, take into consideration that in almost every society, men have the power to shape the world in which women live. New reproductive health strategies must address the ways in which men view and influence women’s reproduction, as well as the ways in which men view their own reproductive lives and responsibilities.

Third, a women-centered approach to reproductive health emphasizes the need to connect the different levels—international, country, community—at which policies and programs are developed and implemented. In some sense, this is the overriding lesson of the last 40 years of the population movement. While that movement has contributed much to our understanding of reproduction and, indeed, to the quality of life in many parts of the world, its history is also the story of grand theories and great expectations sabotaged by the sometimes quiet, sometimes violent refusal of ordinary people—often poor and powerless people—to surrender their own reproductive lives to the cold logic of population planning directed from above.

For population is a quintessentially international field in which big global theories have concrete and sometimes drastic implications for the most intimate, personal elements of a woman’s or man’s life: sexuality and reproduction. The lesson applies to legal theory as well: Simply to declare that there is a universal human right to reproductive self-determination is not enough. We must also look hard at how that right can be translated to the specific situations of dependency, discrimination, and fear that women face.

The Legal Framework

A woman’s status, and with it her ability to safeguard her own health and that of her family, depends not just on her right to decide on the number and spacing of her children; her status also depends on her right to act as an independent adult (her “legal capacity”), to participate as a citizen in her community, to earn a living, to own and control property, to be free from discrimination on the basis of gender, race, and class (see Freeman, 1990). This full constellation of rights makes the specific right of reproductive choice a meaningful one. Conversely, without the right of reproductive choice, each of the other social and economic rights has only limited power to advance the well-being of women.

While it is important not to lose sight of the relationship between these many dimensions of women’s status
and reproductive health, we must not be lulled into thinking that vigorous efforts to advance women’s social and economic position will automatically guarantee for them the right to reproductive autonomy and control. Indeed, if the American experience with the legal status of abortion and contraception over the last several decades has taught us anything, it is that we must pay explicit attention to reproductive rights as such. For even when the commitment to women’s overall equality seems firmly entrenched, at least in the language of the law, the question of control over reproduction remains a highly explosive issue.

This is no less true at the international level. While political, social, and economic rights of women continue to be contentious issues in international fora, at least they are topics of discussion. They are addressed in multiple United Nations (UN) documents and treaties; they are included in the mandates of multilateral agencies and the agendas of women-in-development bureaus everywhere. In recent years, women’s political and civil rights have even been adopted by nongovernmental human rights organizations: Witness the new women’s projects set up by Amnesty International, Human Rights Watch, and Physicians for Human Rights. But on the issue of reproductive rights per se, where emotions run high and political actors feel especially vulnerable—and where conscious avoidance is the safest route—discussion has been conspicuously limited.

And so, with full recognition that the status and health of women are about much more than just reproduction, we assert that one of the most important things that professionals in the health field can and must do is to take a long, unblinking look at the question of reproductive rights and their protection.

Reproductive Rights, Population Policy, and Women’s Health

Human Rights in International Law

Traditionally, international law was concerned solely with the relationships between nation-states. Its reach was limited to matters such as the conduct of war, the regulation of international commerce, and the control of the high seas. In the eyes of the law, the treatment of individuals by their own governments was a matter reserved to each sovereign state to deal with in whatever manner its own legal and political system provided.

World War II changed that situation forever. Determined to construct a new world order after the massive devastation in Europe and Asia, and with the horrors of Nazi Germany fresh in their minds, the victorious allies came together to create the United Nations. Among the specific purposes of the UN outlined in its Charter is “to promote . . . universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion” (United Nations, 1945). Nowhere in the Charter are “human rights and fundamental freedoms” defined. Nevertheless, this provision is significant, primarily because the UN Charter is an international treaty. When a state ratifies the Charter and joins the UN, it undertakes a legal obligation to cooperate with the UN in achieving its purposes, including the promotion of human rights (Article 56). Thus, inclusion of human rights in the Charter constitutes an acknowledgment by the world community and all members of the UN that rights of individual human beings can now be a matter of international concern, no longer exclusively within the jurisdiction of each sovereign state. Consequently, the obligation to promote the observance of human rights is theoretically subject to enforcement by the international community. Even though the UN Charter does not specify particular human rights, it creates the legal basis for the ongoing elaboration of the substance of human rights through international declarations, statements and resolutions, conventions, and treaties.

Reproductive Rights as Human Rights

The first comprehensive statement of human rights, the Universal Declaration of Human Rights, adopted by the UN General Assembly in 1948, failed to mention reproductive rights at all. It was not until 20 years later, at the international human rights conference held in Teheran in 1968, that human reproduction became a subject of international legal concern. The Final Act of the Teheran conference included a provision stating: “Parents have a basic human right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect” (United Nations, 1968).

A careful reading of this short statement quickly reveals the essence of the problem that to this day plagues efforts to apply the human right of reproductive autonomy to specific situations. Virtually every international statement of this right from 1968 until the present has used the core language formulated in Teheran: the right “to decide freely and responsibly on the number and spacing of children.”

Just what does “freely and responsibly” mean? In the most egregious cases, such as the compulsory monthly gynecological examinations instituted in workplaces in Romania or the alleged forced sterilizations of gypsies in Eastern Europe, it might be relatively easy to muster a consensus that a violation of reproductive rights has taken place because the element of coercion is so clear. But how should the international community respond to more ambiguous policies, such as China’s one-child policy, or India’s use of economic incentives to encour-
age sterilization, or rulings by several American judges that women convicted of child abuse must be implanted with NORPLANT® as a condition of probation? Can a government take steps to ensure that its subjects exercise their right to reproductive decisionmaking “responsible”? If so, under what circumstances, in what manner, and using what criteria? If not, then what does deciding responsibly mean in practice?

The lack of any agreed-upon principles for deciding such questions is a central problem of reconciling human rights with government actions to influence population trends, that is, with population policy. The problem is exacerbated by the schizophrenic history of reproductive autonomy as a human right, a schizophrenia that derives from reproductive rights having been formulated and promoted by two very different, sometimes antagonistic, international movements: the population movement and the women’s rights movement. The result has been the articulation of a right that, so far, lacks the clarity to be an effective tool in influencing policy.

The Teheran statement reflects the enormous changes in development theory that had taken place in the 20 years preceding it, for it was in that period of the 1950s and 1960s that the modern population movement was born. The roots of the population movement date back to the early 1800s when Parson Malthus was doing the many revisions of his famous Essay, which spawned active neo-Malthusian movements in many European countries. But it was during the 1960s that the population movement gained momentum, propelled by sophisticated computer models that could chart alternate paths to destruction if population growth were not curbed, an environmental movement that encompassed population concerns, visible evidence of the effects of rapid population growth in countries such as India and China, increasing concern about world food production, the growth of demography as a social science, and the development of contraceptives (the pill and IUDs) with strong potential to change fertility levels. Books such as Paul Ehrlich’s The Population Bomb and articles such as Garrett Hardin’s The Tragedy of the Commons (in which he likened the earth to a common feeding ground that cattle had overgrazed) became essential reading on American college campuses.

Such grim scenarios of global devastation were beginning to fill the air when the international community gathered in Teheran in 1968 at the International Conference on Human Rights to discuss the future of human rights. To the delegates in Teheran, unchecked population growth presented a potentially insurmountable obstacle to the enjoyment of the wide range of human rights they had come to promote. Yet, despite what must have seemed like indisputable logic to a western policymaker reading Paul Ehrlich in 1968, many “overpopulated” countries of the third world had statutes and policies discouraging use of contraceptives, a situation that seemed to present a menace to the future of humankind, a threat so ominous that it could not be left to those countries to handle on their own. It was a menace that had to be dealt with at the highest international levels.

Read in the perspective of its time, the Teheran Declaration’s resolution on population is best understood as a statement of the international community designed to pressure less developed states that had resisted the spread of contraceptives within their borders, and not as an effort to defend the right of individual men and women against coerced population control. Indeed, when the often-quoted phrase enunciating the right to determine the number and spacing of children is read in the context of the entire resolution, this interpretation becomes even more apparent:

...Believing that it is timely to draw attention to the connexion between population growth and human rights [the conference]:

1. Observes that the present rapid rate of population growth in some areas of the world hampers the struggle against hunger and poverty, and in particular reduces the possibilities of rapidly achieving adequate standards of living, including food, clothing, housing, medical care, social security, education and social services, thereby impairing the full realization of human rights;

2. Recognizes that moderation of the present rate of population growth in such areas would enhance the conditions for offering greater opportunities for the enjoyment of human rights and the improvement of living conditions for each person;

3. Considers that parents have a basic human right to decide freely and responsibly on the number and spacing of their children and a right to adequate information in this respect;

4. Urges Member States and United Nations bodies and specialized agencies concerned to give close attention to the implications for the exercise of human rights of the present rapid rate of increase in world population. (United Nations, 1968)

In 1974 the international community gathered at the World Population Conference in Bucharest, Romania to consider the problem of population. But in the six years since Teheran, the world had changed dramatically. At Bucharest the western-oriented population movement was confronted by a third world challenge to its most basic premise: that population growth was an impediment to development. Developing countries argued that the reverse was true and that, in the popular slogan of
the view, “Development is the best contraceptive.” In their
view, population was a convenient excuse for refusing
to overhaul the international economic system along the
lines of the New International Economic Order; the prior-
ity given by western governments to controlling popula-
tion growth appeared more like a plot to ensure their
own primacy in the international order than like a hu-
mane plan to safeguard the standard of living of the
people in less developed countries. The conference nearly
broke up after the first week and was saved only by a
compromise in which it was agreed that population
growth was an important element in development, and
that national development tended to reduce population
growth rates.

The World Population Plan of Action adopted in
Bucharest also included language reaffirming the right
to reproductive decisionmaking:

All couples and individuals have the basic right
to decide freely and responsibly the number and
spacing of their children and to have the infor-
mation, education and means to do so; the re-
sponsibility of couples and individuals in the ex-
ercise of this right takes into account the needs
of their living and future children, and their re-
sponsibilities towards the community. (United
Nations, 1974 at ¶ 14)

The Bucharest language differs from the Teheran
declaration in several respects: (1) it expands the right
from “parents” to “couples and individuals”; (2) it
states that people should have the means, as well as the
information and education, to assert the right; and (3) it
tries to define that elusive concept of responsible
decisionmaking.

When the next international population conference
was held a decade later in Mexico City, the world had
changed dramatically yet again. By 1984 the developing
world was mired in the depths of the debt crisis, its eco-

demic survival pinned to the International Monetary
Fund (IMF) and the World Bank (a strong proponent of
population programs). Hopes for a New International
Economic Order had faded. Rapid development was far
from imminent and many governments now regarded
the population question as a real one.

But the biggest surprise came from the United States,
by far the largest funder of population programs in the
world. At Mexico City, the US did a 180° turn on the
population-development issue. Rather than urging de-
veloping countries to take strong measures to curb popu-
lation growth, as the US had regularly done in the past,
the representatives of the Reagan administration now
declared that “population growth is, of itself, a neutral
phenomenon” (United States, 1984). In its view, the real
route to a better quality of life, no matter how many
people there are, is development; and the real route to
development is economic growth fueled by free markets
and privatization.

Although the United States’ commitment to market
economics and private enterprise was, no doubt, real
enough, in theory that commitment should not have con-
flicted with its long-standing position on the desirabil-
ity of reducing population growth. Something else was
operating in Mexico City. That “something else” had
ominous implications for reproductive autonomy: The
“right-to-life” movement had expanded internationally
and, in Mexico City, American reproductive rights poli-
tics—a battle that had little to do with population growth
and a lot to do with individual reproductive choice—had
spilled over into the international arena.

For the anti-choice forces that had the Reagan admis-
stration’s ear, the notion of tax dollars funding the
distribution of contraceptives and the provision of abor-
tion was galling enough, but the possibility that the
United States was promoting access to abortion outside
its borders was an outrage. In Mexico City the US anti-
choice movement scored a major international victory
when the government announced what became known as
the “Mexico City Policy”: Not only was using Ameri-
can foreign aid to pay for abortions prohibited (a policy
in effect since the 1973 Helms Amendment to the For-

eign Assistance Act), but now, it was announced, the US
would also prohibit American nongovernmental organi-

dations (NGOs) from using funds from the Agency for In-

ternational Development (AID) to assist any foreign NGOs
that “perform or actively promote abortion as a means of
family planning,” even if they do so with funds from non-
AID sources (United States, 1984; Finkle and Crane, 1985).

Although it became an element of United States for-

eign policy, the Reagan administration’s position never
became part of the recommendations adopted by the con-
ference as a whole, which did include the principle that
governments should “as a matter of urgency” make fam-
ily planning services “universally available.” On the sub-
ject of the right to reproductive decisionmaking, the lan-
guage of the World Population Plan of Action adopted
in Bucharest was reaffirmed. In addition, the recom-

mendations from the Mexico City conference noted that “the experience of the past 10 years suggests that Govern-
ments can do more to assist people in making their re-
productive decisions in a responsible way” (United Na-
tions, 1984, recommendation 26). While not detailing
what states should do to encourage responsibility in their

citizens, the conference did include in its recommenda-
tions this strikingly imprecise statement intended to
clarify what “responsibly” means:

Any recognition of rights also implies responsi-

bilities: in this case, it implies that couples and

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products choice: Article 16 explicitly codifies the specific right of repro-
duced by women's reproductive health (see Cook, 1992),

tions that ratified the convention) to address issues re-

cognition to control reproduction. While several articles of the

in 1979. The stated aim of this convention was to achieve

equality between men and women in their right and abil-

Article 12: Every couple and every individual has

the right to decide freely and responsibly

tern their number and spacing, and to have

Article 11: It should be one of the principal aims

of social education to teach respect for physical

integrity and its rightful place in human life. The

human body, whether that of woman or man, is

inviolable and respect for it is a fundamental el-

ement of human dignity and freedom.

A slightly different perspective is taken in what is

perhaps the most important document to emerge from the

UN Decade: the Convention on the Elimination of All Forms of Discrimination Against Women, adopted

in 1979. The stated aim of this convention was to achieve

equality between men and women in their right and abil-

ty to control reproduction. While several articles of the

convention can and should be interpreted to create a

strong legal basis for the obligation of states parties (na-

tions that ratified the convention) to address issues re-

lated to women's reproductive health (see Cook, 1992),

Article 16 explicitly codifies the specific right of repro-

ductive choice:

States parties shall take all appropriate measures

to . . . ensure on a basis of equality of men and

women . . . 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. (United Nations, 1979)

Although the women's conference and women's con-

vention opted to use the same "freely and responsibly" language, the logic behind these documents was differ-

dent from that operating in the human rights and popu-

lation conferences in Teheran, Bucharest, and Mexico

City. Indeed, for a substantial proportion of women's

rights activists, the articulation of a right to decide freely

and responsibly on the number and spacing of children

was asserted not in harmony with, but in opposition to,

the movement to control population growth in the third

world. The DAWN (Development Alternatives with

Women for a New Era) group spoke for many women

when it stated:

Control over reproduction is a basic need and a

basic right for all women. Linked as it is to

women's health and social status, as well as the

powerful social structures of religion, state con-

rol and administrative inertia, and private

profit, it is from the perspective of poor women

that this right can best be understood and af-

irmed. Women know that childbearing is a so-

ial, not a purely personal, phenomenon; nor do we deny that world population trends are likely to exert considerable pressure on resources and

stitutions by the end of this century. But our

bodies have become a pawn in the struggles

among states, religions, male heads of house-

holds, and private corporations. Programs that do

not take the interests of women into account

are unlikely to succeed. . . . (See Sen and Grown,

1987, p. 49)

The Need to Clarify a Human Right of Reproductive Choice

Although the population movement and women's move-

ment were the moving forces behind the articulation of the right to reproductive choice, many other international

izations and conferences have formally recognized

this right as well. For example, the right to decide freely

and responsibly on the number and spacing of children

was adopted by the UN General Assembly in the Decla-

ration on Social Progress and Development, by the World

Food Conference in Rome in 1974, and by conferences of

parliamentarians from various regions of the world. The

effect of all these declarations, statements, and con-

ventions is that there is, undeniably, an internationally

recognized right of couples and individuals to control

their reproduction freely and responsibly.

Given the seeming unanimity of international actors

on the statement of the right, does it really matter what

motivation or rationale lies behind it? The answer should
be a resounding “yes,” because, if this right is to mean anything in practice, some judgment must be made of what actions constitute violations of the right. Without some agreed-upon standards by which to determine the limits of free and responsible decisionmaking, that kind of judgment will continue to be based more on the whims of politics than on the principles of international law, thereby effectively destroying its credibility as a principled basis for challenging violations by local governments, service providers, or other organizations.

Moreover, having a workable definition of the human right to reproductive autonomy at the international level is especially important because such a great proportion of population policy and family planning services is influenced by international actors. For example, the World Bank has become one of the strongest proponents of population programs. In a 1986 policy study entitled Population Growth and Policies in Sub-Saharan Africa, the World Bank stated:

For its part, the Bank views population assistance as its highest priority in Africa. It will increase its spending as rapidly as programs can be developed. Indeed, the capacity to launch new programs is the only constraint on new Bank financing. . . . (World Bank, 1986, p. 6).

Considering that the economic survival of sub-Saharan Africa, the ability to meet the most basic needs of its people, is tied to the IMF and the World Bank, this statement is significant. If a multilateral institution such as the World Bank is to be guided by any legal or ethical standards when it engages in “population dialogues” and approves conditional loans for population programs, such standards should be fashioned by the international community according to international law, including human rights law.

In addition, the rationale behind an international initiative addressing issues of reproduction also affects the acceptability of the initiative’s policies and programs. In many countries population policy is considered an imperialist plot, a Trojan horse hiding imported birth-control (with the emphasis on control) measures. Bertha Pooley, a Bolivian reproductive health activist, put the matter succinctly: “A reproductive health-care program based on a genuine concern for the well-being of women is important and acceptable. One based on population or demographic principles will be rejected” (Pooley, 1990).

But a commitment to reproductive autonomy as an element of reproductive health and well-being is not just window-dressing to be used after the fact to pretty up—or render politically correct—a policy or program in which the real aim is to lower population growth. Perhaps one way to put the question is this: Is the right to reproductive autonomy among the first principles in the development of reproductive health and population programs or is it among the last principles? If the former, then it must shape the way population policy and health services are designed; indeed, commitment to the protection of this right might require abandoning a program that seems certain, in the short run at least, to have the desired demographic effects. If the latter, then it will be used to refine policies and programs in which the primary aim is to meet demographic targets.

Of course, in practice, the choices being made are rarely so black and white. It is possible to be concerned about both population growth and women’s health and well-being. But where decisionmakers stand on the importance of reproductive autonomy as a human right can have a profound, if subtle, effect on the design of policies and the delivery of services.

Incentives and Disincentives: A Case Study

Nowhere is the collision of individual rights with government demographic priorities more starkly presented than in the instance of incentives and disincentives designed to influence childbearing decisions. First used by Indian state governments in the 1960s, when men who opted to be sterilized were compensated for time lost from work and for their expenses, incentives and disincentives in a variety of forms now characterize many Asian population programs. Incentive programs can vary according to who receives the payments (the provider, the user, or the recruiter), how they are given (immediate payment or payment extending over a period of time), what form they come in (money or such commodities as a sari or a radio), and what their stated justification is (compensation for time lost from work or an explicit attempt to influence decisionmaking). Incentives and disincentives that have been attempted include:

1 payments, either in cash or in kind, to “acceptors,” typically for being sterilized. Sometimes payment is made for not having children, in which case money might be put aside every month that a woman uses contraceptives or does not become pregnant.

2 payments to doctors (and other providers), usually on a per-case basis, for sterilizations.

3 payments to recruiters for producing a certain number of “acceptors” (usually of sterilization). This influence can also take the form of penalties for recruiters who fail to bring in their quotas, such as were imposed on schoolteachers and local government officials in India during the mid-1970s.
4 payments in cash or in kind, such as offering communities breeding pigs or water-collection systems. Payment may be made for reaching acceptor targets or for maintaining levels of contraceptive prevalence.

5 rescinding of benefits when couples have more than a specified number of children. For example, taking away tax exemptions, free maternity care, or housing priorities.

6 penalties for high-birth-order children by denying them such benefits as choice of schools.

In some cases, multiple incentives are used. The most wide-ranging is the Chinese one-child-per-family program begun in the late 1970s. Among the incentives offered by provincial governments to families limiting themselves to one child were monthly welfare or nutritional allowances; priorities in housing, education, and medical care; and expanded maternity benefits. Among the disincentives for offenders were fines for extra births; deduction of a percentage of salary; and withdrawal of maternity leave, health coverage, and allowances. The Chinese program is also characterized by intense peer pressure targeted at those who, by having more than one child, put their “selfish” interests over those of their community.

Clearly, incentives and disincentives have the potential to conflict with autonomy in reproductive decisions. The very purpose of most of them is to influence reproductive decisionmaking, to induce people to have fewer children. Incentives can be analyzed from a number of different perspectives. For example:

1 Are incentives inherently coercive? Much of the debate surrounding incentives centers on this question. Some argue that given the social and economic circumstances of poor people (especially poor women) in many less developed countries, a technically voluntary program, such as one that requires proof of sterilization as a condition for receipt of emergency food, becomes coercive in practice, since people's ability to meet their most basic human needs depends on relinquishing reproductive choice (Hartmann, 1987). Others contend that in some poverty-stricken areas, payments in cash or kind enable people to exercise choices that would otherwise be beyond their means, so that incentives facilitate reproductive autonomy. These analysts argue that ending incentive payments discriminates against the poor (Cleland and Mauldin, 1990). At what point do strong incentives cease being voluntary and become coercive? Is it possible to draw any lines along the spectrum of voluntariness?

2 What, if any, responsibility does an individual have to his or her society, and who is entitled to enforce such responsibility? Can incentives be justified by citing the needs of future generations? Is it responsible to have, for example, five children in China or India? Some argue that women have this kind of responsibility to society only when society fulfills its responsibility to them by treating them with dignity, respect, and equality, and by meeting basic social needs (see Berer, 1990).

3 Does the incentive have ripple effects undermining women’s status or ability to participate in other areas of social life? India’s Prime Minister recently proposed a population policy that, among other things, would bar any man or woman with more than two children from holding any local or national office (International Planned Parenthood Federation, 1992). Given that many women in India are married extremely young and have virtually no control over sexual relations, the discriminatory impact of this proposal would seem apparent.

4 Does it matter if the incentives or disincentives were culturally appropriate and accepted by the majority of people? One justification often given for the strong incentives and disincentives enacted by Singapore in the 1970s was their high acceptability to the country’s population (Salaff and Wong, 1978).

5 Is there a conceptual difference between incentives to discourage births as in Asia, and to encourage them as in Europe? Incentives to encourage births have been utilized in Europe at least since Roman times. Such policies became widespread after World War I and exist in nearly every European country. In some countries, including France, incentive policies are frankly pronatalist. In others, including the Nordic countries, the motivation is not to increase the birthrate, but to defray the cost of childrearing. In the United States, tax deductions for dependent children are a longstanding part of the Internal Revenue Code.

6 Can incentives, or even compulsion, be justified in areas such as education and immunization, but be rejected in childbearing decisions? Or is childbearing a decision so basic to a person’s individual liberty that compulsion or even strong
persuasion should never be considered?

7 Does it matter if the rationale for offering incentives to limit fertility springs from health concerns rather than demographic ones? For example, the US tax code permits deductions for medical expenses and for premiums for medical insurance in order to encourage people to seek medical care. Is an incentive to seek family planning services conceptually different? Does the answer depend on whether family planning is part of an integrated reproductive health program that puts a woman’s needs first?

8 Is the process by which an incentive program is designed or implemented relevant to its acceptability? A program imposed from above may be unacceptable, whereas one developed with community participation (especially women’s participation) may be accepted eagerly.

9 Finally, do incentives work? Many argue that incentives simply do not do the job. Evaluation has proved difficult to date.

The statement that there is a basic human right to decide freely and responsibly on the number and spacing of children does not provide the answer to any of these questions. What this right means, what principles can be developed and agreed upon to guide its application in specific circumstances, must be explored. If the reproductive health field is committed to reproductive autonomy and to acting on the increasingly apparent connections between the status of women and the health of women and children, then these questions cannot be avoided.

As a start, the right to reproductive choice should be elaborated as a matter of international law and policy that can influence the activities of international actors in the health and population fields. The upcoming international conferences on human rights (1993), population (1994), and women (1995), as well as the United Nations Year of the Family in 1994, provide important opportunities to pressure governments to wrestle with these issues as a matter of international policy. Simultaneously, the Committee on the Elimination of Discrimination Against Women, the body vested with responsibility for monitoring the implementation of the Women’s Convention, can use its power to adopt general recommendations that elaborate upon the right of reproductive choice as a matter of international law. In both of these processes, the UN’s specialized agencies, including the World Health Organization (WHO), the United Nations Children’s Fund (UNICEF), and the United Nations Population Fund (UNFPA), can play a critical role by providing factual support, as well as the weight of professional authority. On the national level, reproductive health advocates, as individuals and as NGOs, can help diplomats and politicians establish positions on these issues when they attend international fora.

State, Customary, and Religious Law

International standards for a human right of reproductive choice can have a significant effect on the actions of bilateral and multilateral governmental agencies and on the NGOs that are so influential in this field. However, implementing a human right of reproductive choice in national and local legal systems presents another set of vexing questions. For when the specific conditions of an individual woman’s reproductive life are examined, a complex intertwining of state, religious, and customary law and practice are almost invariably confronted. Then, the difference between the law as it is written and as it is practiced must be acknowledged.

In the elaborate systems of formal law that operate in all countries, reproductive autonomy will be determined by a wide range of legal rules and regulations. Some laws, such as those governing abortion, sterilization, and contraception, will relate directly to family planning. There are other laws that continue to influence reproductive autonomy—those regulating relationships between men and women and between parents or families and children. These laws—often referred to as family law—include such matters as marriage, divorce, and custody. Other areas of the law critical to women’s reproductive autonomy are those governing a woman’s legal capacity (for example, her right to enter contracts, inherit and own property, give informed consent, obtain credit, determine citizenship), and those governing employment and business relations (see Freeman, 1991).

In a constitutional system such as that of the United States, there may be broad, fundamental principles (constitutional principles) that are interpreted as guaranteeing a woman the right to reproductive autonomy. In theory, such principles can be used to preempt or invalidate other laws that are deemed to conflict with them because they inhibit reproductive autonomy. So, for example, in 1965, the United States Supreme Court ruled that the US Constitution guaranteed to its citizens a right of privacy; the constitutional right of privacy was then used to invalidate a Connecticut statute that outlawed the use of contraceptives (Griswold v. Conn., 1965). Similarly, in the 1973 case of Roe v. Wade, the Supreme Court ruled that the right to privacy included a woman’s right to terminate a pregnancy. However, that right was not absolute. The Court ruled that at the point of fetal viability, a woman’s right to an abortion could be overridden by the state’s interest in protecting the potential life of the fetus. In its most recent decision, the Court went still further in qualifying a woman’s constitutional right...
to make decisions about her reproduction, holding that even before viability a state may regulate abortion in any way it deems appropriate so long as the regulation does not impose an “undue burden,” that is, so long as it does not have “the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus” (Planned Parenthood v. Casey, 1992).8

Most countries in Europe, Latin America, and East Asia have conceptually similar systems. Laws are enacted by a legislature or promulgated by civil authorities, and then enforced by the state. Specific laws are generally subject to broader, more fundamental principles or doctrines (such as the right of privacy in US constitutional law); in some countries these controlling principles may even be written in language adapted from or similar to international human rights documents. This system of secular state law governs (or is supposed to govern) most aspects of family life, although religious influence can still be seen in the clerical involvement in the marriage ceremony and in debates concerning birth control and abortion.

However, in Muslim countries, in South Asia, and in much of sub-Saharan Africa, there is a more complex interplay of state, religious, and customary law. The complexity of these countries’ systems derives in large part from their history as colonies of European powers. The colonial powers typically imported their own European legal codes to govern public life—matters such as government administration, finance, labor markets, and crime—and established western-style court systems to enforce them. These laws were instrumental and utilitarian in character, that is, they were imposed by centralized authorities as rules consciously and purposefully designed to foster certain forms of social and economic life that the colonizers deemed best suited to achieving their own goals.

The colonial powers had little interest, however, in the conduct of their subjects’ private lives, their family relations, social status, and religious duties, and left most of the rules governing these aspects of life untouched by official enactments (Mayer, 1987). As a result, the religious and customary law that had governed questions of personal status for centuries was allowed to remain nearly intact. Unlike the utilitarian basis of state-created public law, personal status law was grounded in religion and custom; emanating from divine or sacred sources, personal status law was thought to embody values that are intrinsically important, and so, in theory at least, such law admits of no quick manipulation to meet social goals.

When these countries achieved independence, they initially passed acceptance statutes, by which they accepted the colonial laws then in force and gradually, over a period of years, adopted their own set of laws. However, in almost all former colonies, the basic dichotomy between western-derived law governing public life and religion- or custom-derived law governing private life has persisted. This dichotomy has especially important consequences for women. For example, the secular legislature might adopt a constitution that includes a broadly stated provision prohibiting discrimination on the basis of sex. However, if the most fundamental aspects of a woman’s life are governed by a separate set of laws, based on religion, then the secular constitutional principle of nondiscrimination will have little impact on her life. For instance, a state law banning gender discrimination in employment will mean nothing to a woman whose husband forbids her to work.

A central dilemma for reproductive rights advocates is that such a bifurcated system often puts the law governing reproduction beyond the reach of secular authorities. In virtually every Muslim country, for example, family relations are governed by a body of personal status law derived from religion and customary practices. Often these laws are enforced by religious authorities and adjudicated in religious courts. With the rise of Muslim fundamentalism, there has been great pressure to adopt Sharia, or Islamic law, as state law, thereby putting the force of government behind the authority of religion. The growing trend in Muslim countries to rely on Islamic law to govern family matters is a cause of great concern for reproductive rights advocates. The situation was bluntly described by Dr. Nawal el-Saadawi, one of the best-known advocates for women’s rights and health in the Arab world:

In the Arab world of 1990, there is little talk of the reproductive rights of women, or even their work rights. To this day, some conservative political and religious forces maintain that God created a woman in order to stay at home, to serve her husband and children, that she is subject to the law of obedience which is the primary foundation of the institution of marriage in our countries. A woman’s duty is obedience: obedience to her husband, to her father, to the ruler, and to the state. These forces . . . speak in the name of God, religion, religious law, and secular law. All of them regard a woman’s body as part of their property and the children produced by a woman’s body also as the property of the husband or state or both. (Saadawi, 1990)

While some Muslim countries might share this basic attitude toward women, in fact the precise content of the law can vary dramatically from country to country. With no central church or divinely ordained clergy that can declare doctrine (as does the Roman Catholic Church), there is no such thing as the Islamic law. So, for example, under the strong personal guidance of Presi-
dent Bourguiba, Tunisia was able to modify its Personal Status Code with the blessings of Tunisian Islamic scholars, to abolish polygyny, and to permit abortion during the first trimester. In Saudi Arabia a man may have up to four wives, and there is debate among Islamic scholars there about whether abortion is forbidden altogether or is permitted up to the first 60 or 90 days. In Egypt polygyny is allowed if the first wife does not launch a legal protest.

Despite the potential richness of interpretation of Islamic law, it is clear to many observers that some politically active fundamentalists are making selective use of Sharia to legitimate practices that subjugate women to the will of the men in their families and that exclude them from the life of their communities (Shaheed, 1986). The seclusion of married women (purdah) and divorce by repudiation (talaq) are just two examples. Customs such as female genital mutilation—designed to protect virginity by denying a woman sexual pleasure and, in its most severe form (infibulation), by physically preventing penetration—while not originating in or required by Islamic law, have been tenaciously maintained in many Muslim countries.

How those committed to the protection of women’s reproductive rights should deal with the influence of religious fundamentalism of any kind—Muslim, Hindu, Christian, or Jewish—is obviously a central question in the development of a reproductive health strategy that views the promotion of women’s reproductive autonomy as a central value. In Muslim countries, for example, many women activists continue to fight adamantly for secularization of their laws. Others have come to believe that only a grass-roots movement that works from within Islam, from within the cultural reality in which the great mass of Muslim women live, has any hope of making a real change in women’s lives (see, for example, Shaheed, 1986; Kandiyoti, 1989; Hassan, 1989; An-Naim, 1987).

Conclusion

The problem of how to implement international human rights, particularly those concerned with the advancement of women, into domestic legal systems is a complex one to which there is no single, and certainly no quick and easy, solution (Freeman, 1992). But we must at least begin to ask the question. In matters of reproductive choice, changing the formal law is only one small step. The notion of reproductive autonomy as a basic right of every woman must begin to seep into the structures of government, the fabric of health-care systems, and the thinking of women themselves and the men around and with whom they live.

The time has come to make reproductive autonomy a genuine human right and to set standards for its enforcement. The three upcoming international conferences—to consider human rights in 1993, population in 1994, and the status of women in 1995—will help set the agenda for the remainder of the decade and into the next century. Defining the right to free and responsible decisionmaking in reproduction will be one of the critical—and most difficult—issues facing the government representatives attending the conferences. Health professionals have much to contribute to this endeavor, both through their immediate work in health-care systems and through their involvement in the international policymaking process.

We do not purport to have definitive answers to the difficult questions we raise. But we do hope to begin to draw the international health community into the important work of elaborating standards of human rights, and to sharpen the discussion of these issues among health professionals at every level.

Notes

1 Two years earlier, in 1966, the United Nations General Assembly had adopted a resolution on Population Growth and Economic Development recognizing the principle that “the size of the family should be the free choice of each individual family” (United Nations General Assembly Resolution 2211, [XXI]). However, not until the Teheran conference was reproductive choice characterized as a “basic human right.”

2 The philosophical basis for this right remains a matter of some disagreement. For some, reproductive rights are “natural rights”, an inalienable part of each individual’s essential humanity. For others, reproductive rights are socially determined needs derived from the unequal gender relations that prevail in most societies (see Petchesky, 1990).

3 Unlike the other declarations quoted above, the Women’s Convention is an international treaty, theoretically binding on those nations ratifying it. So far, 118 nations have ratified, although some have done so subject to a reservation that local law, such as Islamic law, will apply in case of a conflict.

4 Interestingly, the Forward Looking Strategies adopted by the Women’s Conference in Nairobi in 1985 reflect some discomfort with the notion of responsible decisionmaking. That document declares a “right to decide freely and informedly on the number and spacing of children” (United Nations, 1985, ¶156). Perhaps the view of the drafters was that a woman’s informed choice would, by its very nature, be a responsible one. However, this wording, “freely and informedly,” never caught on and, to our knowledge, has not been used in later statements of the right of reproductive choice.

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