Women's Global Health and Human Rights

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INTRODUCTION

Laws and policies for human rights evolve, with this evolution drawing on the culmination of several facets of social change: the nature of the driving issues, the rhetoric of proponents and adversaries, the strategic decision making of advocates, and the influence of key stakeholders on all sides of the issues.[2] Yet not all movements for social change reach the level of international law. It is only when there is "a set of political/legal concepts or vocabulary by which scientific insights can be reframed into political claims, and a social movement that can press such claims" that new thinking translates in law, policy, or rights.[3] Characterizing this process in human rights evolution through a "tipping point" model of social change, this chapter explores how the international legal language of reproductive rights became nearly synonymous with women's civil rights, laying out a theoretical human rights framework for the largely programmatic public health chapters that follow. Through this review of international legal norms and the social movements that presaged them, we find that this narrowing of human rights discourse in reproduction is due largely to three elements: political climates at specific moments in history; limitations of available legal frameworks; and strong, vocal, and visible social movements for women's equality. These associated elements have created a paradigm shift, restricting reproductive rights to a negative human rights framework (requiring government to cease interferences) rather than a comprehensive framework complemented by positive human rights (requiring government intervention).

Through the 1979 Convention on the Elimination of All Forms of Discrimination Against Women and subsequently in the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing, many of the advocates for women's equality became the lobbyists, the lawyers, and the leaders in the struggle to define and achieve reproductive rights. Bodily integrity, personal autonomy, and the right to choose became the shared discourse for women across the world in realizing freedom from paternalistic

CHAPTER 8

Going Negative: How Reproductive Rights Discourse Has Been Altered from a Positive to a Negative Rights Framework in Support of "Women's Rights"

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It would be a sad irony if our efforts to empower women were to be reduced to a debate on abortion, and if the role and well-being of women were to be reduced, once again, to just one aspect and one moment of their lives and reproductive health, however important it may be.[1]

—Hiroshi Nakajima

regimes. Reproductive rights, rather than goals in and of themselves, were originally framed by women's rights advocates as a means to achieve gender equality. While women's equality would not be whole without reproductive freedom, this predominant demand for a negative rights approach has placed reproductive health outside of the legal obligations of the state.

Yet women's health is different from women's civil rights, requiring more than rights to privacy, nondiscrimination, or participation. Although the right to control one's fertility is a pressing reproductive need,[4] reproductive health also encompasses positive rights—the enabling economic, social, and cultural conditions "in which choices are made" and the infrastructure that allows those choices to come to fruition.[3] Women and men in some cultures are simply not in a position to exercise autonomy or privacy in a way that will lead to sexual and reproductive health. For example, the right to control one's own fertility does not mean much if oral contraceptives are inaccessible or family planning clinics are inadequate, or in a nation in which the health system is crumbling and women's voices are stifled. Thus, "the right to privacy is simply not broad enough to ensure that all women have access to the health services."[3] Where reproductive rights are distilled to a debate on the single issue of abortion (critical as though it may be), myriad other aspects of sexual and reproductive health are left outside of legal discourse.[5]

The current reproductive rights legal framework—formulated as negative rights to protect reproductive decision making—is not independently capable of responding to modern public health challenges. The global capitalist economy has exacerbated disparities in underlying determinants of good health, with neoliberal economic development policies and continued fallout from structural adjustment programs having rendered health care a privilege rather than a basic right. Scholars have only begun to analyze the detrimental long-term effects of the free market economy, which has been shown to affect governmental infrastructures, vulnerable groups, and health outcomes.[6] This global economic shift has harmed, if not decimated, state-sponsored (and therefore universally accessible) health systems, systems which could, if given the infrastructures and resources necessary, address inequities in underlying determinants of women's health.[7] Without economic and social rights to combat these inequities, specifically rights to health and reproductive health care, rights to privacy and bodily integrity cannot fully succeed in improving lives.[8]

In this chapter, we explore how reproductive rights came to fall under this negative rights framework, examining why this strategy dominated the history of ideas on reproductive health as a human right. In Part II of this chapter, we provide an overview of human rights frameworks and discourses, focusing on the historical split between negative and positive rights and contemporary efforts to reunite these interconnected paradigms. In Part III, we trace the historical events that structured the legal framing of reproductive health, highlighting the political debates, the available legal paths, and the social movements that brought reproductive justice to international policy discussions. Part IV then looks to constructivist international relations frameworks, using a tipping point model of norm evolution, to analyze how and why the changing discourses of reproductive health culminated in a negative rights construction. In Part V, we point out the shortcomings of this enduring negative rights framework and posit that current politics, legal paths, and social movements provide a unique opportunity to develop a complementary positive rights discourse for women's health.

Legal Frameworks

Human rights, though at times purporting to represent natural law, are inextricably rooted in historical context, and as a result of this historical construction, can be seen to evolve in response to social movements.[9] The structure of the UN human rights system, from its origins, was tailored to satisfy political will. Although the 1948 Universal Declaration of Human Rights (UDHR) provided the most comprehensive enumeration of all fundamental rights at the time, when it came time for states to ratify legally enforceable instruments based upon the UDHR, international relations necessitated a split. After all, the post-WWII world

itself was divided politically. Western countries were primarily pressing civil and political rights, wary of adopting legally enforceable "welfare" rights. Eastern states, many under communist and socialist rule, were in favor of economic and social rights, but were not willing to adopt legally enforceable civil and political rights. In an effort to salvage the human rights enterprise, state representatives entered into lengthy negotiations and reached what may have been one of the most influential human rights compromises of the century: two separate 1967 treaties—the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). The world was consequently left with an enduring legacy of bifurcation, reifying the historically constructed political split between civil and political rights and economic, social, and cultural rights.[10]

Though arguably superficial in construct, this divide is critical in application. In its most basic form, civil and political rights, enshrined in the ICCPR, are interpreted as "negative" rights. These rights do not purport to require government intervention.[11] Rather, they ask governments to cease engaging in activities such as torture, interference with voting, or intrusion in citizen's private lives. Economic, social, and cultural rights, enshrined in the ICESCR, are typically framed as "positive" rights. These are rights that call for government intervention such as the right to education, the right to housing, and, most importantly for this chapter, the right to the "highest attainable standard" of health.[12] While almost all scholars now agree that there are negative and positive aspects to each human right (e.g., the meaningful realization of the right to vote encompasses both the state ceasing interference and providing a functioning infrastructure),[13] even a codification of this interrelation among rights in the 1993 Vienna Declaration and Programme of Action has done little to mediate the underlying frameworks constructed during the height of the Cold War.

Continued Western influence has led to a more developed jurisprudence for negative rights, which Western scholars continue to term "first-generation rights."[14] As a result, activists often seek to enforce the more acceptable negative aspects of economic and social rights rather than put forward a direct positive rights argument (e.g., a strategic preference for selective violations of the negative right to life over pervasive violations of the positive right to health).[15] Given this legal landscape, reproductive rights advocates have been more readily able to engage civil and political rights than economic, social, and cultural rights as a means to reach their immediate goals of women's freedom, including reproductive freedom. Donna Sullivan summarizes and justifies this strategy:

> Until the mechanisms for supervising and enforcing implementation of social human rights are strengthened . . . the main aspects of individual and community health, including those related to sexual and reproductive health, are probably better protected indirectly, through enforcement of related classical human rights [negative rights], than by way of reliance on the right to health itself.[16]

But just how and why have negative rights become more readily available for the framing of reproductive rights? In the 1979 Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), state representatives agreed to root gender equity through civil and political rights. Although there are provisions for economic, social, and cultural rights, CEDAW calls predominantly for equality, freedom, and nondiscrimination—all principles of negative rights.[17] It was under the aegis of this convention, and its codification of negative rights for women's empowerment, that women's rights advocates for reproductive freedom found their legal voice.

In this historical predisposition for negative rights (in reproductive rights and beyond), the right to health under the ICESCR has been comparatively underutilized by states, international organizations, and international treaty implementation bodies.[16] It was not until 2000 that the Committee on Economic, Social and Cultural Rights produced General Comment 14 on the right to the highest attainable standard of health, providing the international human rights community with the clarification necessary to determine the meaning of the right to health and to realize the right through enforcement of state obligations.[18] With this elaboration of positive rights for health, reproductive rights advocates have a

unique opportunity to expand their human rights discourse to encompass reproductive health issues.

Evolution of Reproductive Rights

Tracing the historical events and political contexts that led up to the modern day conceptualization of reproductive rights, it becomes clear that international legal norms for health correspond historically with social movements. In this part, we trace these movements, discussing the ways in which they pressed for codification of international legal obligations for reproductive rights.

1950s and 1960s: Population Control

The modern era of human rights began with special concern for issues of reproductive decision making, if not reproduction itself. In the 1948 Universal Declaration of Human Rights, states explicitly linked motherhood with health rights and other social services:

- Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.
- Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.[19]

Proceeding from the gender equality mission of the Commission on the Status of Women while ensuring paternalistic chivalry for the "special care" of women, these health concerns would soon become the basis for the ICESCR's Article 12 codification of the right to the "highest attainable standard" of health to include state duties for "provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child."[20]

And yet despite this emphasis on reproductive health, reproduction remained in these early years under the rubric of population control (a sovereign state prerogative) rather than rights (a protected individual entitlement). Demographers in the 1950s and 1960s, drawing on Malthusian fears of overpopulation and holding firm to the theoretical remnants of eugenics, pressed for national policies that would restrain the unchecked growth of the developing world. Despite a consistent emphasis on population control, the tools underlying the debate changed in the 1960s with the advent of medical technologies for hormonal control (most prominently, oral contraceptives) and thereby for population control practiced at the individual level (in opposition to pronatalist developing country policies).[21] Reproductive rights arose in part from the confines of this new population control, with demographers using reproductive technologies to conceive of a "family planning agenda" that would impose Western notions of fertility reduction on developing countries under the rhetorical guise of "reproductive rights."[22] Based on previous United Nations declarations recognizing the importance of slowing reproduction to improve living conditions, this human rights consensus is expressed most expansively in the 1968 International Conference on Human Rights in Tehran, which proclaims the right of "parents...to determine freely and responsibly the number and spacing of their children."[23] This invocation of family planning as an individual human right, making available information along with the benefits of advances in science and technology, would frame women's rights to reproductive health services as extending only as far as access to family planning, a negative framing of reproductive rights that would help structure the debates of the decades to come.[24]

1970s and 1980s: The UN Decade of Women

Despite the emergence of "reproductive rights" as family planning, "reproduction" remained synonymous with "pregnancy," and "pregnancy" remained a site for sexism and paternalism. By the 1970s, the women's rights movement for equality was becoming stronger, more active, and more developed. Starting in 1967 in the United Kingdom, a cascade of domestic abortion court cases and

laws flowed across the Western world. In 1969, Canada began to permit abortions under limited circumstances; in *R v. Davidson* in Australia, abortion was made legal to protect the life or physical or mental health of the woman; in 1973, the US Supreme Court heard *Roe v. Wade*, framing US constitutional protections of abortion; and from 1973 to 1980, France, West Germany, New Zealand, Italy, and the Netherlands passed laws legalizing abortion under certain circumstances.[25] At the international level, the United Nations Decade of Women and the women in development (W.I.D.) movement began to chip away at notions that continued to equate women with pregnancy. In 1967, with the support of the Commission on the Status of Women, the UN adopted the Declaration on the Elimination of Discrimination against Women, making this Declaration legally binding in the 1979 CEDAW. Through CEDAW, autonomous control over one's own body was seen as the key to participation and development:

> 12.1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
>
> 12.2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.[17]

With this language, Article 12.1 couches health in terms of equality and access, not as an explicit social right.[17] Article 12.2, addressing access to services, only applies to pregnancy.[17] Advocates felt that women needed to move toward laws providing for gender equity in all aspects of life. The focus was directed on equality in the public sphere, not the enabling underlying conditions traditionally thought to be in the private sphere or the health rights necessary for reproductive health.[26]

Given this attention to women as rights-holders, the 1985 Third International Conference on Women in Nairobi brought violence against women into global public concern, the first international legal consideration of a women's issue that had previously been relegated to the private sphere.[26] A large NGO forum at Nairobi provided the space for women to explore legal frameworks to combat their unique harms.[26] For example, the final report from Nairobi states: "[t]he continuation of women's stereotyped reproductive and productive roles, justified primarily on physiological, social and, cultural grounds, has subordinated them in the general as well as sectoral spheres of development."[27]

1985–1993: Vienna

With a firm underpinning in international law, the next eight years saw the women's rights movement make significant advances in nations throughout the world.[2] Violence against women, rape, and sexual assault also brought gender inequalities and women's rights to the forefront of international concern. Most rights for women were, at the time, not broadly pursued. Yet the right to be free from violence, internationally well defined, became an important and opportunistic entry point to advocate for rights specific to women. In this context, reproduction and sex were characterized as tools of oppression and the situs of both physical and structural violence against women, restraining women from realizing their civil and political rights to participation and development. Although little is written about this time period, some authors show that this was a time of formulating and debating reproductive justice under this new framework.[28] As international relations changed through the fall of communism and rise of the neoliberal economic model, women's rights advocates were gaining strength and power in domestic circles, networking with one another and preparing to advance their agenda in international law.

The landscape of human rights changed in 1993 in Vienna.[29] As part of a larger recognition that all human rights are interrelated, interdependent, indivisible, and universal (purportedly to reconnect positive and negative rights frameworks), women's rights activists from all over the world came together with governmental and nongovernmental representatives to speak out at the Vienna Convention. Their words were memorialized in

the Vienna Declaration and Programme of Action (Vienna Declaration) on the future of human rights in the post-Cold War era.[30] With regard to the rights of women, the Vienna Declaration recognized that:

> The human rights of women and of the girl-child are an inalienable, integral, and indivisible part of universal human rights. The full and equal participation of women in political, civil, economic, social, and cultural life, at the national, regional, and international levels, and the eradication of all forms of discrimination on grounds of sex are priority objectives of the international community.

Gender-based violence and all forms of sexual harassment and exploitation, including those resulting from cultural prejudice and international trafficking, are incompatible with the dignity and worth of the human person, and must be eliminated. This can be achieved by legal measures and through national action and international cooperation in such fields as economic and social development, education, safe maternity and health care, and social support.

The human rights of women should form an integral part of the United Nations human rights activities, including the promotion of all human rights instruments relating to women.[31]

While the Vienna Declaration did not result in the promised denouement in rejoining positive and negative rights for reproduction, the Vienna Declaration was an important landmark for "increasing public visibility for the human rights of women," setting the stage for achievements that would arise soon thereafter.[32]

1994–1995: Cairo and Beijing

Standing on these years of advocacy work, foundation-building activism, and international law culminating in the Vienna Declaration, the 1994 International Conference on Population and Development (ICPD) in Cairo was a strategic opportunity to move away from fertility control. Discourse framed reproduction and sexuality as a combination of both civil and political rights and economic and social rights, advancing these issues in terms of (1) bodily integrity and self-determination, (2) equality, and (3) enabling conditions or social rights.[29] These concepts were constructed as "prerequisites" for women's full participation in society and development, but not yet as rights unto themselves.[29] Just as paternalistic world leaders had used reproductive rights as a rhetorical guise for population control three decades earlier, now population control provided a rhetorical guise for moving reproductive rights forward.

The Fourth World Conference on Women in Beijing took these hortatory statements even further, endorsing a strong rights-based approach to women's equality and reproductive freedom as well as economic and social rights.[33] Yet even with the guiding principles of Cairo focused on economic and social rights—"[p]opulation-related goals and policies are integral parts of cultural, economic, and social development, the principal aim of which is to improve the quality of life of all people," and "[s]tates 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 rights continued to be aligned with negative civil and political rights.[34] Where political will and global economics did not provide the space or opportunity to meaningfully consider enabling conditions and social rights, reproductive rights continued (and continue today) to be strongly associated with autonomy, self-determination, and equality.

The Framing of Reproductive Rights: Turning a Movement into a Right

Flowing from this historical description of the evolution of international law for reproductive rights, this section examines how these historically constructed developments and political contexts worked in tandem to culminate in the utilization of negative rights to codify reproductive and sexual rights as human rights.

This analysis builds on a rise of constructivism in international relations theory,[35] viewing norms as instrumental in ordering state behavior[36] in the language of human rights jurisprudence and examining the development of each international human right as an iterative process indicative of a

global set of norms. Rather than a human right serving as an individual norm, it is possible to consider each human right as a collection of multiple norms, each of which can independently emerge, evolve, and spread over time.[37] International law has become the predominant way of memorializing these global human rights norms,[38] and, as a result, recent constructivist scholarship has looked to the expression of norms in international legal institutions.[36] In this sense, international law reflects a negotiated codification of global norms already in existence and reifies those norms until changed through normative evolution and subsequent legislative amendment.[39]

Applying this framework for norm evolution to explore how reproductive rights became codified as negative rights, this analysis applies a "tipping point" model of global norm development.[40] Here, norms are seen to emerge in a single state among a small group of actors; only once a critical mass of states have adopted the norm does the norm reach a "tipping" point, followed thereafter by broad international acceptance. Under this model, networks of nongovernmental actors ("norm entrepreneurs" in the language of international relations) persuade powerful domestic and international actors ("norm leaders") on the correctness of their social movement,[41] swaying states and international organizations to endorse norms and press them into domestic, regional, and then international treaty law. Reaching the tipping point of states necessary for international codification of this changing norm, norms thereafter gain broad international acceptance through what is now termed a "norm cascade."[40] During this process, individual state and nongovernmental representatives harmonize individual state norms and advance these ideas into international legal discourse.[42] The final stage, norm internalization, "generates a legal rule that will guide future transnational interactions between the parties; future transactions will further internalize those norms; and eventually, repeated participation in the process will help to reconstitute the interests and even the identities of the participants in the process."[43]

In social movements to declare a norm of reproductive freedom and codify that norm as a human right, women's equality activists were "norm entrepreneurs." They were motivated to lobby for reproductive freedom as part of their larger agenda for gender equality. Their organizational platform was CEDAW, focusing on civil rights. As the movement to translate reproductive health into legally enforceable human rights grew, the next class of norm entrepreneurs was dependent on this legal path and existing normative frameworks of women's equality and negative rights. At the ICPD and Fourth World Conference on Women, the normative framing of reproductive justice as a series of negative rights reached its tipping point, where women's rights groups reached the critical mass necessary to secure a place on the international agenda for reproductive freedom.[44] By this moment, the existing structures and legal norms for population and development were in place and provided the path and political support needed to move a negative conception of reproductive rights forward.[1] The norm entrepreneurs, the organizational platforms (development and gender equality conferences), and the dependency on existing normative frameworks acted in concert to dictate this negative rights approach.[45] Despite some activists' longstanding warnings of the shortcomings of this negative rights discourse—explaining that women's reproductive decision making does not exist in a vacuum, but rather is highly dependent on social, political, and economic contexts[5]—reproductive justice as a negative right is currently in the third stage of norm evolution, "norm internalization," as states and other actors have begun to apply the negative rights codification of reproduction to guide policies and programs.

In depicting the normative evolution of reproductive health norms into a negative international human right, Figure 8-1 highlights each international legal document in the process, delineating each legal standard by its pursuance of negative rights discourse (below the line) or positive rights discourse (above the line). Viewing norms for reproductive rights in this way, it is clear that the framing of reproductive health has changed over time, flowing from negative to positive and back again. Yet internalization of reproductive rights as negative rights may be stymied by competing normative frameworks, with a new human rights landscape seen in the emergence of positive rights norms for a robust right to health, indicated by the arrows showing a potential reframing of reproductive health norms in responding more fully to modern reproductive health needs.

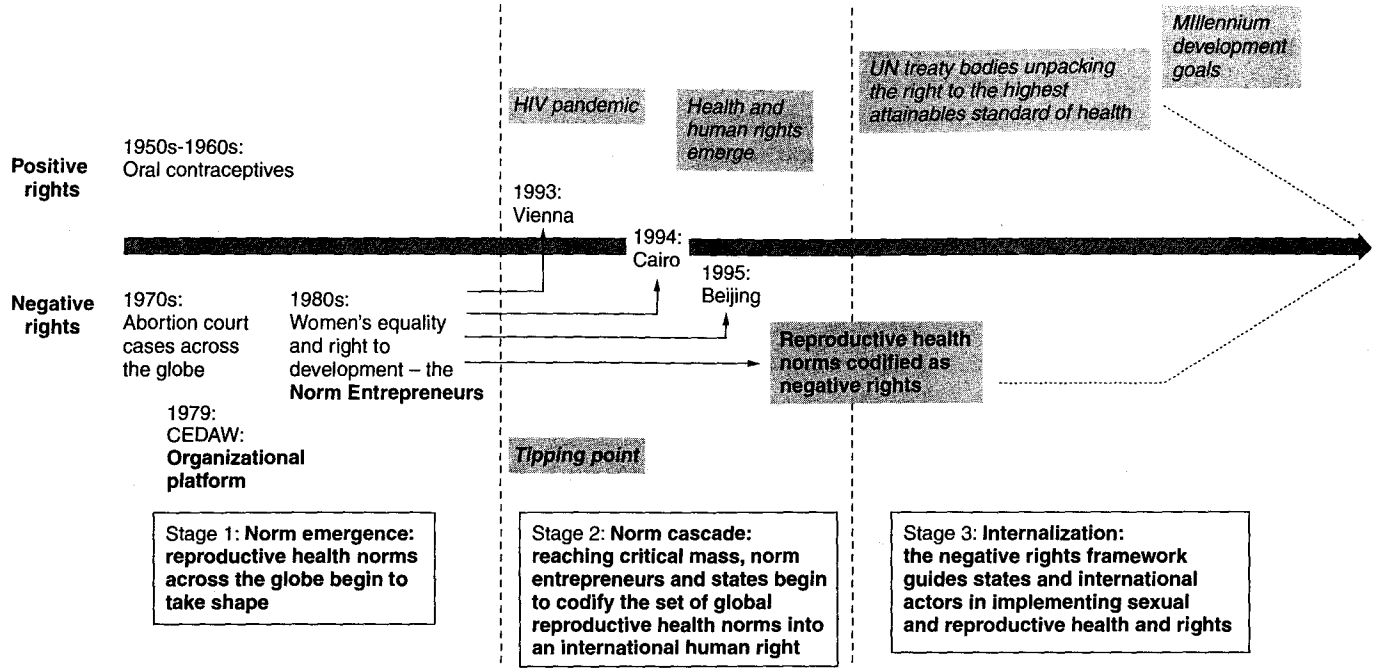

FIGURE 8-1 Timeline of Human Right's Progress towards the Millennium Goals

Within the normative debate outlined above, although there were likely multiple, overlapping forces acting upon and within the reproductive rights movement, it is clear that the following social movements bear a preponderant role in driving reproductive rights discourse in international law.

First, strange bedfellows—the Vatican and Muslim fundamentalists—found agreement in their strong opposition to reproductive and sexual rights.[32] Throughout the course of modern history, religious groups have been successful in mobilizing to exert influence on global politics.[46] While passing a law against violence or rape was morally acceptable to these groups, progressive ideas such as reproductive freedoms and sexuality rights were not, with implicit and explicit homophobia present at negotiating tables into the early 1990s and beyond.[25] For example, the preamble to the ICPD uses language that carves out exceptions for religious and cultural practices.[34] In opening the door to reproductive and sexual justice, LGBT populations would be authorized to claim rights, thereby weakening the basic tenets of these politically powerful religions. Responding to these pressures, women's groups were constrained to press for reproductive freedoms, not a right to reproductive health.

Second, environmental groups, focused on controlling population growth and fertility, also played a role in shaping the discourse for reproductive rights. Reacting against interest groups pressing for government-sponsored fertility control programs, women's rights activists espoused a "hands off my body" approach to reproductive rights, reinforcing a negative rights framing of reproduction. The emphasis on population control also strongly influenced the burgeoning of the reproductive rights movement in the global south, as northern superpowers began to exert pressure on developing nations to control fertility, evident in some of the language and discourse of Cairo.[46] This struggle also pointed to a negative rights framework to give women rights over their own bodies, if only to stave off "insensitive (if not downright coercive) population control policies."[46]

Finally, the global economy, driven by the effects of the Washington Consensus and international financial institutions' structural adjustment programs, led both developed and developing nations to experience massive cutbacks in social welfare systems, especially health care. In light of this

retrenchment in the welfare state under the neoliberal development model, a reliance on a positive right to health framework in the late 1980s and 1990s would likely have led to few, if any, actual achievements or improvements in reproductive health. Where there lacked the state-level capacity to intervene for sexual and reproductive health through a positive rights framework, there could be few obligations placed on states for conditions largely outside their control.

The legacy of this discourse, a negative framing of reproductive rights, is not sufficient to respond to the changing needs, politics, and economics of today's globalizing world. A negative rights framework obligates states to do little more than cease interfering with the individual right to freely choose the timing and spacing of childbearing and to ensure freedom from sexual violence in the public sphere. (In fact, it has been suggested that states intentionally moved toward a negative rights framework to allow states to provide the bare minimum of health protection and yet still claim that they are fulfilling women's rights.[47]) This framing has not succeeded in achieving bodily integrity and respecting the right to privacy in all parts of the world, nor has it led to equal reproductive justice or sexual and reproductive health in the current neoliberal economy. Women and men will need states to provide a functioning healthcare system and the economic and social conditions that underlie reproductive justice in order to realize sexual and reproductive health.

Moving Forward: Normative Frameworks and Legal Paths

Despite this evolution of reproductive justice as negative rights, reproductive rights are not fixed on this path. Highlighting the ever-present gap between rights and reality, sexual and reproductive health in today's economic and political climate has arguably become even less accessible for many, especially vulnerable populations and communities.[48] With more global attention being paid to social determinants of health and a stronger positive rights framework, the stage is set for shifting reproductive rights away from the negative rights discourse and framework. While not criticizing the past negative rights discourse of reproductive rights—on the contrary, this was exactly the necessary strategy to translate the social movement for reproductive justice into human rights—it is clear that this framework alone is not appropriate to today's economic, social, and political climate. Given current global health initiatives, the time has come to build on and complement this negative rights jurisprudence by codifying the positive rights inherent in reproductive health.

The Millennium Development Goals

Today's global economy and the international flow of donor funding, both affecting reproductive and sexual health, suggest that a positive rights framework that supports enabling economic and social conditions for sexual and reproductive health is not only desirable but also necessary.[49] International governance has already partially endorsed such a shift with the advancement of the Millennium Development Goals (MDGs).

Though not legally enforceable, the MDGs clarify international consensus on the enabling conditions and social rights necessary for the meaningful and complete realization of reproductive health and rights. In this way, there is a new shared discourse. Creating prescriptions for policies responsive to the needs of the developing world, four of the eight MDGs involve improvements in health—including the reduction of maternal and infant mortality, the prevention of HIV infection, and the eradication of hunger, and one specific to development.[50] For each goal, the United Nations has outlined a number of targets and indicators by which to assess realization of these goals, providing an important roadmap for policies and programs.[51] While these MDGs have been criticized for not taking a legal approach to human rights and for the selection of maternal and infant mortality over health systems more generally,[52] they have become a favored tool in linking reproductive health with development. They may also provide an important link between sexual and reproductive health within a positive rights framework. While the MDGs are a critical step in moving toward a positive rights framework for reproductive rights through the provision of a new shared discourse rooted in development,

additional steps will be needed to enforce these rights through international law.

The Right to the Highest Attainable Standard of Health

To codify these positive rights for reproductive health, the human right to health provides a foundation upon which these rights can be built. Ten years ago, the right to health was, to many, an underutilized, underexplored, and unexplained framework for reproductive health.[53] The language of the right itself did not provide specific guidance to states under its funding-dependent framework for achieving "the highest attainable standard of physical and mental health."[20] In the absence of specific public health goals, the ICESCR holds only that states must take affirmative steps necessary for "(a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child; (b) the improvement of all aspects of environmental and industrial hygiene; (c) the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases; (d) the creation of conditions that would assure to all medical service and medical attention in the event of sickness."[20] Although criticized for its ambiguity,[54] the individual right to health has been interpreted to embrace, as part of its minimum core content,[55] basic provisions of emergency health care necessary to save lives, including the treatment of prevalent diseases, the provision of essential drugs, and safeguards against serious environmental health threats.[56]

This ambiguity in human rights for reproductive health was largely washed away beginning at the turn of the century, with UN treaty monitoring bodies clarifying the content of the right to health in CEDAW's General Recommendation 24 on women and health (1999)[57] and the ICESCR's General Comment 14 on the right to health (2000).[18] It is likely that the attention now paid to the right to health has as much to do with the explosion of HIV/AIDS in developing countries as with the inability of neoliberal states to address the fallout from HIV/AIDS in sexual and reproductive health. These general comments provide a foundation to enumerate and clarify state obligations and implement programmatic specification from the expansive language of the right to health. General Comment 14 provides a useful framework of accessibility, acceptability, availability, and quality ("AAAQ") to evaluate state actions to realize the right to the highest attainable standard of health.[18] To compliment this discourse, General Comment 14 also calls upon states to respect, protect, and fulfill the right, specifically addressing the components of this right necessary for reproductive health by finding that:

> The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child (Art. 12.2 (a)) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information).[18]

These specific state obligations, coupled with the AAAQ framework, begin to provide a positive rights framework for reproductive rights in today's globalizing world, where women's equality and freedom necessitate positive rights along with negative rights to attain reproductive health.

New Norm Entrepreneurs: Maternal Mortality as a Human Rights Issue

A newly emerging movement to view maternal mortality as a violation of human rights has galvanized new norm entrepreneurs to advocate for a positive rights agenda in reproductive health.[58] Maternal mortality rates offer a stark example of the impact of changing global economies on reproductive health disparities, highlighting the shortcomings of a negative rights framework.[59] From a public health perspective, maternal mortality cannot be addressed solely through a negative rights discourse; the proven solutions to reducing maternal death and disability are best achieved through a strengthened and functioning health system and a focus on underlying economic and social conditions.[60] The determinants of maternal mortality exist at a systemic level, ranging from a lack of access to contraception to infrastructural deficiencies to an unjust international economic system.[61] While select determinants are captured by the classic negative rights framework, most require some-

thing more—a positive rights framework that holds governments accountable for not providing access to acceptable-quality health care and underlying economic and social conditions for reproductive health.[62] Providing an approach that is "sensitive to the historical and political context of the issues, to the dynamics of power, to the impact of language and discourse, and to the agency of multiple actors involved in any given situation,"[60] this systems-based discourse can garner accountability for national improvements in reproductive health. With burgeoning organizational platforms and normative frameworks providing a new path, these new norm entrepreneurs have the language, inspiration, and direction to implement positive rights for reproductive justice.

Conclusion and Steps Forward

When laws are opened to rethinking, reframing, and restrategizing, they are also opened to threats and dangers, in this case, the threat of backsliding in the progression of reproductive rights. With the resurgence of the Catholic Church and religious fundamentalism in the public sphere, reproductive rights are under attack in a backlash against the successes of previous social movements. In addressing the positive rights inherent in reproduction, advocates must be wary of these forces, which threaten to subordinate the hard-earned freedoms of women. If carefully constructed and negotiated, however, the gains of a positive rights framework, complementing current negative rights frameworks, can overcome these dangers and risks and provide the tools necessary for women and men to achieve the highest attainable standard of reproductive health.

Discussion Questions

1. What positive and negative aspects of reproductive rights have evolved from moral rights to state accountability under international law?
2. Why have women's rights groups been unable to frame a comprehensive right to women's health?
3. How are reproductive rights enforced? What role do advocacy organizations play in that enforcement process?

References

1. United Nations Population Information Network. (1994). *International conference on Population and Development Statement by Dr. Hiroshi Nakajima.* http://www.un.org/popin/icpd/conference/una/940909142950.html. Accessed September 27, 2008.

2. Schuler M. From basic needs to basic rights. In: Schuler M, ed. *From Basic Needs to Basic Rights: Women's Claims to Human Rights.* Washington, DC: Women, Law, and Development; 1995:1-26.
3. Freedman LP. Human rights and the politics of risk and blame: lessons from the reproductive rights movement. *J Am Med Womens Assoc.* 1997;52:165-168.
4. Petchesky R. Cross-country comparisons and political visions. In: Petchesky R, Judd, K, eds. *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures.* London, England: Zed Books; 1998:295-323.
5. Petchesky R. Reproductive freedom: beyond 'a woman's right to choose'. *Signs.* 1980;5:661-668.
6. Globalization Knowledge Network. *Towards Health-Equitable Globalisation: Rights, Regulation, and Redistribution.* Ottawa, Canada: University of Ottawa Institute of Population Health; 2007.
7. Knowledge Network on Health Systems. *Challenging Inequity Through Health Systems.* WHO Commission on the Social Determinants of Health: 2007.
8. The right to the highest attainable standard of physical and mental health. Report of the Special Rapporteur, Paul Hunt. E/CN.4/2004/49: 2004.
9. Otto D. Rethinking the "universality" of human rights law. *Colum Hum Rts L Rev.* 1997;29:10.
10. Donnelly J. *Universal Human Rights in Theory and Practice.* Ithaca, NY: Cornell Univ Press; 2003.
11. Cook R. Human rights and reproductive self-determination. *Am U L Rev.* 1995; 5:975.
12. Steiner H, Alston P. *International Human Rights in Context: Law, Politics, Morals.* Clarendon Press: Oxford; 2000.
13. Landman T. Measuring human rights: Principle, practice, and policy. *Human Rights Q.* 2004;26(4):906-931.
14. Yamin A. Transformative combinations: women's health and human rights. *J Am Med Womens Assoc.* 1997;52:171.
15. Hendricks A. The close connection between classical rights and the right to health, with special reference to the right to sexual and reproductive health. *Med Law.* 1999;18:225-242.
16. Sullivan D. The nature and scope of human rights obligations concerning women's right to health. *Health Hum Rights.* 1995;1:368-398.
17. Convention on the Elimination of All Forms of Discrimination Against Women. New York, NY: United Nations; 1979.
18. Committee on Economic, Social, and Cultural Rights, General Comment 14. The Right to the Highest Attainable Standard of Health. E/C.12/2000/4. New York, NY: United Nations; 2000.
19. Universal Declaration of Human Rights. United Nations General Assembly Resolution 217 A (III). New York, NY: United Nations; 1948.
20. International Covenant on Economic, Social and Cultural Rights. New York, NY: United Nations; 1966.
21. Freedman LP, Isaacs S. Human rights and reproductive choice. *Stud Family Planning.* 1993;24:20-21.
22. Grimes S. From population control to 'reproductive rights': ideological influences in population policy. *Third World Q.* 1998;19:375.
23. United Nations. Final Act of the International Conference on Human Rights. A/Conf.32/41:1968.
24. United Nations. Fertility, Contraception and Population Policies. New York, NY: United Nations; 2003.

25. Rahman A, Katzvie L, Henshaw S. A global review of laws on induced abortion, 1985-1997. *Int Fam Plan Perspect.* 1998;24:56-64.
26. Chesler E. Introduction. In: Chavkin W, Chesler E, eds. *Where Human Rights Begin: Health, Sexuality, and Women in the New Millennium.* New Brunswick, NJ: Rutgers University Press; 2005:1-34.
27. United Nations. *Report of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development, and Peace.* Nairobi, Kenya. 1985. Paragraph 93.
28. Hartmann B. *Reproductive Rights and Wrongs: The Global Politics of Population Control & Contraceptive Choice.* New York, NY: Harper & Row; 1987.
29. Copelan R, Petchesky R. Toward an interdependent approach to reproductive and sexual rights as human rights: reflections on the ICPD and beyond. In: Schuler M, ed. *From Basic Needs to Basic Rights: Women's Claims to Human Rights.* Washington, D.C.: Women, Law, and Development International: 1995:343-368.
30. Robinson M. Foreword. In: Chavkin W, Chesler E, eds. *Where Human Rights Begin: Health, Sexuality, and Women in the New Millennium.* New Brunswick, NJ: Rutgers University Press; 2005:ix-xii.
31. Vienna Declaration and Programme of Action, Report of the World Conference on Human Rights. Vienna, Austria: United Nations; 1993.
32. Petchesky R. Introduction. In: Petchesky R, Judd K, eds. *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures.* London, England: Zed Books; 1998:1-30.
33. Beijing Declaration and Platform for Action, adopted September 15, 1995, by the Fourth World Conference on Women: Action for Equality, Development and Peace. In *Women and Human Rights: The Basic Documents.* New York, NY: Center for the Study of Human Rights, Columbia University; 1996.
34. Report of the International Conference on Population and Development. Cairo, Egypt: United Nations; 1994.. United Nations Population Information Network. (1994). *Report of the International Conference on Population and Development.* http://www.un.org/popin/icpd/conference/offeng/poa.html Accessed September 27, 2008.
35. Kratochwill F, Ruggie JG. International organization: a state of the art on an art of the state. *Int Org.* 1986;40:753.
36. Ruggie JG. What makes the world hang together? Neo-utilitarianism and the social constructivist challenge. *Int Org.* 1998;54:855.
37. Sikkink K. Transnational politics, international relations theory, and human rights. *Pol Sci Pol.* 1998;31:516.
38. Finnemore M. Are legal norms distinctive? *Int L Pol.* 2000;32:699.
39. Alston P. Conjuring up new human rights: a proposal for quality control. *Int L.* 1984;78:607.
40. Sunstein C. Social norms and social roles. In: Sunstein C, ed. *Free Markets and Social Justice.* New York, NY: Oxford University Press; 1997.
41. Wiener A. Constructivism: the limits of bridging gaps. *Int Rel Dev.* 2003;6:252.
42. Müller H. International relations as communicative action. In Fierke K, Jorgensen K, eds. *Constructing International Relations: The Next Generation.* New York, NY: M.E. Sharpe; 2001.
43. Koh H. Why do nations obey international law? *Yale L J.* 1997;106:2599.
44. Isaacs S. Incentives, population policy, and reproductive rights: ethical issues. *Stud Fam Plan.* 1995;26:363-367.
45. Mann J, Gruskin S. Women's health and human rights: genesis of Health and Human Rights Movement. *Health Hum Rights.* 1995;1:309-312.

46. Sen G. Southern feminist perspectives on population and reproductive rights: continuing challenges. *Development.* 1999;42(1):25-28.
47. Cardenas S. Norm collision: explaining the effects of international human rights pressure on state behavior. *Int Stud Rev.* 2004;6:213-231.
48. Getgen J. Reproductive injustice: an analysis of Nicaragua's complete abortion ban. *Cornell Int L J.* 2008;41:144-174.
49. Cook R. Women's international human rights law: the way forward. In: Cook R, ed. *The Human Rights of Women: National and International Perspectives.* Philadelphia, PA: University of Penn Press; 1994:3-36.
50. United Nations Millennium Declaration, adopted 8 Sept. 2000, G.A. Res. 55/2, U.N. GAOR, 55th Sess., Supp. No. 49, ¶ 5, U.N. Doc. A/RES/55/2 (2000).
51. Lee K, et al. The challenge to improve global health: financing the millennium development goals. *J Am Med Assoc.* 2004;291:2636.
52. Meier BM, Fox A. Development as health: employing the collective right to development to achieve the goals of the individual right to health. *Hum Rights Q.* 2008;30:259-355.
53. Rahman A, Pine R. An international human right to reproductive health care: toward definition and accountability. *Health Hum Rights.* 1995;1:401-427.
54. Gostin L, Mann J. Toward the development of a human rights impact assessment for the formulation and evaluation of public health policies. *Health Hum Rights.* 1994;1:58-80.
55. Hendriks A. The right to health in national and international jurisprudence. *Euro J Health L.* 1998;5:389.
56. Toebes B. The right to health as a human right. *Int L.* 1999;25:284.
57. Committee on the Elimination of Discrimination against Women. General Recommendation 24; 1999. http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24. Accessed September 24, 2008.
58. Cook RJ, Dickens BM, Fathalla MF. *Reproductive Health and Human Rights.* Oxford: Oxford University Press; 2003.
59. Rosenfield A, Maine D. Maternal mortality—a neglected tragedy. Where is the M in MCH? *Lancet.* 1985;13:83-85.
60. Freedman LP. Shifting visions: "delegation" policies and the building of a "rights-based" approach to maternal mortality. *J Am Med Womens Assoc.* 2002;54:154-158.
61. Freedman LP. Using human rights in maternal mortality programs: from analysis to strategy. *Int J Gynecol Obstet.* 2001;75:51-60.
62. AbouZahr C. Safe motherhood: a brief history of the global movement. 1947-2002. *Br Med Bull.* 2003;67:13-25.