Population and Human Rights

United Nations

Department of International Economic and Social Affairs

ST/ESA/SER.R/107

Population and Human Rights

Proceedings of the Expert Group Meeting on Population and Human Rights, Geneva, 3-6 April 1989

United Nations New York, 1990

NOTE

The term "country" as used in the text and tables of this paper also refers, as appropriate, to territories or areas.

In some tables, the designations "developed" and "developing" economies are intended for statistical convenience and do not necessarily express a judgement about the stage reached by a particular country or area in the development process.

Papers have been edited and consolidated in accordance with United Nations practice and requirements.

ST/ESA/SER.R/107

PREFACE

The Expert Group Meeting on Population and Human Rights was held at the Palais des Nations, Geneva, from 3 to 6 April 1989. The meeting was convened by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat, in collaboration with the Centre for Human Rights of the United Nations Office at Geneva. The purpose of the Meeting was to discuss new and emerging human rights issues related to fertility, mortality and closely related demographic questions. The present publication contains the report of the proceedings, the recommendations adopted by the Meeting and the papers presented.

The Meeting was the third in a series organized by the United Nations to discuss population and human rights issues. The first was the Symposium on Population and Human Rights, held at Amsterdam in 1974 as part of the preparatory activities for the World Population Conference, held at Bucharest in 1974 (United Nations, 1975, annex IV). The second took place in Vienna in 1981, and its conclusions and recommendations (United Nations, 1983) were an important input to the discussions at the International Conference on Population, held at Mexico City in 1984.

The organizers of the Meeting acknowledge with deep appreciation the financial support provided by the Governments of the Netherlands, Norway and Sweden. In addition, full recognition is due to the authors, invited individual experts and representatives of United Nations organizations and agencies and of non-governmental organizations, all of whom contributed significantly and constructively to the work of the Meeting.

References

United Nations (1975). The Population Debate: Dimensions and Perspectives. Papers of the World Population Conference, Bucharest, 1974, vol. II. Population Studies, No. 57. Sales No. E/F/S.75.XIII.5.

__________ (1983). Population and Human Rights. Proceedings of the Symposium on Population and Human Rights, Vienna, 29 June - 3 July 1981. ST/ESA/SER.R/51.

CONTENTS

Part One. Report and recommendations of the Expert Group Meeting

CONTENTS (continued)

Page

Part Two. Background papers

Chapter

CONTENTS (continued)

List of tables

CONTENTS (continued)

List of tables

List of figures

Explanatory notes

Symbols of United Nations documents are composed of capital letters combined with figures.

Reference to "dollars" ($) indicates United States dollars, unless otherwise stated.

The term "billion" signifies a thousand million.

A point (.) is used to indicate decimals.

The following symbols have been used in the tables:

> Two dots (..) indicate that data are not available or are not separately reported.
>
> An em dash (--) indicates that the amount is nil or negligible.
>
> A hyphen (-) indicates that the item is not applicable.
>
> A minus sign (-) before a number indicates a deficit or decrease, except as indicated.

Use of a hyphen (-) between dates representing years (e.g., 1984-1985), signifies the full period involved, including the beginning and end years. A slash (e.g., 1984/85) indicates a financial year, school year or crop year.

Details and percentages in tables do not necessarily add to totals because of rounding.

The following abbreviations have been used in this volume:

AIDS	acquired immunodeficiency syndrome
CICRED	Committee for International Co-operation in National Research in Demography
CIGS	International Center of Social Gerontology
CIOMS	Council for International Organizations of Medical Sciences
ECOSOC	Economic and Social Council
EEC	European Economic Community
ESCAP	Economic and Social Commission for Asia and the Pacific
FAO	Food and Agriculture Organization of the United Nations
GNP	gross national product
HIV	human immunodeficiency virus
ICJ	International Commission of Jurists
ILO	International Labour Organisation
IPPF	International Planned Parenthood Federation
ISSA	International Social Security Association

Explanatory notes (continued)

IUD	intrauterine device
NIAS	Netherlands Institute for Advanced Study in the Humanities and Social Sciences
PATH	Program for Appropriate Technology in Health
PIACT	Program for the Introduction and Adaptation of Contraceptive Technology
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
WHO	World Health Organization

Part One

REPORT AND RECOMMENDATIONS OF THE EXPERT GROUP MEETING

INTRODUCTION

The United Nations Expert Group on Population and Human Rights met at the Palais des Nations, Geneva, from 3 to 6 April 1989. This was the third Expert Group on Population and Human Rights to have been convened by the United Nations: the first was held at Amsterdam in 1974 and the second at Vienna in 1981. The purpose of the meeting was to assess the current status of the relationship of fertility, mortality and population growth to human rights concerns and to recommend such actions as might be called for. Although the two previous meetings had also included internal and international migration issues among the topics dealt with, it was decided not to include them in the third meeting in order to focus the discussions on a more narrowly selected number of issues that required special attention. The meeting worked within the framework of the World Population Plan of Action, the recommendations for the further implementation of the Plan made by the International Conference on Population held at Mexico City in 1984 and the relevant body of human rights instruments that had been formulated and accepted by the international community.

The Meeting, which was made possible by the generous financial support of the Governments of the Netherlands, Norway and Sweden, was organized by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat, in collaboration with the Centre for Human Rights of the United Nations Office at Geneva.

The meeting was opened by the Under-Secretary General for Human Rights, Jan Martenson, Head of the United Nations Office at Geneva and Director of the Centre for Human Rights. In his opening statement, Mr. Martenson said that for more than three decades, increasing concern had been expressed by human rights organs about protecting the privacy of an individual, his personality and his physical and intellectual integrity in the light of advances in science and technology, particularly those in biology, medicine, biogenetics and biochemistry. Scientific advances in these fields had brought many benefits to human beings through improvement of health and medical care, extension of life expectancy and reduction of infant mortality, and alleviation of many diseases and afflictions. At the same time, however, it has been increasingly recognized that the human personality might need to be protected, both physically and intellectually, from some of those advances and their probable misuse. In the 1970s, the Commission on Human Rights had considered human rights aspects and legal and other problems that arose from the development of artificial insemination, and from organ transplantations, pre-natal genetic diagnosis, experiments on human subjects, the possible abuse of drugs as a means of control and the link between the right to access to health care and the rising cost of medicines in the light of new radical medical techniques. In September 1975, a meeting of eminent international experts in the field took place to discuss the balance that should be established between scientific and technical progress and the intellectual, spiritual, cultural and moral advancement of humanity. The experts concluded, *inter alia*, that the positive uses of modern science and technology for the promotion of human rights were potentially vast, but their exploitation depended upon the formulation of appropriate science policies on the national level and the creation of machinery to carry out those policies.

The Under-Secretary-General stated that human rights basically defined a relationship between the individual human being and the State which had the duty to provide and protect those rights and to abstain from actions or to take care of specific measures so as to ensure the enjoyment of human rights for all without distinction as to race, sex, language, religion, social status or origin. With reference to human rights aspects in relation to recent developments in science and technology, many international texts covered aspects of that question. The Universal Declaration of Human Rights and the two International Covenants enshrined a number of those norms. Mention could be made of the protection of the right to life, the right to privacy; the right to an adequate standard of living, including housing; the right to social security and the right of everyone to enjoyment of the highest attainable standard of physical and mental health and the benefits of scientific progress and its applications. However, he took note that although the international human rights norms were well established, they still needed to be further developed at the international level, particularly in the field of population, and to be interpreted and applied at the national level. Difficult though the subject of population and human rights was, it was his firm belief that human rights elements had to make their presence felt in such important issues of public policy. The Under-Secretary-General offered the full support of the Centre for Human Rights in that endeavour.

The Director of the Population Division, Jean-Claude Chasteland, welcomed the participants and expressed his gratitude to the Governments of the Netherlands, Norway and Sweden for their financial support, which had made it possible to hold the meeting. He reviewed the most important conclusions that had been reached by the meeting at Vienna concerning the family, contraception and abortion and on the use of incentives and disincentives intended to modify the level of fertility. Although most of the conclusions reached in 1981 remained valid, what had still to be improved was the extent to which accepted human rights actually became effective. On the other hand, on the question of the legal implications of the new biotechnologies of reproduction and of genetic engineering, the meeting in 1981 had not been called upon to adopt an explicit position, since those techniques had only begun to emerge as a policy question around that time.

The meeting at Vienna had examined in detail the implications for human rights of the persistence of very high mortality, of differential mortality and of the excess mortality of some of the more vulnerable subpopulations. The meeting also considered the questions posed by the situation of persons suffering from incurable diseases and their right to die with dignity.

Mr. Chasteland stated that the age structure of the various countries reflected their past trends in fertility and mortality. In the developed countries, the very rapid aging of the population, which was a result of the decline of fertility and mortality, raised the problems of equality of all, regardless of age. In the developing countries, possible discrimination might affect the young, whose large numbers posed considerable problems for the community. Discontinuity in the volume of various cohorts might raise some problems of equity with respect to the allocation of private and public resources. In conclusion, he recalled that the United Nations had played a fundamental role in the creation and enforcement of human rights and said that in the field of population that role was unique and essential.

Following the opening statements, Mr. Martenson invited the participants to elect a bureau to guide the work of the meeting. Dirk J. van de Kaa (Netherlands) was elected Chairman, Olusola Ojo (Nigeria) was elected Vice-Chairman and M. A. El-Badry (Egypt), Rapporteur.

The agenda, the documentation for the meeting and the list of participants are presented in annexes I-III to this report.

I. DISCUSSION OF AGENDA ITEMS

A. Human rights in a changing political and socio-economic environment

In presenting his report on human rights in a changing political and socio-economic environment (IESA/P/AC.28/4), the author began with the proposition that the essence of human society was co-operation between individuals and their primary groups, such as families, for mutual gain. Effective welfare to promote co-operation required the adoption and observance of general rules of conduct-- rules that rested upon mutual agreement on rights and responsibilities. One important function of such rules was to regulate the size of the society through regulation of entry and exit to and from "membership". Entry through birth was of special interest from the point of view of human rights, the author said. Traditionally, societies had relegated the decision to bring in new members to individual couples and families, subject only to rules and societal expectations as to the proper patterns of conduct.

Changing political and socio-economic circumstances could upset this traditional arrangement, requiring re-examination and perhaps redefinition of reproductive rights and responsibilities, the author said. For example, change might be caused by rapid mortality decline that generated population growth that a society found excessive. Or a society might prefer to assume an increasing share of the costs of bringing up children, thus causing a disjunction between the right to decide about fertility and the responsibility for its consequences. Furthermore, technological or spontaneous value changes might occur that would open up the possibility for welfare-enhancing social innovations that had not existed earlier.

According to the author, such changes tended to induce a reinterpretation and revision of traditional rights and responsibilities associated with procreation and survival. The changes would necessarily vary from country to country, reflecting differences in demographic patterns, developmental stage and cultural preference. While countries had to find a solution that best suited them, the international system had a legitimate interest in assuring that the solutions individual countries adopted were in conformity to universally recognized and agreed-upon principles of human rights.

In his report, the author argued that respect for basic civil and political rights was of special importance. Those rights were typically formulated as "negative" rights: they protected basic political liberties from possible excessive power of the Government. In so doing, they set a frame for political processes and developmental change that tended to assure that decisions about important social and economic rights would be just; and when mistakes were made, they were quickly recognized and corrected.

In general, the author suggested that the primary interest of the international system should centre on processes rather than particular pre-specified outcomes. Concentration on desirable end-results involved the danger that Governments would become overextended: they would try to do more than administrative capacities and other resource constraints would realistically permit. They also could discourage and compete with decentralized initiative and action; yet, history demonstrated that a broad scope for such decentralized initiative and action was an important condition for material improvement, hence for the better satisfaction of economic and social rights.

In opening the discussion on the subject, the discussant questioned the author's assertion that there was "very strong evidence that direct concentration on satisfying economic and social rights through government programmes ... yields results that are distinctly inferior to results delivered by market-based, decentralized or mixed systems", as inconsistent with experience of many countries. The discussant went on to say that a second assertion in the report that needed clarification was that the "relevant human rights issues ... should properly centre not on the apparent severity of particular rules ... but on the nature and legitimacy of the process that generated those rules and on the political arrangements and institutions that carry out and supervise their execution." If not qualified, this "sanctification" of process raised a number of ethical issues and left human rights at the mercy of the differential capacity of various interest groups to impose their views through the political system.

The discussant said that the main problem with the paper was that it attempted to make a clear distinction between civil/political and social/economic rights. In the real world, it was difficult to have one without the other. With particular reference to population, the right to decide on the number and spacing of children implied the right to the fullest possible knowledge, a social right. It also required access to the means necessary to effect choices made and, consequently, action by government to reduce inequalities.

In the discussion that followed, the question of the proper role of government with respect to population was debated. It was observed that in a variety of situations in the modern world, the nature of government intervention was changing but was still needed. The function of human rights was not simply to limit action of Governments with respect to individuals, but also to assist Governments to deal with conditions that might infringe upon the rights of individuals; and the body of human rights that had been accepted by the international community had been designed to protect against the endangerment of rights that might arise from any source of power. It was noted that the current period was one of extraordinary change, not only in the role of government and in concepts of human rights, but in many traditional institutions.

It was also noted that the expression "rights" had not been used consistently in various papers presented to the meeting. Some authors appeared to reflect the view that rights were conditioned historically and culturally. Others assumed rights to be universal and rooted in the nature of human beings and society, even though they might only be recognized and codified at a given moment in history. It was generally agreed that meeting a minimum standard of economic and social well-being was necessary for the enjoyment of political and civil rights.

B. Relationship between human rights and population issues: standard-setting activities of the United Nations Organization, 1980-1988

The author of the paper on the relationship between human rights and population issues (IESA/P/AC.28/3) reported that the major overall trends during the 1980s in the area of population and human rights had been: (a) the more precise targeting of the subjects of rights and responsibilities and some increased emphasis on the individual as the subject of the legislation; (b) greater awareness of the need for balance between individual liberty and collective rights; (c) increased emphasis on equality and non-discrimination; and (d) greater concern for protection of vulnerable groups in the population.

With particular respect to fertility, he noted that emphasis had been given to the necessity for free consent for marriage and the barring of child marriage. The right of all couples and individuals to decide on the number and spacing of their children, and to have the information and means to do so, had achieved the status of treaty law, as part of the 1979 Convention on the Elimination of All Forms of Discrimination against Women. The author noted that international law was not opposed to abortion, but that several declaratory texts were negative towards the practice.

With respect to health and morbidity, emphasis in human rights legislation was on the needs of special groups and on maternity care. In the area of the right to life and morbidity, global norms, such as the right to peace and the limitation of capital punishment, were noted, as was protection of special groups in the Conventions on Genocide and Apartheid. He also described recent legislation on the protection of the handicapped and on the rights of indigenous peoples to the means of subsistence.

In his review of the paper, the discussant said that it provided a useful description of the importance of the standard-setting activities of the United Nations in the human rights field, including work in the area of population, and appropriately gave attention to basic concepts, such as equality, non-discrimination and vulnerable groups. The paper should help clarify such issues as the evolution of the family, the idea of a normal family life and the right of the child. In the area of human rights and population, it was important to recognize the balance between universality and diversity, giving due attention to the importance of religious and cultural values. It was also essential to work towards the development of methods and procedures to monitor and evaluate the extent to which the principles of human rights were in fact implemented.

A number of broad themes and suggestions emerged during the general discussion. It was stated that human rights might not be most appropriately viewed as being rigidly universalistic in character. Differences in the cultural, social and ethical values on which human rights were based implied that human rights were not necessarily the same for all times and places. Human rights reflected the consensus that could be reached by the international community at a specific time. The development of human rights relevant to populations themselves continued to change. There might be need for reformulation of existing human rights or the formulation of new rights.

It was suggested that given the evolutionary nature of human rights in general, one important need was for a thorough and broadly inclusive review of those human rights relevant to population which had been accepted by the international community. Currently, human rights relevant to population were widely dispersed in a variety of international instruments. What was needed was a systematic assembling and review of the pertinent human rights formulations, in order to identify better ways of dealing with population questions and to decide in an informed manner if there were any serious problems of inconsistency, omission or overlap.

It was also suggested that what might be needed at some stage was a more regionalized as well as a global review and assessment of population and human rights. For example, in the future a series of regional meetings on population and human rights might usefully be convened, along with any new global meeting on the subject.

Lastly, it was emphasized that there was an urgent need to monitor and evaluate the observance and implementation of existing human rights. For the effective performance of such monitoring and evaluation exercises, it would be necessary to find appropriate methodologies that could take into account significant differences in culture, mores and values. It was observed that although much remained to be done, progress was being made in the monitoring of the implementation of human rights. One promising direction was in the growing practice of using periodic reports by Governments to an intergovernmental body on implementation of the human rights legislation to which those Governments had acceded. It might be useful to consider whether such a mechanism might be developed in the areas where population issues were involved.

C. Population trends and policies

The participants reviewed the major population trends and policies in the 1980s (IESA/P/AC.28/2) that were relevant to the particular focus of the Meeting.

It was observed that the population issues of the 1980s had attracted the attention of an increasing number of countries and that the concerns expressed by Governments referred not only to issues related to high rates of population growth but also to a variety of problems associated with the level achieved by countries at various stages in their demographic transition.

The review of mortality trends indicated the impressive achievements made by some countries and recognized also those cases where recent developments had been rather limited. The Meeting identified a number of human rights issues associated with those poor achievements.

In the area of fertility, the Meeting observed the notable differentials not only between developed and developing countries but also within the latter group. That variety of situations had produced the range of responses to the inquiries in the field of population made by the United Nations concerning the policy measures they had adopted in the area of fertility. The Meeting discussed some of those measures and observed that although many of them would enhance recognized human rights, as in the case of promotion of the status of women, others could infringe upon or cancel other human rights, as would be the case in situations where Governments had adopted incentives and disincentives that limited access to social services. Special mention was made of the important role that social and economic factors had in clarifying changing fertility preferences, even in the absence of, or against, prevailing population policies.

The Meeting observed that as a consequence of recent fertility and mortality changes, population structure was also changing. In some instances, as in sub-Saharan Africa, there was a trend towards "juvenation", reflected by a decline in the median age of the population as a consequence of high or increasing fertility. The wider global trend, however, was in the opposite direction, that is, aging of the population, as indicated by an increase in the median age. Special attention was also given to the increasing number of the elderly in developing countries, which created additional strains on the already limited capacity of those countries.

Lastly, the Meeting recognized that although the focus of the discussion excluded both internal and international migration, it was necessary to recognize that such movements might significantly influence fertility and mortality.

D. Contraception and family planning

In presenting the background document on contraception and family planning (IESA/P/AC.28/5), the author began with the observation that the right to decide on the number and spacing of children was well accepted in principle at international and national levels. Nevertheless, access to the means to exercise that right remained limited. Unlike the situation two decades earlier, deliberate government restriction of access to family planning was currently less an impediment than a failure to provide access.

The right to reproductive choice was a social right--although the potential for coercion in population policies or in their implementation brought it close to a civil right. As formulated in the World Population Plan of Action, that right had two components: (a) the right to decide on child-bearing; and (b) the right to have the information and means to exercise the decisions. The corollary duties of Governments were not to inhibit reproductive choice and to provide the means for putting those decisions into practice--but not to enforce their use.

"Free and responsible" decision-making in reproductive behaviour posed a challenge to policy makers in any attempt to formulate population policies intended to influence individual reproductive decision without limiting freedom of choice and without infringing on the right to have access to the means to exercise those decisions.

The right to reproductive choice was also an individual right which provided a conceptual basis on which a woman's right to control her fertility could be asserted. At a broad policy level, the right to decide on child-bearing had gained world-wide recognition, but it was rarely perceived or promoted as a personal prerogative. There was need to generate greater awareness of reproductive choice as an individual right.

Human rights implications of family planning programmes arose in reference to: (a) effectiveness and equality of accessibility; (b) availability of informed choice in the selection of a contraceptive method; and (c) safety in contraceptive practice and in contraceptive research, within the general framework of generally accepted principles of biomedical research.

The discussant commented that in the area of contraception and family planning, governmental policies were often adopted but not fully implemented. Actual availability of information and access to services in many countries lagged behind. He posed the question whether an individual's freedom of decision on the number and spacing of children was an absolute right or might be limited in the interest of other concerns of the larger community. He also raised the question of priority of rights in the event that the two members of a couple differed on whether more children were wanted. The need for educating husbands to recognize women's larger biological involvement in child-bearing was obvious in this regard. The discussant also noted the importance of giving due attention to cultural values, especially in such sensitive areas as adolescent fertility.

In the discussion that followed, the point was raised that from a human rights perspective, permanent or irreversible measures were not preferable; it might be appropriate to view surgical contraception in that light.

The view was expressed that governmental involvement in the provision of family planning had historically been and should more properly be viewed as a measure to deal with the social problem of too rapid population growth. It was neither necessary nor appropriate to view it as a requirement for government to provide contraceptive services when such a problem did not exist. Other participants disagreed on the grounds that contraception was a health measure and thus related to the right to life. Others noted that in a small number of countries Governments still tried to limit individuals' access to contraception and thus to infringe upon their right to plan a family.

One participant suggested that from a human rights perspective it might be useful to consider a reformulation of the right to decide on the number and spacing of children. He proposed that it would be more appropriate to use the formulation, "Everyone has the basic human right to use the means and methods of fertility regulation and not to procreate against his/her will". In that form, it would be an individual non-derogatable human right. The provision of information and means by Governments could then be dealt with separately.

The participants agreed that in the area of human reproduction, the diversity of cultural values was a matter of very great importance; however, one participant suggested that it could be argued that cultures could and did change and that the cultural values should not be used as a justification for not beginning the effort fully to implement basic rights in family planning and contraception. On the question of the respective rights of men and women in decisions about the number and spacing of children, note was taken of the importance of the role of mothers to the survival of other children, as well as women's greater biological involvement. It was also recalled, however, that when one exercised the right to enter into a family, some degree of autonomy was given up.

E. Abortion

The author of the background paper (IESA/P/AC.28/6) began by pointing to the dilemma in the relationship of human rights with abortion. The human right invoked depended upon what position a person took on the issue of induced abortion. Those in favour of prohibiting abortion cited the right to life of the foetus; those who favoured legislation that permitted abortion cited a woman's right to control her own body and the right of reproductive choice. It was also necessary to see abortion in terms of the reality of the situation in which it currently occurred in the world. The author proposed the hypothesis that there was a common historical process in recourse to abortion. In a pre-demographic transition society, there was little call for abortion. Then at the early stages of a demographic transition, when the awareness of the need to control fertility first began to be strongly felt and when access to contraception might not be adequately available, termination of pregnancy- often illegally- was likely to be widely used. Lastly, after fertility regulation by means of effective contraception had become widely available and acceptable, use of induced abortion declined in importance. At the same time, there was a notable current tendency for countries to adopt legislation that permitted abortion on increasingly liberal grounds. Through legalization, the worst effects of widespread use of illegal abortion could be minimized. Although abortion was not a method of fertility control to be encouraged, it was a phase through which many countries passed in the course of their demographic transition. Legalization might be a useful means to speed the transition and thus ultimately reduce its use.

The discussant commented that among professionals concerned with health and population questions, there was no consensus about the circumstances in which abortion was acceptable. There appeared to be agreement that abortion was not ethically desirable, but no consensus existed about when abortion was ethically tolerable. He added that the debate over the use of abortion was fuelled by the increasing interaction of people from diverse cultures, religions and ideologies, and noted that in that global context, increasing numbers of countries were legalizing abortion or liberalizing the indications for abortion, but at the same time restricting such indications to the early termination pregnancy.

The discussant observed that the lack of consensus on abortion had been most evident at the International Conference on Population held at Mexico City in 1984. The Conference had urged Governments "to take steps to help women avoid abortion, which in no case should be promoted as a method of family planning..." (United Nations, 1984, p. 21). The Conference had not addressed the issue of abortion as a back-up to contraceptive failure and the important health complications of illegal abortion.

The discussion on the legal access to abortion was an additional opportunity to debate the issue, mentioned in section B, on whether human rights were historically determined or rather had a universal basis. The question of status of the foetus was also raised. The Meeting pointed out that there was a controversy about both whether the foetus had rights, and if so, how the conflict with maternal rights was to be resolved in particular circumstances. It was also observed that as concerned abortion, the rights of the foetus, of the mother and of children already born and yet to be born were involved.

In general, it was agreed that abortion remained a controversial issue. It was not desirable as a means to control fertility, but it was at times the outcome of a difficult choice, faced with social realities, such as the absence of access to contraceptive services, that resulted in high levels of illegal abortion in some countries. There were numerous unresolved issues on the question of abortion that called for research. In the absence of consensus on the acceptability of abortion, laws often could do no more than formulate a compromise. It was generally agreed that a goal should be to hasten any transition to less frequent recourse to abortion.

F. Incentives and disincentives in fertility policies

The author of the paper on incentives and disincentives in fertility policies (IESA/P/AC.28/7) presented an overview of the subject and indicated that there were situations in which the individual decisions on the number of children did not add up to the societal optimum. In those circumstances, Governments might consider the adoption of fertility policies that could include incentives and disincentives. He noted that extreme conditions might justify strict norms and strong sanctions. In his presentation, the author gave many examples of measures used by Governments corresponding to different types of population policies and of demographic situations. He concluded that Governments might use those schemes as far as they were not coercive, discriminatory or contrary to recognized human rights, as stated in the recommendations of the International Conference on Population, in 1984.

The discussant commented on the important role played by a variety of forms of incentives and disincentives as part of the measures adopted by Governments to affect fertility. She posed the question how to formulate a sound and effective policy without such measures. The discussant suggested that although incentives tended in general to reduce inequalities, disincentives tended to increase them and thus might infringe upon the rights of children and mothers.

The Meeting discussed the role of those measures in relation to their potential not only to modify fertility preferences but also to achieve a reduction of inequalities. The discussion was illustrated with a number of examples, particularly in relation to human rights, in situations of high as well as of low fertility. The Meeting noted the difficulty of defining in a universalistic manner which were the conditions that might justify strong actions and strong sanctions. Although some participants were inclined to see the positive side of incentives as part of redistributive policies and the use of such payments as a form of compensation, it was pointed out that economic incentives could have a differential effect on social classes and hence raised questions of equity. Others noted that economic disincentives had the potential of punishing both children and parents. Lastly, some participants expressed the opinion that such measures were in any case ineffective in modifying fertility levels.

G. New biotechnologies, population policy and human rights

The agenda item was introduced by the author of the paper on new biotechnologies, population policy and human rights (IESA/P/AC.28/8). After a general overview that highlighted the rapid speed of technological innovations as compared with the slow response of the codification of laws, he presented three main problems associated with the availability of the new biotechnologies: (a) medically assisted conception with the intervention of a third partner, which could be very helpful in overcoming subfecundity or sterility, but which could also produce situations where legal, biological and genetic parenthoods were separated; (b) pre-natal diagnosis which had the potential of being used to select those who were to be born and to discard the embryos of those who were not desired; and (c) research on the embryo which raised the problem of the origin of the embryo and the legitimacy of using them, particularly if they were susceptible to genetic manipulation. The author underlined the fact that there were no adequate legal responses to the risks associated with parenthood, eugenics practices and the integrity of the human species. He concluded that the best response would include the adoption/recognition of principles and the establishment of rules and institutional safeguards.

The discussant noted that although the new biotechnologies had the potential of modifying family relations, they could also help to respond to a variety of complex and difficult problems. Until recently, those issues had been discussed mainly within the medical profession; it was necessary to initiate an effort for legal codification, particularly in relation to filiation and to the control of foetal research and medical practice involving the foetus. He pointed out some specific problems that required attention, such as the legal validity of stipulated agreements between surrogate and genetic mothers, the payment of fees and the commercialization of body parts and organs, the anonymity of donors and the right of children to know their own origins.

The discussant noted that from a demographic point of view, the use of those biotechnologies was not a response to low fertility, such as was found in a large number of European countries, because those low levels were not the result of subfecundity or sterility. Rather, the low fertility largely reflected voluntary decisions made by couples and individuals. On the other hand, their generalized use in developing countries could be a different matter, given the high levels of subfecundity and sterility found in some of those countries, but their costs there remained excessive. He observed that the resources needed for the use of those technologies in a rich country could also be used to save a large number of children already born from diseases and malnutrition. The real technological revolution related to fertility that was needed in developing countries, he concluded, remained the availability of modern methods of fertility regulation.

The Meeting recognized that many of the technologies did not yet have a significant demographic impact on such variables as the sex composition of populations. It was also recognized that some of them could be utilized in some instances for eugenic purposes or as substitutes for other measures intended to increase the levels of fertility. A number of participants were of the opinion that national commissions on ethics should consider the implications of those technologies and that regulations and legislation, where appropriate, should be considered at that time.

Although the author and some participants were opposed to the commercial use of parts of the human body, including blood, sperm and organs, and suggested the adoption of laws in that respect, others were opposed to that proposal in the light of the evolving character of those new technologies, the lack of universal consensus on how to regulate them and the impracticability of such measures.

Other participants referred to some specific issues. In the case of surrogate motherhood, which in the opinion of the author and some participants could be very difficult to accept, other participants expressed the view that access to such procedure was the only available solution to an otherwise insoluable problem of infecundity or sterility.

The Meeting concluded that the problems raised by the development of those procedures were real although not with the same degree and magnitude in every instance. It was also observed that it was not possible to adopt in the immediate future a set of universal measures to respond to all the conceivable situations; nevertheless, it was urged that more emphasis should be devoted to research in that area, to examine those issues, bring them to the public arena and try to develop in international forums a set of general principles that could guide Governments when they began to formulate and implement pertinent legislation.

H. Health care and human rights, including the special issue of the acquired immunodeficiency syndrome (AIDS)

The author of the paper on health care and human rights (IESA/P/AC.28/9) introduced the topic by noting the pragmatic criterion. Three major issues were covered in his presentation. First were the rights to life, nutrition and health care. The right to life included not only protection against violence but maintenance of life as long as possible. In that respect, he indicated the enormous disparities between and among countries in child and female mortality (maternal mortality, for example, could be 100 times higher in some developing countries than in developed countries). In relation to food security, he mentioned that one third of the populations of the developing countries (excluding China) were not receiving enough food to lead a productive life, usually not because of food scarcity but because of poverty.

The second issue covered was access to health services; the author underlined the importance of equity and social justice in the provision of health care and emphasized the necessity of taking into account local conditions and needs, as well as cost effectiveness in establishing health priorities. A particular case in point was the choice faced in a developing country between giving higher priority to costly health programmes that would benefit a wealthy minority or to less spectacular programmes that would respond to the need of larger groups of the population. It was also important to pay special attention to the needs of the handicapped and to those of the frail elderly, whose numbers would continue to increase in the foreseeable future.

The author discussed the infringement of the human rights of patients with AIDS, who had been discriminated against in housing, employment, schools and even health care. Those patients obviously had a right to be treated with the same dignity and understanding as all other members of society. Since the negative attitude was due largely to ignorance about the nature of the disease, it was essential to strengthen educational campaigns to bring the facts of that disease to the public. It was in the public interest, and a right of the patients, that they be treated with confidentiality, that they be provided with medical care without prejudice and that research for the purpose of coping with the disease should be strengthened.

In opening the discussion, reference was made to the problems associated with terminal illness, particularly in the context of the increase of the length of life, and the question of health care of the elderly as a key issue. In relation to AIDS, the difficulties of analysing and interpreting the existing data was underlined, given that it had become a highly politicized issue. Lastly, reference was made to the long list of declarations, plans of action and resolutions adopted by the international community as part and parcel of a necessary understanding of those issues.

Some participants pointed out the difficulties facing many developing countries in the financing of their health programmes, associated in many cases with the burden of a high external debt or the deterioration of their economic conditions and aggravated in other instances by local or regional conflicts. It was observed that some of those countries ran the risk of copying the expensive health-care systems of more affluent countries. The experience and achievements of non-governmental organizations, particularly at the grass-roots level, were emphasized, as was the need for the communities themselves to play a much larger role in their health-care programmes. The need for attention to environmental concerns when dealing with human rights and health was also pointed out.

In relation to the area of social justice and health care, the discussion turned to the concept of solidarity as a key rationale for many health-care activities. It was noted in that context that major advances in improving the health of the population were made in those cases where Governments had a strong political commitment to such programmes, independently of the kind of political system they might have.

With regard to AIDS, the Meeting concurred on the need to inform the public about the nature and characteristics of the disease. It was also emphasized that with the spread of the disease there would be increasing pressure on public funds.

I. Human rights, terminal illness and euthanasia

In his introduction, the author of the background paper (IESA/P/AC.28/10) noted that past and current demographic trends, coupled with significant normative changes, had made terminal illness and euthanasia important issues in many developed countries. Future demographic trends were likely to make those problems even more serious. The demographic dimensions of these issues remained largely unknown. As figures from the Netherlands demonstrated, however, it was evident that requests for euthanasia rose rapidly with age. With further increases in life expectancy at birth to more than 80 years, the proportion of all deaths occurring at very advanced ages would also increase. Even currently, more than 80 per cent of all deaths in developed countries tended to occur at ages 65 and over.

From a human rights perspective, a strong theoretical justification of a moral right "to die with dignity" would match current practice and opinion in a broad area of human activity. Central to that rights concept was the view that what was valued most in a human being was an identity as an individual with a will, discernment, well-formed opinions and norms, and with unique experiences and characteristics. That view was what was protected by morality and law. Safeguarding the essential characteristics of a person in a situation where increased suffering occurred and loss of identity and depersonalization threatened would be precisely what the right to die with dignity would entail. However, the argument in favour of such a moral right did not go unchallenged. Therefore, recognition of a right to die with dignity as a possible basic human right appeared to be far away. That situation was particularly evident if that right was tested against criteria of universality, individuality, paramountcy, practicability and enforceability. There was, similarly, no agreement on the question whether current, fairly liberal practice in some countries should be legalized.

The discussant concentrated on the main argument of the paper. He indicated that the approach followed by the State Commission on Euthanasia, as presented by the author of the paper, was characterized as treating passive euthanasia as "proper medical practice" and not euthanasia at all, but he observed that medical practice in many parts of the world did not yet accept such procedures. For the discussant, the author's view that active euthanasia was not necessarily, at least by current consensus, a case of "manifest arbitrary" killing was not self-evident.

The discussant stated that an attempt to formulate a right to die with dignity as an instance of a general right to liberty for self-regarding action faced several objections: (a) there was no consensus that any such general liberty existed; (b) general liberty still did not show that one could consent to his or her own torture, slavery or murder--so why to active euthanasia (indeed, that proposition suggested that the right to life might be inalienable); (c) active euthanasia, if legalized, might not be simply a self-regarding act, because it would put people on a slippery slope towards doing serious harm to one another. Only if those objections could be overcome could a right to die with dignity be sustained.

In the discussion it was suggested that current human rights instruments were not very pertinent to the important issues raised in the paper because those instruments had been drafted with different concerns in mind and at a time when medical technology had been much less advanced. Did the fact that the right to life was an inalienable right imply that one could not even give it up in circumstances where living had become a heavy burden? Or might one presume that where a positive right had been formulated, its negative form also existed, e.g., the right to have a religion implied the right not to have one. It was noted in this regard that if renunciation of a given right was not possible, current instruments invariably included an explicit statement to that effect. That was not the case with regard to the right to life.

The discussion also considered the applicability of a human rights perspective and the notion of law to the issues under consideration. It was pointed out that such concepts as "informed consent" and "moral agency" were difficult to handle in practice and that people could not always foresee the type of situation they might encounter. The Meeting recognized that the paper had raised issues of great and immediate significance. It was concluded that it would be necessary and valuable to undertake more detailed analyses of trends and to review current practices and proposals.

J. Human rights, population aging and intergenerational equity

The author of the background paper on human rights, population aging and intergenerational equity (IESA/P/AC.28/11) began with the observation that rapid aging of populations, an advanced process in many developed countries and a process under way in many developing countries, had profound implications for the welfare rights articulated in articles 23-26 of the Universal Declaration of Human Rights. As society aged, new needs and new distributions of needs developed. Perceptions of generational conflict emerged and calls for "intergenerational equity" were heard. To say what such equity really meant and to clarify what aging of society meant for welfare rights, one must distinguish and solve the problems of distributive justice: justice between age groups and equity between birth cohorts.

The author suggested that to solve the age group problem, one should imagine that he or she does not know how old he or she is and then allocate a lifetime "fair share" of health care or income support among the stages of life. What was prudent to give to each stage, so that life as a whole would go better, would be what was fair to give to each age group. Furthermore, successive birth cohorts, passing through such distributive systems, must be treated with appropriate equality if they were to co-operate to keep those schemes stable. Those solutions to the two problems had important implication for the design of health-care and income-support systems, and thus for the resolution of conflicting claims by the old and young to have their welfare rights met. Specific mention was made of the importance of meeting the long-term health-care needs of an aging society and of adjusting retirement and employment practices so that the elderly would not be in need of extremely costly resource transfers from the young, especially in developing countries or in developed countries with relatively a small work-force.

Lastly, the author said that great care must be taken so that Governments would both respect and supplement the family structures that provided support for the frail elderly. Cultural diversity between and within societies must be respected, at the same time that welfare rights were met. However the burdens of distributing goods were divided between Governments and families, it ultimately remained a government responsibility to ensure that the welfare rights of each age group and birth cohort should be met.

In commenting on the paper, the discussant emphasized the importance of the demographic factors that underlay intergenerational issues. Changes in levels of fertility were a major factor leading to changes in the age distribution; recognition of that relationship would suggest that policies intended to deal with age distribution issues should also consider fertility levels as a possible point of intervention. In addition, he noted the possibilities open to many societies to make institutional adjustments to respond to changing age distributions; the comparatively young ages of mandatory retirement found in some countries and organizations were mentioned as examples of institutional arrangements that might be adjusted.

The discussant suggested that the approach taken in the report was limited in that it suggested a kind of "Bismarckian" model of the state, where resources flowed from the young to the old to provide stability. He noted that the report made extensive reference to distribution and redistribution, but not to production. Nevertheless, savings for old age was a powerful human motive with positive economic effects. Moreover, in general, people could be relied upon to act as prudent planners; they would plan for their old age.

In the general discussion of this issue, attention was drawn to the special problem of unemployment among older persons. It was noted that the issue was not one of income alone but also of the morale of older persons. It was also observed that compulsory retirement as a means to create jobs for younger workers did not necessarily work. Studies had shown that jobs vacated by older workers were often not filled by younger workers.

At the same time, note was taken that the strong desire to continue active employment for as long as possible was characteristic especially of professional workers in developed countries. Those who were employed in less intellectually rewarding jobs had been found in many countries to be quite willing to retire at a comparatively young age. In addition, and perhaps even more importantly, in an increasing number of countries there was evidence that the older members of the society were increasingly well off while poverty tended to be concentrated among the young and especially among children. In low-fertility societies, if the families with children were becoming poorer, there might be an anti-natalist effect, which in turn might lead to still older age structures.

There was considerable discussion of the difficulty of developing income support and health-care policies in developing countries, considering their lack of means to use taxation and savings, as in developed countries, but whose traditional family support system had become unable to meet those needs. It was observed that there was need to develop innovative ways to meet the financial needs of older persons that would make the best possible use of both public and private systems.

It was suggested that the Western societies could learn much from other countries, and perhaps especially those of the less developed regions, about family and social arrangements for the care of older persons. Others cautioned that there was considerable risk of romanticizing the treatment of the old, both in some idealized past or in less developed countries. In some cases, appeals to mythical past arrangements were used to justify changes in welfare systems that had the effect of damaging the poor.

A particular problem that faced older persons in modern society was the need for a clearer definition of their unique role and what they could contribute to fellow citizens at all other ages in a philosophical as well as a political and social sense. Lastly, it was observed that the issues associated with aging in societies that were experiencing this demographic process had thus far been little considered in the framework of human rights and that there was a need for more work in that area.

K. General discussion

Statements were made by the representatives of the Council for International Organizations of Medical Sciences (CIOMS), the United Nations Population Fund (UNFPA) and the United Nations Educational, Scientific and Cultural Organization (UNESCO), who described the activities of their organizations relevant to the meeting.

Reference

United Nations (1984). Report of the International Conference on Population, Mexico City, 6-14 August 1984. Sales No. E.84.XIII.8.

II. RECOMMENDATIONS OF THE MEETING

The Meeting adopted the recommendations listed below.

Recommendation 1. The Secretary-General should communicate the present report to the Commission on Human Rights, the Sub-Commission on Prevention of Discrimination and Protection of Minorities and the Population Commission, and to other relevant commissions, such as the Commission on the Status of Women and the Commission for Social Development, as well as to other concerned United Nations bodies and specialized agencies, as he considers appropriate, calling their attention to the human rights aspects of population questions.

Recommendation 2. The Sub-Commission on Prevention of Discrimination and Protection of Minorities may wish to consider under its item "Human rights and scientific and technological developments" or, if it wishes to do so, under a separate item, the human rights aspects of population questions, in particular those referred to in recommendation No. 1.

Recommendation 3. In order to keep the relevant bodies informed, the Population Commission should receive on a regular basis those parts of the reports of the human rights bodies that are directly pertinent to population questions; conversely, the human rights bodies should receive on a regular basis those parts of the reports of the Population Commission that raise human rights aspects.

Recommendation 4. The Secretary-General is invited to bring the present report to the attention of the United Nations University so that it can take the report into account in the preparation of its study on both the positive and the negative impact of scientific and technological developments on human rights.

Recommendation 5. The debate on questions of population and human rights should continue also at the national level, involving non-governmental and local organizations. This question should be included on the agenda of national population commissions, wherever they exist.

Recommendation 6. Committees dealing with ethical questions at the local and national levels should be established in order to review such subjects as the application of new medically assisted methods of reproduction and their social, economic and legal consequences.

Recommendation 7. The attention of international organizations, national Governments, non-governmental organizations and the general public should be drawn to the benefits as well as the risks of recent advances in biology and medicine, such as medically assisted reproduction, pre-natal diagnosis, genetic manipulation and research on the embryo.

Recommendation 8. Governments should elaborate ethical and juridical standards, taking into account the respect due to the human person, that assure fully free and informed consent in matters related to any external intervention in the process of reproduction.

Recommendation 9. Governments, international and non-governmental organizations should consider the human rights implications of the aging trends in world population. Therefore, they should provide their support to actions intended to respond to the problems of the handicapped, the chronically ill and the frail elderly. These actions should be directed to treating these groups with justice, compassion and a due sense of public responsibility without putting undue pressure on public funds.

Recommendation 10. To enable individuals and couples fully to exercise human rights with respect to population matters, it is essential that they have access to reliable, pertinent and up-to-date information, as well as to the means to exercise these rights. Governments and the international community should make the necessary institutional arrangements and provide sufficient resources to improve the availability and the widest possible dissemination of such information to the general public and to concerned decision makers.

Recommendation 11. Recognizing the urgent need for an increased contact between international, national and non-governmental organizations concerned with population and human rights, and the need to follow up on the progress achieved at the Expert Group on Population and Human Rights held at Geneva, 3-6 April 1989, the Secretary-General is invited to give close attention to three themes of high priority: (a) population policies concerned with contraception and family planning, with special reference to accessibility, informed consent, coercion and incentives and disincentives; (b) social, economic and legal aspects in the field of medically assisted reproduction; (c) demographic change and intergenerational equity. For this purpose, the Secretary-General is invited to consider the use of modalities, such as an interdisciplinary working group, a special rapporteur or a symposium, as may be most effective and appropriate, making use in particular of the joint efforts of the Department of International Economic and Social Affairs and the Centre for Human Rights. Such activities should be financed with extrabudgetary resources. In carrying out these activities, the Secretary-General may wish to bear in mind that the outcome of these efforts should be available in time to be fully made use of in the preparation of any intergovernmental meeting on population that may be convened in 1994.

Recommendation 12. The discussions on these issues on human rights and population should be continued through national and international conferences.

Annex I

AGENDA

1. Opening of the meeting.

2. Adoption of the agenda and other organizational matters.

3. Human rights in a changing political and socio-economic environment.

4. Relationship between human rights and population issues: standard-setting activities of the United Nations Organization, 1980-1988.

5. Population trends and policies in the 1980s.

6. Contraception and family planning.

7. Abortion.

8. The use of direct incentives and disincentives; indirect social/economic measures.

9. New biotechnologies, population policy and human rights.

10. Health care and human rights, including the special issue of the acquired immunodeficiency syndrome (AIDS).

11. Human rights, terminal illness and euthanasia.

12. Changing fertility/mortality and dependency, the family and society, changing age/sex structures and intergenerational shifts in responsibility.

13. Adoption of the report and recommendations.

14. Closing of the meeting.

Annex II

LIST OF DOCUMENTS

Document No.	Agenda item	Title and author
IESA/P/AC.28/1	2	Provisional agenda and annotations
IESA/P/AC.28/2	5	Population trends and policies in the 1980s (United Nations Secretariat)
IESA/P/AC.28/3	4	Relationship between human rights and population issues: standard-setting activities of the United Nations Organization, 1980-1988 (United Nations Secretariat)
IESA/P/AC.28/4	3	Human rights in a changing political and social-economic environment (Paul Demeny)
IESA/P/AC.28/5	6	Contraception, family planning and human rights (Nuray Fincancioglu)
IESA/P/AC.28/6	7	The problem of induced abortion from the standpoint of human rights (Mariano Requena-Bichet)
IESA/P/AC.28/7	8	The use of direct incentives and disincentives and of indirect social/economic measures in fertility policy and human rights (Rudolf Andorka)
IESA/P/AC.28/8	9	New biotechnologies, population policy and human rights (Guy Braibant)
IESA/P/AC.28/9	10	Health care and human rights, including the special issue of AIDS (M. A. El-Badry)
IESA/P/AC.28/10	11	Human rights, terminal illness and euthanasia (Dirk J. van de Kaa)
IESA/P/AC.28/11	12	Human rights, population aging and intergenerational equity (Norman Daniels)

Annex III

LIST OF PARTICIPANTS

Experts

Rudolf Andorka	Head, Department of Sociology, University of Economica Karl Marx, Budapest, Hungary
Guy Braibant	Président, Section du rapport et des études, Conseil d'Etat, Paris, France
Norman Daniels	Professor, Department of Philosophy, Tufts University, Medford, Massachusetts, United States of America
Paul Demeny	The Population Council, New York, United States of America
Luiz de Sena	Education et developpement interculturels, IRFED, Paris, France
M. A. El-Badry	Former Assistant Director for Research, Population Division, United Nations; former Director, Cairo Demographic Centre, Cairo, Egypt
Charles Fahey	Director, Third Age Center, Fordham University, New York, United States of America
Nuray Fincancioglu	Consultant, Istanbul, Turkey; former Head of Policy Analysis, International Planned Parenthood Federation
Ulla Britt Lithell	Associate Professor of History, Uppsala University, Uppsala, Sweden
Olusola Ojo	Professor, Department of International Relations, Obafemi Abolowo University, Ile-Ife, Nigeria
Mariano Requena-Bichet	Latin American Institute for Health and Population, Santiago, Chile; former professor, School of Public Health, University of Chile
Maxime Tardu	Former Chief, Research and Studies Unit, Division of Human Rights, United Nations Office at Geneva, Switzerland

Annex III (*continued*)

Experts

Dirk J. van de Kaa	Director, Netherlands Institute for Advanced Study in the Humanities and Social Sciences, Wassenaar, Netherlands; Professor of Demography, University of Amsterdam
Karel Vasak	World Tourism Organization, Madrid, Spain; former staff member of the Centre for Human Rights, United Nations Office at Geneva

United Nations Secretariat

Population Division, Department of International Economic and Social Affairs

Jean-Claude Chasteland, Director
Donald F. Heisel, Assistant Director
Germán A. Bravo-Casas, Co-ordinator, World Population Conference Implementation

Centre for Human Rights, United Nations Office at Geneva

Jan Martenson, Under-Secretary-General for Human Rights and Head of the United Nations Office at Geneva.
Thomas E. McCarthy, Chief, Research and Studies Unit
Horst W. Keilau, Chief, Prevention of Discrimination Unit
Johannes G. Van Aggelen, Human Rights Officer

United Nations Population Fund (UNFPA)

Bashir S. Muntasser, Principal External Relations Officer, European Liaison Office, Geneva
Yoh-ok Lee, Technical and Evaluation Division

Specialized agencies

International Labour Organisation (ILO)

Richard Anker, Employment Planning and Population Branch
Christine Oppong, Employment Planning and Population Branch

United Nations Educational, Scientific and Cultural Organization (UNESCO)

Raúl Urzúa, Director, Population Division

Annex III (continued)

Specialized agencies

World Health Organization (WHO)

Angèle Petros-Barvazian, Director, Division of Family Health
José Barzelatto, Director, Special Programme of Research, Development and Research Training in Human Reproduction
Axel Mundigo, Manager, Task Force on Behavioural and Social Aspects of Fertility Regulation
Odile Frank, Task Force on Behavioural and Social Aspects of Fertility Regulation
Susan Holck, Manager, Task Force on Safety and Efficacy of Fertility Regulating Methods
Paul Van Look, Manager, Task Force on Natural and Post-ovulatory Methods of Fertility Regulation

Non-governmental organizations

Category I

International Planned Parenthood Federation (IPPF)	Cyril Ritchie
International Social Security Association (ISSA)	Jean Iliovici
League of Red Cross and Red Crescent Societies	Kingsley J. Seevaratnam

Category II

International Centre for Social Gerontology (CIGS)	Joseph Flesch
International Commission of Jurists (ICJ)	Cecilia Thompson

Roster

Committee for International Cooperation in National Research in Demography (CICRED)	Léon Tabah
Council for International Organizations of Medical Sciences (CIOMS)	Zbignien Bankowski
International Right to Life Federation	Jean-Bernard Grenouilleau

Part Two

BACKGROUND PAPERS

III. POPULATION TRENDS AND POLICIES IN THE 1980s

United Nations Secretariat*

The goal of this paper is to provide essential background information on population for a review and evaluation of the current status of population and human rights. The focus is on fertility, mortality and the most closely related population characteristics. Questions related to international and internal migration and urbanization are not considered.

The World Population Plan of Action (United Nations, 1975, chap. I) adopted in 1974 sets forth the global consensus on population matters as of that time. Since then, one extensive review and appraisal of activities in the area of population has been carried out, at the International Conference on Population held at Mexico City in 1984 (United Nations, 1984, chap. I, sect. B).

On the basis of its deliberations, the International Conference made a set of recommendations for the further implementation of the World Population Plan of Action. Those recommendations were explicitly based on the proposition that the principles and objectives of the World Population Plan of Action remained fully valid. Thus, much of the framework of the relationship between population and human rights was not at issue at Mexico City. Most of the direct references to human rights in the recommendations for further implementation take the form of a reaffirmation in a preambular form. There are, however, some new topics and other topics on which the emphasis shifted which may usefully be noted here.

In its preamble, the recommendations of the International Conference refer to progress in molecular biology, with potential for influencing levels of both fertility and mortality, whose economic and social consequences raise serious ethical questions (United Nations, 1984, p. 10). This issue is not explicitly mentioned in the Plan of Action, even in its paragraph 78, which lists the areas considered to require research in order to fill existing gaps in knowledge in 1974 (United Nations, 1975, pp. 20-21).

A major innovation in the recommendations was the introduction of a separate chapter on the role and status of women. The Plan of Action gives considerable attention to the status of women, but mainly as a subtopic in the section covering reproduction, family formation and the status of women. With respect to human rights as such, most of the propositions set forth in the recommendations reaffirm positions previously agreed to in the Plan or other international instruments. However, the language used with reference to the rights of women in general is strengthened. Furthermore, recommendation 6 sets forth a proposition that:

---

*Population Division, Department of International Economic and Social Affairs.

> "Governments should ensure that women are free to participate in the labour force and are neither restricted from, nor forced to participate in, the labour force for reasons of demographic policy or cultural tradition. Further, the biological role of women in the reproductive process should in no way be used as a reason for limiting women's right to work. Governments should take the initiative in removing any existing barriers to the realization of that right and should create opportunities and conditions such that activities outside the home can be combined with child-rearing and household activities." (United Nations, 1975, p. 17)

This proposition, which approaches women's participation in the labour force as a right having priority over demographic goals, is notably different from the way the topic was dealt with in paragraph 32 of the Plan of Action, which states that "the removal of obstacles to [women's] employment in the non-agricultural sector wherever possible" would "generally have an effect on the socio-economic context of reproductive decisions that tends to moderate fertility levels" (United Nations, 1975, p. 12).

In the chapter on reproduction and the family contained in the recommendations, the primary emphasis is again given to the reaffirmation of propositions on population and human rights that had been agreed to in the Plan of Action. In particular, the recommendations echo several times the principle set forth in paragraph 14(f) of the Plan:

> "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities towards the community." (United Nations, 1975, p. 7)

There are two changes in the recommendations from the treatment of the topic in the Plan of Action. First, the rights and responsibilities of individuals and couples to decide on the number and spacing of their children is posed as a qualification in the use of national quantitative targets, which Governments that have adopted fertility policies are urged to set. Secondly, the necessity to avoid coercion in fertility policies is made explicit.

There is scant reference to human rights as an issue in the chapters on mortality and on population structure in the recommendations, nor did the topic come up directly in the general discussion of the role of national Governments.

Broadly speaking, the basic structure of rights and responsibilities worked out and agreed to in the Plan of Action was reaffirmed in the recommendations. Such modifications as were adopted in 1984 tended to introduce new priority topics, most notably the status of women, and to emphasize rights rather than responsibilities in fertility behaviour.

A. Overall trends

In 1988, the United Nations produced its revised estimates and projections for the total population of the world (United Nations, 1988c). According to these results, the world population projected to mid-1989 is estimated to be 5.2 billion. With an annual rate of growth of 1.7 per cent, the planet is currently adding approximately 89 million new inhabitants per year, 93 per cent of which correspond to the developing countries. From 2.5 billion in 1950, the world population is expected to reach 6.3 billion by the end of this century and 8.5 billion in 2025. These projections, which are based on the medium variant, indicate an annual increase of 80 million people for the period 2020-2025. However, the annual increase could be as low as 55 million or as high as 117 million, corresponding to the low or high variants followed by future population growth.

The foregoing picture corresponds to the aggregate figures at the world level and hides important and diverse demographic conditions. In spite of the rapid decline in its rates of population growth (from 2.44 per cent during the period 1965-1970 to 1.86 a decade later), Asia continues to hold more than half of the world population (58.6 per cent in 1989). While Latin America slightly increased its rate of growth from the 1950s to the 1960s (2.74 per cent in the period 1950-1955 to 2.80 a decade later) and then began a continuous decline (2.09 in 1985-1990), Africa is better characterized by a continuously increasing rate of population growth since the 1950s (2.18 per cent in 1950-1955, 2.95 in 1985-1990 and 3.01 for the next quinquennium). With this rhythm, Africa, which had 8.9 per cent of the world population in 1950, currently has 12.2 per cent and is projected to contain 18.6 per cent by 2025. In contrast, Northern and Western Europe exhibit the lowest population growth, and some countries have begun to experience negative rates of growth.

The above-mentioned differences correspond to the position reached by countries at the various stages of transition from high levels of fertility and mortality to a new régime characterized by low fertility and mortality. Today, approximately four fifths of the world population have entered or completed their demographic transition, but close to one fifth are just at the beginning of their transition or are still at a pre-transitional stage. The countries that are leaving the early transitional stage exhibit simultaneously a very high fertility and a rapidly declining mortality, thus producing rates of growth rarely experienced before. At the other extreme of the spectrum, some countries that have reached the end of the transition (low levels of fertility and mortality and nearly nil rates of growth) appear to continue through a post-transitional phase characterized by rates below the replacement level.

Changes in fertility and mortality produce changes in the age distribution of a population. In turn, any significant shifts in the relative proportions of persons in the various age groups are likely to alter the ability of the succession of generations to fulfil their traditionally expected mutual obligations and responsibilities. In the modern world, such demographic trends quite frequently occur in association with other changes taking place in the structure of the family. In a great many developed and developing societies, such changes have led the State to take on more of the functions that were previously left to the family and other traditional social institutions.

B. Mortality

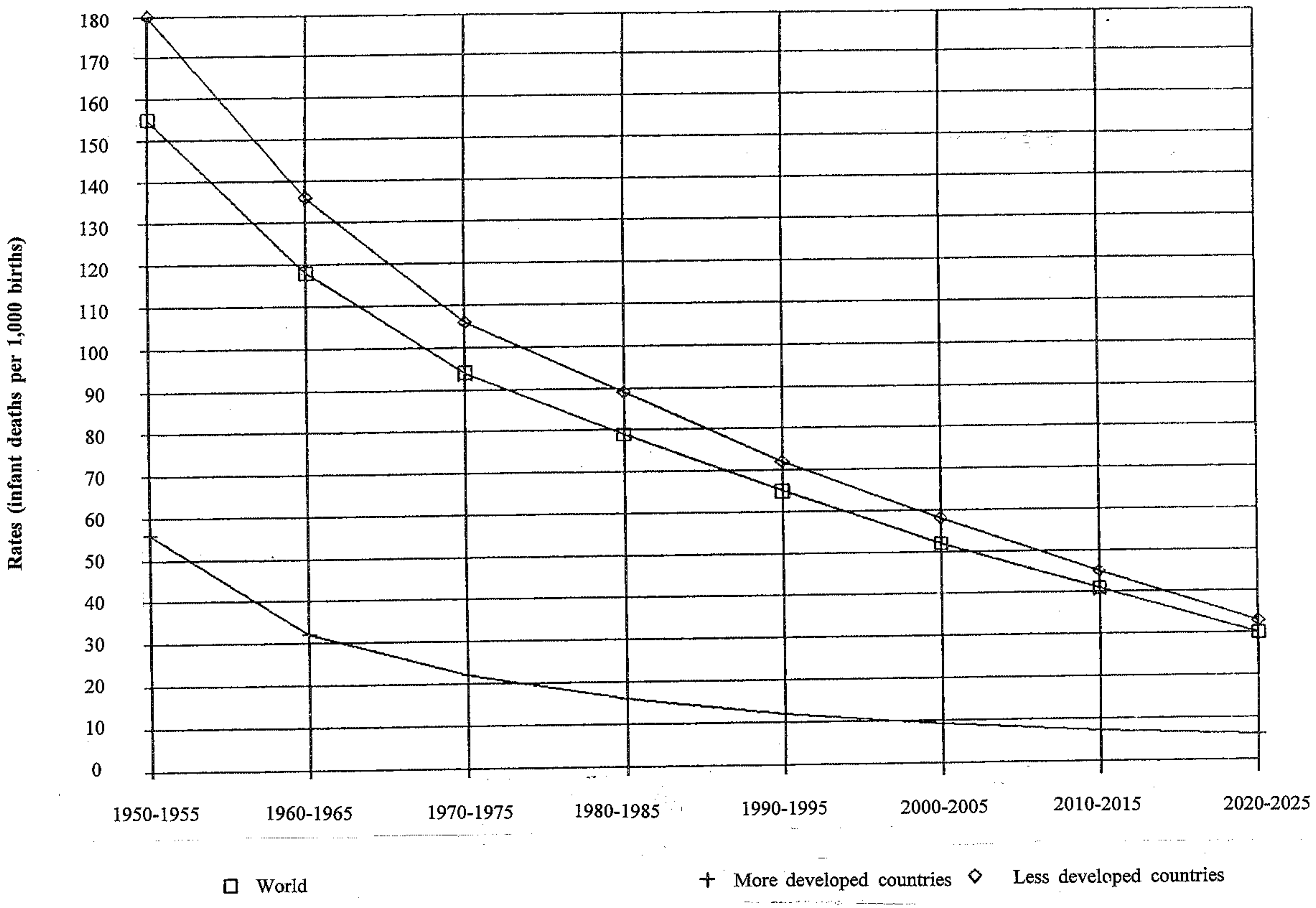
1. Trends

At the global level, the 1988 revision indicates that progress in mortality reduction is continuing in both the more developed and the less developed regions. For the period 1985-1990, life expectancy at birth is estimated to be 62 years (63 for women and 60 for men). For the group of developed countries, life expectancy at birth is estimated to be 69.8 years, which is significantly higher than the value of 58.6 years corresponding to the developing countries. The same results indicate 71 infant deaths per 1,000 live births for the same period. The corresponding figures for infant mortality rates are 15 and 79 deaths per 1,000 live births for the developed and the developing countries, respectively. Figure I presents the evolution of infant mortality rates for the period 1950-2025 at the world level as well as for the groups corresponding to the more developed and less developed countries. Estimates and projections of mortality levels under age 5, which have been recently prepared by the United Nations, indicate that about 15 million children in this age group died annually during the period 1980-1985 and that 98 per cent of those deaths occurred in the less developed regions (United Nations, 1988b). Although the pace of mortality reduction has slowed somewhat from the tempo reached in the late 1950s and early 1960s, there is no clear or reliable evidence of any region experiencing a rise in mortality during recent years.

Very large differentials in mortality persist in the world. These variations refer to differences in mortality between rich and poor countries, as well as between regions, socio-economic groups, occupations and sexes; and substantial and persistent differentials may indicate that a human rights issue exists. The most notorious mortality differential between developed and developing countries is that of maternal mortality. The range of maternal deaths is enormous. In the more developed regions, the more advanced countries have an annual rate of fewer than 10 deaths per 100,000 live births that would be attributed to complications of pregnancy, childbirth and the puerperium; in some developing countries, maternal mortality can reach rates as high as 1,000 deaths per 100,000 births (United Nations, 1989c). At the aggregate level, maternal mortality rates have been estimated to be 390 per 100,000 births at the world level, 30 per 100,000 among the more developed regions and 390 among the less developed regions.

Since the end of the Second World War, the less developed regions have increased their life expectancy at birth substantially more rapidly than have the more developed regions. While those regions raised life expectancy from 66 to 73 years, in Africa it was increased from 38 to 52, in Latin America from 51 to 66 (beginning from a base that was already substantially higher than those in the other less developed regions) and in Asia by over 20 years, from 41 to 62. Moreover, the less developed regions are continuing to record larger gains in life expectancy. The global pattern is for an overall convergence in mortality levels as measured by life expectancy at birth.

Figure I. Infant mortality rates, world, more developed countries and less developed countries, 1950-2025



On the other hand, if attention is focused on infant mortality rather than on the mortality experience at all ages for a single period of time, increasing divergence over the past 35 years is found. Currently, there are six countries where infant mortality is still 150 or more and 43 where the rate is 100 or more; at the same time, there are 35 countries where the rate is 15 or fewer and 18 where the rate is 10 or fewer. Infant mortality in the developed countries has declined from the early 1950s by just under 75 per cent. In the less developed regions as a whole, the corresponding decline was slightly over 55 per cent. The decline in Africa was 43 per cent; in Asia, 60 per cent; and in Latin America, 56 per cent. In contrast, the declines in most of Europe were over 50 per cent between the early 1950s and the late 1960s and then were again over 50 per cent from the late 1960s to the present. The declines in Japan were even more rapid: some 70 per cent during the earlier 15-year period and nearly 65 per cent during the past two decades.

2. Views and policies concerning mortality

According to the most recent data available in the United Nations Population Policy Data Bank, one third of all Governments reported their level of mortality to be acceptable; the other two thirds view it as unacceptable (United Nations, 1989c). Among the developed countries, as can be seen in table 1, the proportions are reversed: one third, with 43 per cent of the regional population, view the level as not acceptable; in the developing countries, three out of four Governments, with two thirds of the regional population, view it as not acceptable. It is important to observe that there has been very little change in the proportions of governmental assessment of prevailing mortality levels since the mid-1970s.

Table 1. Number of countries according to government perceptions with respect to levels of mortality, by level of mortality and by level of development, 1988 a/

Level of development	Under 50 years		50-59 years		60-69 years		Over 70 years		All ages All ages		
	(A)	(N)	(A)	(N)	(A)	(N)	(A)	(N)	(A)	(N)	Total
Less developed countries	3	32	3	34	12	31	14	2	32	99	131
More developed countries	-	-	-	-	-	-	26	13	26	13	39
World	3	32	3	34	12	31	40	15	58	112	170

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

a/ The number of Governments that accept their current level of mortality appear under columns (A) and those which consider that their levels are unacceptable appear under columns (~~B~~ N).

Preliminary results of the Sixth Population Inquiry Among Governments (United Nations, 1990) indicate that although 52.4 per cent of the Governments reported their current levels of life expectancy at birth to be acceptable, 70.7 of Governments indicated that their current levels of infant mortality rates are unacceptable. The concerns and policies expressed by Governments exhibit a large degree of variation. In Africa, for example, more complete implementation of a basic health-care approach remains a major policy goal. Efforts to control malaria, particularly in the face of the emergence of insecticide-resistant mosquitoes and chloroquine-resistant parasites, is a major concern. In a large number of countries, considerable effort has been devoted to programmes of immunization against six major childhood diseases. In very recent years, a great deal of attention has been given to programmes to control the spread of AIDS.

In Europe, where mortality levels are generally already low, a major preoccupation is with deaths as a result of diseases of the circulatory system and cancer. Increasing attention is being paid to preventive measures, including control of hypertension, encouragement of physical activity, better diet; and reduction of smoking, alcohol consumption and use of drugs. In addition, major efforts to prevent the spread of AIDS are under way in virtually all countries of the region.

In general, the policies and programmes of the countries of Asia, Oceania and Latin America have many themes in common. Governments in all three regions report an emphasis on the extension of primary health-care programmes, in an attempt to reach broader segments of their populations. Mass immunization programmes against common infectious diseases are being strengthened, and an increasing number of countries are beginning to report nearly complete coverage. A strong effort to reduce smoking has been made by the Arab countries. Excluding some of the developed countries in the region covered by the Economic and Social Commission for Asia and the Pacific (ESCAP) and some countries of the Caribbean, the prevalence of AIDS or human immunodeficiency virus (HIV) infection is not so high as to warrant calling for immediate large-scale action. Some countries have begun to take measures intended to prevent the spread of the disease, both through its introduction by foreigners and through infection surveillance of the national population.

The World Population Conference of 1974 adopted few quantitative targets in the area of mortality reduction, and in paragraph 23, the Plan of Action indicates that by 1985 countries with the highest mortality should have reached a life expectancy at birth of at least 50 years and an infant mortality rate of fewer than 120 per 1,000 live births (United Nations, 1975, p. 10). Nevertheless, the results of the 1988 revision indicate that nearly half of the countries of Africa, 9 out of 39 countries in Asia and 1 in Latin America were not able to reach those targets (United Nations, 1989c). The International Conference on Population in 1984 updated the targets related to mortality reduction of the Plan of Action on the basis of the experience of countries in applying the Plan. Countries with higher mortality should strive to reach a life expectancy at birth of at least 60 years and an infant mortality rate of fewer than 50 per 1,000 live births by the year 2000, while those with intermediate mortality should try to achieve a life expectancy of 70 years and an infant mortality rate of fewer than 35 per 1,000 (recommendation 14). The results of the 1988 revision permit one to foresee that only 15 countries of Africa would be able to reach a life expectancy higher than 60 years; 7 countries would be able to reach the infant mortality targets; only 2 would achieve the targets stipulated for countries with an intermediate mortality by the the year 2000 (United Nations, 1988c).

3. Major issues in the area of mortality

Some major issues in the area of mortality are discussed below.

Quality of health services

At the national level, it is useful to distinguish between differentials associated directly with characteristics of the health service institutions and others that reflect broader social and economic forces. With respect to the health service institutions, inequalities of access to health care have been a well-recognized issue on the international agenda since at least the time of the International Conference on Primary Health Care at Alma-Ata in 1978. The great majority of countries now assert that they are attempting to reach the goal of Health for All by the Year 2000. It is increasingly widely recognized that hospital-based curative services need to be supplemented by widely available basic health-care services, if economically disadvantaged and dispersed groups are to have their medical needs met. What appears to be called for at this time is to act more effectively on the knowledge and experience that are already available (see chap. I, sect. H of this publication).

The status of women

An increasing number of studies of mortality in the developing countries have indicated that the most important differentials are less the result of inequalities in access to medical services than they are of other social and economic factors (Caldwell, 1986; United Nations, 1985). One point of common agreement in virtually all such studies is on the importance found for the status and the level of education of women. The role of women in caring for sick children and deciding when they need medical care, in making use of and indeed in demanding medical advice and in introducing basic hygienic practices in the home suggests that in very many societies, the one most important factor in explaining differences in mortality is differential access to education by women. Thus, it may be that one most crucial factor affecting mortality and every person's right to life is the ability of women to exercise their right to an education as set forth in article 26 of the Universal Declaration of Human Rights (United Nations, 1988a, p. 6).

Ethnicity

Another social factor that has been found to be of major importance is ethnicity. In a study of variations in child mortality in 15 developing countries, ethnic variation within countries stood out as a major explanatory variable even after all other variables had been controlled (United Nations, 1985). Of course, not all inter-ethnic differentials are necessarily the result of a violation of rights; it is quite possible that some groups may enjoy cultural or social traditions that are more conducive to good health or may simply value health or education of women more highly than others. What would be called for is a case-by-case review in which differentials between ethnic groups would be observed to see if a human rights issue is involved.

Preference for sons

The literature on differential mortality presents another issue that poses human rights problems: evidence from some countries where there is strong son preference indicates that mortality of girls in some circumstances is considerably higher than would normally be expected (see, for example, D'Souza and Chen, 1980; Dyson and Moore, 1983; Makinson, 1986; and Rutstein, 1984). What appears to occur in such societies is that infant and child mortality rates for girls, and especially for second- or higher-order daughters, reach significantly higher levels than do those of boys of comparable age and birth order. Das Gupta reports that in the Punjab, for example:

> "Boys born when the mother already has one more surviving sons have slightly higher child mortality than boys born to mothers with no surviving sons. Girls born to mothers with no surviving daughters experience child mortality rates that fall between the two rates for the boys. However, ... girls born to mothers who already have one or more surviving daughters ... experience 53 per cent higher mortality than the other children." (1987, p. 82)

Das Gupta further states:

> "Since fertility levels are falling, younger cohorts of educated women are likely to have an average completed family size of fewer than three living children. Since those women continue to want one to two living sons, they are under greater pressure not to have more than one surviving daughter than is the case for uneducated and older women, who have higher fertility." (1987, p. 84)

Moreover, increased education of mothers does not in this instance appear to lead to lower mortality levels among higher-order daughters.

Another manifestation of a possible human rights issue that is related to son preference can be found in the concerns that have been expressed in some countries recently about excessive use of amniocentesis. According to press reports, some couples are believed to be using the procedure to determine the sex of foetuses in order to abort females. Most recently, it has been reported that Maharashtra State in India has banned all pre-natal tests to determine a child's sex (ESCAP, 1989).

Acquired immunodeficiency syndrome

It is necessary to consider one additional topic that is less a matter of differential mortality than of attitudes associated with a specific cause of death, the acquired immunodeficiency syndrome. AIDS, which has been recognized for less than a decade, has thus far caused an estimated 250,000 deaths world-wide (Chin, Lwanga and Mann, 1989). This number is obviously a minuscule factor in global mortality. Nevertheless, the AIDS pandemic is a matter of the utmost seriousness, given the number of deaths due to it that can be projected with considerable certainty. The high rates of HIV infection that have been documented in some populations will result in very large increases of AIDS cases in the near future. Thus, by the early 1990s, the cumulative number of global AIDS cases that can be expected is over 1 million and by the late 1990s over 3 million, according to the World Health Organization (WHO). Given the long and expensive care needed and the lethal nature of the disease, health-care systems throughout the world will be placed under far greater stress than they now experience.

What is particularly an issue in the case of the AIDS pandemic is that, perhaps because of the way it is transmitted (by exchange of body fluids and thus commonly through sexual relations or between drug users who share needles), the disease has produced a reaction of fear, avoidance and condemnation in some sectors. Others have reacted negatively to the need for increased expenditures required to deal with victims of AIDS. Lastly, there are difficult unresolved problems in securing the privacy of those with HIV infection or AIDS and at the same time limiting the spread of the disease and protecting others who may be exposed to the risk of infection.

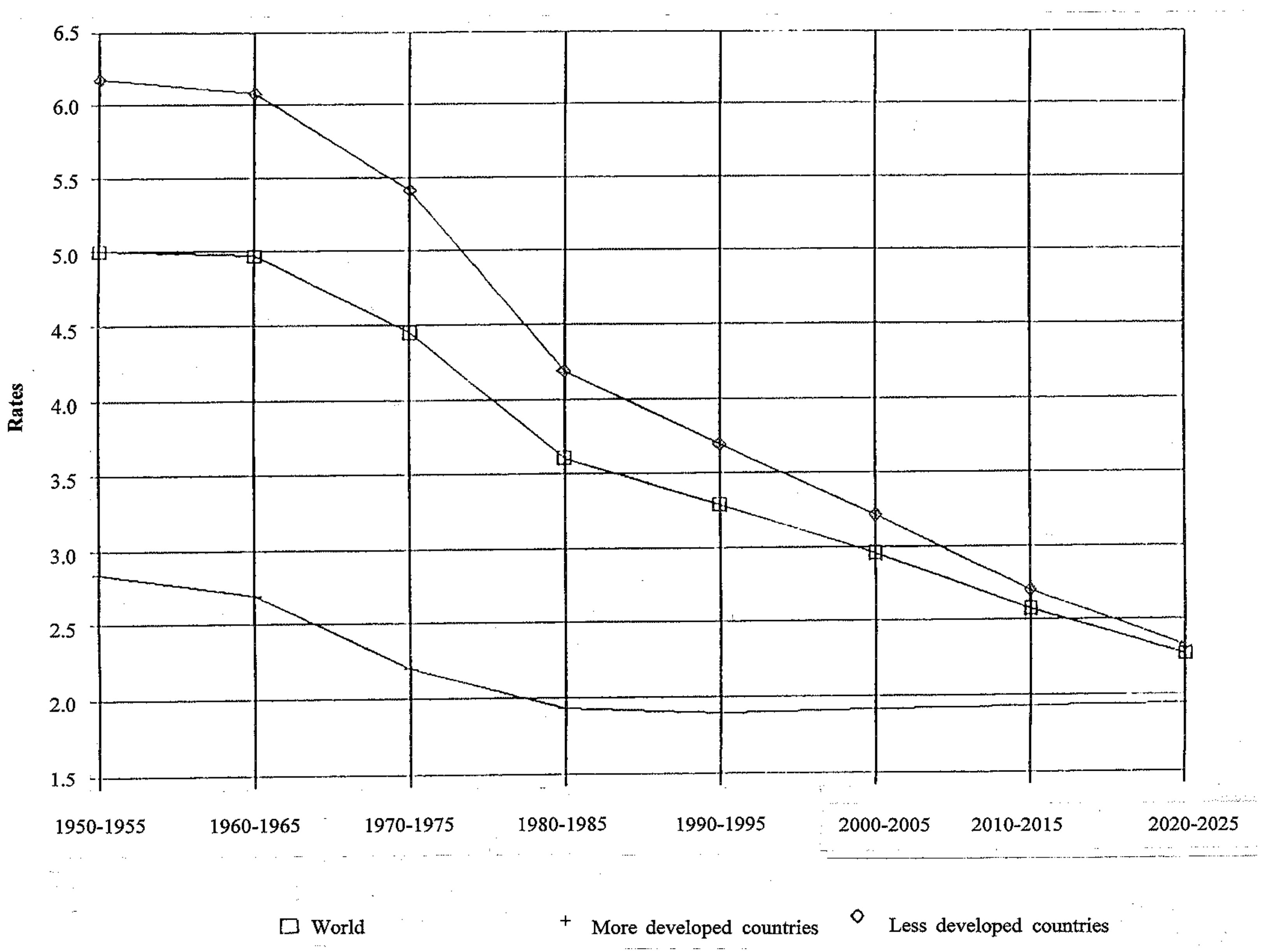
C. Fertility

1. Trends

At the world level, fertility did not change considerably during the 1950s and 1960s; the total fertility rate 1/ remained at the level of 5.0 births per woman. For the period 1985-1990,it is projected to be slightly under 3.5. The high, medium and low variants of the 1988 revision project total fertility rates of 3.3, 3.0 and 2.5 for the period 2000-2005, and 2.8, 2.3 and 1.8 by 2025, respectively. The more developed countries exhibit a continuous decline from 2.8 (1950-1955) to 1.9 (1985-1990); and they are expected, according to the medium-variant projection, to maintain that level through the first quarter of the next century. The less developed countries have also reduced their fertility: from 6.2 (1950-1955) to 3.9 (1985-1990); and according to the medium variant, projected fertility is 3.2 for the period 2000-2005 and 2.3 for 2020-2025 (United Nations, 1988). Figure II presents the evolution of total fertility rates at the world level as well as for the groups of more developed and less developed countries.

During the 1950s and 1960s, fertility levels were used as another indicator of the sharp differences between the more developed and the less developed countries; this is no longer true. Today, although the group of more developed countries exhibits a high degree of homogeneity with low fertility (only five--Albania, Ireland, Poland, Romania and the Union of Soviet Socialist Republics--are above replacement level), heterogeneity is the main characteristic of the less developed countries. Although some developing countries have fertility rates comparable to those of the developed countries (with some cases below the replacement level, such as Barbados, Cuba, Martinique, Mauritius, the Republic of Korea and Singapore), some countries of

Figure II. Total fertility rates, world, more developed countries and less developed countries, 1950-2025



Africa not only exhibit high rates (6.7 for Eastern Africa and 6.8 for Western Africa, respectively), but some of them have been increasing their rates (from the early 1950s to 1980-1985, Cameroon, for example, passed from 5.8 to 6.2, Côte d'Ivoire from 6.9 to 7.4, Kenya from 7.5 to 8.1 and Rwanda from 7.1 to 8.5). It is expected that fertility will decline in sub-Saharan Africa, as has happened in a large number of countries in Asia and Latin America. Nevertheless, the rhythm of such a decline is uncertain, as it is reflected in the wide range of variation of the projected total fertility rate for the year 2025 for the entire continent, which goes from 2.4 (low variant) to 4.0 (high variant).

2. Views and policies concerning fertility

Of the three components of population growth, migration has not proved to be a subject amenable to a significant and durable manipulation. Mortality, which is very responsive to policy intervention, is universally regarded as an inevitable event that has to be postponed as late as possible. Not surprisingly, when Governments decide to modify their rates of population growth, they decide to intervene through policies and actions directed to modifying fertility. Fertility policies are perhaps the most controversial component of population policies because, on the one hand, they refer to one of the most intimate aspects of human life, human reproduction; and, on the other hand, their results may be viewed as altering the numerical balance of social groups, social classes, ethnic groups or even countries.

Two of the most important pillars of the World Population Plan of Action are the recognition of the right of couples and individuals to decide freely and responsibly the number and spacing of their children and the right of societies to adopt their population policies. In some instances, the two rights may be in conflict. If this is the case, Governments may try to reconcile individual and societal rights by creating the necessary conditions in order that individuals and families may be able to desire a number of children that will correspond more closely to what is perceived as a desirable fertility level for the society. This creation of awareness may be accompanied by suggesting that the existence of individual rights carry also a series of duties and responsibilities and that persisting extreme levels of fertility may raise questions about the needs and rights of living and future children. In other instances, Governments may adopt measures that could infringe on, or cancel, the exercise of rights of couples and individuals to decide freely and responsibly the number and spacing of their children; in so doing, Governments may find the legitimacy of its measures in the principle that the well-being of society has a primacy over individual rights.

According to the information available in the Population Policy Data Bank, 97 countries indicated that they are not satisfied with their levels of fertility, 22 because they found them to be too low and 75, too high (table 2). The same data indicate that 85 developing countries are dissatisfied, 10 because their fertility is too low and 75 because it is too high; the 12 developed countries that indicated their dissatisfaction concur with the statement that their fertility is too low (United Nations, 1989c).

Table 2. Number of countries according to government policies with respect to levels of fertility, by level of development, 1988

Level of development	Rates too low	Rates neither too low nor too high	Rates too high	Total
More developed countries	12	27	-	39
Less developed countries	10	46	75	131
World	22	73	75	170

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

The same sources of information indicate that 102 countries have decided to intervene in order to modify their levels of fertility: 21 to increase them, 20 to maintain their current levels; and 61 to decrease them (table 3). Among the 85 developing countries that have fertility policies, the same data show that 11 would like to increase their current levels, 13 to maintain them and 61 to decrease them; of the 17 intervening developed countries, 10 intend to increase their levels and 7 plan to maintain them.

Table 3. Number of countries according to government policies of interventions with respect to levels of fertility, by level of development, 1988

Level of development	To increase fertility	To maintain fertility	To decrease fertility	No intervention	Total
More developed countries	10	7	-	22	39
Less developed countries	11	13	61	46	131
World	21	20	61	68	170

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

The draft of the World Population Plan of Action, which was submitted to the World Population Conference at Bucharest in 1974, included the adoption of fertility targets, but the Conference rejected that proposal on the grounds that world targets would imperil the sovereign right of every country to define its own fertility policies. It is important to observe that the adoption of mortality targets at Bucharest, and their revision 10 years later at the International Conference on Population held at Mexico City, did not raise the same kind of opposition. Nevertheless, in paragraph 37, the Plan of Action states that those "countries which consider their birth-rates detrimental to their national purposes are invited to consider setting quantitative goals... Nothing herein should interfere with the sovereignty of any Government to adopt or not to adopt such quantitative goals" (United Nations, 1975, p. 13). Currently over one third of the countries having adopted fertility policies have also defined quantitative targets.

3. Major issues and policies in the area of fertility

In order to achieve their purposes, policies need to be instrumented into a series of programmes and actions. The Sixth Population Inquiry Among Governments invited Governments to enumerate the measures adopted by them to modify their levels of fertility; the results for the 82 countries that responded to the inquiry appear in table 4.

Table 4. Number of Governments that have adopted measures intended to affect fertility, 1988

Measures	Being implemented	Not implemented	Non-response	Total
1. Improvement of the status of women	66	8	8	82
2. Family planning programme	58	16	8	82
3. Promotion of public awareness	57	18	8	82
4. Day-care/nursery centres	52	20	10	82
5. Maternity or paternity benefits	42	31	9	82
6. Comprehensive pension schemes	41	32	9	82
7. Care and protection of the aged	39	30	13	82
8. Family allowances	38	32	12	82
9. Tax exemptions to parents	30	39	13	82

Source: Partial results from the Sixth Population Inquiry among Governments.

Status of women

Governments are becoming increasingly aware of the large array of social and economic determinants that can influence fertility decisions and they may try to use them as conditioning factors to change fertility levels in one direction or the other. Some of the measures currently in use by Governments to modify the levels of fertility were not designed for a demographic purpose but rather as social or economic procedures intended to respond to other topics of issues. This is the case, for example, for measures intended to improve the status of women. In fact, those measures were adopted as justified by social justice concerns and in response to the increasing demands made by women's movements through the world in terms of human rights. However, Governments also are aware that if women are better educated and participate more in activities that compete with the roles assigned to women in traditional societies, they will be able to achieve their full integration in society, and their desire to have a large number of children will decline.

Family planning programmes

Family planning programmes have been established around the world on the basis of different grounds that include recognition of the right to decide the number and spacing of children, protection of maternal and child health or provision of an instrument to modify fertility levels. According to the information available at the Population Policy Data Bank, in 1988, a large majority of Governments (125 of 170 countries) were offering direct support to the use of modern methods of fertility regulation, 21 were offering indirect support, 17 were not offering any support and 7 restricted access to those methods. Two of the last-named are among the group of developed countries and five among the developing countries (see table 5). Those figures contrast with those corresponding to 1974, when 11 countries restricted access, 35 did not offer any support, 20 provided indirect support and 80 gave direct support.

Table 5. Number of countries according to government policies with respect to access to modern methods of fertility regulation, by level of development, 1988

Level of development	Access restricted	Access not restricted No support	 Indirect support	 Direct support	Total
More developed countries	2	7	8	22	39
Less developed countries	5	10	13	103	131
World	7	17	21	125	170

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

It is important to take into account that not providing any support does not mean opposition to family planning. In fact, in many countries where such programmes are offered by the private sector and their financing is provided by the users (as is the case in many developed countries) or by grants, Governments do not offer any support, but access is not restricted. Of a particular interest is the case of the seven countries that restrict access to modern methods of fertility regulation; the rationale used by those countries is based on various reasons, of which demographic reasons are the most common. Nevertheless, the restriction of access raises important questions concerning exercise of the right of couples and individuals to decide freely on the number and spacing of their children (see chap. I, sect. D of this publication).

The Sixth Inquiry asked Governments to report if they had legal or administrative restrictions limiting access to specific methods of fertility regulation; and if they mentioned that access was permitted, they were invited to indicate if direct or indirect support was being provided and the level of subsidy offered for each specific method. The results of the responses of 82 Governments appear in table 6.

Table 6. Number of Governments permitting the access to fertility regulation methods and providing support and subsidies, by method, 1988

Method	Access to method			Support		Subsidy for method		
	As a method	For health	Prohibited	Yes	No	Free	Some subsidy	None
Intrauterine device (IUD)	77	–	–	66	6	39	21	16
Condom	77	–	–	68	6	36	19	22
Oral pill	76	1	–	68	6	39	23	15
Vaginal suppository	73	–	–	61	9	30	16	25
Diaphragm	68	–	1	55	11	25	16	26
Injection	56	7	6	49	14	27	13	21
Female sterilization	51	20	4	52	12	35	18	11
Male sterilization	50	9	9	46	11	31	16	10
Subdermal implant	34	4	9	19	18	9	6	20
Vaginal ring	30	4	9	18	17	7	4	20

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

According to the results of a study on contraceptive use recently completed by the Population Division, 51 per cent of couples in which the woman is in her reproductive years are currently using contraception; for the developed countries the proportion is 70 per cent, and for the developing countries, 45 per cent (United Nations, 1989a). Nevertheless, there are important regional variations: in East Asia the corresponding figures are close to 75 per cent, whereas they are 56 per cent in Latin America and 14 per cent in Africa.

Induced abortion

The World Population Plan of Action, and particularly the International Conference on Population, indicated that abortion should not be promoted as a method of family planning (recommendation 18(e)). Nevertheless, it is estimated that between 24 and 32 per cent of known pregnancies end in induced abortion (United Nations, 1989b). Those figures approximately correspond to from 40 million to 60 million abortions per annum (i.e., a rate of 37 to 55 abortions per 1,000 women aged 15-44). Of those figures, it is estimated that from 25 to 40 per cent are performed illegally. There has been a long-term trend towards liberalizing the access to abortion. Today, it is estimated that roughly three quarters of the world population live in countries where access to abortion is permitted for health reasons and 63 per cent for broader social reasons or on request. It is important to observe that the lowest incidence, as indicated by 10 per cent of known pregnancies ending in abortion and by rates of approximately 6 abortions per 1,000 women aged 15-44, takes place where the use of modern contraceptive methods is high in all sectors of the population (see chap. I, sect. E of this publication).

The Sixth Inquiry included some questions related to abortion. While 11 Governments indicated that they were not concerned about their current levels of abortion, 22 said they did not have any official position and 47 responded they were very concerned. In reviewing the 82 responses, it can be seen that access to abortion is not a simple yes or no issue but rather a procedure to be granted according to some reasons adduced for its request, as is shown in table 7. From those responses it is possible to make the inference that abortion is perceived by Governments as a lesser evil and not as a procedure to be promoted. The same results indicate that 12 Governments do not require professional approval to perform an abortion, while 64 of them require such approval. Lastly, 29 Governments said they subsidized abortion and 49 said they did not.

Table 7. Number of Governments granting access to abortion, by type of request, 1988

Cases in which access is granted	Yes	No	Non-response	Total
1. To save the life of the mother	72	6	4	82
2. To protect the physical health of the mother	59	17	6	82
3. Foetal impairment	49	24	9	82
4. Rape of the mother	46	28	8	82
5. To protect the mental health of the mother	45	29	8	82
6. Economic hardship	19	55	8	82
7. On request	18	60	4	82

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

Access to new biotechnologies affecting fertility

During recent years, there has been an important development of new biotechnologies that can affect human reproduction. Those technologies make possible artificial insemination, *in vitro* fertilization and embryo transfer, surrogate motherhood, cryogenic storage of sperm and ova, and pre-natal sex determination and genetic selection. Access to those procedures may facilitate a successful solution to problems associated with subfecundity or sterility. In some instances, they have been used by homosexual women to circumvent laws related to adoption where such laws are in force. Access to some of those technologies and the use of human foetal tissue for research and therapy raise other important questions that go beyond demographic considerations. But the generalization of some of those procedures has the potential of altering certain important demographic characteristics, particularly the sex composition of the population. The use of those technologies presents a major social challenge, particularly in terms of ethical values and human rights (see chap. I, sect. G of this publication).

Additional issues

As in the case of actions intended to improve the status of women, other measures that have been adopted by Governments independently of any demographic purpose may influence families in their fertility preferences. Such measure include, for example, the provision of day-care and nursery facilities and maternity and paternity benefits in countries that would like to increase their levels of fertility; or postponement of the legal age at marriage or use of comprehensive pension schemes and the care and protection of the aged when Governments intend to decrease their levels of fertility. Tax exemptions and access to health care, education and other benefits have been used in one or the other direction.

Another generalized measure is the use of incentives and disincentives. Although the term can encompass some of the measures mentioned in the previous paragraph, it is generally used in association with the provision of family planning services. Those incentives can be provided in cash or in kind to either the acceptor of the service, the motivator or the service provider. In some cases, the recipient of the benefit is the community rather than the individual or the family (see chap. I, sect. F of this publication).

The adoption of some of those measures, as is also the case for other redistributive policies, exposes Governments to the public eye, and the sources of disagreement and tensions are activated. Because of this characteristic, those policies are highly advocated by zealous partisans of government intervention because they are the most visible indicator of governmental commitment. Although they are intended to influence a particular segment of the population (either those who have too many or those with too few children), such measures may arouse some resentment among those affected and risk being perceived as a coercive action coming from those not affected. In paragraph 34, the Plan of Action affirms that "if such schemes are adopted or modified it is essential that they should not violate human rights" (United Nations, 1975, p. 13); and the International Conference on Population states in recommendation 3 that "incentives and disincentives should be neither coercive nor discriminatory and should be consistent with internationally recognized human rights as well as with changing individual and cultural values" (United Nations, 1984, p. 25). It seems that only a generalized societal perception that the measures adopted would benefit the society as a whole in the near future, and that in the long run everybody would benefit, may guarantee that the measures are not infringing fundamental human rights.

D. Population age structure

1. Trends

For the world as a whole the predominant trend continues to be one of demographic aging. As of 1985, the median age of all human beings was 23.4 years, nearly two years older than it had been a decade and a half earlier, when the global median reached its lowest point since the middle of the century. It is only in Africa, where fertility remains very high, that there is as yet no indication of the beginning of a demographic aging process; the median age for Africa declined to 17.3 years as of 1985 (United Nations, 1989c).

Despite the trend towards demographic aging, children (conventionally defined as persons 0-14 years of age), remain the largest group of dependants nearly everywhere in the world. In 1985, there were some 1.6 billion children, one third of the total population. About 16 per cent of them lived in the more developed regions and 84 per cent in the less developed regions. Sixty-one per cent of all children--nearly a billion--live in Asia. What is most striking, however, is that the child population is currently growing at less than half the rate of the world population at all ages. Moreover, in every region of the world except for Africa and the rather special case of the Union of Soviet Socialist Republics, the child population is growing more slowly than the total population. In Europe, the child population has been declining in absolute numbers since 1970; in 1985, there were just over 5.6 million fewer children in Europe than in 1980.

For the years ahead, the number of children in the developed countries is expected to continue to decline, from the 261 million of 1985 to 264 million in the year 2000 and 242 million in 2025. In 1985, children constituted about 22 per cent of the population of the more developed regions; by 2025, they will account for 18 per cent. In the less developed regions, 37 per cent of the population in 1985 were under 15 years of age. The absolute number of children is expected to continue to increase through the first quarter of the next century, from 1.4 billion to 1.8 billion; as a proportion of the total population, however, children are expected to decline from 37 to 26 per cent.

It should be noted that although the medium-variant projection foresees a decline in the proportion of children during the next 35 years, the potential for growth remains very high. In the less developed regions, any decline in the proportion of children is the result of a projected fall in fertility; both the numbers and the proportion of women in the child-bearing ages will continue to rise until about the year 2015. It is expected that by 2015, just under 26 per cent of the total population of the less developed regions will be women aged 15-49 years. Around 1965, when the rate of population growth reached its peak, 22.3 per cent of the population of the less developed regions were women aged 15-49.

Turning now to the elderly, here defined as those aged 60 years or over, there were 432 million in 1985, 9 per cent of the total at all ages. Continuing reductions in mortality and fertility are raising the proportion of the elderly in all regions of the world, the rate of growth among them is about 40 per cent higher than it is for the total population. By the year 2000, it is projected that the elderly will comprise 10 per cent of the world population. In 2025, it is expected that the population aged 60 or more years will be 15 per cent of the world population; they will number some 1.2 billion. In the more developed regions, the elderly constituted some 16 per cent of the total population in 1985; by the year 2000, they will increase moderately to 19 per cent of the total population, after which time the proportion will increase more rapidly to reach 25 per cent of the total by the year 2025. They accounted for 7 per cent of the population of the less developed regions in 1985, their proportion will reach just under 8 per cent by the year 2000 and 12 per cent by 2025.

In the developed countries, one of the most striking features of the age/sex distribution is the very low sex ratios found at the older ages. For persons 65-69 years of age, there are 71 men for every 100 women; for those 75 and older, there is about one man for every two women. Those very low sex ratios reflect not only the higher mortality experienced by men in normal circumstances, but also the losses of men during the Second World War, as the most heavily affected age cohorts move into the older years. Current projections indicate a steady rise in sex ratios in those age groups in the developed countries from the current time through the first quarter of the next century.

Sex ratios vary much less by age in the less developed regions. The ratio remains above 100 through all age groups below 60 years and does not fall below 90 until it reaches age group 70-74. No very great change is projected for the next 40 years. At the same time, it must be recalled that the common social practice of men to marry later and die younger than women assures widespread widowhood. The vulnerability experienced by widows in many societies calls for particular concern that their rights be assured.

Lastly, it is useful to consider the so-called "old-old" population, the very elderly, here defined as those aged 80 years or more. Clearly, this age group poses most sharply the issue of old-age dependency. At the same time, it must be noted that there are unavoidable problems of data quality in focusing on a single group at the extreme of the age distribution. In 1985, there were estimated to be some 45 million persons aged 80 or over in the world. The number had more than trebled since 1950, when there were estimated to have been about 13 million. Of the 45 million in 1985, 28 million lived in the more developed regions and 17 million in the less developed regions. By the end of the century it is expected that the very elderly will number just over 67 million, 35 million in developed countries and 32 million in developing countries. Their numbers are expected to just more than double during the following 25 years, to reach 138 million. At that point, those aged 80 or over in the less developed regions, 79 million, will outnumber the 58 million in the more developed regions. As a proportion, the old-old are currently just about 1 per cent of the world population. They are 2.5 per cent of the developed and 0.5 per cent of the developing regions. The proportions will rise by the year 2025 to 1.6 per cent of the world population, 4.3 per cent in the more developed regions and 1.1 per cent in the less developed regions.

2. Views on population age structure

In more recent years and probably largely as a result of rapid and historically unprecedented changes in age distribution, especially among developing countries, that themselves result from major changes in fertility and mortality, changes in age structure in and of themselves are coming to be seen as a matter of policy concern. In the responses of 82 countries to the Sixth Population Inquiry concerning their overall appraisal of their current age distribution, 52 per cent indicated that they viewed it as to some degree unsatisfactory or problematical; 12 per cent saw it as satisfactory while the remaining 34 per cent of all countries reported that the Government had taken no official position on the matter. Concern about the age distribution is more frequently reported by developing countries; 60 per cent of those countries expressed some degree of dissatisfaction about their age distribution, just 30 per cent of the developed countries did so. On the other hand, under 50 per cent of the developed countries that responded indicated that they did not have an official view on their age distribution. Not surprisingly, the overwhelming concern of the developing countries is that the proportion under age 15 is too high. Concern about the proportion aged 60 and older is more commonly reported by developed countries, but even for that group, fewer than one in four Governments considers it to be a matter of concern.

It must be recognized, however, that the current global trend of demographic aging is no more than two decades old and that the most substantial increases in the proportions of older persons lie in the future. Therefore, Governments were also asked about their appraisal of the overall age structure that they anticipate for the year 2025. In both the more developed and the less developed regions, just 30 per cent of the countries responded that they viewed their anticipated age distribution as likely to be unsatisfactory. In both regions, some 50 per cent indicated that the Government had not formulated an official position on the matter. In general, Governments reported much less concern about the proportion below age 15 anticipated for the year 2025 than they indicated for the present. On the other hand, the developed countries are more likely to report concern about the proportion 60 and over in 2025, although currently no more than one third of them view the expected proportion of older persons as unsatisfactory.

3. Major issues in the area of population age structure

Given the process of shifting functions from the family to the State, the rights of persons in dependent ages has been a matter of concern to the international community from the time of the establishment of the United Nations. With respect to children, an important step was the adoption in 1959 by the General Assembly of the Declaration of the Rights of the Child (United Nations, 1988a). The Declaration sets forth 10 principles on the rights and entitlements of children and calls upon all "parents, upon men and women as individuals, and upon voluntary organizations, local authorities and national Governments" to strive to observe them (United Nations, 1988a, p. 367). The Declaration covers a very broad range of concerns and interests of children and, as the term "principles" indicates and is suggested by specification of those to whom the Declaration is directed, gives the impression of being intended as general guidance rather than as a clear specification of rights. Very recently, renewed interest in a further formulation of the rights of the child has appeared; the issue may be taken up by the General Assembly or some other appropriate intergovernmental body later this year.

The fact that the aging of populations in most regions of the world is a rather more recent demographic trend may explain why comparatively less attention was given to the rights of the aged in some of the earlier formulations of human rights (see chap. I, sect. J of this publication). For example, in article 25 of the Universal Declaration of Human Rights, "old age" is included in a list of events that might befall a person, along with "unemployment, sickness, disability, widowhood...or other lack of livelihood in circumstances beyond his control" in which the person's right to security is to be maintained (United Nations, 1988a, p. 6).

The most important international instrument in which the concerns and the rights of older persons is dealt with is the Vienna International Plan of Action on Aging, adopted in 1982 (United Nations, 1982). The rights of older persons are broadly implicit throughout the document, but explicit reference to human rights as such are not widespread through the 62 recommendations made in the Plan. The preamble reaffirms that "the fundamental and inalienable rights enshrined in the Universal Declaration of Human Rights apply fully and undiminishedly to the aging..." (United Nations, 1982, p. 47). Specific reference is made to the need to ensure that women as well as men shall acquire their own rights in social security systems, to the right of older workers to employment based on ability to work rather than on chronological age, to the transferability of social security for migrant workers and, as a basic human right, to the availability of education without discrimination against the elderly. It may be noted that the Vienna Plan is subject to periodic review and appraisal; in a recently completed review and appraisal, no direct reference was made to the question of rights of older persons as such.

Note

1/ The total fertility rate corresponds to the expected number of live births that a woman would have if, as she passes through the reproductive years (15-49), she has children at the same rates as experienced by women during the year and within the geographical unit to which the rates relate.

References

Caldwell, John C. (1986). Routes to low mortality in poor countries. Population and Development Review (New York), vol. 12, No. 2 (June), pp. 171-220.

Chin, James, S. Lwanga and Jonathan Mann (1989). The global epidemiology and projected short-term demographic impact of AIDs. Population Bulletin of the United Nations, No. 27. Sales No. E.89.XIII.7.

Das Gupta, Monica (1987). Selective discrimination against female children in rural Punjam, India. Population and Development Review (New York), vol. 13, No. 1 (March), pp. 77-100.

D'Souza, Stan, and Lincoln C. Chen (1980). Sex differentials in mortality in rural Bangladesh. Population and Development Review (New York), vol. 6, No. 2 (June), pp. 257-270.

Dyson, Tim, and Mick Moore (1983). On kinship structure, female autonomy, and demographic behavior in India. Population and Development Review (New York), vol. 9, No. 1 (March), pp. 35-60.

Economic and Social Commission for Asia and the Pacific (1989). Maharashtra bans pre-natal sex tests. Population Headliners (Bangkok), No. 167 (February), p. 2.

Makinson, Carolyn (1986). Sex differentials in infant and child mortality in Egypt. Unpublished doctoral dissertation. Princeton, New Jersey: Princeton University.

Rutstein, Shea O. (1984). Infant and Child Mortality: Levels, Trends and Demographic Differentials. World Fertility Survey Comparative Studies, No. 43, rev. ed. Voorburg, Netherlands: International Statistical Association.

United Nations (1975). Report of the United Nations World Population Conference, Bucharest, 19-30 August 1974. Sales No. E.75.XIII.3.

__________ (1982). Report of the World Assembly on Aging, Vienna, 26 July - 6 August 1982. Sales No. E.82.1.16.

__________ (1984). Report of the International Conference on Population, Mexico City, 6-14 August 1984. Sales No. E.84.XIII.8.

__________ (1985). Socio-economic Differentials in Child Mortality in Developing Countries. Sales No. E.85.XIII.7.

__________ (1988a). Human Rights: A Compilation of International Instruments. Sales No. E.88.XIV.1.

__________ (1988b). Mortality of Children Under Age 5: World Estimates and Projections, 1950-2025. Population Studies, No. 105. Sales No. E.88.XIII.4.

__________ (1988c). World Population Prospects, 1988. Population Studies, No. 106. Sales No. E.88.XIII.7.

__________ (1989a). Levels and Trends of Contraceptive Use as Assessed in 1988. Population Studies, No. 110. Sales No. E.89.XIII.4.

__________ (1989b). Review and Appraisal of the World Population Plan of Action: 1989 Report. Population Studies, No. 115. Sales No. E.89.XIII.11.

__________ (1989c). World Population Monitoring, 1989. Population Studies, No. 113. Sales No. E.89.XIII.12.

__________ (1990). Results of the Sixth Population Inquiry among Governments. ST/ESA/SER.R/104.

IV. RELATIONSHIP BETWEEN HUMAN RIGHTS AND POPULATION ISSUES: STANDARD-SETTING ACTIVITIES OF THE UNITED NATIONS ORGANIZATION, 1980-1988

United Nations Secretariat*

Since the early 1980s, peoples and States have become increasingly aware of the relationship between human rights standards and population issues. The United Nations Organization has played a leading role in this process.

At the United Nations Organization, these problems are currently understood within an expanding conceptual framework on human rights. This framework embraces, or tends to include, new standards, such as the right to development and the right to peace. The very fact of this conceptual expansion tends to increase the number and complexity of the links perceived between human rights and population issues.

Furthermore, accelerating scientific and technological progress raises novel human rights problems concerning, notably, procreation, contraception, abortion, health care and longevity.

Growing economic disparities between regions and within societies, as well as related conflicts, repression and migratory flows, lead to renewed concerns for the right to life, protection against inhuman and degrading treatment, freedom of movement and the protection of migrants.

The instruments studied illustratively in this paper take a variety of forms: treaties; declarations; resolutions; plans of action; strategies. It is often not clear whether the intent is to set international legal rules or to indicate specific objectives. Leaving largely aside issues of legal characterization, an effort is made here to bring out broad normative trends.

Although this paper focuses on developments since 1980, earlier instruments mentioned in the first two reports (United Nations, 1975b and 1983a) should be kept in mind and will be recalled, in order to understand current concerns.

This surveys covers the standard-setting activities of the United Nations relating to: (a) human rights and fertility issues; (b) the question of induced termination of pregnancy; (c) human rights, health and morbidity; (d) human rights of the aging; and (e) right-to-life and mortality issues.

---

*Centre for Human Rights, United Nations Office at Geneva. Prepared by Maxime Tardu, former Chief, Research and Studies Unit, Division of Human Rights, United Nations Office at Geneva.

A. United Nations standards concerning human rights and fertility issues

1. Marriage and the family

The family continues to be hailed in United Nations instruments as a basic unit of society worthy of care and protection to a high degree.

Many United Nations recommendations, for example, the Guiding Principles for Developmental Social Welfare Policies and Programmes in the Near Future, (United Nations, 1987, chap. III), endorsed by the General Assembly in resolution 42/125, have called for social policies to give greater attention to the family. In 1988, the General Assembly endorsed these views and envisaged the proclamation of an International Year of the Family (resolution 43/135). 1/

In article 16 of the Convention on the Elimination of All Forms of Discrimination against Women (1979), marriage continues to be highly valued as an act of, inter alia, "full and free consent" (United Nations, 1988a, p. 120).

Furthermore, this treaty strengthens the protection against child marriage. Under article 2 of the Convention of 1962 on this matter, no one could be married below a minimum age specified by law "except where a competent authority has granted a dispensation as to age, for serious reasons, in the interest of the intending spouses" (United Nations, 1988a, p. 362). In 1979, this limitation clause was not carried over to the Convention on Discrimination Against Women, which states in absolute terms in article 16 that "the betrothal and the marriage of a child shall have no legal effect" (United Nations, 1988a, p. 121).

Social and legal norms concerning the permissible age of sexual union and marriage have a strong impact on fertility rates. The relevant human rights treaties of the United Nations oblige States parties to set a minimum age of marriage by law, but none so far fixes an internationally agreed minimum. In 1965, the General Assembly proposed 15 years of age as the absolute minimum (resolution 2018 (XX), part II).

The Nairobi Forward-looking Strategies for the Advancement of Women, out of concern for the adverse effects of adolescent pregnancies on the morbidity and mortality of mother and child, recommends in paragraph 158 that "Governments should make efforts to raise the age of entry into marriage in countries where this age is still quite low" and also stressed the need to ensure that "adolescents, both girls and boys, receive adequate information and education [on marriage and procreation]" (United Nations, 1985, p. 40).

The human rights law of the United Nations repeatedly condemns discrimination on all grounds with respect to the right to marry and to found a family. Articles 2, paragraph 1, and article 23, combined, of the Covenant on Civil and Political Rights may be cited in this regard. The equality of men and women as to marriage, during marriage and at its dissolution is especially emphasized in the Covenant as well as in article 16 of the

Convention on Discrimination against Women (1979). The latter provision is more detailed than previous ones, mentioning such aspects as, for example, equality of rights as to the choice of a family name, profession, matrimonial property.

Article 16 further stresses equality of rights in all matters concerning children, adding, however, that "in all cases the interests of the children shall be paramount" (United Nations, 1988a, p. 121).

It is recalled that the prohibition of racially mixed marriages and all other forms of racial discrimination as concerns marriage are condemned by article 5 (IV) of the Convention on the Elimination of Racial Discrimination (1965) and by article II of the Convention on the Suppression and Punishment of the Crime of Apartheid (1973) (United Nations, 1988a, pp. 60 and 71-72, respectively).

Family reunification tends to be recognized increasingly as a distinct human right. One may cite in this regard article 10 of the Draft Convention on the Rights of the Child (E/CN.4/1989/29), which sets forth the right of the child to "personal relations and direct contacts with both parents [residing in a different State]", a right to be guaranteed "save in exceptional circumstances". The Draft Convention defines the child as anyone below 18 years of age. In article 44 of the United Nations Draft Convention on the Protection of the Rights of All Migrant Workers and their Families, currently being prepared in a working group of the General Assembly, family reunification is proclaimed as a right for spouses and minor children, who would be entitled to stay in the country of employment "for a duration not less than that of the worker" (A/C.3/38/WG.1/CRP. 1 and 2/Rev. 1).

2. The right to decide freely and responsibly on the number and spacing of children

The concept of the right to decide freely and responsibly on the number and spacing of children was first declared a "human right" in 1968, in article 16 of the Proclamation of Teheran, and subsequently in 1969 by the Declaration on Social Progress and Development (articles 4 and 22) and other declaratory instruments. 2/

It appears that this right has now become part of international treaty law through article 16(1)(e) of the Convention on Discrimination against Women. It seeks to ensure that men and women shall enjoy "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, 1988a, pp. 120-121).

The concept has been restated and further elaborated, in a specific context, by recent instruments, especially those adopted in 1984 by the International Conference on Population (United Nations, 1984a) and by the Nairobi Strategies for the Advancement of Women (United Nations, 1985). Both conferences proclaimed this right as "an important basis for the enjoyment of other rights".

Question of who has the right to decide on the number and spacing of children

In the first and second reports on population and human rights (United Nations, 1975b and 1983a), an analysis was made of the significant conceptual variants in United Nations instruments concerning the holders of this right: "the family"; "parents"; "couples"; "all persons who so desire"; and "all couples and individuals".

Since the mid-1970s, the prevailing emphasis has been upon the rights of "couples and individuals". This formula, adopted by the World Population Plan of Action in 1974, was restated with added stress in recommendation 30 of the International Conference on Population (United Nations, 1984a, p. 24) and in the Nairobi Strategies for Women (United Nations, 1985, para. 156).

Paragraph 29 of the Strategies, while referring to the broad formula agreed on at Mexico City, focuses specifically on the right of women "to exercise effectively their rights in matters pertaining to population concerns, including the basic right to control their own fertility which forms an important basis for the enjoyment of other rights ..." (United Nations, 1985, p. 13).

These texts add some precision to the mid-1960s instruments. It appears, in particular, that the authority of the family or at least of ascendant and collateral members of families in decision-making with respect to fertility is now rarely--if at all--mentioned.

Conceptual and legal clarifications are still needed concerning the relationship between the respective entitlements of women, of men and of "couples--married and unmarried--in this field, as well as on the meaning of the term "couple". What seems clear is a trend to focus more sharply on the persons directly concerned in fertility decisions.

Scope of the right

The concept embraces all fertility issues. It includes the freedom to procreate as well as the freedom not to have children. This was shown, for instance, in the substitution of the word "couples" for the word "parents" in the debates on resolution XVIII of the 1968 Teheran Conference (United Nations, 1968). Except in the Declaration on Social Progress and Development of 1969 (General Assembly resolution 2542 (XXIV)), which in article 4 proclaims an "exclusive right" of parents, and a few other instruments, the word "couples" was preferred in formulating subsequent texts, including those from the International Conference at Mexico City and the World Conference at Nairobi (United Nations, 1984a and 1985).

The right as formulated goes even beyond fertility problems: the decision may be to adopt, rather than procreate, children. United Nations standards on legitimate adoption should be recalled in this regard (see, in particular, General Assembly resolution 41/85; and E/CN.4/1989/29, article 4).

The United Nations has increasingly stressed full information and the availability of relevant means as basic prerequisites of "free" decisions on fertility. Thus, in paragraph 156, the Nairobi Strategies refer to "the basic human rights to decide freely and informedly on the number and spacing of their children" (United Nations, 1985, p. 39).

Right to information, education and means

In recent United Nations instruments, the three-pronged concept of a right to "information", to "education" and to "services and/or means" is proclaimed as a whole and as an essential part of the right to take fertility decisions. As is shown below, however, the international legal problems involved differ somewhat from one component to the next.

The terms used since the mid-1970s reveal a general trend towards strengthening the obligations of States. "Access" was the only concept in earlier texts, including the 1979 Convention on Discrimination against Women. In recommendation 25, the International Conference at Mexico City goes further in recommending that information, education and means "to assist" couples and individuals be made "universally available" by Governments "as a matter of urgency" (United Nations, 1984a, p. 23). The same text states that such services "should include all medically approved and appropriate methods of family planning including natural family planning, to ensure a voluntary and free choice in accordance with changing individual and cultural values"; lastly, the clause calls for "particular attention" to be given "to those segments of the population which are most vulnerable and difficult to reach" (United Nations, 1984a, pp. 23-24).

In paragraph 156, the Nairobi Strategies for Women even emphasizes that education for responsible parenthood should be "widely" available and that family planning services should be "strengthened" and, if necessary, "created" (United Nations, 1985, p. 39).

Attention may be paid to some problems of harmonization between the right to information, education and means relevant to fertility, as set forth in recent texts, on the one hand, and general provisions on freedom of information and the right to education, on the other.

The right to information on fertility matters is formulated with few qualifications in the Convention on Discrimination against Women (1979), the text of the International Conference (1984) and the Nairobi Strategies (1985). The main proviso is that the data should bear on "appropriate" and "medically approved" methods. However, freedom of information in general is subject to more extensive limitations in articles 19 and 29 of the Universal Declaration, article 19 of the Covenant on Civil and Political Rights and articles 13 and 17 of the Draft Convention on the Rights of the Child. The last-named treaty (E/CN.4/1989/29) is relevant to fertility problems, as the child is defined therein as anyone under 18 years of age. General limitations on freedom of information may be imposed, under these texts, *inter alia*, on grounds of national security, public order, public health and public morality. The Human Rights Committee, acting under the Optional Protocol, has declared prima facie reasonable certain restrictive measures on freedom of expression (not directly relevant to fertility, however) on grounds of public morality. 3/ Furthermore, article 4 of the Covenant states that the right to information may be derogated from under a state of emergency. Nevertheless, the Covenant continues, these limitations may not aim "at the destruction of the rights and freedom recognized herein" (United Nations, 1988a, p. 20).

Access to education on family planning is similarly enunciated with few provisos in recent texts. However, the right to education in general is subject to several orientations and limitations in various instruments, notably article 13 of the Covenant on Economic, Social and Cultural Rights and articles 28 and 29 of the Draft Convention on the Rights of the Child.

Recent texts emphasize that access to education, information and services concerning fertility planning should never be restricted because of a Government's population policies (United Nations, 1984a, recommendation 35; United Nations, 1985, para. 156).

Responsibilities involved in fertility planning

The concept of responsibility in the context of family planning has been somewhat elaborated since the mid-1970s.

In paragraph 14 (f), the World Population Plan of Action of 1974 mentions the need for couples and individuals to take into consideration their own situation, as well as the implications of their decisions for the balanced development of their children and of the community and society in which they live (United Nations, 1975a, p. 7).

In recommendation 30, the International Conference at Mexico City restated these views with some added emphasis on the needs of living "and future" children (United Nations, 1984a, p. 24).

Does recognition of the community's needs justify state intervention in the sphere of fertility decision-making? If so, to what extent and in what manner? This fundamental issue continues to be debated in United Nations bodies.

In recommendation 31, the International Conference in 1984, while restating the right and duty of States to adopt population policies suited to their needs, stressed that "legislation and policies concerning the family and programmes of incentives and disincentives should be neither coercive nor discriminatory and should be consistent with internationally recognized human rights as well as with changing individual and cultural values" (United Nations, 1984a. p. 25). A similar formula is found in paragraph 159 of the Nairobi Strategies for Women (United Nations, 1985, p. 40).

As compared with some earlier texts, the emphasis on "changing individual and cultural values" is new. There is no clear indication in the debates as to the precise relationship between the latter concept and the former idea of "internationally recognized human rights".

The prohibition of even indirect coercion in the field of fertility planning is illustrated in a number of specific provisions. In particular, article 11 of the Convention on Discrimination against Women condemns "dismissal on the grounds of pregnancy or of maternity leave and discrimination of dismissals on the basis of marital status" (United Nations, 1988a, p. 118).

One should recall article II (d) of the Genocide Convention of 1948, which condemns as a crime against humanity "imposing measures intended to prevent birth within [a national, ethnic, racial or religious] group" with intent "to destroy" such a group "in whole or in part" (United Nations, 1988a, pp. 143 and 144). United Nations bodies have discussed this provision on several occasions, for example, as concerns violations of human rights in southern Africa (see, for instance, E/CN.4/1984/Add.18, paras. 22-30) and in the course of debates on the need to strengthen international protection against genocide (General Assembly resolution 43/138).

It should further be recalled that article 7 of the International Covenant on Civil and Political Rights, stating that "no one shall be subjected without his free consent to medical or scientific experimentation" (United Nations, 1988a, p. 121), was adopted expressly in order to prevent a recurrence of the atrocities perpetrated against human beings in Nazi concentration camps. 4/ As the Secretary-General noted in a report on the fate of the survivors of concentration camps, the judgement on "the medical experiments" handed down by one of the United States military tribunals at Nuremberg following the Second World War demonstrated that those criminal experiments had included numerous cases of forced sterilization. 5/

B. Question of induced termination of pregnancy

The United Nations debates and instruments relevant to the issue of abortion in the context of human rights are not as clear as one might wish.

The issue has been raised at the United Nations in terms of the "right to life" as well as during the debates on the legitimacy of diverse fertility regulation methods. It tends to become a distinct population/human rights issue; hence, the decision to devote a separate section to this question.

Instruments that appear to admit or not to oppose the international legal validity of abortion may be said to include the Universal Declaration of Human Rights and the Covenant on Civil and Political Rights.

During the debates that resulted in article 3 of the Universal Declaration on the right to life, two amendments designed to make it clear that the article would apply "from the moment of conception" were submitted (see, in particular, E/CN.4/21, p. 74). Other representatives preferred a concise formulation without qualifications, and some objected that such amendments could not be reconciled with certain national legislations (E/CN.4/AC.2/SR.3, pp. 5, 7 and 8). The General Assembly, without taking up a position on the problem of abortion, preferred a very general formula.

The discussions of article 6 of the Covenant on the right to life were somewhat more decisive. An amendment designed to protect the right to life "from the moment of conception" was rejected by 31 votes to 20, with 17 abstentions (A/C.3/SR.820). Those in favour of the amendment had stressed, in particular, that the right as thus defined was protected in a number of countries, and they felt it would be logical to bring the general definition of the right to life into line with the specific clause in article 6 prohibiting the execution of a pregnant woman who is sentenced to death. Among the opposing arguments, it was pointed out that it was impossible to determine the precise moment of conception, that the amendment would raise delicate questions relating to the rights and duties of the medical profession; and that, in order to ensure the largest possible number of ratifications, it was preferable not to raise such a controversial matter in the Covenant. Article 6, it is recalled, is one of the Covenant's provisions of special importance, entrenched as not subject to derogations even under a state of emergency. 6/

The thrust of some other texts appears to be generally adverse to abortion.

The Declaration on the Rights of the Child of 1959, in its preamble, affirmed that "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth" (United Nations, 1988a, p. 366). It may also be mentioned that in the Declaration on Social Progress and Development (1969), the "exclusive right" of parents "to determine freely and responsibly the number and spacing of their children" and to dispose of "means" for that purpose (United Nations, 1988a, pp. 381 and 389) was presented by some of the sponsors as not including the right to abortion (A/C.3/SR.1599, p. 15; and A/C.3/SR.1682, p. 3).

Somewhat more explicitly, recommendation 18(e) of the International Conference on Population urges Governments "to take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and, whenever possible, provide for the humane treatment and counselling of women who have had recourse to abortion" (United Nations, 1984a, p. 21). On this recommendation, Sweden, while joining the consensus, made a formal statement that it "regrets very much that an amendment was adopted to delete the word "illegal" from recommendation 18(e) as proposed by the Preparatory Committee, which suggests that this Conference failed to recognize the importance of this very serious problem. The Swedish delegation would like to reiterate that a major step towards the elimination of illegal abortions is to provide all women in the world with access to legal and safe abortions" (United Nations, 1984a, p. 21). The Swedish statement was included in full in the Conference report as a note to recommendation 18.

The ethical and legal issues surrounding abortion were debated anew (1989/WG.1/L.4, paras. 31-43) in the preparation of the Draft Convention on the Rights of the Child. In the preamble, a sixth paragraph was adopted by the Working Group of the Commission on Human Rights restating the clause of the 1959 Declaration on the need for safeguards and care "before as well as after birth". An essential part of the consensus was a statement adopted by the Working Group that this preambular clause "does not intend to prejudice the interpretation of Article 1 or any other provision of the Convention by States parties". In the light of this decision on the preamble, amendments to article 1 defining the child as any human being "from conception until the age of 18 years" were withdrawn. Draft article 1 as currently worded does not contain the term "from conception".

From this survey it appears that the human rights treaty law of the United Nations now in force--mainly the Covenant--does not prohibit abortion. On the other hand, opposing trends have had an impact on various declaratory texts. International human rights law is not yet crystallized in this field.

C. Human rights, health and morbidity

1. General standards

It is recalled that two major conventions of the United Nations system, the Constitution of the World Health Organization (WHO) and the Covenant on Economic, Social and Cultural Rights, set forth the "human right" to enjoyment of the "highest attainable standard" of health. The WHO Constitution, in paragraph 233, defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (United Nations, 1988b, p. 29). Social Progress and Development of 1969--among subsequent instruments--deals with rights relating to health and refers to the desirability of extending free health services.

Health care is reaffirmed as a right in articles 11 and 14 of the Convention on Discrimination against Women (1979) and in the Draft Convention on the Rights of the Child. The latter instrument uses, to the benefit of the child, formulae more extensive than those found in earlier texts. Thus, while article 12 of the Covenant on Economic, Social and Cultural Rights sets forth a right to the "highest attainable standard of physical and mental health" (United Nations, 1988a, p. 12), article 24 (i) of the Draft Convention on the Rights of the Child further affirms a right "to facilities for the treatment of illness and rehabilitation of health" (E/CN.4/1989/29).

The recommendations of the International Conference at Mexico City (1984) and the Nairobi Strategies for Women (1985) contain many provisions on the right to health, with emphasis on maternal and infant care.

The most comprehensive statement of the right to health in all its aspects is contained in the Global Strategy for Health for All by the Year 2000, adopted by the World Health Assembly in May 1981 and approved by the General Assembly later that year in resolution 36/43.

2. Combating discrimination in health-care issues; protection of vulnerable groups

Combating discrimination in all aspects of health care and also meeting the specific needs of vulnerable categories of peoples are major concerns expressed in the human rights normative activities of the Organization.

The basic norms of equality and non-discrimination in regard to health, irrespective of sex, race, religion, social origin or any other conditions, are embodied in numerous instruments, including the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on Discrimination against Women, the Convention on the Elimination of Racial Discrimination, General Assembly resolution 36/43, the recommendations of the International Conference on Population (1984) and the Nairobi Strategies for the Advancement of Women (1985).

In recent years, attention has been paid increasingly to the striking and persistent inequalities, expressed in differing morbidity rates, between developing countries and industrialized societies, and, within each country, between various segments of the population. These concerns are emphasized, for instance, in recommendations 10-21 of the International Conference on Population (1984). The Declaration and Programme for a New International Economic Order are often recalled in this regard.

There is a contemporary trend to identify the needs of vulnerable groups and to affirm their human rights in regard to health. This analysis, increasingly refined, identifies a growing number of subcategories.

Thus, the Convention on Discrimination against Women, the Nairobi Strategies and other texts stress not only the rights of women in general but also the special health needs and specific rights of pregnant and nursing women, mothers of young children, working mothers, rural women etc.

Similarly, the Draft Convention on the Rights of the Child deals with the health needs of all children (article 24), as well as the needs of the mentally or physically disabled child (article 23) and those of children placed in institutions (article 25).

The persistent higher morbidity rates of various ethnic groups, compared with the rest of the population, have been brought to light specifically in the reports of the Working Group of Experts on the Situation of Human Rights in Southern Africa (see, for instance, E/CN.4/1989/8), the study on the human rights of indigenous populations (United Nations, 1986b) and the annual reports of the Working Group on that subject (for example, E/CN.4/Sub.4/1988/24 and Add. 1 and 2; and E/CN.4/Sub.2/1988/25.

On the basis of such findings, article 5 of the Convention Against Racial Discrimination (1965) prohibits inequality as regards "the right to public health, medical care, social security and social services" (United Nations, 1988a, p. 61). Article II of the Convention on the Crime of Apartheid (1973) condemns as criminal the "deliberate imposition on a racial group or groups of living conditions calculated to cause its or their physical destruction in whole or in part" (United Nations, 1988a, p. 71). This formula was taken over from article II (c) of the Genocide Convention (1948). The current normative debates of the Working Group on Indigenous Populations deal in part with the living conditions and right to health care of indigenous peoples. These concerns will probably be reflected in the Declaration being prepared by the Group.

Disabled or handicapped persons, in the broadest sense of the term, form a huge population of some 500 million persons, which is still growing (E/CN.4/Sub.2/1988/11, para. 23). The discrimination against them is being increasingly denounced.

The Declaration on the Rights of Mentally Retarded Persons of 1971 proclaims, in particular, their rights to protection from exploitation, abuse and degrading treatment. In 1988, the Sub-Commission completed the preparation of Draft Principles for the Protection of Mentally-ill Persons (E/CN.4/Sub.2/1988/23). They gave rise, however, to lengthy debates. In its resolution 1989/49, the Commission on Human Rights decided to consult Governments and organizations on the present Draft Principles.

Concerning disabled persons in general, the Declaration of 1975 emphasized not only equality of rights with other human beings but also their entitlement to measures for self-reliance (article 5) and to the full consideration of their "special needs" (article 8). A proposal that the United Nations should prepare a Convention on the Human Rights of Disabled Persons, made to the 1987 General Assembly, gave rise to divergent opinions (CSDHA/DDP/FME/7, para. 31).

A comprehensive study on the human rights problems of handicapped persons is in progress at the Sub-Commission (E/CN.4/Sub.2/1988/11).

The catastrophic AIDS situation raises many human rights problems, especially issues of discrimination in education, employment, housing and other fields of social life against AIDS sufferers and seropositive HIV people. Both the General Assembly, in resolution 42/8, and the World Health Assembly, in resolution WHA 41.24, have expressed their deep concern on this subject. The Sub-Commission, in decision 1988/111, considered the possibility of making a study on the matter (E/CN.4/1989/3).

D. Human rights of the aging

According to United Nations projections, the ratio of people over 60 to the global population should increase from 15 per cent in 1975 to 18 per cent in the year 2000 and to 23 per cent or more in the year 2025 (United Nations, 1982). This major demographic trend is a positive reflection of medical progress. It raises, on the other hand, considerable human rights and social problems.

In 1982, the World Assembly on Aging affirmed its belief that the fundamental and inalienable rights enshrined in the Universal Declaration of Human Rights apply fully and undiminishedly to the aging. It recognized that the quality of life was no less important than longevity, and that the aged should therefore, as far as possible, be enabled to enjoy in their own families and communities a life of fulfilment, health, security and contentment, appreciated as an integral part of society (United Nations, 1982).

Detailed provisions of the Plan of Action on Aging deal with the rights to health and nutrition (recommendations 1-17), housing and environment (19-24), the family (25-29), social protection (30-35), income and employment maintenance (36-43) and education (44-51).

The General Assembly, in resolution 35/51, called upon Governments to make continuous efforts to implement the principles and recommendations contained in the Plan of Action in accordance with their national structures, needs and objectives.

Many of those principles were restated and developed, in particular, in the recommendations of the International Conference on Population in 1984 and the Nairobi Strategies for Women in 1985.

So far, however, concerns for the human rights of the aging have found but few expressions in the treaty law of the Organization.

E. Right-to-life and mortality issues

1. Global issues

The "inherent right to life" is enshrined in the Universal Declaration of Human Rights and in the Covenant on Civil and Political Rights. The latter treaty does not admit to any derogation to article 6 on the right to life, under a state of emergency. However, article 6 of the Covenant, without spelling out limitations to the right to life, admits them implicitly by mentioning (without some approval) the death penalty and by stating that no one shall be "arbitrarily" deprived of the right to life.

It was clear from the debates preparatory to the Covenant that the term "arbitrarily" did not refer only to violations of national law but, further, embraced measures that would be "unjust" as contrary to general principles of human rights law recognized by all or most countries, even though they might be in accord with domestic norms. 7/ It proved impossible, however, to obtain a consensus on an exhaustive or even an illustrative list of such "arbitrary" measures in the Covenant.

The Human Rights Committee, entrusted with the monitoring of state action to apply the Covenant, has issued general comments on the right to life based on state periodic reports. The broad meaning of those comments is that article 6 "should never be interpreted restrictively" (A/37/40, annex V). Exceptions to it must be fully justified by the strongest evidence.

Various Final Views of the Human Rights Committee on individual communications have also contributed to clarify the scope of article 6. One may refer, for instance, to the Guerrero case against Colombia, 8/ and to a number of cases against the former régime of Uruguay 9/ and against Suriname. 10/

The United Nations Organization has emphasized some global issues on the right to life, reaching actually or potentially all sectors of the population. They include the right to health care, the right to live in peace and questions relating to capital punishment, summary executions and enforced disappearances. The first type of problems (health care) was dealt with earlier in this paper.

The question of induced termination of pregnancy (abortion) is sometimes discussed in United Nations bodies as a right-to-life issue. At other times, it is debated within the context of fertility planning. This choice of framework may carry value orientations. To avoid possible confusions, this paper has treated abortion as a separate issue in a distinct section.

Both the relationship between peace and human rights and related issues concerning disarmament were stressed by the Human Rights Committee in its general comments on article 6. In 1982, the Committee stated that the prevention of war, especially of thermonuclear war, and efforts to strengthen peace and security were major prerequisites of the implementation of article 6 (A/37/40, annex V). Furthermore, in 1985, the Committee expressed the view that the production, testing, possession, deployment and use of nuclear weapons were "among the greatest threat to the right to life" and should be "recognized as crimes against humanity" (A/40/40, annex VI).

One should recall, in regard to peace/human rights issues, that the Nürnberg Principles of 1945--endorsed by the General Assembly in 1946--condemned "crimes against peace" (see United Nations, 1988b, p. 216). The paramount goal of the United Nations as stated in the Charter is to prevent and sanction the threat or use of force in international relations and to secure lasting peace and security for mankind. The Definition of Aggression was approved by the General Assembly in resolution 3314 (XXlX) of 1974. A Draft Code of Offences against Peace and the Security of Mankind continues to be prepared by the International Law Commission.

In this respect, some recent statements should be noted: the Declaration on the Preparation of Societies for Life in Peace, which recognized that "every nation and every human being ... has the inherent right to live in peace" (see United Nations, 1988b, p. 299); the Declaration on the Participation of Women in Promoting International Peace and Understanding (1982); and the Declaration on the Right of Peoples to Peace (1984).

There exist many international instruments that seek to ensure respect for the right to life and for other human rights, to the largest extent possible, in armed conflicts. Concern has been expressed in this regard by the United Nations as modern warfare affects a growing number of civilians and non-combatants. Foremost among these instruments are the Nürnberg Principles on "war crimes", as well as the four Geneva Conventions on War Victims of 1949 and their two Protocols. The General Assembly has enunciated Basic Principles for the Protection of Civilian Populations in Armed Conflicts, in support of the Geneva instruments, for instance, in resolution 2675 (XXV) of 1970. One should further mention the Declaration on the Protection of Women and Children in Armed Conflict (1974), as well as article 38 of the Draft Convention on the Rights of the Child.

Recently, United Nations bodies have voiced distress at reports concerning the increased use of chemical weapons on a massive scale, especially against civilians, in violation of the Protocol of 1925. The Sub-Commission, in resolution 1988/27, requested the Secretary-General to submit in 1989 a report based on pertinent and reliable sources.

Another basic issue is the question of the death penalty. Article 6 of the Covenant does not prohibit capital punishment but restricts its imposition to "the most serious crimes" after a fair trial according to law. It shall not be applicable to minors below 18 years of age or to pregnant women. In its General Comments of 1982 (A/37/40, annex V), the Human Rights Committee stressed that the thrust of article 6 was to favour abolition of the death penalty and that any progress in that direction was in accord with the Covenant.

The question of the abolition of capital punishment continues to be fully debated in the General Assembly and other United Nations bodies, especially the Committee on Crime Prevention and Control. Proposals for the abolition of the death penalty were submitted but not pressed or not adopted, notably at the Sixth and Seventh United Nations Congresses on the Prevention of Crime and the Treatment of Offenders.

At its thirty-fifth session in 1980, the General Assembly, by decision 35/437, took note of a draft resolution entitled "Measures aiming at the ultimate abolition of capital punishment (Draft Second Optional Protocol to the International Covenant on Civil and Political Rights)". In 1982, the General Assembly, in resolution 37/192, requested the Commission on Human Rights to consider the idea of elaborating the proposed second draft protocol. The Commission, in March 1984, transmitted the draft protocol to the Sub-Commission, which authorized a Special Rapporteur to prepare an analysis of the proposal, taking into account all of the available documentation. By resolution 1988/22, the Sub-Commission submitted the report of the Special Rapporteur (E/CN.4/Sub.2/1987/20) to the Commission on Human Rights for consideration.

Aside from efforts concerning the abolition of the death penalty, a parallel United Nations strategy is the strict definition of the legal guarantees that should be recognized for those facing capital punishment. Thus, the Seventh Congress, held at Milan in 1985, endorsed "safeguards guaranteeing the rights of those facing the death penalty" (United Nations, 1986a, p. 83, resolution 15), previously approved by the Economic and Social Council in resolution 1984/50.

Despite these appeals by the United Nations, the massive incidence of summary or arbitrary executions in the world continues to be alarming. The General Assembly expressed its distress in resolution 35/172 of 1980 and again in resolution 36/22 of 1981, urging States, *inter alia*, to strengthen their legal procedures and make appeal automatic against death sentences.

Having considered recommendations of the Sixth United Nations Congress (United Nations, 1981, resolution 5), the Economic and Social Council (resolution 1982/35) and the Commission on Human Rights decided to request a Special Rapporteur to examine concrete problems of summary or arbitrary executions in the world. The Special Rapporteur, whose annual mandate has been renewed consistently, has so far submitted six critical reports to the Commission.

The Committee on Crime Prevention and Control continues to review the situation on summary and extra-legal executions and surveys state legislation and practice on all aspects of the problem of the death penalty.

Closely related to the issue of summary or arbitrary executions is that of enforced or involuntary disappearances. In resolution 33/173 of 1978, the General Assembly expressed its deep concern over this widespread phenomenon and requested the Commission on Human Rights to make appropriate recommendations. The Commission, by resolution 20 (XXXVI) of 1980, set up a working group to examine the question, taking into account information from Governments, intergovernmental organizations, non-governmental organizations concerned and other reliable sources. The group, whose annual mandate has been renewed, has submitted seven reports. It has transmitted more than 15,000 unexplained cases for inquiry to over 40 States (United Nations, 1988b).

The Sub-Commission is currently considering a Draft Declaration on Enforced or Involuntary Disappearances prepared by its Working Group on Detention (E/CN.4/Sub.2/1988/28, annex I).

2. Right-to-life issues relating to certain groups or to certain types of situation

The right to life of sick, handicapped or genetically defective persons has been affirmed by the international community on several occasions.

The systematic mass murders by the Nazis of persons suffering from physical or mental diseases or handicaps regarded as incurable were punished by the Nürnberg International Military Tribunal in 1945 (United Kingdom, 1946, p. 60). The Principles of Nürnberg were affirmed by the General Assembly in 1946.

During the drafting of the Universal Declaration, amendments were proposed ensuring "the right to life of incurables, imbeciles and the insane" (A/C.1/38, E/CN.4/2, E/CN.4/21 and A/C.3/L.654). The omission of these terms from the final text does not result in any way from objections to the substance of the amendments, but from a concern to retain a fairly general formulation. It also appears that the debates were complicated because of the juxtaposition of phrases relating to "the right to life from the moment of conception" in some of those amendments.

The thrust of article 6 of the Covenant on the right to life, as was seen earlier, is to reduce to a very minimum the scope of exceptions to it. As the Nürnberg Principles and the Genocide Convention were often reaffirmed in the preparatory work, it is clear that all forms of "eugenic" killing are condemned under the Covenant.

In articles 3 and 4, the Declaration on the Right of Disabled Persons (1975) restates that they are entitled to the same civil and political rights as other human beings, including "first and foremost the right to enjoy a decent life, as normal and full as possible" (United Nations, 1988a, p. 401).

The Draft Convention on the Rights of the Child affirms not only the "inherent right to life" of all children but also the right of mentally or physically disabled children to "enjoy a full and decent life" (E/CN.4/1989/29, articles 6 and 23).

In principle 3, the Principles of Medical Ethics in relation to Torture of 1982 (General Assembly resolution 37/194) call it "a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical or mental health" (United Nations, 1988a, p. 235).

The human rights problems which are said by some scholars to arise in respect of incurable and terminally ill patients suffering great pain, in the current context of rapid medical progress, have been considered by some United Nations bodies. A study by the Secretary-General (E/CN.4/1172 and Add.1-3), mandated by the Commission on Human Rights, did examine, inter alia, these problems in a preliminary manner. In its current state as surveyed above, the human rights law of the United Nations does not condone the withdrawal of care from terminally ill patients.

The right to life is guaranteed in the Declaration and the Covenant without any discrimination whatsoever.

The entire body of United Nations instruments for the elimination of discrimination against women, including the 1979 Convention and the 1985 Nairobi Strategies, expressly or implicitly affirms the right of women to life and to the best health care and assistance on a basis of equality with men.

As noted earlier, the Declaration and Draft Convention on the Rights of the Child similarly condemn violations of the right of children to life.

Several United Nations texts further assert the right to life of especially vulnerable subgroups of women (e.g., pregnant women, nursing mothers and rural women) and of children (e.g., disabled, children in institutions and children in armed conflicts).

As concerns women and children, a Working Group of the Sub-Commission, with WHO participation, has expressed concern for traditional practices harmful to their health and survival, for instance, a frequent preference for male infants, in terms of feeding and physical care, at or shortly after birth (E/CN.4/1986/42).

The ultimate act of discrimination, genocide, perpetrated against members of "national, ethnic, racial or religious groups", whether during armed conflicts or in peacetime, is condemned as a crime against humanity by the Genocide Convention of 1948. In article 11, genocide is defined, inter alia, as "(a) killing members of the group; (b) causing serious bodily or mental harm to members of the group" with "intent to destroy [it] in whole or in part" (United Nations, 1988a, p. 143). Views in favour of enlarging these definitions have been expressed in United Nations debates.

Similarly, article II of the Convention on the Crime of Apartheid (1973) condemns as a crime in international law, inter alia, the murder of members of a racial group "for the purpose of establishing and maintaining domination by one racial group of persons over any other racial group of persons and systematically oppressing them" (United Nations, 1988a, p. 71).

These principles were reaffirmed and expanded in 1983 by the Declaration and Programme of Action for the Second Decade against Racism and Racial Discrimination (General Assembly resolution 42/47; and United Nations, 1983b, chap. II).

The study and reports on indigenous populations, notably the reports of the Sub-Commission's Working Group, emphasize "their collective right to exist and to be protected against genocide, as well as the individual rights to life, physical integrity, liberty and security of person". 11/ They stress in this regard the right of indigenous peoples to be secure in the enjoyment of their traditional means of subsistence" and never "to be deprived of their means of subsistence". 12/

The Declaration on the Elimination of Intolerance and Discrimination based on Religion or Belief (1981) is not as explicit on the right to life as the instruments against racial discrimination. It does, however, condemn all "coercion" and discrimination "in all fields of civil...life" (United Nations, 1988a, p. 125, articles 1 and 4). Since 1981, the Commission and the Sub-Commission have expressed deep concern 13/ over reports of massive repression, sometimes resulting in massacres, against groups who practise certain religions or who hold certain belief. Two United Nations studies have been issued on the problem of implementing fully the 1981 Declaration (E/CN.4/Sub.2/1987/6 and E/CN.4/1987/35). The General Assembly in resolution 42/97, noted with approval these activities and the Commission's intent to consider the question of a binding instrument in order to strengthen the right to life and other human rights against religious intolerance.

Concluding observations

The mission of the United Nations to formulate universal norms on human rights is today more relevant than ever for population and human rights issues as in other human rights fields. As the third millenium approaches, traditional structures and beliefs disintegrate while new problems arise from the scientific and technological explosion. Therefore, a critical need arises for stable, rational standards to safeguard human dignity, justice and peace, adapted to the changing physical and mental environment of man.

As concerns population and human rights issues, this need for standards may not appear as pressing as it is in respect of, say, the sanction of gross violations. On closer scrutiny, however, it becomes clear that these are structural problems of basic importance. The most sensitive issues of human destiny are at stake- the status of women, marriage, procreation, contraception, abortion, the rights of the child, aging, migration and death. In the medium or long term, grave imbalances in the demographic variables are major contributing factors to gross violations of human rights. Conversely, disregard for the basic rights of man leads to serious demographic distortions. The entire cluster of population and human rights issues must therefore be reviewed in order to develop international human rights standards on fertility, health, mortality and migration suited to the needs of current and future generations.

Faced with this normative challenge, the United Nations Organization has already achieved substantial results in a short time. Many ethical and legal problems have been identified, and universal standards have been created or adapted in an innovative manner on the right to fertility planning, the advancement of women, the right to health care, the rights of the child, the rights of the aging and other issues. In a number of fields, the United Nations standard-setting activities have often been ahead of other international institutions, and even of many national systems.

Several normative issues, however, remain unanswered and new problems constantly arise. To fill those lacunae it is desirable to seek a more integrated planning of normative efforts by the many United Nations organs involved in the fields of human rights, population, the status of women and social development, as well as in others. Appropriate liaison should be strengthened, in standard-setting as well as on the operational plane, between each of those United Nations Organization programmes and between the United Nations Organization and the specialized agencies, regional organizations and interested non-governmental organizations. This was one of the major themes of the two previous symposia of 1974 and 1981 on population and human rights. It remains topical today, in spite of notable progress in co-ordination.

Attempts at rationalization and co-ordination should not, however, be regarded as leading to a rigid, _ne varietus_ codification. Human rights norm-setting, at the domestic level as well as on the international plane, should always be made under a flexible and empirical approach, with frequent critical reviews, to allow for adaptations in the light of social changes. In this sense, human rights standard-setting can never be regarded as "achieved". It is comforting to note that concern for social relevancy has so far been one of the most positive aspects of the United Nations activities in the field of population and human rights.

Notes

1/ The right to marry and to protection of one's family, set forth in article 23 of the Covenant on Civil and Political Rights, has also been upheld in several important cases by the Human Rights Committee. See, in particular, _Cziffra_ v. _Mauritius_, case 35/1978 (United Nations, 1984a).

2/ For a study of the early conceptual development of this right, see "United Nations standards concerning the relationship between human rights and various population questions" (United Nations, 1975a, p. 350, paras. 9-11).

3/ _Herzberg_ v. _Finland_, case No. 61/1979 (United Nations, 1984a). The Committee expressed the view that a Government's decision to probihit a public television programme on homosexuality on grounds of public morality appeared to be within the bounds of the limitation clause of article 19 of the Covenant.

4/ Official Records of the General Assembly, Tenth Session, Annexes, document A/2929, agenda item 28 (part II).

5/ Official Records of the Economic and Social Council, Twelfth Session, "Progress report by the Secretary-General on the plight of survivors of concentration camps" (E/1915), paras. 6-8; Trials of War Criminals before the Nürnberg Military Tribunals, vol. II, "The medical cases", pp. 174-182.

6/ Official Records of the General Assembly, Twelfth Session, Annexes, document A/3764, para. 113.

7/ Official Records of the General Assembly, Tenth Session, agenda item 28, part II (A/2929), p. 30, para. 3.

8/ Case 45/1979 (see United Nations, 1984a, p. 116).

9/ For example, Bleier v. Uruguay, case No. 30/1978 (see United Nations, 1984a, p. 113).

10/ For example, Baboeram v. Suriname (A/40/40, annex X, para. 9.1).

11/ Preliminary Draft Declaration, part II, article 3, in E/CN.4/Sub.2/1988/25.

12/ Op. cit., part IV, article 18.

13/ See resolution 1986/20 of the Commission on Human Rights.

References

United Kingdom of Great Britain and Northern Ireland (1946). Judgement of the International Military Tribunal for the Trial of Major War Criminals. Cmd. 6964. London: His Majesty's Stationery Office.

United Nations (1968). Summary Records of the First to Thirteenth Meetings of the Second Committee of the International Committee of Human Rights, Teheran, 25 April-9 May 1968. A/CONF.32/C.2/SR.1-13.

__________ (1975a). Report of the United Nations World Population Conference, Bucharest, 19-30 August 1974. Sales No. E.75.XIII.3.

__________ (1975b). United Nations standards concerning the relationship between human rights and various population questions. In The Population Debate: Dimensions and Perspectives. Papers of the World Population Conference, Bucharest, 1974, vol. II, pp. 349-369. Population Studies, No. 57. Sales No. E/F/S.75.XIII.5.

__________ (1981). Sixth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Caracas, 25 August-5 September 1981. Sales No. E.81.IV.4, resolution 5.

__________ (1982). Report of the World Assembly on Aging, Vienna, 26 July-6 August 1982. Sales No. E.82.I.16.

__________ (1983a). Population and Human Rights. ST/ESA/SER.R/51.

__________ (1983b). Report of the Second World Conference to Combat Racism and Racial Discrimination, Geneva, 1-12 August 1983. Sales No. E.83.XIII.4.

__________ (1984a). Report of the International Conference on Population, Mexico City, 6-14 August 1984. Sales No. E.84.XIII.8 and corrigenda.

__________ (1984b). Selected Decisions of the Human Rights Committee under the Optional Protocol. Sales No. E.84.XIV.2.

__________ (1985). Report of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, Nairobi, Kenya, 15-26 July 1985. Sales No. E.85.IV.10.

__________ (1986a). Seventh United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Milan, 26 August - 6 September 1985. Sales No. E.86.IV.1.

__________ (1986b). Study of the Problems of Discrimination Against Indigenous Population. Sales No. E.86.XIV.3.

__________ (1987). *Report: Interregional Consultation on Developmental Social Welfare Policies and Programmes, Vienna, 7-15 September 1987*. E/CONF.80/10.

__________ (1988a). *Human Rights--A Compilation of International Instruments*. Sales No. E.88.XIV.1.

__________ (1988b). *United Nations Action in the Field of Human Rights*. Sales No. E.88.XIV.2.

V. HUMAN RIGHTS IN A CHANGING POLITICAL AND SOCIO-ECONOMIC ENVIRONMENT

Paul Demeny*

Human societies regulate their size and, to an important extent, their composition, by establishing rules that affect entry into and exit from membership in the society. Such rules confer rights to, or restrict privileges of, the members of the society, especially with respect to reproduction. The advantages people derive from co-operation with others in the society provide the incentive for mutual accommodation and agreement concerning individual rights. 1/

Reproductive success on a societal level is, by definition, characterized by an expanding or stable population size. Most often, this success is achieved through a level of fertility that at least matches mortality, rather than through admitting migrants. Traditionally, the right to add new members to society by birth has been relegated to individuals or to couples whose reproductive behaviour, shaped by selective pressures, obeyed implicit, rather than explicit, societal rules and signals.

Satisfaction on the part of the members of society holding political power with the aggregate demographic outcomes of such implicit rules tends to make the allocation of membership rights to individuals stable. So also does the inability of power holders deliberately to modify social arrangements on terms that are, on balance, advantageous to them. Over time, the rules affecting membership become accepted custom, buttressed by ethical norms and legal sanctions. Such protection makes effecting changes in reproductive rules costlier and therefore more difficult, which reinforces stability of reproductive behaviour.

Stability of an existing system of affecting membership rules is also enhanced if societal arrangements impose the costs of reproductive behaviour on the social units making the relevant decisions. If all such costs are internalized, the possibility of engineering a change in the allocation of reproductive rights that is advantageous to all members of the society is minimal. Malthus gives an extreme formulation of arrangements that reject cost-sharing in the consequences of reproductive decisions. 2/

---

*The Population Council, New York.

Three types of changes can render an existing system of rights affecting membership less acceptable to society; hence, potentially amenable to change.

First, shifts in some component of demographic behaviour can make demographic outcomes, on balance, less satisfactory than before. In the contemporary world, the reduction of mortality has greatly accelerated the rate of population growth.

Secondly, in pursuing objectives not related to demographic consequences as such, society may change arrangements that determine how costs of demographic decisions are borne. As a result, a disjunction may emerge between rights and responsibilities. In particular, an increasing portion of the costs of child-bearing may become collectively shouldered, rather than remain internal to the unit responsible for reproductive decisions. This development logically increases the inclination of those sharing the costs to demand participation in reproductive decision-making.

Thirdly, alterations of the political decision-making process, or cultural or technological changes, may render the cost of reallocating, redefining or otherwise influencing the outcome of reproductive rights less onerous. This makes efforts to affect demographic outcomes potentially more welfare-improving or technically feasible. Thus, for example, transaction costs involved in political trade-offs may be reduced; societal values attached to reproductive behaviour may spontaneously shift; or the introduction of new contraceptive technologies may affect fertility behaviour.

The emergence of the modern international system as a system of independent States and the concomitant development of national sovereignty as a fundamental principle of international law allowed the coexistence of a variety of political responses to national problems, including those arising from demographic change. Thus, in any given country, the distribution of rights and privileges concerning reproductive rights might reflect such factors as peculiarities of political and cultural history, existing power relations between social strata and differences of demographic patterns.

The accumulation of lessons of history, and especially, the cataclysmic experience of the Second World War, led to the recognition that the nature of national political régimes, in particular, the human rights records of individual countries, could have external, potentially very serious consequences. Accordingly, in the United Nations Charter adopted in 1945, Member States pledged themselves to "take joint and separate action" for the achievement of common purposes, inter alia, towards securing "universal respect for, and observance of, human rights and fundamental freedoms for all" (Article 56; and Article 55, para. c). Further international documents, covenants and declarations reconfirmed, elaborated and amplified this international interest in human rights.

Thus, since 1945, primarily under the tutelage of the United Nations, a qualitative evolution has occurred in international relations and is still in progress. In effect, within a historically short time span, the long-standing principle of national sovereignty as to internal political arrangements has become qualified. The legitimate interest of States Members of the international system in the human rights records of other States has become increasingly recognized. Giving substance and legitimacy to such interest, a number of international agreements have sought to achieve a broad common understanding of the human rights standards that the Member States ought to adopt and of objectives they should strive to attain.

Seeking agreement on the proper and desirable content of internationally recognized human rights is a difficult and, necessarily, still incomplete process. Values and aspirations affecting the concept of human rights are themselves evolving, shaped and modified by the accumulating experience of political and socio-economic change. Broadly speaking, contemporary articulation of human rights is centred on two main areas of concern. These two types of concerns, already present in the United Nations Charter and in the Universal Declaration of Human Rights, have been separately articulated and simultaneously adopted in two international instruments: The Covenant on Civil and Political Rights and that on Economic, Social and Cultural Rights.

Concern with civil and political rights represents the continuation of a tradition the foundations of which were elaborated by the political theorists of the Enlightenment. Its focus is on negative rights, i.e., rights that protect the individual citizen from arbitrary governmental power and interference and seek to ensure that government is responsive to the wishes of the governed. Although this tradition recognizes that the exercise of coercive power is essential for performing government functions, it seeks to limit the Government to such functions as are both essential and only capable of achievement through collective action. 3/ Duties correlative to civil and political rights often merely require the Government to abstain from an action rather than to undertake one. For example, article 7 of the Covenant on Civil and Political Rights states: "Sentence of death shall not be imposed for crimes committed by persons below eighteen years of age and shall not be carried out on pregnant women" (United Nations, 1988, p. 21). The scope of government action that securing civil and political rights may require can be extensive, depending upon circumstances. The ideal, however, is limited government, whose rules and services encourage and protect the voluntary interaction of citizens and their various groupings and associations.

Concern with economic and social rights reflects a more expansive, more paternalistic and more optimistic view of the proper government functions and potential capacities. Growing out of various traditions of socialist and Christian thought, it enumerates desiderata that tend to be recognized as such by most people and seeks to chart a course for economic, social and cultural development through the elevation of denominated objectives to the rank of human rights. Such positive rights, even as spelled out in the relevant formal covenant, include such far-reaching and specific objectives as, for example, the right to "rest, leisure and reasonable limitation of working hours and periodic public holidays with pay, as well as remuneration for public holidays" (United Nations, 1988, p. 10, article 7). The agents obligated to perform the duties correlative to economic and social rights are typically not specified, but in most instances those tasks clearly fall on the Government.

The debates on human rights during the early decades following the establishment of the United Nations demonstrate the existence of considerable disagreement between countries concerning the relative importance that these overlapping yet distinct sets of rights ought to be accorded. The practice of post-Second World War international co-operation and developmental action has indicated, however, the ascendancy of emphasis on economic and social rights. Often, this emphasis has been justified as expressing a proper hierarchy of rights: before abstract civil and political rights can be meaningfully exercised, it is argued, basic economic rights must be satisfied. Equally influential has been, however, the apparent organizational logic of the evolving system of international agencies and of bilateral programmes of international economic assistance. These agencies and programmes have come to assume an organizational articulation along problem areas, each seen as characterized by its own array of unsatisfied needs, hence characterized by the "denial" of specific human rights.

Health, by definition an issue with far-reaching demographic dimensions, was one of the early fields in which international co-operation attained significant momentum. It was also an area that exhibited highly successful examples of action through international co-operation and assistance. Some of the health services--for example, malaria eradication programmes--possess near-classic properties of public goods: inadequate functioning of private markets mandates remedial government action. Tolerating easily preventable deaths can also be properly interpreted as a violation of the ultimate human right: the right to life. The gratifyingly precipitous decline of mortality in the decades following the end of the Second World War has, however, created the potentially serious problem of rapid population growth. By the late 1960s, population, with a primary focus on the problem of rapid population growth and hence, operationally, on the reduction of high fertility, had joined the lengthening list of problems identified as distinct sectors for international attention and action.

In the spirit of the Covenant on Economic, Social and Cultural Rights and the conception of these rights as giving rise to a distinct set of activities designed to satisfy them, population questions also became, at least by intent, a substantial addition to already overcrowded governmental agendas. The United Nations World Population Plan of Action, adopted in 1974, is articulated in 109 paragraphs (United Nations, 1975). Some of these, notably the realization of what came to be labelled the "right to family planning" (Cook, 1984), call for governmental action of a scope and ambition without precedent in this field. Achievements, however, chronically fell short of objectives. Ten years after the adoption of the original Plan, the International Conference on Population in 1984 noted that the "lack of definite commitment, inadequate resources, ineffective co-ordination and implementation ... limited the effectiveness of Governments in the implementation of their national population policies" (United Nations, 1984, para. 36).

Undoubtedly, greater commitment, more adequate resources, better co-ordination and implementation could have made a difference, and could make one in the future. But, arguably, the problems encountered also reflect conceptual and systemic problems. The International Conference on Population (1984) issued a document entitled "Recommendations for the further implementation of the World Population Plan of Action". This document contains 88 specific recommendations, many of overweening ambition, and many of which, if follow-through were attempted, would be bound to branch out into vast arrays of programmes and subprogrammes. Many of the recommendations identify objectives to which Governments "should give high priority", while specific tasks, in the language of the recommendations, require that Governments "aim to affect", "make efforts", "pursue action programmes more aggressively", "give paramount importance" and "lend due support". In so doing, the recommendations adjure Governments to achieve, improve, formulate, accelerate, increase, lower, strive, restore, maintain, redress, implement, expedite, create, ensure, provide and foster.

But the 88 recommendations are merely a single-sector sample of similar, if sometimes overlapping and interconnected, sectoral plans and specialized or overarching resolutions and declarations, also calling for high-priority attention from Governments. Documents cited by the recommendations include those relating to the rights of children, the human environment, the eradication of hunger and malnutrition, the International Women's Year, industrial development and co-operation, employment, income distribution and social progress and the international division of labour, human settlements, desertification, water, primary health care, racism and racial discrimination, technical co-operation among developing countries, agrarian reform and rural development, science and technology, the Global Strategy for Health for All by the Year 2000, new and renewable sources of energy and the Plan of Action on Aging. Thus, the Population Plan of Action appears to embody a vision of an omnipresent and omnipotent State (Demeny, 1986). Arguably, a more accurate characterization of most Governments of developing countries, however, is that they are overextended. Such plans as the World Population Plan of Action often seem to lack a clear sense of priorities. Their enumerations of social desiderata--human rights to be satisfied--do not appear to be informed by a philosophy by which their amenability to government intervention could be assessed and calibrated. They fail to distinguish between government as a doer of things by direct action and government as an organizer and guarantor of a legal-institutional framework that allows individuals and their voluntary associations to seek betterment.

When such a distinction is not made, presumption and practice tend to be biased towards direct government action. In the words of Adam Smith, the sovereign attempts to discharge duties "for the proper performance of which no human wisdom or knowledge could ever be sufficient"--the duty "of superintending the industry of private people". 4/ Paradoxically, foreign assistance, to the extent that it plays a significant role in underwriting a particular line of sectoral programmes (as is often the case in the field of population), tends to reinforce this tendency even when it pays homage to decentralized administration and to market-based solutions. For donors in international assistance, considerations of efficiency and accountability make it desirable to deal with competent recipient agencies endowed with clear lines of authority. If they do not exist, their creation is encouraged or even expressly demanded by international assistance.

Emphasis on direct satisfaction of economic and social rights through Government-organized programmes is, of course, consistent with the frank admission that success in that endeavour is constrained by the scarcity of resources available to the Government. If the resources are extracted from the domestic economy, such as through taxation, the likely loss of efficiency introduced by assembling and then reallocating resources is typically justified by two main arguments. One is that the Government will place higher priority on satisfying a recognized basic need and thus better serve human rights than would decentralized or market-based arrangements. The second invokes distributional considerations: government programmes will prevent inequities of allocation and, in particular, will better serve the poor. Neither of these claims is supported by economic analysis based on deductive reasoning. But a more convincing test is observation of actual outcomes. Retrospective evaluation of policy performance seldom yields unqualified conclusions. Yet, the experience accumulated by the developing countries during the past two or three decades supplies very strong evidence that direct concentration on satisfying economic and social rights through government programmes that enjoy a de facto monopoly in their area of responsibility yields results that are distinctly inferior to results delivered by market-based, decentralized or mixed systems, where the Government concentrates on securing and preserving the civil and political rights of citizens. The conclusion applies both to performance concerning the overall level of satisfying economic rights and to performance assessed by considerations of distributional equity. It also characterizes experience in both major areas of policy endeavours in the population field--preventable mortality and excessive fertility.

Sectoral compartmentalization of government programmes concerned with direct satisfaction of economic and social rights tends to lead to a narrow international agency view approach to assessments of the human rights aspects of population programmes. Specialized agencies are inclined to deal with counterpart organizations and end-result manifestations of country programmes in their field: for example, examining human rights performance in population "as they apply to all aspects of population programs" (Partan, 1979, p. 536). Such an approach can lead to a myopic assessment. Examples are finding "violations of the right to family planning" because of less than satisfactory availability of some particular means of contraception or concern with some aspect of reproductive ethics that is of marginal importance in a given setting. Clearly, for example, it is fanciful to construe lack of access to some recently developed modern contraceptive device in a low-income country as evidence of an unsatisfied basic human right. In the same fashion, some of the ethical puzzles introduced by modern biotechnology are likely to remain esoteric issues in most developing countries for many years to come.

As was suggested above, the two population issues that do loom large or, by the logic of facts, should loom large on the policy agenda in most developing countries are excessive mortality and rapid population growth--that is to say, excessive fertility. In the large majority of developing countries, human rights abuses as they are commonly defined in population programmes are likely to be non-existent or very rare. The typical country programme is a composite of plans and declarations of good intent (e.g., "good health for all in 2000," or "full cafeteria approach"), a delivery performance that falls far short of what is intended but is amply excused by inadequate resources available to the programme and a "soft-state" emphasis on the obligation of the Government to supply services without asking anything in return or without spelling out obligations that fall on the intended clientele of the programme. Indeed, this last feature is often considered prima facie evidence that the programme respects human rights. But identification of the real ethical and human rights issues in such a situation may call for examination of some roads not taken: policy opportunities and options that were ignored and remain unexploited; exploration of inadequacies of the information and understanding that was brought to the policy debates that resulted in adopting the existing strategy; identification of practices of rent-seeking within the programme. Much of this examination would involve looking at the characteristics of the broader political process, leading, in short order, to assessment of the state of civil and political rights prevailing in the country. That issue, as noted above, is currently or is becoming a matter of legitimate international concern. It is, however, scarcely considered a proper topic for discussion between specialized technical agencies.

A small minority of developing countries do not fit the foregoing description. These countries demand from couples patterns of reproductive behaviour which, if they assessed their interests in isolation from the rest of the society, they would not voluntarily choose. Such a policy obviously imposes high political costs on the Government. Barring malice or masochism as a motive, one must assume that the responsible political leadership had examined what the country's demographic and related socio-economic future would be like in the absence of such a policy and had determined that such a future must be prevented from materializing. It is possible to disagree with the validity of the demographic/socio-economic analysis that underlay such determination, but not with the proposition that such a calculation is within the proper scope of the political process. As a counterfactual speculation, one can be quite certain, for example, that if Japan, Western Europe or the United States of America faced the prospect of doubling their respective populations within the next three decades, the implications of such an anticipated change would be the subject of intense examination and national debate. Plausibly, such debate would lead to suitable rearrangements of economic signals that would deter couples from carrying out their demographic intentions or to other policies sufficient to persuade couples to change their fertility plans. The debate might also lead to the conclusion that no intervention was needed because a spontaneous adjustment mechanism would in time be brought into action. But the superiority, let alone sole legitimacy, of the latter solution would not be taken for granted, a priori. It is true that these societies now regard the right of couples to determine the number of their children as sovereign and inalienable, rather than subject to social control. But granting that right is based on the confident if unacknowledged assumption that the average couple will exercise their right in moderation. Should that assumption turn out to be invalid by a significant margin, the implicit social contract underlying the granting of such an inalienable right would be subject to renegotiation.

The relevant human rights issues in such a situation therefore should properly centre not on the apparent severity of particular rules that have been adopted concerning reproductive rights but on the nature and legitimacy of the process that generated those rules and on the political arrangements and institutions that carry out and supervise their execution. Measured by such criteria, a successfully enforced one-child policy, for example, may be found consistent with accepted international human rights standards, while a four-children policy may be found in clear violation of it. The point is not that the likelihood of such paradoxical findings is high but, rather, that population policies and their human rights record should be assessed in the broader context of civil and political rights.

The preceding arguments were presented in more assertive terms than would perhaps be appropriate. The issues touched upon in this brief discussion are controversial, if only because they have been inadequately aired, examined and debated. For long, practitioners working in this field have taken for granted that the proper framing of population policy questions had been found and commanded consensus, hence, that the remaining tasks were essentially limited to solving technical and organizational problems. There is little doubt, however, that thinking about strategic population policy issues and their human rights dimension is again in a state of flux. A re-examination and reformulation of fundamental principles underlying the rationale, desirable modes and likely future directions of population policies are under way. They are likely to lead to important changes in the nature and scope of the role of government in population matters and also to changes in the style and content of supporting international action. Human rights considerations should play a central role in these processes.

Notes

1/ In 1651, Hobbes wrote on man in a state of nature as follows:

"Whatsoever therefore is consequent to a time of Warre, where every man is Enemy to every man; the same is consequent to the time, wherein men live without other security, than what their own strength, and their own invention shall furnish them withall. In such condition, there is no place for Industry; because the fruit thereof is uncertain: and consequently no Culture of the Earth; no Navigation, nor use of the commodities that may be imported by Sea; no commodious Building; no Instruments of moving, and removing such things as require much force; no Knowledge of the face of the Earth; no account of Time; no Arts; no Letters; no Society; and which is worst of all, continuall feare, and danger of violent death; And the life of man, solitary, poore, nasty, brutish, and short." (Hobbes, 1977, p. 186)

On the social contract, Hobbes states:

"And because the condition of Man ... is a condition of Warre of every one against every one; in which case every one is governed by his own Reason; and there is nothing he can make use of, that may not be a help unto him, in preserving his life against his enemyes; It followeth, that in such a condition, every man has a Right to every thing; even to one anothers body. And therefore, as long as this naturall Right of every man to every thing endureth, there can be no security to any man, (how strong or wise soever he be,) of living out the time, which Nature ordinarily alloweth men to live. And consequently it is a precept, or generall rule of Reason, That every man, ought to endeavour Peace, as farre as he has hope of obtaining it; and when he cannot obtain it, that he may seek, and use, all helps, and advantages of Warre. The first branch of which Rule, containeth the first, and Fundamentall Law of Nature; which is to seek Peace, and follow it. The Second, the summe of the Right of Nature; which is, By all means we can, to defend our selves.

"From this fundamentall Law of Nature, by which men are commanded to endeavour Peace, is derived this second Law; That a man be willing, when others are so too, as farre-forth, as for Peace, and defence of himselfe he shall think it necessary, to lay down this right to all things; and be contented with so much liberty against other men, as he would allow other men against himselfe. For as long as every man holdeth this Right, of doing any thing he liketh; so long are all men in the condition of Warre. But if other men will not lay down their Right, as well as he; then there is no Reason for any one, to devest himselfe of his: For that were to expose himselfe to Prey, (which no man is bound to) rather than to dispose himselfe to Peace. This is that Law of the Gospell; Whatsoever you require that others should do to you, that do ye to them. And that Law of all men, Quod tibi fieri non vis, alteri ne feceris." (Hobbes, 1977, pp. 189-190)

2/ In 1803, Malthus made the following statement on social entitlements:

"A man who is born into a world already possessed, if he cannot get subsistence from his parents on whom he had a just demand, and if the society do not want his labour, has no claim of right to the smallest portion of food, and, in fact, has no business to be where he is. At nature's mighty feast there is no vacant cover for him. She tells him to be gone, and will quickly execute her own orders, if he do not work upon the compassion of some of her guests. If these guests get up and make room for him, other intruders immediately appear demanding the same favour. The report of a provision for all that come fills the hall with numerous claimants. The order and harmony of the feast is disturbed, the plenty that before reigned is changed into scarcity; and the happiness of the guests is destroyed by the spectacle of misery and dependence in every part of the hall, and by the clamorous importunity of those, who are justly enraged at not finding the provision which they had been taught to expect. The guests learn too late their error, in counteracting those strict orders to all intruders, issued by the great mistress of the feast, who, wishing that all her guests should have plenty, and knowing that she could not provide for unlimited numbers, humanely refused to admit fresh comers when her table was already full." (Malthus, 1986, pp. 697-698)

3/ In 1859, Mill wrote as follows on conditions for restricting liberty:

"The sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him, must be calculated to produce evil to some one else. The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

"It is, perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children, or of young persons below the age which the law may fix as that of manhood or womanhood. Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury." (Mill, 1974, pp. 14-15)

On the limits of law, Mill states:

"Every one who receives the protection of society owes a return for the benefit, and the fact of living in society renders it indispensable that each should be bound to observe a certain line of conduct towards the rest. This conduct consists, first, in not injuring the interests ofone another; or rather certain interests, which, either by express legal provision or by tacit understanding, ought to be considered as rights; and secondly, in each person's bearing his share (to be fixed on some equitable principle) of the labours and sacrifices incurred for defending the society or its members from injury and molestation. These conditions society is justified in enforcing at all costs to those who endeavour to withhold fulfilment. Nor is this all that society may do. The acts of an individual may be hurtful to others, or wanting in due consideration for their welfare, without going the length of violating any of their constituted rights. The offender may then be justly punished by opinion, though not by law. As soon as any part of a person's conduct affects prejudicially the interests of others, society has jurisdiction over it, and the question whether the general welfare will or will not be promoted by interfering with it, becomes open to discussion. But there is no room for entertaining

> any such question when a person's conduct affects the interests of no persons besides himself, or needs not affect them unless they like (all the persons concerned being of full age, and the ordinary amount of understanding). In all such cases there should be perfect freedom, legal and social, to do the action and stand the consequences." (Mill, 1974, pp. 92-93)

4/ In 1776, Smith made the following statement on natural liberty and the functions of Government:

> "All systems either of preference or of restraint, therefore, being thus completely taken away, the obvious and simple system of natural liberty establishes itself of its own accord. Every man, as long as he does not violate the laws of justice, is left perfectly free to pursue his own interest his own way, and to bring both his industry and capital into competition with those of any other man, or order of men. The sovereign is completely discharged from a duty, in the attempting to perform which he must always be exposed to innumerable delusions, and for the proper performance of which no human wisdom or knowledge could ever be sufficient; the duty of superintending the industry of private people, and of directing it towards the employments most suitable to the interest of the society. According to the system of natural liberty, the sovereign has only three duties to attend to; three duties of great importance, indeed, but plain and intelligible to common understandings: first, the duty of protecting the society from the violence and invasion of other independent societies; secondly, the duty of protecting, as far as possible, every member of the society from the injustice or oppression of every other member of it, or the duty of establishing an exact administration of justice; and, thirdly, the duty of erecting and maintaining certain publick works and certain publick institutions, which it can never be for the interest of any individual, or small number of individuals, to erect and maintain; because the profit could never repay the expence to any individual or small number of individuals, though it may frequently do much more than repay it to a great society." (Smith, 1979, pp. 687-688)

References

Cook, Rebecca J. (1984). The legal promotion of the right to family planning. In *The Human Right to Family Planning*. London: International Planned Parenthood Federation, pp. 36-48.

Demeny, Paul (1986). Population and the invisible hand. *Demography* (Alexandria, Virginia), vol. 23, No. 4 (November), pp. 473-487.

Hobbes, Thomas (1977). *Leviathan*. New York: Penguin Books.

Malthus, Thomas Robert (1986). An essay on the principle of population. 2nd ed. In *The Works of Thomas Robert Malthus*, vol. 3. London: William Pickering.

Mill, John Stuart (1974). *On Liberty*. London: Oxford University Press.

Partan, Daniel G. (1979). Human rights aspects of population programs. In *World Population and Development: Challenges and Prospects*, Philip M. Hauser, ed. Syracuse, New York: Syracuse University Press, pp. 486-537.

Smith, Adam (1979). *An Inquiry into the Nature and Causes of the Wealth of Nations*. Oxford: Clarendon Press.

United Nations (1975). *Report of the United Nations World Population Conference, Bucharest, 19-30 August 1974*. Sales No. E.75.XIII.3, chap. I.

__________ (1984). *Report of the International Conference on Population, Mexico City, 6-14 August 1984*. Sales No. E.84.XIII.8 and corrigenda, chap. I, sect. B.

__________ (1988). *Human Rights: A Compilation of International Instruments*. Sales No. E.88.XIV.1.

VI. CONTRACEPTION, FAMILY PLANNING AND HUMAN RIGHTS

Nuray Fincancioglu*

A. Recognition of the right to reproductive choice

The principle that reproductive choice is a basic human right is widely accepted. At the international level, the United Nations General Assembly asserted in 1966, in resolution 2211 (XXII) on Population Growth and Economic Development, that the size of the family should be the free choice of each individual family. Two years later, in article 16 of the Proclamation of Teheran, the International Conference on Human Rights elaborated on the principle and stated it in terms of a basic right, asserting that "parents have a basic human right to determine freely and responsibly the number and spacing of their children" (United Nations, 1988a, p. 45).

Since then, the basic right to making decisions about child bearing has been reaffirmed in a number of international documents and instruments. Its most elaborative formulation is found as a principle in paragraph 14 (f) of the World Population Plan of Action, adopted by the World Population Conference in 1974:

> "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities toward the community." (United Nations, 1975, p. 7)

These international declarations, resolutions and documents expressed a political commitment to ensuring reproductive choice but they were not binding on Governments (Cook, 1984). The right to decide on the number and spacing of children and to have access to the means to do so became an enforceable right with the ratification of the Convention on the Elimination of All Forms of Discrimination against Women. The Convention was adopted by the General Assembly in December 1979 and became effective in December 1981, following its ratification or accession by 20 States Members. By July 1988, 94 countries had ratified or acceded to the Convention (International Women's Rights Action Watch, 1988). Article 16 of the Convention recognizes the right of women, on an equal basis with men, to decide on child-bearing and to have access to the information and means to exercise the right (para. 1 (c)). Several other clauses mandate the provision of family planning information, counselling and services.

---

*Consultant, Istanbul, Turkey; former Head of Policy Analysis for the International Planned Parenthood Federation.

At the national level, political commitment to the right to decide on child-bearing is usually implied in policy support to family planning although the objectives of family planning policies and programmes are mainly expressed in terms of health or demographic goals to be achieved. In some countries, constitutional provisions and laws may effectively guarantee the right of access to family planning education and services, but this may not be formally stated in human rights terms (Meredith and Thomas, 1986).

Policy support to family planning is expressed in constitutional provisions, legislation, policy statements, sections of national development plans and ministerial guidelines (Isaacs and Fincancioglu, 1987). In some cases, official policy statements endorsing family planning may be in conflict with prevailing laws, for instance, these prohibiting the provision of contraceptive information or supplies. Such conflicts are sometimes resolved through law reform and sometimes through non-enforcement of restrictive laws.

Governmental support to family planning has been steadily growing. Recent analyses by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat show that, as of 1986, Governments directly supported family planning in 122 countries, and access to modern contraception was restricted, as a matter of policy, in only six countries (United Nations, 1988b).

Thus, political commitment to the principle of people's right to reproductive choice and to have access to the means to exercise this choice appears to be well established. But the extent to which these means are actually accessible varies widely among and within countries. Studies undertaken in the mid-1980s found significant differences in availability of contraceptive services and supplies among the major regions of the world. In about one third of Latin American countries, more than 80 per cent of the population had easy and ready access to family planning services but this level of accessibility existed in only one fifth of Asian countries and only 2 per cent of African countries. The same variations were seen in the proportions of countries where half the population had easy and ready access: 82 per cent in Latin America; 44 per cent in Asia; and 12 per cent in Africa (Lapham and Mauldin, 1984, 1985).

These limitations on the accessibility of contraceptive services and supplies, despite widespread, although not universal, policy support to family planning imply that, at the end of the 1980s, deliberate governmental action to restrict reproductive choice may be less of an impediment to the exercise of the right to this choice than failure to provide the necessary means for its exercise. Furthermore, even when these means are generally available, there may be other deliberate or unintentional obstacles to the exercise of individual reproductive and contraceptive choices.

This paper discusses current constraints on individual choice and the challenges that they pose to family planning programmes. Three major topics related to reproductive choice--incentives and disincentives, abortion and reproductive technologies--are not included in the discussion as they are reviewed under other agenda items.

B. Nature and scope of the right to reproductive choice

1. Reproductive choice as a social right

The right to reproductive choice falls into the category of human rights defined as social rights. It is similar in its nature to the rights to health care, education and work. Social rights are enabling rights. Inherent in them is a corollary duty of Governments to provide the means for their exercise.

As formulated in the World Population Plan of Action, the right to reproductive choice encompasses both the right to make decisions on child-bearing and the right to have access to the information and means to exercise those decisions. It therefore imposes two obligations on Governments: (a) not to inhibit reproductive decision-making either through coercion or by withholding the knowledge that is necessary for making a decision; and (b) to provide the means to exercise the decisions made.

Conceptually, the right to reproductive choice protects individuals from two possible infringements: interference with their decisions regarding child-bearing; and interference with their use or non-use of the services provided. In other words, Governments have a duty to enable their citizens to make and to exercise reproductive choices, but they cannot enforce those choices or the use of the services they provide. As Macklin states, granting persons "freedom to act in certain ways does not imply that they must act in those ways" but that "they may act in those ways" (1988a).

The right to make reproductive decisions has generally been perceived as a right accorded to those who do not wish to have children at a given point in time and who need access to contraceptive services and supplies to avoid unwanted pregnancy. This perception has provided a major justification for fertility reduction policies and family planning programmes with both demographic and health objectives. But the concept of free reproductive choice encompasses the right to have children as well as protecting people against enforced contraceptive practice and making infertility treatment an integral component of family planning.

2. Free and responsible reproduction

A built-in limitation on the freedom of reproductive choice is explicit in the World Population Plan of Action. It obligates Governments to respect the reproductive choices of individuals and couples but, at the same time, expects them to make responsible choices--bearing in mind their responsibilities towards their living and future children and towards the community. At least a potential source of conflict is apparent in the concept of free and responsible decision-making with regard to reproduction in both high-fertility and low-fertility countries. Concern has been expressed that responsible child-bearing may justify governmental intervention in choice and in access to the means--in terms of either withholding access or enforcing use of the means provided.

Application of the concept of free and responsible child-bearing to fertility policies and programmes requires the delineation of the boundaries of freedom of choice and of responsibility, and it gives rise to difficult questions. Under what conditions and at what threshold level may persons be asked to have fewer children than they actually desire or to procreate for societal good regardless of their personal choices? Through which process and by whom may societal good be determined? What criteria govern the acceptability of the methods of persuasion a Government may use when asking its citizens to adjust their reproductive choices to social needs and governmental expectations? This last question gains particular importance when incentive and disincentive schemes are regarded as necessary tools for implementing population policies.

It is difficult to find universally applicable answers to these questions. In an effort to clarify the complexities involved in this issue, the International Planned Parenthood Federation (IPPF) suggests that a distinction be made between the two components of the right to reproductive choice: (a) the right to have ready access to information, education and services for fertility regulation; and (b) the right to make decisions about reproductive behaviour (IPPF, 1984). It puts forward the view that the right of access to the means for fertility control "transcends population policies and should not be withheld for demographic or other objectives", while reproductive choices are, of necessity, "influenced by personal and societal perceptions of responsible childbearing" (IPPF, 1984). In this interpretation, the acknowledgement of the limitations of reproductive freedom, which are inherent in its definition, seems to elevate the right of access over the right to free choice.

IPPF also points out that the need for individual responsible reproductive behaviour does in no way free a Government from its obligation to ensure easy access to fertility regulation information and services and that a Government may not expect its citizens to behave responsibly without first having provided adequate knowledge about the individual and societal consequences of reproductive behaviour. In other words, Governments may try to influence individual decisions, through ethically acceptable processes, but they may not prevent the exercise of those decisions once they have been made.

3. Reproductive choice as an individual right

A significant conceptual change can be seen in the three formulations of the right to reproductive choice quoted above. General Assembly resolution 2211 (XXII) of 1966 accords this right to families, the Proclamation of Teheran to parents and the World Population Plan of Action to individuals and couples. These variations are more than semantic. The Plan establishes the right to reproductive choice "as a personal prerogative, bringing it closer to other individual human rights" (IPPF, 1984).

The recognition of the right to choice about child-bearing as an individual right, distinct from the right of a couple, provides a conceptual basis on which a woman's right to have control over her fertility can be asserted, especially when her preferences differ from those of her husband or partner. This may be considered a right that exists only in theory in societies where cultural perceptions of male and female roles in society deny women any say in the decisions that affect their lives and where they are expected to behave according to the decisions made by their fathers, brothers or husbands. Nevertheless, it has important implications for family planning programmes. For instance, the practice, in some programmes, of making provision of reproductive health services conditional upon the husband's consent is an obvious violation of a woman's right to reproductive choice.

It may be argued that a man also has an individual right to reproductive choice which is violated when his wife or partner refuses to bear a child. This apparent conflict between the rights of two individuals gives rise to the question of whose right should prevail. But in this case, the boundaries of the respective rights of men and women can be more clearly defined. Men and women play an equal genetic role in the reproductive process but only women have a major biological role: "The woman's right to self-determination, that is to control her body, is not matched by an analogous right of the man" (Macklin, 1988a).

The connection between the right to reproductive choice and several other basic human rights is most clearly seen in the area of women's rights. Their rights to be healthy and to have equal access with men to educational and employment opportunities are seriously hampered when they have little control over their fertility. Conversely, education and gainful employment are major determinants of women's fertility behaviour. Access to contraceptive education and services enables women to exercise both their right to reproductive choice and their right to health care.

C. Exercise of the right to reproductive choice

A prerequisite of the exercise of a right is the knowledge that it exists. Although the basic right to decide on child-bearing has gained world-wide recognition at a broad policy level, access to family planning is rarely perceived as a personal right. This is particularly true in areas where concepts of individual rights and governmental obligations for their fulfilment are not well established.

The spread of family planning programmes has contributed little to raising the consciousness of the right to reproductive choice. Because the primary goals of these programmes are to protect the health of mothers and children and/or to reduce the rate of population growth, their educational activities usually promote contraceptive practice either as a health measure or as a responsibility towards the society rather than as a personal prerogative.

Two recent developments may help strengthen the perception of reproductive choice as a right, especially for women. The first is a growing awareness of women's conditions and rights, brought about particularly by the United Nations Decade for Women and related activities. Women's right to have control over their lives, including making decisions about their fertility, is taking an increasingly firm place among their other inalienable rights.

The second development is the emergence of the pro-choice movement in North America and in some European countries. This movement, which began as a response to attempts by anti-abortion groups to delegalize abortion, has as its fundamental philosophy the protection of the right to reproductive choice. The influence of the pro-choice movement on consciousness-raising with regard to reproductive rights has as yet been limited in developing countries.

Currently, the absence of widespread consciousness of the human right to family planning does not appear to be a major obstacle to its exercise because of increased governmental support to family planning and, consequently, wider availability of family planning services, albeit for other purposes. Nevertheless, creating this consciousness is important for two reasons.

First, governmental commitment to providing services and supplies may be vulnerable to political, demographic or economic considerations and to the influence of opposition groups. Social pressure is necessary to ensure continuation of services and to challenge Governments to fulfil their obligations.

Secondly, reproductive choice is a multi-dimensional right which involves a series of choices to be made (e.g., whether to have a child, when to have a child, which contraceptive method to use) and actions to be taken. Availability of services is only one of several elements that facilitate these choices and actions, and the exercise of reproductive choice may be inhibited even in the presence of extensive service delivery networks. All the dimensions of the right to decide on reproduction, and its implications for family planning policies and programmes, need to be better and more widely understood.

The major issues involved in the exercise of the right to reproductive choice revolve around the questions of effective and equal accessibility, contraceptive choice and safety in contraceptive practice and contraceptive research.

1. Effective and equal access

With growing support to family planning, the availability of contraceptive services and supplies has considerably increased within the past 10-15 years. According to a 1984 review, more than 50 Governments have taken positive action in the previous decade, to strengthen family planning laws, policies and programmes (Isaacs and Cook, 1984). These actions included elimination of restrictions on family planning information and services, allocation of increased resources to family planning activities and indirect measures affecting fertility behaviour--for example, actions to improve the conditions and status of women. Since that review, governmental support to family planning has extended to additional countries, particularly in Africa. In addition, many more non-governmental organizations have become involved in family planning activities either directly or by adding family planning to their work on other aspects of community development.

Another important factor in increasing the availability of contraceptive services has been the diversification of service delivery channels. In most family planning programmes, additional channels for delivering contraceptive education and services have been established in order to overcome the shortcomings of clinic-based networks. Among these channels, community-based distribution and commercial retail sales schemes have been particularly effective in expanding service delivery, especially in rural areas where health infrastructure is weak. Legal or regulatory provisions allowing trained auxiliary health personnel and, in some countries, non-medical people to provide some contraceptives have facilitated expansion of non-clinic delivery channels and have increased the capacity for service provision in clinic-based systems.

The limitations of the physical accessibility of services, despite these significant improvements, have already been noted. This problem is most severe in rural areas of the majority of developing countries and almost everywhere in countries that have set up family planning programmes only recently. From a human rights perspective, uneven availability of services indicates that access to the means to exercise reproductive choices is, as yet, neither universal nor equal--the two fundamental tenets of basic human rights.

Physical inaccessibility entails more than distance to service points. Inconvenient working hours, chronic supply shortages and lack of trained personnel are well-known shortcomings of family planning programmes which impede effective access.

Restrictions on access to contraception

Added to the problems described above are policy or administrative decisions or clinical practices that restrict the access of particular population groups to contraceptive services or to individual methods. For example, in some countries, contraceptive services are provided only to married couples. A study in 1987 found five countries where, as a matter of policy, unmarried people were denied access to contraceptive services (Paxman and Zuckerman, 1987).

In other areas, similar restrictions may be imposed by health or clinic administrators. For example, people may be asked to produce a marriage certificate in order to receive service even though it is not required by law.

A particularly vulnerable group whose access to contraceptive services is severely restricted in many societies is unmarried young people. Social taboos on adolescent sexuality are reflected in the design and implementation of contraceptive delivery programmes. Lack of contraceptive advice and services causes irreparable physical and social damage to adolescents, especially girls. They are denied not only their right to make decisions about their reproductive lives but also their other basic rights, in particular, their right to health and to education and employment opportunities. They are exposed to the well-known risks of adolescent pregnancy and childbirth and, in many cases, illegal and unsafe abortion. They are rejected by their families and by the education system. Studies in Botswana, for instance, show that 56 per cent of female school drop-outs are caused by unwanted pregnancy (Mashalaba, 1988).

Making the provision of contraceptive services to young people dependent upon the consent of their parents has been a controversial issue in several countries; and, in some cases, court decisions have been sought as to whether physicians may give contraceptives to adolescents without notifying their parents. There is accumulated evidence that parental notification and consent requirements have a major inhibiting influence on adolescents' willingness to seek contraceptive advice and services. This influence and its consequences are far greater for adolescent girls than boys, as the methods girls use are prescribed or provided by physicians or other health personnel while condoms require no medical intervention.

Spousal consent as a condition for service provision also affects accessibility. The virtually irreversible nature of voluntary surgical contraception explains the requirement for having the consent of the spouse to the operation; and as long as it is applicable to both male and female, sterilization does not violate the principle of equality. But making the husband's consent a requirement for provision of temporary methods can have serious implications for women's right to contraceptive choice and practice and for the principle of equality. Ideally, contraceptive practice must be the result of a joint decision of the couple concerned. But when social customs and gender roles do not allow this form of decision-making, requiring the husband's consent gives him the power to veto his wife's choice to practise contraception. It may also force women to use methods that are not their real choices but that they can use without the knowledge of their husbands.

As a principle, access to a specific method should be determined by its safety and appropriateness for the individual user. In practice, however, unnecessary restrictions may be added to those which are medically or legally needed. There have been examples of physicians at service delivery points refusing to perform voluntary surgical contraception unless the person seeking it has five or more children, regardless of the criteria set out in the law. Thus, a measure intended to protect the acceptor against the possibility of future regret may turn into a limitation on choice and on access.

The cost of contraceptive services may constitute a constraint on their accessibility at two levels. At the governmental level, economic difficulties may prevent the expansion of service delivery activities and/or improvements in their quality. This point gains particular importance as international assistance to family planning falls behind increasing needs. Although self-sufficiency in service delivery is a desired goal, the challenge is in achieving this goal without jeopardizing accessibility of services to the less well-off who are in greatest need for public services.

At the individual level, the actual or perceived cost of contraceptive services and methods may be prohibitive to people with low income. In most developing countries, contraceptive services are provided free of charge or at a nominal fee. But this practice is not always widely known; and, especially if other health services are to be paid for, the perceived cost of contraceptive practice may inhibit acceptance and use. The cost of contraceptive practice to the user is not confined to the fee at the service point. Loss of earnings due to time spent away from work, fare paid to get to and from the clinic and other incidental expenses all add to the perceived cost.

3. Contraceptive choice

Range of methods

Effective access to contraceptive services also requires the availability of a wide range of methods either directly or through a referral network. In the early days of many family planning programmes, despite the adoption of a cafeteria approach as a policy decision, there was heavy emphasis on one or two more effective methods. This was caused by a relatively widespread belief that couples and individuals, particularly women, would be incapable of using effectively those methods which are controlled by the user--e.g., oral contraceptives and barrier methods.

In some countries where reduction of fertility was a policy goal, irreversible methods were widely promoted to achieve a rapid demographic impact. As a result, the contraceptive needs of young couples who wanted to postpone pregnancy were grossly neglected. The size of this neglected group may be quite large, costing programmes a potential reduction in fertility through longer birth intervals. It is also known that some spacers eventually decide not to have any more children and to practise temporary methods effectively to limit their family size.

A study on the impact of quality of family planning services on fertility (Jain, 1988) concludes that an increase in the number of methods available can raise contraceptive prevalence by increasing both acceptance and continuation. Introduction of new methods may attract people who have not previously used any contraceptive method, as well as create better opportunities for switching methods, thus raising overall practice rates.

In the past decade, legal reform and advancement in contraceptive technology have contributed to increased method choices. As a general trend, legal and regulatory requirements for advertising, import and provision of contraceptives have been relaxed. In several countries, oral contraceptives are now available without prescription and are more easily accessible to the user. Restrictions on voluntary surgical contraception have been reduced or removed in the United States of America and most parts of Europe and Asia. In other areas, however, its legal status is unclear; and some physicians are reluctant to perform it in case it is considered a criminal offence (Isaacs and Fincancioglu, 1987).

Technological advances have also had a positive influence on contraceptive choice. While there has been little change in the contraceptives available--with the notable exception of implants--more effective forms of existing contraceptives and simpler and quicker techniques for surgical contraception with fewer side-effects have made contraceptive practice more convenient and more acceptable to the user.

A recent review of current status of contraceptive technology (PATH/PIACT, 1988) concludes that only a few new methods will be available by the end of the century but that significant modifications of existing methods will make a broader choice of effective, safe and acceptable contraceptives available.

Service delivery models also influence contraceptive choice. As noted earlier, the development of non-clinic channels for distribution of contraceptives has increased their accessibility, but a limited range can be offered through these channels--mainly barrier methods and, where laws permit, oral contraceptives. Because of this limitation on method choice, effective referral and medical back-up systems should be set up. There is also some concern that the knowledge of non-clinic distributors of contraceptives on the methods they do not provide may be inadequate to enable people to make informed choices regarding contraceptive practice.

Contraceptive choice may be limited where there are no governmental or non-governmental service delivery networks and thus private physicians and commercial outlets are the only sources for obtaining contraceptive supplies. In some countries, especially in Latin America, there is heavy dependence upon oral contraceptives sold through pharmacies and upon voluntary surgical contraception performed by private physicians. This dependence may not be regarded as a serious problem if contraceptive prevalence is high. But under such conditions, a young woman for whom oral contraceptives are contraindicated has little contraceptive choice and, in practical terms, no access to effective contraceptive practice.

Nature of methods

Trends in the characteristics of contraceptive methods that become increasingly available have a bearing on individual contraceptive choice. An important aspect of contraceptive development has been the increase in the variety of methods for use by women. Mauldin and Segal note that in 1965, contraceptive practice among men was greater than that among women. Since then, however, improvements in male methods have been limited to "somewhat simpler surgical techniques for vasectomies to slightly improved condoms" (Mauldin and Segal, 1988, p. 343), while contraceptive options for women have considerably increased with the introduction of new and more effective methods. As a result, the ratio of female to male contraceptive practice was about 2.7 to 1 in the mid-1980s (Mauldin and Segal, 1988).

This trend creates some concern that men are not sharing an equal degree of responsibility for contraceptive practice as women. As Spencer (1988) points out, although a broader choice of female contraceptive methods may have enabled women to control their fertility more effectively, it has placed the burden of contraceptive practice "squarely on their shoulders".

Another important consideration is the degree to which the user has control over the contraceptive method--that is, the power to initiate and to terminate its practice (Bruce, 1987). User control over method is conversely related to its efficacy, the highest control being on abstinence and the lowest on surgical contraception. The trend in modern contraceptive technology has been towards reduced user control and increased dependence upon the provider. Provider dependence may be an inhibiting factor on users' decision-making regarding contraceptive choice, especially where training and supervision of providers are inadequate.

To a large extent, the choice of contraceptive method to be used is made by the provider rather than the user. Mauldin and Segal comment that "in most developing countries, the medical authorities and clinic personnel have more to do with choice than any other factor" (1988, p. 343). The attitude of providers has a crucial role in individual decision-making. Studies show that provider attitudes inhibit user choice and may deter people from contraceptive practice "especially when clients are lower-class, of low caste, or uneducated" (Schuler and others, 1985, p. 260).

Informed choice and informed consent

In the early 1970s, the hypothesis that easy availability of contraceptives would lead to a rapid acceptance of contraceptive practice was put to the test in several countries. Experience showed that this was not the case. Long-term, carefully controlled studies give ample evidence that "even an effective service system does not automatically transform latent demand into effective use" (Phillips and others, 1988, p. 318).

Increasing emphasis is now being placed on tailoring services to the needs, preferences and perspectives of users and potential users. Whether it is called "user perspective" or "quality care", this approach has the potential for enhancing personal choice and decision-making in service delivery programmes. A large number of operations research projects are under way to determine the relative effects of the specific elements of quality of care on user satisfaction and contraceptive practice.

A major weakness in family planning service delivery almost everywhere has been the absence of proper counselling to enable clients to discuss their concerns, fears and anxieties and to receive full and unbiased information on the various contraceptive options they have, so that they can make informed choices. It is difficult, however, to provide this kind of counselling in overcrowded clinics staffed by overworked health personnel. Counselling through home visits and other community channels and training community members, including satisfied users as educators and counsellors, are some of the approaches used to overcome these problems. Studies that compare the perceptions of providers and of users on the scope and the content of the information provided will help improve the quality of counselling.

Documenting the consent of the acceptors of voluntary surgical contraception has long been a practice in service programmes providing this method. Public and private health services, as well as donor agencies, have insisted on having written proof of the client's consent to have the operation. Consent forms serve a dual purpose; they are intended to protect the user against undue pressure for having the operation and to protect the provider against any future claims for coercion or misinformation given to the client.

It is of crucial importance, from the point of view of human rights as well as medical ethics, that prospective acceptors of surgical contraception fully understand that its effect must be regarded as permanent, that it is a surgical procedure and therefore carries the risks involved in all surgical interventions and that the acceptor has the right to change his or her decision any time before the operation. Other generally accepted principles are that the decision to accept voluntary surgical contraception is not made when the patient is under duress (for instance, during labour), that a sufficient interval is allowed between counselling and the procedure and that full information on all other contraceptive options are given.

Consent forms usually cover all these points and some additional aspects. Sometimes the signature of a witness is also wanted as evidence that all these requirements have been met and that the signature on the form belongs to the acceptor.

These precautions and consent forms are directed to preventing possible abuses of the right to contraceptive choice and practice. However, while the signature or the fingerprint on the form protects the provider against legal action, it does not necessarily prove that the acceptor was given and understood all the benefits, risks and other implications of the procedure, nor that the decision was based on full information and consideration of all other options. This point is particularly important when surgical contraception is provided through short-term camps or mobile teams. In addition to consent forms, training and retraining of service personnel in counselling and the qualitative aspects of patient care, regular supervision and monitoring are also necessary to ensure informed choice in acceptance of this method.

The question whether informed consent should be required for long-acting contraceptives, such as intrauterine devices (IUDs), implants and injectables, is debatable. The relative benefits to be gained from such a practice seem to be outweighed by the possibility that it may inhibit the acceptance of these methods. In many cultures, especially where the educational level is low, having to sign a paper before receiving a contraceptive method may give the impression that it has greater risks than other methods. Instead of consent requirements, reassuring the client that she can have an IUD or implant removed or can discontinue the injectable contraceptive at any time she wishes may be more effective in helping her to make a contraceptive choice.

Cross-national influences

Contraceptive choice has an international dimension too. The transfer of political, legal or commercial considerations across national borders may limit contraceptive options. Contraceptive research, development and manufacture take place mainly in the developed countries. Developing country Governments have legitimate concerns about the importation and provision of devices and drugs that are not used for contraceptive purposes in the manufacturing countries. Although well justified, such concerns may, nevertheless, limit the availability of some methods on political rather than medical grounds. This has been the case with the injectable Depo-Provera, which is licenced for use in more than 90 countries but is not allowed to be used for contraceptive purposes in the United States. Because of the decision taken in the United States, a number of other Governments also exclude this contraceptive from their programmes despite its high user acceptability and its safety level, which is comparable to that of other hormonal methods widely used throughout the world.

A current concern is whether the withdrawal of IUDs from the United States market affects their availability elsewhere. In 1986, the firm manufacturing major types of IUDs decided to withdraw them from the market because of cost and liability considerations. Apart from curtailing the contraceptive choice of American women, this decision may have repercussions in other countries. Reasons for such decisions are sometimes not known, understood or believed abroad, and the sudden withdrawal of a major contraceptive in a manufacturing country may be attributed to safety problems.

Decisions by Governments, organizations and commercial firms in the developed countries may have a more direct impact on reproductive choice in developing countries. Examples of this impact thus far relate to abortion. The policy adopted in 1984 by the United States Administration not to provide funds to organizations whose activities include referral or provision of abortion has reduced the funds available for multilateral assistance. A more recent example is the decision to withdraw from the market the newly developed abortifacient drug, RU-486. This decision by its manufacturers was taken for political and commercial reasons rather than medical considerations. By order of the French Government, the firm later reversed its decision and the drug is now available in France. But its future availability in other countries is uncertain.

4. Safety in contraceptive practice and contraceptive research

The question of contraceptive safety covers two main considerations: safety in contraceptive practice; and safety in contraceptive research and development. No contraceptive method is completely safe, and research findings on risks and benefits of contraceptives are still contradictory. For example, studies on the relationships between oral contraceptives and cancer continue to give conflicting results despite the widespread use of this method for more than three decades. This is confusing to the user and the provider alike.

The dilemma of the user is whether to choose a more effective method and risk potential side-effects or to use a relatively less effective but safer method and risk unwanted pregnancy. This is a difficult choice, especially if abortion is not legally or easily available. The challenge to the provider is in safeguarding the interests of users and potential users without unnecessarily restricting their access to acceptable forms of contraception.

These decisions must be made on the basis of knowldge of the relative risks and benefits of individual contraceptive methods for a given population under specific conditions. For example, heavy bleeding which might be caused by IUD use would present a more serious health risk where weak nutritional status and low haemoglobin levels are common among women, as compared with areas where these problems are not prevalent.

Not all the health risks are inherent in individual contraceptive methods. Additional risks may arise from clinic procedures and practices for their delivery. It has been pointed out, for instance, that in many clinics, women requesting IUDs are not routinely screened and treated for reproductive tract infections prior to the insertion of the device. This increases the risk of pelvic inflammatory disease, which is a major cause of infertility (Germain, 1987).

Once laboratory tests with a new method or with a modified version of an existing contraceptive have been completed, clinical trials need to be conducted in a variety of settings. The general principles governing other biomedical research on human subjects are also applicable to clinical trials of new contraceptives. Macklin (1988b) reviews the Declaration of Helsinki 1/ from this point of view. The Declaration sets an ethical principle that each biomedical research project should be preceded by careful assessment of the predictable risks and foreseeable benefits "to the subject or to others"; but it rules that "concern for the interests of the subject must always prevail over the interests of science and society". Another important principle is that benefits and burdens of research should be distributed fairly among the population and that research subjects should not be chosen predominantly from among poor or uneducated people (Macklin, 1988b).

At the clinic level, care must be taken to ensure that the client's choice of method should not be unduly influenced by the quest for knowledge of service providers about a new method under trial. Potential acceptors of the new method must be made fully aware that they will be taking part in an experimental project and that the contraceptive they will be using is still in its early stages of use. Those who are likely to face serious difficulties in coming back to the clinic for a regular check-up, for instance, because of the distance involved or other possible inconveniences, should not be included in clinical trials which require close monitoring.

Conclusion

Policy support for family planning has grown considerably within the past two decades. Removal or reduction of legal restrictions on access to contraceptive information and supplies and developments in contraceptive technology have increased people's access to the means to exercise their basic right to decide the number and spacing of their children. Reviewing family planning policies and programmes from a human rights perspective, however, reveals some actual and potential constraints on reproductive and contraceptive choices and on effective and equal access to services and supplies.

Several promising new approa to the delivery of family planning services have the potential for imp g their quality and acceptability and overcoming some of the constraints ssed above. There is also a need for creating greater consciousness that make and to exercise reproductive and contraceptive choices is a fundamen human right to which all persons are equally entitled.

<u>te</u>

1/ Adopted by the 18th Worl Medical Assembly, Helsinki, 1965; and revised by the 29th World Medical As bly, Tokyo, 1975.

References

Bruce, J. (1987). Users' perspectives on contraceptive technology and delivery systems: highlighting some feminist issues. Technology and Society (Elmsford, New York), vol. 9.

Cook, Rebecca J. (1984). The legal promotion of the right to family planning. In The Human Right to Family Planning. London: International Planned Parenthood Federation.

Germain, A. (1987). Reproductive health and dignity: choices by Third World women. Technical background paper for the International Conference on Better Health for Women and Children through Family Planning, Nairobi, Kenya, 5-9 October 1987.

International Planned Parenthood Federation (1984). The Human Right to Family Planning. London: IPPF.

Isaacs, Stephen L., and Rebecca J. Cook (1984). Laws and Policies Affecting Fertility: A Decade of Change. Population Reports, Series E: Law and Policy, No. 7 (November). Baltimore: Population Information Program, The Johns Hopkins University.

__________, and Nuray Fincancioglu (1987). The policy and programme implications of promoting family planning for better health. Background document for the International Conference on Better Health for Women and Children through Family Planning, Nairobi, Kenya, 5-9 October 1987.

International Women's Rights Action Watch (1988). Assessing the Status of Women: A Guide to Reporting Using the Convention on the Elimination of All Forms of Discrimination against Women. New York: The Development Law and Policy Program, Columbia University.

Jain, Anrudh K. (1988). Assessing the Fertility Impact of Quality of Family Planning Services. International Programs Working Paper No. 22. New York: The Population Council.

Lapham, Robert J., and W. Parker Mauldin (1984). Family planning program effort and birthrate decline in developing countries. International Family Planning Perspectives (New York), vol. 10, No. 4 (December), pp. 109-118.

__________ (1985). Contraceptive prevalence: the influence of organized family planning programs. Studies in Family Planning (New York), vol. 16, No. 3 (May-June), pp. 117-137.

Macklin, Ruth (1988a). Ethical perspectives on unwanted pregnancy. Paper presented at the International Christopher Tietze Symposium on Women's Health in the Third World: The Impact of Unwanted Pregnancy, Rio de Janeiro, 29-30 October.

_________ (1988b). Ethics and human values in family planning: perspectives of different cultural and religious settings. Paper presented at the XXIV Conference of the Council for International Organizations of Medical Sciences, Bangkok, 19-24 June.

Mashalaba, N. N. (1988). Commentary from an African perspective on causes and consequences of unwanted pregnancy. Paper presented at the International Christopher Tietze Symposium on Women's Health in the Third World: The Impact of Unwanted Pregnancy, Rio de Janeiro, 29-30 October.

Mauldin, W. Parker, and Sheldon J. Segal (1988). Prevalence of contraceptive use: trends and issues. Studies in Family Planning (New York), vol. 19, No. 6, Part 1 (November-December), pp. 335-353.

Meredith, Philip, and Lyn Thomas, eds. (1986). Planned Parenthood in Europe: A Human Rights Perspective. London: Croom Helm for International Planned Parenthood Federation.

Program for Appropriate Technology in Health/Program for the Introduction and Adaptation of Contraceptive Technology (PATH/PIACT) (1988). More contraceptive choices likely by end of century. Outlook, vol. 6, No. 4.

Paxman, John M., and Ruth Jone Zuckerman (1987). Laws and Policies Affecting Adolescent Health. Geneva: World Health Organization.

Phillips, J. F., and others (1988). Determinants of reproductive change in a traditional society: evidence from Matlab, Bangladesh. Studies in Family Planning (New York), vol 19, No. 6, Part 1 (November-December), pp. 313-334.

Schuler, S. L., and others (1985). Barriers to effective family planning in Nepal. Studies in Family Planning (New York), vol. 16, No. 5 (September-October), pp. 260-270.

Spencer, B. (1988). Male involvement in family planning. IPPF Medical Bulletin (Manchester, England), vol. 22, No. 4 (August), pp. 2-3.

United Nations (1975). Report of the United Nations World Population Conference, Bucharest, 19-30 August 1974. Sales E.75.XIII.3.

_________ (1988a). Human Rights--A Compilation of International Instruments. Sales No. E.88.XIV.1.

_________ (1988b). World Population Trends and Policies: 1987 Monitoring Report. Population Studies, No. 103. Sales No. E.88.XIII.3.

VII. THE PROBLEM OF INDUCED ABORTION FROM THE STANDPOINT OF HUMAN RIGHTS

Mariano Requena-Bichet*

Among the topics of this meeting, induced abortion is one of the most polemical, and it takes on greater intensity when situated within the context of human rights. It is a question of bringing together two systems that are complex, much controverted and charged with a high emotional and value content. When people talk about it, they resort to an oblique form of argumentation. In every polemicist there exists a biographically internalized system of values and cultural and ethical principles. This view gives rise to behaviour that is more defensive/aggressive than rational.

Furthermore, induced abortion is a subject characterized by a multiplicity of polemical perspectives. It is a problem of public health and also one of individual health, especially where it is illegal; it is a moral problem owing to the value attributed to human life in the first embryonic phases; it is a sociological problem due to its connotations for community life; it is a legal problem owing to its relationship with the creation of social norms; it is a demographic problem due to its effect on fertility and population growth; it is a political problem due to the differences in discriminatory practice between economic and power groups; and it is a psychological problem owing to its effect on behaviour, the emotions and the volition of the woman and her social surroundings. But, including all of these factors, it is an unresolved human rights problem.

Despite this, a decision has been taking shape throughout the world over the past few decades. Since the time of the Second World War, the tendency has been towards legalization. A number of developed countries throughout the world have gradually been accepting the practice legally. This social consciousness has been reflected in the granting of access to legal abortion, especially for women subject to economic discrimination: the granting of priority to maternal morbidity and mortality; and the rendering effective of the woman's right to control her fertility.

---

*Latin American Institute for Health and Population, Santiago, Chile. Former professor at the School of Public Health, University of Chile.

A. Working hypothesis

This situation confronts one with a twofold challenge: on the one hand, to neutralize the subjectivity implicit in this topic; and, on the other, to use an approach that will make it possible to look at this interrelationship objectively, with balance and in depth. An effort is made to overcome these challenges, guiding the analysis by a hypothesis of the social evolution of the use of induced abortion as a means of regulating fertility, within the perspective of human rights. In any event, the task here is not to go in depth into the determinants of fertility. Even less does the paper involve a discussion of the related theories, which, as a matter of fact, have preoccupied social scientists since Malthus and Marx. Outside of that, considerable efforts are currently being made to advance along those lines (Simmons and Farooq, 1985), in theoretical development and empirical investigation as well as in the interrelationship between the two.

In view of the complexity of the subject, it is advisable to specify its content and limits, for which purpose use is made of the general theory of systems. 1/ On the one hand, there is the system of human fertility and, on the other, the system of human rights. Neither induced abortion nor human rights can be interrelated unless one considers each of them as elements dependent upon their respective systems.

Between the system of human reproduction and the system of human rights there arises a complex relationship, mediated in turn by other complex social systems, such as the health system and the legal, economic, political and religious systems. They all maintain dialectical interrelations with one another and also with abortion and human rights.

The hypothesis here takes form in terms of these three aspects: (a) the system of human fertility; (b) the system of human rights; and (c) the dynamics of their interrelationship.

1. The social system of fertility control

The social system of human reproduction is defined and identified by its product: human beings. Consequently, the set of components of the aggregate whose interaction produces live-born babies is what defines and identifies the limits of the human reproductive system. By way of variables that are direct determinants of fertility, this system has intermediate variables. 2/ Among them, the variables of interest here are those which can be consciously and deliberately directed towards modifying the spontaneous trend of fertility and can consequently be changed from within the bounds of the system.

Therefore, for the purposes of this hypothesis these variables are requalified as: (a) instrumental variables; and (b) non-instrumental variables. The instrumental variables are those used, consciously and intentionally, to control fertility, i.e., the use of contraceptives and induced abortion. The former modify the probability of becoming pregnant, or fecundity. Induced abortion, on the other hand, modifies the probability of live-born infants, or fertility, by interrupting embryonic development. The non-instrumental variables are the remaining intermediate variables, which cannot be used consciously in order to act on fecundity or fertility.

Other intermediate variables that one can try to modify are breast-feeding and the age at which unions between couples are initiated. However, these are difficult elements to manipulate and the predictability of their effects on fertility is low.

The use of contraceptives or induced abortion is the result of human conduct, and its material support is the woman and the man, i.e., the couple, with the assistance of a third component generically referred to here as "satisfier". Of these elements, the man and the woman are necessary, albeit not sufficient, elements; they must be present in order for reproduction to exist, but their presence does not guarantee it. The satisfier, on the other hand, is neither necessary nor sufficient and may be anyone from the specialist physician to the empirical accoucheur who happens to be present.

On the social level, contraceptives and induced abortion are the instruments employed for affecting fertility. Nevertheless, based on the accumulated experience of intervention by means of governmental programmes directed to modifying fertility trends, the conditions and determinants of the success of programmes for disseminating and handing out contraceptives or of legal and administrative decisions on abortion are still not known. Empirical studies for the evaluation of programmes generally tend to show an influence of those programmes on fertility (see Stinson and others, 1982; Stycos and others, 1982; and Cuca and Pierce, 1977). However, the problem with such studies is the difficulty in separating these variables analytically from the effects that social, economic, political and cultural changes have simultaneously had on fertility.

These instrumental variables of fertility control are also used for public health purposes. For example, concern over induced abortion as a social health problem began to be felt in Latin America in the 1960s. In some countries, it gave rise to the development of "induced abortion control" programmes (Requena, 1971). These programmes explicitly stressed that it was not their intent to act on fertility, though it was known that the use of contraceptives had to affect it.

2. The human rights system

Human rights are historically determined products. They are not eternal values inherent in human nature. On the contrary, they are the result of the struggles of social groups to consecrate that which they consider good but which has not yet been assumed by the society in question. Human groups, more concretely, struggle to extend, qualify and give greater depth to the basic rights to life, subsistence and reproduction. Human rights, the product of this historic struggle, are assimilated by the collective consciousness and converted into a social patrimony. History has shown that the fight for human rights has been waged by groups that have been barred from their enjoyment, either by repression, exploitation or domination. As human rights are those related to fundamental, permanent juridical relationships binding persons and the people, on the one hand, and the State, on the other (Domínguez, 1989), the fight for them has a political character. A change or renewal of the foundations of society is sought whereby they can be respected. This characteristic of human rights is a key to the understanding of the subject that is of concern here.

Individual human rights cannot be analysed in isolation. Their effectiveness depends upon the feasibility of other rights. The effectiveness of those which appear to be directly connected with induced abortion, for example, require that other human rights that determine the conditions of the former should be in force. The rights of the Universal Declaration 3/ would have neither value nor implementing force except for the fact that they mutually support, condition and instrument one another. The right to life has no value unless the rights to equality and liberty or security of person are respected. Often, repressive situations violate a right indirectly by limiting or not respecting other related rights. This is why the right to life and the rights of women will be achieved only in societies that fully respect those values.

The human rights contained in the Universal Declaration and subsequent documents have arisen since the Second World War. Yet, they are not new for all that. The basic ideas they contain can be found earlier, in the Magna Carta, in the Declaration of the Rights of Man of the French Revolution, in the constitutions of some countries and in the writings of such authors as Locke and Jefferson. Nevertheless, the human rights proclaimed by the United Nations have characteristics that make them unique and differentiate them from those which preceded them:

(a) They are international, due not only to their world-wide extent but also, and above all, to their universal implementation and the insistence upon their being respected by the international community, despite the zeal with which countries demand respect for their sovereignty;

(b) They are egalitarian, owing to the emphasis placed on avoiding discrimination, on respecting equality before the law and due process, on including social rights on an equal basis, on establishing individual political rights etc. The international community and individual countries demand that Governments comply with them so as to overcome exploitation and discrimination, in order to include social, political and economic rights as an inseparable whole and in order that wretchedness and inequalities may be governed by the moral control of economic and social policies;

(c) They are less individualistic in that they incorporate as their beneficiaries the basic groups of society. Referring to the family, communities and countries as recipients is something relatively new in the world.

In this context, the human rights relating to abortion are an intimately related whole the purpose of which is to establish bonds between the State and individuals and the people in connection with the practice of induced abortion. Its content, its orientation and its juridical ties with the State are conditioned by numerous structural and value variables.

In the subject of induced abortion, what is unique is not the human rights with which it is connected, as they are common to many other subjects, but its antithetical and contradictory character. The position from which abortion is being argued determines the right that is invoked. Those who are in favour of a coercive or pro-life policy base their position on the embryo's right to life. Those who call for and defend a permissive or pro-choice policy base their position on the woman's right to dispose of her body and to decide her own reproductive matters. Both rights are fundamental, and usually they complement each other. Here, however, they are opposed and mutually exclusive.

The debate on abortion between the two camps should move towards some form of minimum accord whereby it would be possible to balance the irreconcilable disputes that still dominate the subject, to seek some minimum ethical agreement. The legislation has not managed to do so; and after legalization has taken place, movements to repeal the law still continue, as in California (United States of America) and England.

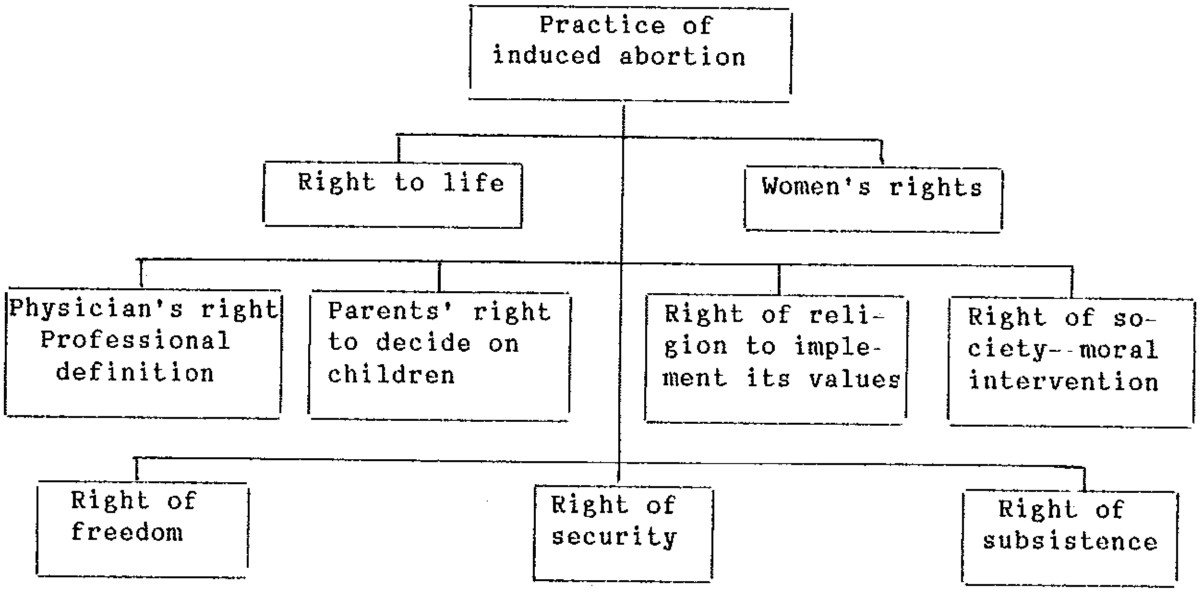
In the search for a basis for consensus that may serve to bring the two opposed sides closer together, what finally remains is the idea of the sanctity of life or, if one wishes to avoid the religious connotation of the word "sanctity" and the lack of specificity of the word "life", one might speak of the "dignity of human life". An examination of this concept might serve as a basis for the desired consensus, not so much because of the human quality of the product of conception, but due to the competition for rights that in concrete situations might arise between the foetus and the mother. Consequently, the gist of the controversy lies in competition of rights, and this question has not been resolved.

This situation gives rise to numerous questions: are human rights contradictory and mutually exclusive in certain specific cases, such as the one that of concern here? Does this occur in other cases? How is this contradiction to be resolved? In this matter, there appears to be a twofold confusion when the subject of the right is not distinguished from the circumstances. The subject of the right to life is an embryo, whereas in the case of the right to dispose of one's own body, the subject is the woman. Thus, the conflict of rights is also a conflict of the subjects involved. The woman and the embryo, her own child, come into dispute over their respective rights. A definition has yet to be given of the criterion and the path that must be followed in order to overcome this contradiction and the exclusive character of these rights, which can be achieved by defining a hierarchical scale of those rights or the extent to which one is willing to sacrifice the one for the benefit of the other.

In addition to the rights mentioned, there are others of lesser importance which also relate to abortion, such as the right of the physician or the person who performs the abortion to apply professional judgement without outside interference, the right of parents to decide the size of their family and the means of achieving it, right of religious groups to implement their values without interference and, lastly, the right of society to interfere in private moral questions.

At the root of the human rights mentioned there are still others which, while they may not have a direct determinant bearing on abortion, do have it with respect to those rights connected with it, i.e., the basic rights, which this author sees as being three in number--the rights to freedom, security and subsistence. Whatever one's stand may be on the right to life or women's rights, their exercise will be possible only if there exists freedom, if subsistence is assured and if personal security is a reality. Figure III summarizes the system of human rights connected with induced abortion.

Figure III. Induced abortion and human rights



3 2. Structure and dynamics of system levels

In the theoretical or empirical study of the variables of fertility, three levels are generally formulated:

(a) The direct level, immediate biological variables, referred to as "intermediate" by Davis and Blake (1956) and as "proximate determinants" by Bongaarts (1978);

(b) The intermediate level, the group and family variables having an influence on the former and influenced in turn by the structural variables of the following level;

(c) The basic level, variables designated by Farooq and Simmons (1985) as "general" and referred to by others as "structural", "socio-economic/cultural" or "macrosocial", containing political, economic, cultural, ideological and legal elements and affecting fertility through the group variables and immediate variables.

The variables that are designated here as "instrumental" are situated clearly at the level of intermediate variables and are consequently linked as direct determinants of the level of fertility. Human rights, on the other hand, are included among the structural variables and are therefore at the opposite extreme from the instrumental variables. Within the latter group, human rights belong to the area of ideology.

Human rights have many avenues of relationship to induced abortion. A few of these avenues include, of course, the constitution of the family, maternal work, economic conditions, child labour and, in consequence, its economic value, educational possibilities. All these in one way or another modify and are modified by human rights, which will ultimately determine one's conduct with regard to abortion. These ideas are illustrated in figure IV.

4. Stages of fertility control

The theoretical proposition here has it that the conscious social regulation of fertility operates through induced abortion and the use of contraceptive means, which are referred to as instrumental variables. The conscious control of fertility by human societies is a process that exhibits four successive stages, which also overlap in the transition from one to the next, namely:

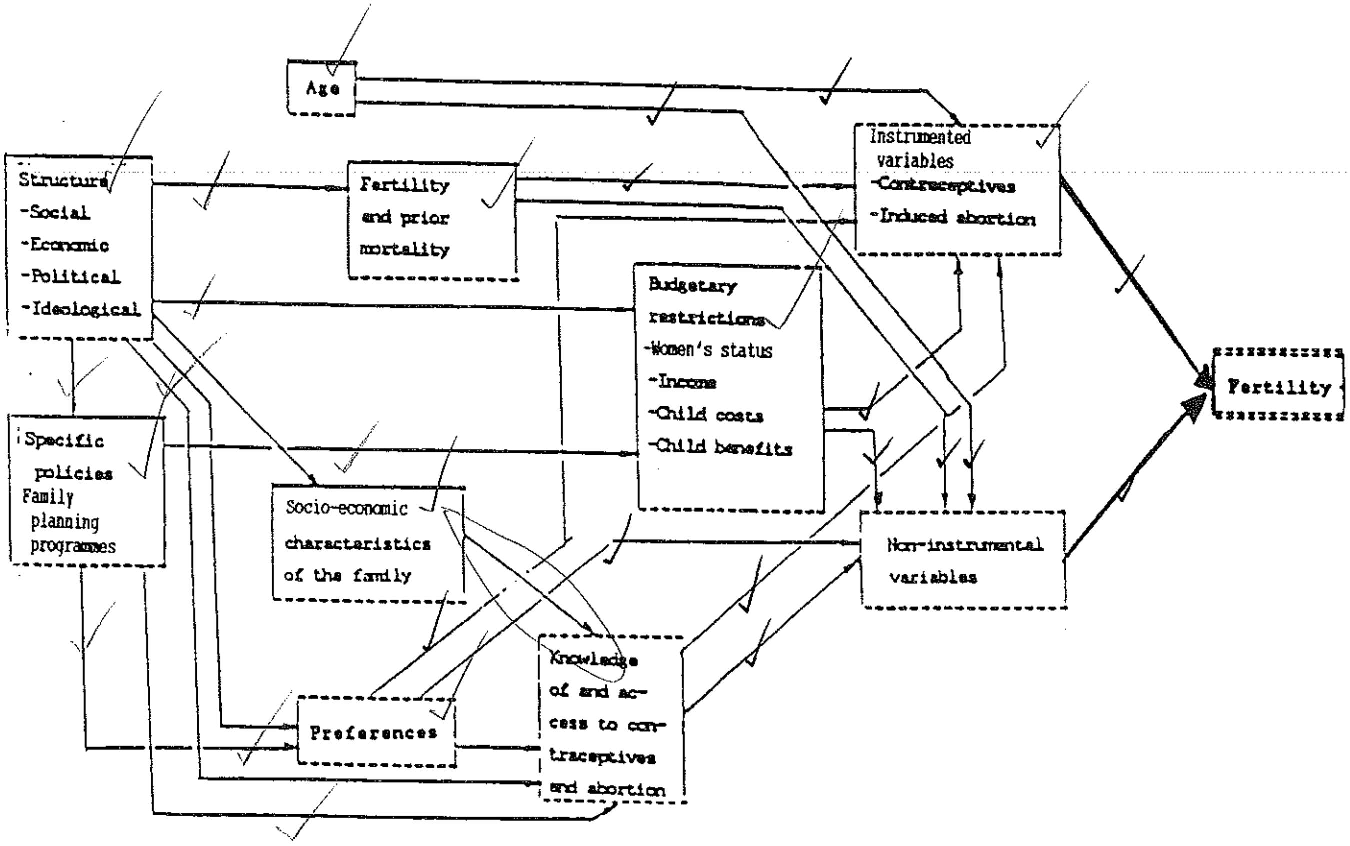
1. Pre-control stage. The social consciousness for regulating fertility is sporadic and incipient, and the social group leaves fertility to uncontrolled regulation. Changes in fertility, generally of low intensity, take place in response chiefly to changes in the non-instrumental variables;

2. Reparative stage. The regulatory social consciousness is more extensive. The first attempts to regulate fertility appear in the social group, with action on fertility in the form of termination of pregnancy, usually illegal. Access to contraceptives is limited by cultural, religious, political and economic barriers;

3. Reparative/preventive stage. The social consciousness for controlling fertility is almost totally generalized. The social group has begun to control fertility through the use of contraceptive methods and maintains regulation of fertility through abortion, either as a primary recourse or as a corrective in case of failure of a contraceptive;

4. Preventive stage. Consciousness for instrumental control of fertility is generalized, and there is widespread availability of effective means. Groups control the reproductive process scientifically, and only sporadic failures are corrected by induced abortion.

Figure IV. Determinants of fertility



Source: Ghazi M. Farooq and George B. Simmons, eds., Fertility in Developing Countries: An Economic Perspective and Policy Issues (London, The Macmillan Press Ltd., 1985), figure 3.1.

5. Regulative consciousness

This hypothesis makes the transition of a society from the reparative stage contingent on the appearance of what is called here the "fertility-regulative consciousness". Women need to limit or control their reproduction. Their interests and needs compete with the effort to raise children. Either because of cultural limitations that prohibit knowledge or prejudge the use of contraceptives or due to economic barriers that place them out of their reach, they do not take steps to prevent unwanted pregnancies. The solution is the interruption of pregnancy.

But what are the conditions that develop this regulative consciousness? By way of family or micro-economic conditions, one must mention the decrease in infant mortality or, what is more sensitive, the survival of children already procreated. Yet, the empirical studies on the association between infant mortality and fertility are not definitive. There exists an abundant literature that reports on the relationship (see Winegarden, 1985; and Simmons, 1985). The effects of the reduction of mortality do not, in any event, appear to be linear. Not only does the survival of children change parents' reproduction plans; it produces other, apparently incongruent, effects in them, deriving from the improvement in women's health. As widows become fewer and as post-partum amenorrhoea becomes shorter, there will be less involuntary sterility and subfertility and fewer spontaneous abortions, and this should result in an increase in fecundity. Also at the family level, it has been found both empirically and theoretically that there is an influence of other variables capable of developing regulative consciousness, for example, family and per capita income, the education and participation in work of the mother and child size and sex preferences.

In this connection, attention should be called to the fact that this set of variables constitutes a totality. This being the case, its product is more than the simple sum of its components. In consequence, analyses between only one of the factors and fertility result in inconsistent statistical associations, both between different groups and for the same group at different points in time. This analysis at the microsocial level proves to be an environment open to the influence of the common experience of the stratum to which one belongs, which, together with hegemonic ideological influences, gradually forms a consciousness among whose components are here postulate as the regulative consciousness. It is difficult, especially in periods of rapid social change, to predict the reproductive behaviour of a family unit, due to its sensitivity to macrosocial changes. For this reason, the interest here is in considering the family as a social micro-environment that is sensitive to macrosocial changes.

6. Abortion as a method of fertility control

Induced abortion, as an instrument for regulating fertility, is the one that predominates in and characterizes the reparative stage. It expresses the regulative consciousness and, at the same time, the cultural and economic limitations that stand in the way of recourse to contraceptives. It is practised under conditions of illegality, with the known consequences, among lower economic level groups, for the health and life of the mother and her family.

This function as an instrument of fertility control imparts to abortion in this stage a character different from that of abortion used to correct errors occurring with contraceptives. The author's experience, first in Chile and subsequently in a number of Latin American countries, 4/ confirmed the idea of induced abortion as the first instrument used by women when they begin to regulate fertility. In Latin America, when fertility began to diminish in different countries, the use of induced abortion increased. In each country, this decrease began with the higher social and economic groups, followed by the middle groups and lastly the lowest groups.

In any case, induced abortion is not a desirable practice as a way of resolving problems of fertility control, not even in contexts where it is legalized and is practised under optimum technical and human conditions. As noted above, however, human groups resort to abortion in the process of maturation of their regulative consciousness, where it constitutes a compulsory transitional stage. Consequently, what is being sought is a way to call attention to induced abortion and, through its users, to speed up the transition to the preventive stage.

B. Women's rights and abortion in recent decades

1. Situation of legalization of induced abortion throughout the world

According to the proposed hypothesis, the social evolution of the incidence and prevalence of the use of induced abortion is in keeping with regularities or laws generated in a process rooted in the historical and structural conditions of the society in question. All these conditions taken together form a complex system of elements widely differing in character: ethical and religious; political and ideological; economic and social. Consequently, the legislation on induced abortion arises from the historical and structural reality of each country. If one examine the current situation of legalized abortion, one sees the variety of criteria, conditions and facilities to which the practice of legal abortion is subject.

Permissive legalization of abortion is, historically speaking, something quite recent in the world. From 1920 to 1959 only three countries liberalized their legislation on abortion: the Union of Soviet Socialist Republics in 1920; England in 1938; and Japan in 1948. In the decade that followed, 1950-1959, five more were added. The figure doubled, reaching 10, between 1960 and 1969. The rate then accelerated during the periods 1970-1979 and 1980-1987, when the laws were liberalized in 26 and 15 countries, respectively. In other words, in slightly under 55 years, legislation was passed on a polemical, controversial problem in more than 50 countries, representing 76 per cent of the world population. Some 980 million women of child-bearing age legally have the possibility, with varying degrees of permissiveness, of having an abortion as a means of controlling their fertility. As shown in table 8, degrees 5 and 6, whereby abortion can be obtained practically on request, today account for 63 per cent, or 820 million women of child-bearing age. Nevertheless, in the majority of countries with less permissive legislation, the practice of abortion is widely tolerated and it is exceptional for cases to be denounced and prosecuted.

Table 8. Legal situation of the practice of induced abortion throughout the world, 1986

Degree of permissiveness a/	Total population		Countries under legislation	
	Thousands	Percentage		
1. Health: life	1,416	24.0	Muslims, Africa, 50 per cent of countries	Europe: Belgium, Ireland, Malta Latin America: 66 per cent of countries
2. Health: sickness	767	13.0	Africa: 50 per cent of countries	Asia: various Latin America: 33 per cent of countries
3. Health: euthanasia			Switzerland	
4. Legal: rape, incest				
5. Socio-economic	1,416	24.0	Central Europe b/ England Germany, Federal Republic of	Eastern Europe b/ India Japan c/
6. At request	2,301	39.0	Austria Cuba France c/ Italy c/ Norway c/ Turkey USSR United States of America Yugoslavia	China Denmark c/ Germany, Federal Republic of c/ Netherlands Singapore Sweden Tunisia Viet Nam
Total	5,900	100.0		

Source: Christopher Tietze and Stanley K. Henshaw, Induced Abortion: A World Review, 1986 (New York, The Alan Guttmacher Institute, 1986).

a/ The degrees of permissiveness are: (1) medical grounds: saving the mother's life; (2) medical grounds: sickness of mother; (3) medical grounds: impairment of the foetus; (4) legal grounds: rape and incestuous relations; (5) socio-economic grounds: unfavourable situation for child, family or pregnant woman; (6) on request, without statement of grounds.

b/ Socialist countries.

c/ Permission of parents is required in the cases of pregnancy in minors, generally under 18 years.

C. Factors in the legalization of abortion

1. Role of the State

If one accept that human rights are those which concern the fundamental, permanent juridical relationships binding persons and the people, on the one hand, and the State, on the other (Domínguez, 1988), one can see their relationship to legislation. Legislation on abortion is the society's recognition of the existence of abortion and the degree of tolerance that it is willing to show with respect to its practice. The society, in turn, hands over the control and supervision of this regulation to the State.

Restrictive legislation on abortion is not a good indicator of the practice of abortion. In countries where such restrictions exist, abortion is tolerated and is not prosecuted legally. This is the case in most Latin American countries, where abortion is illegal and where very rarely--generally for reasons foreign to juridical intentions--is it brought to court (Tietze and Henshaw, 1986). There are even countries where abortion is illegal, such as Colombia, in which there exist private clinics, identified by the euphemism "clinics for the control of menstrual irregularities", which are tolerated by the authorities.

Although a number of human rights support the laws on abortion, the right directly involved is a woman's right to dispose freely of her body.

The stages of social regulation of human fertility suggested above also have their expression in the State, which in some way takes cognizance of the solutions that society provides for the need to control fertility and reacts by attempting to regulate the related practices, especially induced abortion. In order to do so, States resort to direct intervention through legislation or de facto intervention, either by limiting or facilitating the human means necessary for the practice of abortion.

The rules and conduct promoted and implemented by the State would appear to reflect the ideology of the groups in power and the concessions required by political juggling with social referents and pressure groups. Thus, step by step, the legislation on abortion reflects the social reality, with greater or lesser latent periods. It is a bidirectional dialectical relationship; and the society, in turn, is influenced by the State, through the legislative or administrative measures that it adopts.

The sensitivity of the State, in turn, is the result of its political evolution. From table 8 it can be seen that, very generally, there is a relationship between democracy and legislation on abortion. Those States which most genuinely represent the needs of their peoples are the States that have legislation on abortion.

In the world of today, human rights have suffered substantial changes. The idea of human rights of the past century has taken on a new, important meaning through the incorporation of the notion of society as being responsible for those rights. In the area of health, for example, one cannot conceive of a State that does not guarantee medical care, that does not take scientifically recommended preventive measures or that fails to protect man from the effects of the environment. What is sought is not merely to guarantee the right to pursue happiness, but the right to achieve happiness in all spheres of life (Antonovsky, 1983).

2. The women's rights movement

Human rights, as stated above, are a historical product. They are recognized and legitimized by society as a result of the struggle of social groups, at specific stages of history, based on what they consider good. Women constitute one of those groups, and one of their problems pertains to the sphere of reproduction. In the case of abortion, specifically, the role played by women has been great.

When in a society the regulative consciousness arises, what that society uses to regulate its fertility is induced abortion. Its illegality forces women to struggle for recognition of the right to practise it. The concern also spreads throughout the society, and persons and groups band together for action. For some, induced abortion is to be condemned as constituting the destruction of a human life and consequently as violating the sacred right to life. Others, situated at the opposite extreme, proclaim the right of the woman to dispose of her body and her fertility. Depending upon the historical point in time through which the society is living, these positions may take the form of laws, which, unlike other laws, are supported or rejected by social groups.

Since the beginning of the 1970s, during which it is estimated that a minimum of 340,000 illegal abortions were performed annually, women formed one of the important pressure groups for its legalization. In 1987, after nearly a decade of public debate, the law designated as Rules Governing the Prevention of Maternity and the Voluntary Interruption of Pregnancy was passed in Italy (Berlinguer, 1978). Other countries, such as France and the United States, also experienced the pressure of the feminist movement for legalization.

In the developing countries, and also in the developed countries, the greatest contradiction that exists is in the economic discrimination that characterizes this practice. Women in the affluent socio-economic strata resort to the practice of abortion with greater ease and under better safety conditions, and they enjoy the possibility of choosing the best professionals. In the literature, demonstrations of these differences abound, not only in the possibilities women have but also in the more condescending attitude of the private sector of medical care. In the United States, Hall (1976) found differences in the ratio of abortions to live-born infants: it ranged from 1:250 in private hospitals to 1:10,000 in municipal hospitals.

However, not only as a pressure group do women have a connection with the legalization of abortion. In tables 9 and 10, countries are listed according to their degree of legalization, on the one hand, and the degree of differentiation between the sexes and the status of women, on the other.

Table 9. Degree of legal permissiveness of abortion and social difference between the sexes, a/ 1988

Social difference between sexes	Degree of permissiveness							
	Degrees 1 and 2		Degrees 3 and 4		Degrees 5 and 6		Total	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Low (5-14)	5	55.6	3	33.3	1	11.1	9	100.0
High (15-25)	4	11.1	7	19.4	25	69.4	36	100.0
Total	9	20.0	10	22.2	26	57.8	45	100.0

Sources: For legal permissiveness, Rebecca J. Cook, "Abortion law and policies: challenges and opportunities", paper presented at the International Christopher Tietze Symposium on Women's Health in the Third World: The Impact of Unwanted Pregnancy, Rio de Janeiro, 29-30 October 1988; and Christopher Tietze and Stanley K. Henshaw, Induced Abortion: A World Review, 1986 (New York, The Alan Guttmacher Institute, 1986). For social difference between the sexes, Population Crisis Committee, Country Rankings of the Status of Women: Poor, Powerless and Pregnant, Population Briefing Paper No. 20 (Washington, D.C., 1988).

a/ The indicator, computation of the sex difference, has a score of 1-25 resulting from the sum of female/male ratios each having a maximum of 5 points, grouped under: (a) life expectancy at birth; (b) widowed, divorced and separated; (c) differential literacy; (d) proportion of paying jobs; (e) equality of men and women in the society.

Table 10. Degree of legal permissiveness of abortion and index of the status of women, a/ 1988

Status of women a/	Degree of permissiveness							
	Degrees 1 and 2		Degrees 3 and 4		Degrees 5 and 6		Total	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Low (15-34)	8	57.1	5	35.7	1	7.2	9	100.0
High (35-75)	4	10.8	7	18.9	26	70.3	36	100.0
Total	12	23.5	12	23.5	27	53.0	45	100.0

Sources: For legal permissiveness, Rebecca J. Cook, "Abortion law and policies: challenges and opportunities", paper presented at the International Christopher Tietze Symposium on Women's Health in the Third World: The Impact of Unwanted Pregnancy, Rio de Janeiro, 29-30 October 1988; and Christopher Tietze and Stanley K. Henshaw, Induced Abortion: A World Review, 1986 (New York, The Alan Guttmacher Institute, 1986).

a/ The indicator "status of women" has a score of 5-75 resulting from 15 indicators each having a maximum of 5 points, grouped under: (a) health; (b) nuptiality and children; (c) education; (d) employment; (e) social equality.

Table 9 shows a statistical relationship between the permissiveness of the legislation and the status that the woman has achieved. Groups that coincide in terms of the two variables (high/high and low/low groups) contain the highest percentages and the non-coincident groups (high/low and low/high) have the lowest percentages. Although the relationship requires further elaboration, it is indicative of the force that the woman's position exerts on abortion legislation. It is odd that the literature pertaining to the social process that has surrounded legalization and the changes in permissiveness has not made more forceful mention of the relationship to the status of women. Within a strategic perspective, especially in Latin America, the role of women as a pressure group should be explored further.

3. The role of medicine and physicians

In the history of the legalization of abortion it has been clear that medicine has an important influence. It is exerted through the medical doctors themselves, who in turn adopt positions influenced by the characteristics and magnitude of the problem. Society accords more importance to the problem when it is the physicians themselves who express views and take stands. They are the natural leaders of opinion on matter of health, the range of which also takes in extraneous areas, such as ethics and morality. This has been the experience in the use of contraceptives and in the problems of illegal abortion in Latin America. Since the mid-1960s, these aspects have been under the leadership of medicine. The history of the family planning movement in Latin America was based fundamentally on the health problems caused by illegal induced abortion (Viel, 1988).

The high mortality due to illegal abortion has been one of the most powerful arguments for its legalization; and where it is restricted, the use of contraceptives has been implemented as a substitute for illegal abortion. In countries where abortion is legal, the case mortality ratio ranges from 0.28 to 1.00 death per 100,000 women aged 15-44 years (Moore-Cavar, 1974); in those where it is illegal, it jumps to 10 and even 30 deaths per 100,000 women of child-bearing age. In maternal mortality, from one third to one half of all deaths are due to abortion.

This has been an incontrovertible argument for implementing fertility control programme. Apart from the decline in lethality, however, the hoped for results on the incidence and prevalence of abortion have not been confirmed. Indeed, they increase after a family planning programme is set up, as took place in Chile (Requena-Bichet, 1971), the Republic of Korea (Hong, 1966) and Taiwan Province of China (Chow and others, 1970). There has also been an increase in countries following legalization.

In view of these facts, not all physicians react in accordance with the logic of the health realities. There are still those who are opposed to the practice. In Latin America, the opinion and leadership of the medical doctors have been definite in supporting family planning and in opposing the legalization of abortion.

4. Religion and human rights

In the religious area, positions on interruption of pregnancy have generally been ambivalent and unstable. The value given to the new life and the definition of its inception do not coincide in time: the new life may precede the assignment of value or vice versa. Nor have religious stances been consistent historically, and they have shown evidence of important changes, a fact that supports the evolutionary orientation in the study of religions. Various authors, among them Weber (1963) and Durkheim (1954), recognize the influence of religion on the system of standards of society, apart from recognizing that they are a mechanism of social control. What is of interest here as concerns religion is its influence on the specific legislation and, through it, on the human rights connected with abortion.

There is at least a relationship between religious positions on abortion and the corresponding legislation. Among those populations where the religion is restrictive, the related legislation is coercive or moderate for the most part. On the other hand, countries with permissive religions have permissive and moderate legislation. There is thus a high degree of consistency between these two variables.

It must be pointed out that the legislation of these countries, not their practice, is being analysed. The incidence of abortion, leaving legislation out of consideration, does not differentiate women according to their religion. This was one of a number of surprises found in studies in Chile during the 1970s, which led researchers to explore the "religiosity" of the women. It was found that the more carefully they observed their religious practices, the lower the incidence of abortion, which in this case is illegal (Requena-Bichet, 1965a).

Religion, therefore, has a considerable impact in formal respects and on the public decisions of the State, but not on the consciousness of the women. This factor gives rise to the illegality of abortion and, what is more serious, significantly increases the number of deaths due to its complications. Two thirds of the population of Latin America and half the population of Africa are victims of this inconsistency between legislation and reality. This situation should be explored more objectively. There is no doubt that the strategies devised with a view to resolving the high incidence of illegal induced abortion in Latin America must consider this variable.

To sum up, the legal regulation of women's rights in connection with abortion is a complex social process. In it, the factors enumerated are interrelated, in magnitudes and in forms that differ for each situation. Nevertheless, they do work together and no doubt they are more powerful when they coincide.

5. Social, economic and cultural level

What is decisive, however, is what has been called the "regulative consciousness". This category, which requires much more elaboration, is the result of massive experience with abortion itself and fulfils a twofold role in legalization. First, it is a factor of pressure on the legislative authorities to create or amend abortion laws; and secondly, it assures receptiveness to the measures adopted in this connection.

All of the foregoing represents the view at the country level; the characteristics of the problem of the groups within each country are not uniform. These differences exist in particular among groups of different socio-economic levels. In each group, a transition takes place from the use of abortion alone to the use of abortion together with contraceptives, in a chronological order that begins with the highest socio-economic group and ends with the lowest. In consequence, particularly in those countries where social differences are very marked, the rights of the woman gradually become effective by social strata. The information provided by each country reflects only the behaviour and values of the most numerous groups, which are those at the lowest level. For this reason, the elements co-operating towards legalization must be studied for each country and, within each, for each of its socio-economic groups.

6. Cultural aspects

In connection with the foregoing discussion, but from a slightly different viewpoint, some preliminary findings relating to the cultural and ideological backgrounds of individuals are urgently in need of further investigation. Luker (1984) studied the differences in a group of 212 activists, both pro-choice and opposed. It was found that these two groups of activists differed in their social, economic and cultural characteristics and in their manner of assessing fundamental life questions, such as maternity, sexuality, sexual differences and roles, the role of children, morality and the role of family planning.

In very broad terms, it was observed that those in the activist group opposed to legalization and the practice of abortion came from social segments characterized by a higher economic, though not cultural, level, with more conservative and traditional fundamental concepts about life and greater wariness regarding change. The pro-choice group was, one might say, the other side of the coin.

Many of the suggestions to which this preliminary investigation gives rise are extremely important to take into account in fertility control programmes.

7. Replacement of induced abortion with contraceptives

Today, a large percentage of the world's countries are at the corrective/preventive stage. Before going further in depth into this, it is operationally considered for the time being that a country has entered the corrective preventive stage when 50 per cent or more of all induced abortions are intended to correct failures of contraceptives; and, conversely, 50 per cent or fewer of the abortions are induced for the purpose of controlling fertility, without the woman's having used contraceptives prior to the pregnancy in question. All this is independent of the legalization of abortion or its degree of permissiveness. The proportion in which one or the other is used can vary, depending upon the social, political and economic factors that concur in each country. In any event, the general trend observed in recent decades has been towards the replacement of abortion with contraception.

Only two examples that illustrate this notion have been found. One is Japan: Muramatsu (1988) calculates that in 1955, out of every 100 pregnancies avoided, in 68 it was by abortion and in 32, by means of contraceptives. Fifteen years later in 1970, this ratio was inverted, with abortion being used to avoid only 28 pregnancies, while the remaining 72 were avoided through the use of contraceptives.

Another example is Hungary, for which data are given in table 11.

Table 11. Percentage distribution of women of child-bearing age who induced abortion, according to use of contraceptives, Hungary, 1971-1982

Year	Users of contraceptives			Non-users	Total
	Regular	Irregular	Subtotal		
1971	18.9	9.7	(28.6)	71.4	100.00
1975	25.7	14.9	(40.6)	59.4	100.00
1980	39.8	13.1	(52.9)	47.1	100.00
1981	39.5	16.0	(55.5)	44.5	100.00
1982	41.6	17.6	(59.2)	40.8	100.00

Source: András Klinger, "Hungary," in International Handbook on Abortion, Paul Sachdev, ed. (New York, Greenwood Press, 1988), p. 233.

The 12 years covered by the table provide interesting facts that support the hypothesis formulated here. Induced abortion is used consistently less as a primary fertility-regulating method and, consequently, more and more as a way of correcting failures of contraceptives. In 1971, out of every 10 women who had recourse to abortion, in only three cases was it to correct contraceptive failures. Twelve years later, for 6 out of every 10 women it was done to correct a failure of contraception. In addition, there was an increase in the percentage of women who used contraceptives regularly. According to the index used here, Hungary entered the reparative/preventive stage in the second half of the 1970s.

The proposed index requires a special investigative effort that it was not possible to carry out for this paper. Nevertheless, other information, while less sensitive, does provide some orientation. What is referred to is observation of the development of the rates of prevalence and incidence of induced abortion in countries where it is legalized (see table 12).

Table 12. Users of contraceptives, abortion rate per 1,000 women of child-bearing age and abortion rate per 100 pregnant women, selected developed countries, specified years

Country	Users of contraceptives per 100 women of child-bearing age	Abortions per 1,000 women of child-bearing age		Abortions per 100 pregnant women	
		Year	Rate	Year	Rate
Federal Republic of Germany	78	1972	33.1	1972	37.4
		1984	26.2	1982	28.0
Finland	High	1973	22.4	1973	27.9
		1984	12.0	1984	16.8
Hungary	62	1964	82.2	1964	58.2
		1984	37.1	1982	37.2
Norway	84	1974	20.0	1977	23.3
		1984	15.9	1984	21.9
Poland	85	1970	28.7	..	..
		1982	26.9	..	..
Sweden	85	1975	20.0	1975	23.8
		1984	17.7	1984	24.7

Source: Paul Sachdev, ed., International Handbook on Abortion (New York, Greenwood Press, 1988).

All the countries indicated in table 12 have legalized abortion with high levels of permissiveness. The comparison of rates shows a consistent decrease in the use of abortion, whether by women of child-bearing age or by pregnant women. As there has been a decline in fertility in all these countries, one can assume that it is controlled primarily by contraceptives and that these countries are in the reparative/preventive stage.

D. Legalization of abortion

1. Conditions of effectiveness of the right

The legalization of abortion is not sufficient for legal abortion to begin to be replaced by legal abortion and for contraceptives to be promoted as its rational substitute. In this respect, two problems must be analysed. One is to discover the conditions under which it is possible to render effective the right granted or, viewed from the opposite side, to determine what conditions are restricted or simply are not implemented, as if to neutralize the law. The other is the meaning that users, whether current or potential, give to the option offered to them by the new legislation. If the two problems are viewed together, what is involved is to harmonize the two terms of medical attention: to bring the supply into concert with the demand for services.

Concerning the role that should be performed by the State in respect of human rights in the world today, it was stated above that in modern times countries are called upon to move from the demand to obtaining the rights, or in other words, to create favourable conditions for the fulfilment of the right. This means providing the human and material means and, at the same time, limiting as greatly as possible the conditions imposed on the user for its practice.

Some countries that have legalized abortion still make access to it difficult. Some require the agreement of the husband. Others set up a compulsory time-lag between the application and the performance of the operation. In the case of adolescents, the permission of the parents is required. In other countries, the opinion of an ad hoc committee is required. In general, one may or may not be in agreement with these conditions, but they are always a barrier that can be manipulated by persons interested in preventing the materialization of the right.

Another set of limiting factors relates to the opportune and sufficient supply of trained personnel, materials, equipment and premises. A legal conquest such as the legalization of abortion can be neutralized by a Government that does not make available the necessary means and resources.

2. Effect on illegal abortion

The pre-regulation stage today belongs to the past. That was the condition of societies that did not consciously practise fertility control. Mortality, especially infant mortality, was very high; and, consequently, population growth was low or even negative. The information available on ancient cultures shows the existence of the practice of abortion from high antiquity. 5/ In China, the Shen Nong Bencao Fang (Shen Nong Classic of Herbal Medicine) indicates that abortion was practised as early as 2,000 years ago.

The reparative or corrective stage is characterized by the fertility regulative, social consciousness. The recourse is intended to correct an unwanted pregnancy due to ignorance and/or mistrust of contraceptive methods. In Latin America, this situation was very obvious. In those countries where fertility remained high or medium in the years preceding the decade 1960-1969, when family planning programmes were initiated, use was made predominantly of induced abortion. There were important studies that demonstrated this practice. 6/ It was also manifested in the incidence and prevalence of abortion according to socio-economic level, as shown in Chile and in some Latin American cities.

The Japanese experience with induced abortion validates this hypothesis. Japan is one of the countries that drastically changed its legislation on abortion (in 1948). The Criminal Code of 1907, which accepted abortion only to save the mother's life, was amended by the Eugenic Protection Law of 1948, under which it is possible to perform an abortion even for socio-economic reasons of the woman. Consequently, the incidence of legal induced abortions increased nearly fivefold over 10 years--from 241,104 in 1946 to 1,170,143 in 1955. Subsequently, abortion began to be replaced by contraceptives; and by 1983, it had dropped to 567,500.

Even today, the reason for the Eugenic Protection Law is not clear in Japan. But opinions are divided between those who feel that it was for reasons of health and those who believe that it was directed to slowing down population growth. What is more, the law has been amended and discussed, and there are still groups that lobby for making it restrictive.

Japan and other countries that have liberalized the legislation on induced abortion have recognized and responded to a social reality: the existence of the regulative consciousness and the utilization of abortion as an efficient and possible method. They show how one can go beyond the reparative stage through which it is postulated that populations must pass when they decide to control their fertility. Countries that have not adopted this policy, as is the case of two thirds of the countries of Latin America, must suffer the consequences of illegal abortion as the primary cause of maternal mortality, which in some cases is as high as 50 deaths per 10,000 pregnancies.

Even though there is not sufficient evidence, the increase in the number of abortions and the abortion rate following legalization has been due in large part to the replacement of illegal abortion. The intensity of this growth is related both to the permissiveness of to the law and the availability of suitable services for its performance. The case of Japan just mentioned illustrates this point. Cuba, a country with different characteristics, also experienced an increase in legal abortion when it liberated the practice of abortion and made adequate services available: it rose from 28,485 in 1986 to 131,536 only six years later, which is 4.6 times higher.

Summary

The control of fertility in a society is understood to be a process resulting from a combination of multiple factors that run through the entire society, ranging from intermediate variables, and specifically abortion and contraceptives, to the social structure, within which one considers ideological processes and human rights. This complexity tempted the author to try to give an explanation that would overcome the reductionism with which problems of human fertility are so frequently considered.

What this involves is a hypothesis to explain the evolution of the conscious control of fertility by human groups. It is asserted that this evolution proceeds in a regular fashion, in four stages, ranging from a lack of conscious regulation of fertility, a situation presumed only for bygone historical periods, to the scientific control of the process, a situation to which no society has yet acceded. From these premises, and without any claim at this juncture to prove the hypothesis, abortion is brought into focus within the perspective of human rights.

Within this framework, a number of factors that determine this process were explored. The general impression that emerges from this is:

(a) Social groups begin consciously to regulate the process of human reproduction when they acquire what is called here a regulative consciousness, the product of a combination of elements not yet specified;

(b) The first means to which recourse is had is the interruption of pregnancy. The influence of contraception over the past 30 or 40 years has surely modified this stage, though not essentially;

(c) Societies develop towards the use of rational means, relegating abortion more and more to the role of a corrective to be used when those means fail;

(d) Human rights play a number of important roles in the process of conscious control of fertility:

(i) They have been a decisive factor in the legalization of women's right to abortion among approximately three quarters of the world population;

(ii) The legalization of abortion has reduced morbidity and mortality due to induced abortion to a minimum by converting the illegal procedure, with it consequent high risk for health, into a highly safe one;

(iii) Acceleration of the transition of human groups to the preventive stage and, ultimately, to the scientific regulation of human reproduction.

Notes

1/ The general theory of systems has been in the process of development since it was first stated by the biologist L. von Bertalanffy in 1928. Essentially, it is a theory of the laws that govern complex totalities, from the cell to society. At the same time, it is a powerful method of investigation of reality when analysed as a dynamic whole open to interchange with its environment. It has been successfully applied in the field of social sciences and in that of administration.

2/ The intermediate variables are those which directly determine fertility and were defined and classified by Davis and Blake (1956) and subsequently reclassified by Bongaarts (1978).

3/ The Universal Declaration of Human Rights states that everyone has the right:

(a) To life, liberty and the security of person (article 3);
(b) To recognition everywhere as a person before the law (article 6);
(c) To equality before the law (article 7);
(d) To justice through competent tribunal (articles 8 and 10);
(e) To non-interference with his privacy, family, home or correspondence (article 12);
(f) To freedom from attacks upon his honour and reputation (article 12);
(g) To freedom of movement and residence (article 13);
(h) To asylum (article 14);
(i) To a nationality (article 15);
(j) To marry and to found a family (article 16);
(k) To own property (article 17);
(l) To freedom of thought, conscience and religion (article 18);
(m) To freedom of opinion and expression (article 19);
(n) To freedom of assembly and association (article 20);
(o) To freedom to elect and be elected (article 21);
(p) To social security and to the realization of indispensable economic, social and cultural rights (article 22);
(q) To rest, leisure and holidays (article 24);
(r) To a proper standard of living (article 25).

(See United Nations, 1988, pp. 2-6.)

4/ The use of abortion as a method of control was analysed in Chile and subsequently studied in the Programa de Aborto Inducido en América Latina (PEAL) and carried out by the Centro Latinoamericano de Demografía (CELADE) (Requena-Bichet, 1971).

5/ For a review of the historical development of the legalization of abortion, see, among others, Moore-Cavar (1974), Sachdev (1988) and Callahan (1970).

6/ The first studies on induced abortion were hospital studies and reflected only those cases which reached the hospital because of complications--only a percentage of the real incidence. An extensive bibliography on this subject can be found in Requena-Bichet (1971).

References

Antonovsky, Aaron (1983). Morbidity and mortality and human rights. In Population and Human Rights. ST/ESA/SER.R/51. New York: United Nations, pp. 63-83.

Berlinguer, Giovanni (1978). La legge sull'aborto. Rome: Editori Riuniti.

Bongaarts, John (1978). A framework for analyzing the proximate determinants of fertility. Population and Development Review (New York), vol. 4, No. 1 (March), pp. 105-132.

Callahan, Daniel (1970). Abortion: Law, Choice and Mortality. London: Macmillan Press Ltd.

Chhabra, S. Gupte, and others (1988). Medical termination of pregnancy and concurrent contraceptive adoption in rural India. Studies in Family Planning (New York), vol. 19, No. 4 (July/August), pp. 244-247.

Chow, L. P., and others (1970). Abortion in Taiwan. In Abortion in a Changing World, Robert E. Hall, ed. New York: Columbia University Press, pp. 251-259. (This article refers to Taiwan Province of China.)

Cook, Rebecca J. (1988). Abortion law and policies: challenges and opportunities. Paper presented at the International Christopher Tietze Symposium on Women's Health in the Third World: The Impact of Unwanted Pregnancy, Rio de Janeiro, 29-30 October.

Cuca, Roberto C., and Catherine S. Pierce (1977). Experiments in Family Planning: Lessons from the Developing World. Baltimore: The Johns Hopkins University Press for the World Bank.

Davis, Kingsley, and Judith Blake (1956). Social structure and fertility: an analytical framework. Economic Development and Cultural Change (Chicago), vol. 4, No. 3 (April), pp. 211-235.

Domínguez, Andres (1989). Derechos humanos y estado. Santiago, Chile: Comision chilena de derechos humanos (Chilean Human Rights Commission).

Durkheim, Emile (1954). The Elementary Forms of the Religious Life. New York: Macmillan.

Farooq, Ghazi M., and George B. Simmons, eds. (1985). Fertility in Developing Countries: An Economic Perspective and Policy Issues. London: The Macmillan Press Ltd.

Hall, Robert E. (1967). Abortion in American hospitals. American Journal of Public Health (Washington, D.C.), vol. 57, No. 11 (November), pp. 1933-1936

Heisterberg, Lars (1988). Denmark. In International Handbook on Abortion, Paul Sachdev, ed. New York: Greenwood Press, pp. 138-151.

Hollerbach, Paula E. (1988). Cuba. In International Handbook on Abortion, Paul Sachdev, ed. New York: Greenwood Press, pp. 138-151.

Hong, S. B. (1966). Induced abortion in Seoul, Korea. In Population Problems in the Pacific: New Dimensions in Pacific Demography, M. Tachi and M. Muramatsu, eds. Tokyo: Eleventh Pacific Science Congress, pp. 313-316.

Klinger, András (1988). Hungary. In International Handbook on Abortion, Paul Sachdev, ed. New York: Greenwood Press, pp. 218-234.

Léridon, Henri (1983). Fertility, the family and human rights. In Population and Human Rights. ST/ESA/SER.R/51. New York: United Nations, pp. 84-101.

Luker, Kristin (1984). Abortion and the Politics of Motherhood. Berkeley, California: University of California Press.

Moore-Cavar, Emily C. (1974). International Inventory of Information on Induced Abortion. New York: Columbia University International Institute for the Study of Human Reproduction.

Muramatsu, Minoru (1988). Japan. In International Handbook on Abortion, Paul Sachdev, ed. New York: Greenwood Press, pp. 293-301.

Nickel, James (1987). Making Sense of Human Rights: Philosophical Reflections on the Universal Declaration of Human Rights. Berkeley, California: University of California Press.

Population Crisis Committee (1988). Country rankings of the status of women: poor, powerless and pregnant. Population Briefing Paper No. 20 (June). Washington, D.C.

Ramachandran, Prema (1988). India. In International Handbook on Abortion, Paul Sachdev, ed. New York: Greenwood Press, pp. 235-250.

Requena-Bichet, Mariano (1965a). Social and economic correlates of induced abortion in Santiago, Chile. Demography (Alexandria, Virginia), vol. 2, pp. 33-49.

__________ (1965b). Estudio sobre la planificacion de la familia en la comuna de quinta normal de Santiago de Chile. The Milbank Memorial Fund Quarterly, vol. 43 (October), pp. 66-93.

__________ (1971). The problem of induced abortion in Latin America. In International Population Conference, London, 1969. Liège: International Union for the Scientific Study of Population, pp. 1189-1207.

Sachdev, Paul, ed. (1988). International Handbook on Abortion. New York: Greenwood Press.

Sara-Lafosse, Violeta (1983). Status of women, population and human rights. In Population and Human Rights. United Nations non-sales publication, ST/ESA/SER.R/51, pp. 142-159.

Simmons, George B. (1985). Theories of fertility. In Fertility in Developing Countries: An Economic Perspective and Policy Issues. Ghazi M. Farooq and George B. Simmons, eds. London: The Macmillan Press Ltd.

__________, and Ghazi M. Farooq (1985). Toward a policy-relevant framework. In Fertility in Developing Countries: An Economic Perspective and Policy Issues, Ghazi M. Farooq and George B. Simmons, eds. London: The Macmillan Press Ltd., pp. 109-122.

Stinson, Wayne, and others (1982). The demographic impact of the contraceptive distribution project in Matlab, Bangladesh. Studies in Family Planning (New York), vol. 13, No. 5 (May), pp. 141-148.

Stycos, J. Mayone, and others (1982). Contraception and community in Egypt: a preliminary evaluation of the population/development mix. Studies in Family Planning (New York), vol. 13, No. 12, part 1 (December), pp. 365-372.

Tietze, Christopher, and Stanley K. Henshaw (1986). Induced Abortion: A World Review, 1986. New York: The Alan Guttmacher Institute.

Tuan, Chi-hsien (1988). China. In International Handbook on Abortion, Paul Sachdev, ed. New York: Greenwood Press, pp. 98-111.

United Nations (1988). Human Rights: A Compilation of International Instruments. Sales No. E.88.XIV.1.

Viel, Benjamin (1970). La explosion demográfica. Mexico City: Editorial Pax.

Weber, Max (1963). The Sociology of Religion. Boston, Massachusetts.: Beacon Press.

Winegarden, C. R. (1985). Can income redistribution reduce fertility? In Fertility in Developing Countries: An Economic Perspective and Policy Issues, Ghazi M. Farooq and George B. Simmons, eds. London: The Macmillan Press Ltd., pp. 462-489.

VIII. THE USE OF DIRECT INCENTIVES AND DISINCENTIVES AND OF INDIRECT SOCIAL ECONOMIC MEASURES IN FERTILITY POLICY AND HUMAN RIGHTS

Rudolf Andorka*

In matters of fertility policy two principles might be equally acceptable:

(a) "The basic objective of the state is to promote the economic and social development of the country and to ensure the maximum well-being of its citizens. The objective applies to the future as well as to the present... Avoiding a long-term weakening of a country brought about by a dangerously low birth rate and, inversely, avoiding excessive population growth when it becomes an obstacle to economic development and to the well-being of the population must certainly be among the basic goals of all governments" (Veil, 1978, p. 314-315);

(b) Governments have to ensure that "all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so" (United Nations, 1984, recommendation 30). This follows from the basic human right of freedom from interference in private and family life.

The two principles, however, might be in contradiction and are, indeed, often in contradiction, perhaps more often in the twentieth century than in earlier times.

These contradictions evolve in consequence of the fact that the decisions on their fertility of free and responsible couples do not necessarily coincide with the interests of the national community. There is no invisible hand assuring that individual decisions with respect to fertility add up to a recognized common good (Demeny, 1986a). The conditions in which individuals and couples decide on the number of their children are similar to the conditions in the so-called "prisoners' dilemma" or to the "tragedy of the commons". In these conditions, if everybody follows his own individual interests, without being willing to shoulder some sacrifice for the sake of the common good, each individual comes to grief; and, consequently, the community as a whole fares worse than it would if its members were willing to co-operate.

---

*Head, Department of Sociology, University of Economics. Karl Marx, Budapest, Hungary.

Societies faced with similar recurrent problems having important social consequences usually develop norms and values that help to prevent less than optimal outcomes. People tend to follow these norms and values in their individual decisions rather than to calculate, taking into consideration simply their selfish interests. Such normative and value systems, however, emerge, rather slowly. Therefore, in times of rapid social transformations, the existing norms and values might not help to attain the optimal outcome, or the norms and values might simply break down and might not be followed by an important segment of the members of the community.

This paper tries to investigate situations in which the above-mentioned two principles are in contradiction and tries to find solutions for these contradictions without infringing the two principles.

A. Situations and tendencies of non-optimal fertility in the modern world

Since the Second World War the demographic explosion has been one of the favourite topics of social scientific literature and of the mass media. The unprecedented rapid growth of the world population was caused by the fact that the decline of fertility did not follow or followed only with an important time-lag the rapid decline of mortality in the developing countries.

The causes of the persistent high level of fertility or of its slow decline are still debated in demography. The size of the gap between desired and achieved fertility, i.e., how much the level could be reduced simply by providing easy access to contraceptives for all couples in the developing countries, is not completely clear (Westoff, 1988). Nevertheless, it seems clear that the high fertility levels are owing not only to inacessibility of contraceptives or lack of information on contraceptive methods but also to the large number of children that the couples desire. Excellent analyses and field studies have demonstrated that many couples in these countries want to have many children and they consider, rightly or wrongly, that having a large number of children best serves their own individual interests (Caldwell, 1982; Cain, 1981, 1983; Duza, 1985).

Although the high level of fertility in the developing countries is rather differently evaluated in the individual countries, by their Governments and by their demographers (Frejka, 1986; Sirageldin, 1986), obviously depending to a large extent upon their actual conditions, and although the economic and social consequences of the rapid population growth are not unanimously evaluated to have been very negative (e.g., Coale and Hoover, 1958, versus Johnson and Lee, 1987), a great number of Governments consider that a lower level of fertility would be more advantageous for the economic and social development of their countries. The usual policy of the Governments in these cases is to develop the supply of family planning information and of contraceptives, hoping that by meeting the existing demand for birth control the level of fertility can be reduced. In some cases and in some countries, it was, however, recognized that in addition to the insufficient supply of information and of contraceptives the desires of the couples also impede the decline of fertility. Thus, some Governments introduced anti-natalist policies intended to influence the desires of the couples by incentives or disincentives and, in a few cases, policies to coerce the couples to have fewer children than they desired. In these latter cases, the principles of the well-being of the society and of the free decision of couples might be in contradiction.

By the 1930s, in some of the developed countries the level of fertility has already declined below the level necessary for simple replacement of the population. Some of these countries introduced pro-natalist population policies, aiming at a higher number of children per family than the average number of children desired by the couples. After the post-war "baby boom", which ended around 1965, the level of both period and cohort fertility rates declined to below replacement level in almost all developed countries (Bourgeois-Pichat, 1986; Preston, 1986; Blayo, 1987). The only real exceptions appear to be Ireland and Poland. In the Union of Soviet Socialist Republics, the somewhat higher period fertility is caused only by the relatively very high fertility of the population groups having a non-European cultural background, which compensates for the below-replacement fertility of the majority of the European parts of the USSR, which have levels of fertility similar to the other European societies (Borisov, 1985; Borisov and Kiseleva, 1984).

Currently, there is no agreement among social scientists on the economic and social consequences of the below-replacement cohort fertility rates and of the ensuing aging of the population (McNicoll, 1986; Ermisch and Joshi, 1987; Pestieau, 1988; Nickell, 1988; Höhn, 1987; Schmid, 1987a, 1987b). Nevertheless, at least some of the Governments of developed countries having below-replacement fertility are considering the introduction of fertility policies intended to stimulate couples to have more children than they currently desire and plan, in order to attain the fertility needed for simple replacement of the population, i.e., in the long term, the zero-growth level. It should be added that in at least one country, which is in the less developed group but which has attained a high level of economic development--namely, Singapore--the Government is concerned about the below-replacement level of fertility that has recently emerged and is considering the introduction of pro-natalist policies (Saw, 1986).

In these cases, the question again arises, as it often does also in the mass media and in public debates, as to how the freedom of decision of the couples can be reconciled with the assumed interests of the society, which would require a somewhat higher level of fertility than that resulting from the desires of the individuals and couples.

B. Types of population policies

A population policy is defined here as a system of integrated programmes formulated and implemented with the explicit intention of orienting or modifying the movement of population in a specific direction (Gérard, 1983b). According to Gérard, the measures of fertility policies might be classified as follows:

(a) Measures influencing the supply or the availability of methods of birth control;

(b) Measures influencing the economic conditions of the families having children, i.e., incentives or disincentives in cash or in kind influencing directly the financial situation of the family, depending upon the number of children;

(c) Measures ranging from simple propaganda to psychological pressure on the couples in order to induce them to have the number of children considered optimal by the Government or the society;

(d) Coercive measures.

In societies where the Government considers fertility to be higher than optimal from the point of view of the interests of the society, these different types of measures in practice consist of the following mesures: (a) supply of contraceptives and birth control information; (b) economic disincentives; (c) propaganda/psychological pressure; (d) coercive measures (Chasteland, 1984).

The supply of contraceptives and of other means of birth control, the provision of information on these methods and the services providing birth control are expanded in most of the countries that consider that it would be advantageous to have a lower fertility. In addition to the population policy argument, there is a similarly important and more popular argument in favour of this policy, namely, that by having access to the methods of birth control the individuals and couples are able to achieve their desires concerning their number of children, i.e., they are able to avoid unwanted parities. The free availability of induced abortion and of sterilization is, however, opposed in some countries and by some social movements and organizations; for example, Governments of some Roman Catholic and Muslim countries do not provide access to such measures as induced abortion or voluntary sterilization.

Economic disincentives in cash or in kind have been applied in a few cases, e.g., in China (Hardee-Cleaveland and Banister, 1988). Recently, China households in rural areas of China were required, according to the so-called "double-contract system", to sign a contract guaranteeing to have only one child or, if they had more children, a contract guaranteeing to have no additional children. If a child was born in the subsequent year, the couple was considered to have violated the double contract and was subjected to economic penalties. On the other hand, single-child families are entitled to certain financial rewards and to other privileges, e.g., in obtaining a dwelling or a place for the child in the educational institutions.

Propaganda and psychological pressure are not easily distinguished, as simple propaganda itself might create a public atmosphere strongly limiting the freedom of decision of couples. Again, the example of China might illustrate these measures. In 1982, the Central Committee of the Chinese Communist Party and the State Council jointly issued a directive that among government cadres, workers and urban residents, each couple should have only one child, except for those who, for special reasons, had obtained permission to have a second child. In rural areas, each couple should, in principle, limit themselves similarly to one child, but some couples might be given permission for a second child. No one, other than those in national minorities, was allowed to have a third child. It is not completely clear how these directives are implemented in practice, but propaganda, persuasion and strong pressure from the local authorities have undoubtedly played a major role.

Different types of coercive measures are used in order to decrease the fertility level. The simplest and most widespread is the legal determination of a minimum age at marriage. In China, the marriage law of 1980 determined a minimum age of 22 years for men and 20 years for women. The national population policy of India in 1976 determined a minimum of 21 years for men and 18 years for women. The severity of these measures depends, of course, upon whether pre-marital cohabitation is permitted and whether pre-marital pregnancies are permitted to result in a birth outside of marriage.

Compulsory sterilization is obviously an even more important interference in the private life of couples. In 1976, the national population policy of India permitted state legislatures to enact laws for compulsory sterilization; and during the following national emergency period, several million forced sterilizations were performed (Balasubramanian, 1985). This measure contributed to the defeat of the government party at the general election. The new Government terminated compulsory sterilization and the practice was never resumed.

In China, coercion was used more extensively and for a longer period, although with fluctuations (Aird, 1982; Greenhalgh, 1986; Hardee-Cleaveland and Banister, 1988). In addition to compulsory sterilization of one member of couples having two children and compulsory insertion of (and refusal to remove) IUDs, induced abortions were reportedly performed by using coercive measures.

The types of concrete measures introduced by some Governments that consider the level of fertility to be lower than desirable from the point of view of the society show remarkable similarities to the above-mentioned measures implemented with an anti-natalist view. Examples of these pro-natalist measures are given below (see Andorka, 1978, 1985, 1988; Klinger, 1987; McIntosh, 1983, 1986; Demeny, 1986b):

(a) In some cases, such as Germany governed by the Nazi Party, the supply of contraceptives was restricted, although usually not completely stopped, most of all because "folk" methods of contraception are always available, although less reliable and causing much inconvenience for the population;

(b) Economic incentives in cash or in kind were widely used by many countries, e.g., Czechoslovakia, France, Hungary, Sweden. The contribution of these incentives to the family income and welfare, however, varied widely, according to period and country. The main forms of these incentives are: family allowances; child-care allowance for mothers with very young children; personal tax reductions; cost-free kindergarten and school education. The advantage of these benefits is that they usually contribute to diminish social inequalities and are therefore popular; their disadvantage is their high cost;

(c) It is usually recognized in these pro-natalist countries that a favourable social climate is desirable for the increase of the number of children per family, but moral pressure is avoided in most cases;

(d) The restriction of induced abortions is sometimes used as a pro-natalist measure. It might be considered a coercive measure, although women might avoid becoming pregnant by using contraception and are forced to bear a child only in the case of contraceptive failure. The prohibition of induced abortions, although existing in principle, was often not enforced, so that induced abortions could be performed clandestinely. Strict systems of prohibition were enforced, however, in Nazi Germany and Fascist Italy.

In most pro-natalist policies, these types of measures appear in a mixed form. Therefore, it is not easy to find examples of pure types. The Swedish population policy, the principles of which were first formulated by the Myrdals (1934) and subsequently by A. Myrdal (1940) and G. Myrdal (1945), might be considered the best example of a pro-natalist policy based on economic incentives, not restricting but encouraging access to contraception and not intended to coerce couples to have unwanted children by prohibiting of induced abortions. These principles are given below:

(a) Freedom for the individual to decide the number of children, i.e., there should be voluntary parenthood, which implies no coercion; the permission of induced abortions on therapeutic, eugenic, ethical and also social grounds and at the same time, widespread reliable information for everyone on methods of birth control, in order to avoid induced abortions as far as possible;

(b) Encouragement of couples to have larger families through provision of social benefits to families with children;

(c) Preservation of the quality of life for children; it should not be sacrificed for a larger number of children; social benefits improve the life of children by providing better opportunities for their care and education;

(d) Social benefits for families with children; these benefits serve also to assure more equal conditions for children born into different social strata and for those from smaller or larger families.

The opposite type of pro-natalist policy, based primarily on coercive measures and using relatively unimportant economic incentives, might be exemplified by the policy of Nazi Germany (Glass, 1967). When the National Socialist Party came to power, induced abortions were first very severely prosecuted on the basis of the existing laws- which were valid but which had been much less severely enforced in earlier years. Later, in 1943, a new law threatened with severe penalties, including the death sentence, those "who damage continuously the vital force of the German nation". The promotion and sale of contraceptives were prohibited. Social benefits were given only to large families, first to families with five and more children, later to those having three and more children. The amount of the family allowances was relatively low, e.g., a family with seven children obtained a benefit equivalent only to 12 per cent of the average income.

C. Evaluation of the different types of fertility policies from the point of view of human rights

This paper is not intended to deal in a more detailed way with the question whether there is an overriding correct ethical system. Although noting that some authors doubt the existence of such an ethical system (Berelson and Lieberson, 1979), it is accepted here that the Declaration of Human Rights provides at least the basic principles of a system that can be used to evaluate the different types of fertility policy measures.

It follows from the human right of non-interference by Governments into private and family life and from the right of free decision on the number of children of the couples that no coercive measure, anti-natalist or pro-natalist, of any type can be considered permissible. Thus, compulsory abortion, compulsory sterilization and prohibition of abortion and sterilization are equally unacceptable measures.

The prohibition of induced abortion raises some questions of principle. It is sometimes argued that the protection of human life has to be extended to human foetuses. The theoretical question, which would need more space to be discussed adequately, is when human life and personality begin: at birth; at conception; or at some time during the nine months of pregnancy. It appears that the great majority of people consider that human life does not begin with conception, but either at birth or in some later phase of pregnancy (e.g., stillborn foetuses are not buried with ecclesiastical ceremonies similar to three for newly born infants who die in the first hours or days of their life). The general unacceptability of the prohibition of abortions in the first three months of pregnancy does not exclude the possibility that any human community, such as the Roman Catholic Church, is free to consider that its members should avoid abortions. There seems also to be a general agreement that induced abortions are the least preferable measures of birth control; and consequently population policies should encourage couples to use other methods of birth control. It appears also to be generally accepted that induced abortion should not be permitted after a certain duration of pregnancy, usually three months, for protection of the woman's health.

It follows from the principle of free decision that policies intended to increase the supply of contraceptives and the information on them are completely acceptable, as they increase the possibilities of choice for the couples; or, in other terms, they make it easier for them to achieve their desired number of children. Measures restricting the supply and the accessibility of contraception, on the other hand, tend to limit the possibilities of choice and are therefore infringing upon basic human rights. Obviously, the Government has a duty to prevent the supply of contraceptives that are dangerous to life or health. In the case of each contraceptive, it is a matter of special decision whether the danger is serious enough to prohibit its sale.

Propaganda, persuasion and even social pressure do not appear to infringe upon basic human rights, as long as it is possible for individuals and couples who do not want to comply with the norms of behaviour proposed by the propaganda or required by social pressure to leave the community freely, e.g., by emigration. All human societies have to follow some norms of behaviour accepted by the members of the community. Usually there are also more or less strict norms on the optimal number of children a family should have. In each individual case, i.e., in each community and in each period it ought to be decided whether the prevalent norms are warranted by economic and social conditions and whether the degree of their strictness, or the sanctions in case of their infringement, are justified. Extreme conditions might justify strict norms and strong sanctions, such as moral disapproval by the other members of the society, but more tolerant norms and attitudes are probably beneficial for the ability of the society to adapt to new conditions and challenges.

As compared with the three types of fertility policy measures discussed above, economic incentives and disincentives raise more complicated problems. These problems are considered to be the central topic of this paper. Governments unquestionably have the right to introduce taxes, but that might be interpreted as disincentives; they have not only the right but also the duty to support selected groups of the society by social benefits, but that might be interpreted as incentives. However, it does not seem to be unanimously accepted that Governments might or should use incentives or disincentives to stimulate couples towards the fertility considered optimal from the point of view of the society.

The recent counter-arguments against pro-natalist and anti-natalist incentives and disincentives appear to be based, as described by Demeny (1986a), on the assumption that the "invisible hand" works also in the field of fertility decisions, i.e., if market forces are permitted to govern the decisions of the couples, then the couples, by pursuing their own interests, will produce the number of children optimal for the entire society. This standpoint fits into the neo-liberal view on economic and social processes.

Although the market proved to be the best regulator of many economic and social phenomena, there are obviously some cases when the market does not produce the optimal outcome for the entire society. Therefore, some type of societal mechanism is needed in order to correct the results that would come spontaneously from the market mechanisms. Three such cases or situations might be mentioned, which to a certain extent might be considered three facets of the same situation. All three apply to the problem decisions on fertility.

In the case of externalities, individual decisions under the influence of the market conditions result in a non-optimal outcome. The externalities are either external costs, i.e., costs of the process that occur in units--in this case, families--which are not themselves involved in the decisions concerning the process; or external benefits, i.e., benefits that are enjoyed by units, families who do not contribute to the production of these benefits. In these cases, a societal mechanism is needed to force the units producing the external costs to pay for those costs and to redistribute the external benefits to the units contributing to their production.

In societies where the level of fertility is higher than the societal optimum, i.e., in at least part of the developing countries, the higher than optimal number of the child population causes economic hardships or costs for all the families in the given society; i.e., they are external costs. In societies where the level of fertility is lower than the societal optimum, i.e., in many developed countries, the benefits produced by the children later in adult life--the national income they produce or the social security transfers they pay--are distributed among all members of the society or among all pensioners; i.e., there are external benefits. In the first case, economic disincentives, and in the second case, economic incentives for the families making the fertility decisions, are warranted in order to approach the societal optimum.

Alternatively, children might be conceptualized as public goods in the industrialized societies having a highly developed social security system and a low level of fertility. Goods that are jointly consumed and from the consumption of which it is impossible to exclude "free-loaders" are defined as public goods (McLean, 1987). Thus, in the current welfare States, it is unimaginable to exclude the childless pensioners from the pension system, the financial basis of which is produced by the adult children of the pensioners who were willing to shoulder the costs of child care and education. In similar cases of public goods, societal or governmental intervention to redress the individual balances of costs and benefits is warranted; otherwise, the number of children in the next generation will be smaller than the societal optimum.

The third alternative conceptualization interprets the situation as the tragedy of commons or as a prisoner's dilemma game. Couples in at least some developing countries are in a situation similar to individual farmers who graze their cattle on the common pasture. Although it is necessary to limit the number of cattle grazed on the pasture land in order to avoid its deterioration, each individual farmer is interested in sending as many cattle as possible to the commons and expects that the other farmers will eventually limit the number of their cattle. The result is obviously the deterioration of the pasture, to the detriment of all the farmers.

Couples in developed countries having a below-replacement fertility level face a situation similar to the prisoners. It will be necessary for the common good to co-operate and produce the optimal number of children, but each individual couple is interested in having the fewest possible number of children--eventually no children--in order to avoid the costs of child care and education, and expects that the other couples will be willing to produce the sufficient number of children. If couples simply follow their economic interests or if children do not provide them much more satisfaction, than their economic contribution to the parental family, obviously no children will be born; and some decades later, no adults will be available to pay the social security transfers from which pensions can be financed.

Although these three approaches are outlined in the most rudimentary way and many refinements would be necessary to approach to the real situations, it is hoped that they clarify the justification of incentives and disincentives in fertility policy (Demeny, 1986b, 1987a). A great variety of incentives, such as financial and in-kind support to parents, child-welfare services, parental leave and assistance in acquiring suitable housing (United Nations, 1984, recommendation 34) relink the number of children and economic security in old age through the pension system or otherwise (Demeny, 1987b, 1988; Simon, 1988).

The additional advantage of all these incentives is that they might result in reversal of the trend of the growing disadvantage of children parallel with the increasingly advantageous conditions of the elderly (Preston, 1984), which might in turn lead towards more social equality and justice and improve the life chances of children.

Disincentives, i.e., taxes levied on children, do not infringe upon the right of free decision of couples, but they might have a very negative impact on the opportunities of children of large families, i.e., they might punish the children themselves. Therefore, such disincentives most probably increase the existing social inequalities. Thus, they might be justified only in cases of extreme difficulties caused by a high rate of fertility.

D. Efficiency of different types of fertility policies

Although fertility policies have to be evaluated first of all on the basis of their acceptability from the point of view of human rights, it might be useful to add some remarks on their efficiency.

Coercive policy measures are usually rather inefficient. Compulsory sterilization is obviously completely efficient in individual cases, but it does not appear to be feasible on a large scale and in the few cases where it was practised, it always resulted in very strong resistance from the population and had to be terminated within a short time. Historical experience seems to prove that neither compulsory induced abortion with an anti-natalist aim nor the prohibition of induced abortions with a pro-natalist aim has had a really important and durable impact on cohort fertility. The violent fluctuations of annual fertility rates caused by these measures usually proved later to be simply the consequences of changes in timing of parities (Andorka, 1978).

The development of the supply of contraception was proved to have a moderately strong impact on the reduction of fertility in developing societies (Lapham and Mauldin, 1985; Birdsall and others, 1985).

As there are no absolutely reliable methods to measure the intensity of propaganda, persuasion and social pressure, and to measure their impact, no completely verifiable statement can be formulated on the efficiency of these measures. It appears, however, that they have an impact on fertility only when their content essentially corresponds to the open or latent opinions prevalent in the majority of the population.

The widespread scepticism among demographers concerning the influence of pro-natalist incentives on fertility in developed countries does not appear to completely justified, as several careful studies of cross-sectional and cohort fertility rates seem to prove convincingly that such measures, e.g., family allowances, child-care allowances and tax reductions, had a moderate positive impact on fertility rates in France (Calot and Hecht, 1978; Calot and Chesnais, 1983), in the German Democratic Republic (Chesnais, 1985) and in Hungary (Andorka and Vukovich, 1985; Andorka, 1989).

Thus, considerations of efficiency also argue for a non-coercive fertility policy, based on a wide supply of contraception and on incentives. It might be argued that at least in developed countries with a below-replacement fertility level, both easy access to contraception and social benefits given to the families having children should be elements of a population policy based on considerations of human rights and of efficiency.

E. Social and economic policies having an indirect influence of fertility

It is accepted in the social sciences that essentially all the elements of economic and social development tend to influence the level of fertility. In the period of demographic transition, all these factors influence fertility in a downward direction. The growth of income per capita, the diminishing of income inequalities, the decrease of poverty, the growth of education, land reform, the development of social security systems and the emancipation of women are negatively correlated, both in time-series and in cross-sectional survey data, with the level of fertility. Policies stimulating or implementing these changes therefore not only contribute to the provision of better conditions for the realization of human rights and for the achievement of human potentialities but also help to reduce fertility towards the societal optimum level.

In developed countries that consider their fertility to be lower than the optimal level, opinions are rarely expressed which might imply that policies slowing down some of the above-mentioned processes, e.g., reversing the tendency to liberalize the divorce laws or turning back the emancipation of women, would have a positive impact on the level of fertility and might therefore be necessary. In addition to the impossibility of reversing developmental trends by policy measures, it is also doubtful whether such policies would have any influence on fertility.

Conclusion

The author of this paper firmly believes that, in contradiction to the opinion expressed by Berelson and Lieberson (1979) and some others, it is indeed possible to lay down once and for all standards for population policy and that these standards should follow the Declaration of Human Rights accepted by the United Nations. On the other hand, it is the duty of the State, as a representative of the society, to devise and implement population policies when the individual decisions about fertility do not attain the societal optimum. These policies, however, should not infringe upon the human rights of the members of the society. It is hoped that by such population policies the population processes can approach the societal optimum, or at least that catastrophic population problems can be avoided in the future.

References

Aird, John (1982). Population studies and population policy in China. Population and Development Review (New York), vol. 8, No. 2 (June), pp. 267-297.

Andorka, Rudolf (1978). Determinants of Fertility in Advanced Societies. London: Methuen; and New York: Free Press.

__________ (1985). Political, cultural and institutional factors affecting the utilization of demographic knowledge for the formulation and implementation of pro-natalist policies in developed countries. Paper prepared for the Seminar on Policy Formulation, Implementation and Evaluation, Bombay, 24-28 January 1985, sponsored by the International Union for the Scientific Study of Population.

__________ (1988). Policy responses to low fertility in Europe. Paper prepared for the Symposium on Population Change and European Society Florence: European University Institute.

__________ (1989). Pro-natalist population policies and their impact in Hungary. Manuscript prepared for Politiques de population, études et documentation (Louvain-la-Neuve, Belgium), No. 2, pp. 7-70.

__________, and Gy. Vukovich (1985). The impact of population policy on fertility in Hungary, 1960-1980. International Population Conference, Florence, 1985, vol. 3. Liège: International Union for the Scientific Study of Population, pp. 403-412.

Balasubramanian, K. (1985). Use of demographic knowledge in formulation, implementation and evaluation of population policies and programmes in India. Paper prepared for the Seminar on Policy Formulation, Implementation and Evaluation, Bombay, 24-28 January 1985, sponsored by the International Union for the Scientific Study of Population.

Berelson, Bernard, and J. Lieberson (1979). Government efforts to influence fertility: the ethical issues. Population and Development Review (New York), vol. 5, No. 4 (December), pp. 581-613.

Birdsall, Nancy, and others (1985). The Effects of Family Planning Programmes on Fertility in the Developing World. World Bank Staff Working Paper, No. 677. Washington, D. C.: The World Bank.

Blayo, Ch. (1987). La fécondité en Europe depuis 1960 : convergence ou divergence. In European Population Conference, 1987. Helsinki: Central Statistical Office of Finland, pp. 47-111.

Borisov, V. (1985). Vozproizvodstvo naselenia SSSR: tendencii i perspektivy. (The reproduction of the population of the USSR). In Demograficzeskoe razvitie v SSSR (The demographic development of the USSR). Moscow: Mysl, pp. 34-52.

__________ and G. P. Kiseleva (1984). Reproductive behaviour and methods for its study. In *Proceedings of the First Finnish-Soviet Seminar on Demography*, S. Lalluka, ed. Helsinki: Finnish Demographic Society, pp. 1-23.

Bourgeois-Pichat, J. (1986). The unprecedented shortage of births in Europe. *Population and Development Review* (New York), vol. 12 (Supplement), pp. 3-25.

Cain, Mead (1981). Risk and insurance: perspectives on fertility and agrarian change in India and Bangladesh. *Population and Development Review* (New York), vol. 7, No. 3 (September), pp. 435-474.

__________ (1983). Fertility as an adjustment to risk. *Population and Development Review* (New York), vol. 9, No. 4 (December), pp. 688-702.

Caldwell, John C. (1982). *Theory of Fertility Decline*. London: Academic Press.

Calot, G., and J.-C. Chesnais (1983). L'efficacité des politiques incitatrices en matière de natalité. Paper presented at the "Colloque: évolution démographique et transfers sociaux" of the International Union for the Scientific Study of Population, Liège.

__________, and J. Hecht (1978). The control of fertility trends. In *Population Decline in Europe: Implications of a Declining Stationary Population*. London: Edward Arnold for the Council of Europe, pp. 178-196.

Chasteland, Jean-Claude (1984). Les politiques de population dans le Tiers Monde huit ans après Bucarest: espoirs et réalités. *Politiques de population: études et documentation* (Louvain-la-Neuve, Belgium), NO. 2, pp. 7-70.

Chesnais, J.-C. (1985). Les conditions d'efficacité d'une politique nataliste : examen théorique et exemples historiques. *In International Population Conference, Florence*, vol. 3. Liège: International Union for the Scientific Study of Population, pp. 413-425.

Coale, Ansley J., and Hoover, M. (1958). *Population Growth and Economic Development in Low-income Countries: A Case Study of India's Prospects*. Princeton, New Jersey: Princeton University Press.

Demeny, Paul (1986a). Population and the invisible hand. *Demography* (Alexandria, Virginia), vol. 23, No. 4 (November), pp. 473-487.

__________ (1986b). Pro-natalist policies in low-fertility countries: patterns, performance, and prospects. *Population and Development Review* (New York), vol. 12 (Supplement), pp. 335-358.

_________ (1987a). The economic rationale of family planning programmes. Population Council Center for Policy Studies Working Papers, No. 133. New York: The Population Council.

_________ (1987b). Re-linking fertility behavior and economic security in old age: a pronatalist reform. Population and Development Review (New York), vol. 13, No. 1 (March), pp. 128-132.

_________ (1988). Re-linking fertility behavior and economic security in old age: reply to Simon. Population and Development Review (New York), vol. 14, No. 2 (June), pp. 332-337.

Duza, B. (1985). Policy interventions in fertility: the Bangladesh experience. Paper prepared for the Seminar on Policy Formulation, Implementation and Evaluation, Bombay, 24-28 January 1985. Sponsored by the International Union for the Scientific Study of Population.

Ermisch, J., and H. Joshi (1987). Demographic change, economic growth and social welfare. European Population Conference, 1987. Helsinki: Central Statistical Office of Finland, pp. 329-386.

Frejka, T. (1986). The use of demographic knowledge for policy formulation, implementation and evaluation: the case of Latin America and the Caribbean. Manuscript prepared for the International Union for the Scientific Study of Population.

Gérard, H. (1983a). Politique de population: à la recherche du sens perdu... ou à donner. Politiques de population: études et documents (Louvain-la-Neuve, Belgium), No. 1, pp. 9-27.

_________ (1983b). Types d'intervention d'une politique démographique. Approche théorique. Politiques de population, No. 1, pp. 29-62.

Glass, Daniel V. (1967). Population Policies and Movements in Europe, 2nd ed. London: Cass.

Greenhalgh, Susan (1986). Shifts in China's population policy, 1984-86: views from the central, provincial, and local levels. Population and Development Review (New York), vol. 12, No. 3 (September), pp. 491-515.

Hardee-Cleaveland, Karen, and Judith Banister (1988). Fertility policy and implementation in China, 1986-88. Population and Development Review (New York), vol. 14, No. 2 (June), pp. 245-286.

Höhn, Ch. (1987). Soziale Konsequenzen eines Bevölkerungerückgangs (Social consequences of a population decline). Zeitschrift für Bevölkerungswissenschaft (Wiesbaden), vol. 13, No. 3, pp. 289-302.

Johnson, D. Gale, and Ronald D. Lee, eds. (1987). Population Growth and Economic Development: Issues and Evidence. Madison: University of Wisconsin Press.

Klinger, András (1987). Policy response and effects. In European Population Conference, 1987. Helsinki: Central Statistical Office of Finland, pp. 387-434.

Lapham, Robert J., and W. Parker Mauldin (1984). Family planning program effort and birthrate decline in developing countries. International Family Planning Perspectives (New York), vol. 10, No. 4 (December), pp. 109-118.

__________ (1985). Contraceptive prevalence: the influence of organized family planning programs. Studies in Family Planning (New York), vol. 16, No. 3 (May/June), pp. 117-137.

McIntosh, C. Alison (1983). Population Policy in Western Europe: Responses to Low Fertility in France, Sweden, and West Germany. Armonk, New York; and London: M. E. Sharpe.

__________ (1986). Recent pronatalist policies in Western Europe. Population and Development Review (New York), vol. 12 (Supplement), pp. 318-334.

McLean, Iain (1987). Public choice. An Introduction. Oxford and New York: Basil Blackwell.

McNicoll, G. (1986). Economic growth with below-replacement fertility. Population and Development Review (New York), vol. 12 (Supplement), pp. 217-238.

Myrdal, A. (1945). Nation and Family: the Swedish Experiment in Democratic Family and Population Policy. London: Kegan Paul.

__________ and G. Myrdal (1934). Kris i befolkingsfragan (Crisis in the population question). Stockholm: Albert Bonniers Förlag.

Myrdal, G. (1940). Population: A Problem for Democracy. Cambridge, Massachusetts: Harvard University Press.

Nickell, S. (1988). Unemployment and population growth. Paper prepared for the Symposium on Population Change and European Society. Florence: European University Institute.

Pestieau, P. (1988). Population, productivity and technology. Paper prepared for the Symposium on Population Change and European Society. Florence: European University Institute.

Preston, Samuel H. (1984). Children and the elderly: divergent paths for America's dependents. Demography (Alexandria, Virginia), vol. 21, No. 4 (November), pp. 435-457.

__________ (1986). The decline of fertility in non-European industrialized countries. Population and Development Review (New York), vol. 12 (Supplement), pp. 26-47.

Saw, S.-H. (1986). A decade of fertility below replacement level in Singapore. Journal of Biosocial Science (Cambridge, England), vol. 18, No. 4 (October), pp. 395-401.

Schmid, Josef (1987a). Wo Kinder fehlen, stirbt später der Wohlstand. Raum ohne Volk (Where children are missing, well-being will later die. Room without children). Sonderdruck aus Rheinischer Merkur, Christ und Welt, pp. 5-8.

_________ (1987b). Im reichen Land ticken Zeitbomben (In the rich country time bombs are ticking). Sonderdruck aus Rheinischer Merkur, Christ und Welt, pp. 8-11.

Simon, Julian L. (1988). Re-linking fertility behavior and economic security in old age: an exchange; comment. Population and Development Review (New York), vol. 14, No. 2 (June), pp. 327-331.

Sirageldin, I. (1986). The use of demographic knowledge for policy formulation, implementation and evaluation: the case of Asia. Manuscript prepared for the International Union for the Scientific Study of Population.

United Nations (1984). Report of the International Conference on Population, Mexico City, 6-14 August 1984. Sales No. E.84.XIII.8 and corrigenda.

Veil, Simone (1978). Human rights, ideologies, and population policies. Population and Development Review (New York), vol. 4 (June), No. 2, pp. 313-321.

Westoff, Charles F. (1988). Is the Kap-gap real? Population and Development Review (New York), vol. 14, No. 2 (June), pp. 225-232.

IX. NEW BIOLOGIES, POPULATION POLICY AND HUMAN RIGHTS

Guy Braibant*

Scientific and technological progress, while basically beneficial to human beings, also has adverse effects and dangerous repercussions. These advances can lead to encroachments on fundamental rights. This is obviously true for nuclear energy, which considerably augments the productive strengths of modern societies and at the same time carries the risk of causing massive destruction, exterminating entire populations and even wiping out the human race. It is the case for the means of production and transport in such fields as chemical industry or petroleum, which have already brought about the deaths of thousands of persons and have polluted vast expanses of land, air and water. It applies also to informatics, which facilitates human work while threatening, with its files, to develop excessive corporate control over individuals. It is the case with the considerable, rapid progress that has characterized medicine and biology over the past 25 years.

This development of life technologies has had positive effects in the area of prevention and treatment of disease, infirmities, epidemics and physical and mental handicaps. But it can lead, if one is not on one's guard, to abuses, to relations of inequality, to commercialization of the human body, to destruction of life and, in the last analysis, to a downright manipulation of humanity. What are these advances, the risks that they involve and the measures to be taken to protect human rights in this domain?

A. Progress

Some medical advances, however important they may be, do not have direct, specific effects on the evolution of the population, but affect it only through the general improvement of public health. This is true, for example, of organ transplants, which make it possible to save human lives; or of methods of experimentation, which improve different types of therapy; or even of demographic records, which contribute to better knowledge and consequently better treatment of disease. Others, however, have an obvious and immediate impact on reproduction and consequently on demography. These advances are, essentially, medically assisted reproduction, pre-natal diagnosis and embryonic studies.

---

*Chairman, Reporting and Study Section of the Council of State, Paris.

1. Medically assisted reproduction

For the first time in human history, procreation can be effected by artificial, unnatural methods, which introduce third parties into the intimate life of the couple: on the one hand, the doctor and the biologist; on the other, in certain cases, donors of genetic strength.

Thus, sterility is no longer an obstacle to procreation. A barren couple desirous of having a child can obtain one through these procedures, which are common practice today, at least in the developed countries.

The methods are varied and have different applications: (a) it may be simply a matter of promoting natural fecundation that runs up against a mechanical obstacle; (b) the sperm of an outside donor can be used; (c) procreation may be entirely "medicalized" (in the test-tube in the case of in vitro fertilization), and the embryo can then be used by the couple that supplied the gametes or given to another couple; or (d) a woman can lend her uterus in order to bear the child of another, in what is called "surrogate motherhood". Thus, one sees legal kinship becoming dissociated from biological kinship. In some cases, the genetic mother, the gestating mother and the legal mother are three different persons; a mother can bear the child of her daughter. Furthermore, thanks to the freezing of embryos, birth can be postponed and two children conceived at the same time will be born several years apart. One can see immediately the possible effects of these techniques on relationship structures and on demographic developments.

2. Pre-natal diagnosis

Although artificial reproduction may lead to a population increase by enabling sterile couples to have children, pre-natal diagnosis is likely to have the opposite effect. It permits one to determine, during pregnancy, congenital and hereditary abnormalities from which the child may suffer after birth.

The procedures used, which are quite diverse, boil down to two main categories: specimens taken from the foetus or its environment; and visualization procedures, in particular, ultrasonography. Some of these techniques are now commonplace, but others are cumbersome or traumatic and involve dangers to the foetus and sometimes the mother. Like medically assisted reproduction, they must be performed by highly qualified teams with the necessary equipment for proper execution of the operations and proper analysis of the results.

3. Embryonic studies

Artificial reproduction methods lead to the production of surplus embryos in the case of in vitro fertilization. Indeed, the number of samples taken must be sizeable, owing to the frequent failure of implantation. With a view to increasing the chances of success of the operation, use is made of stimulation methods whereby it is possible in a single operation to collect several oocytes and thus produce several embryos. Once transplantation has taken, the remaining embryos represent a surplus; they can be frozen and preserved for several years. What will be done with them?

Naturally, these excess embryos can be used for a new parental project, either of the same couple or another couple, or they can be destroyed. They can also be given to scientific research. Technically, nothing stands in the way of embryos being manufactured exclusively with a view to research. This is certainly useful, providing better knowledge of reproduction mechanisms and contributing to the prevention of abnormalities. But this scientific work can also lead to genetic manipulations; the fabrication of chimeras or, in other words, monsters resulting from the mixing of the human species with an animal species; cloning, i.e., the mass production of human beings; or complete gestation *in vitro*, eliminating every natural element from reproduction. This is not science fiction, but developments that are within reach and might be realized in the coming decades.

B. Risks

The new techniques have unquestionable advantages, but they entail serious risks for human rights and for the future of humanity, particularly as relates to the collapse of kinship structures, the possibility of eugenics and the eventuality of encroachments on the integrity of the human species.

1. Kinship structures

Medically assisted reproduction makes it possible to separate completely the coming into being of a child and the existence of a family. A child may at the same time have several fathers and several mothers and may be programmed for that purpose. If it is simply a question of remedying genuine sterility, one can only rejoice at the possibility thus given to parents to have children despite the obstacles of nature. Yet, these techniques should not be the instrument of a demographic and family policy. It would be grave if, by financial means and for simple reasons of comfort, a rich couple had a child borne by a poor mother, or if a child were fabricated under such conditions that it was destined from the outset not to have a father.

Medically assisted reproduction must remain a remedy for a couple's sterility and not become a more convenient way of having children.

The question has been raised whether it might also be used in the case of "sterility" that is not medical, but social and psychological, as in the case of unmarried mothers or couples of homosexual women; in the majority of countries where the problem has been brought up, the answer has been negative. The "right to have a child" must give way to the "right of the child" to have a normal family.

2. Eugenic practices

Eugenic practices pose an even more serious risk, with a threefold origin.

In the first place, pre-natal diagnosis, if it is not controlled, may result in voluntary interruptions of pregnancy based solely on the fear of defects or handicaps, even minor or hypothetical ones. Furthermore, in societies that manifest a preference for the birth of boys, the possibility of determining the sex of the foetus brings with it the risk of systematic elimination of girls, which would obviously result in a severe demographic imbalance and would ultimately do away with the very possibility of reproduction of the human race.

In the second place, the constitution of embryo banks to which potential parents would come to choose their offspring would give rise to more or less conscious eugenic practices based on preferences of sex, race, conformation or social origin.

Lastly, if no precaution is taken, studies of embryos will lead to the systematic elimination of differences, that is, of characteristics that are wrongly or rightly viewed as anomalies. In certain countries, the temptation to try to improve the stock through artificial means would be great.

3. Integrity of the human species

As concerns the integrity of the human species, it is again embryo studies that harbour the greatest dangers. It is not a great jump from passive eugenics, consisting in selecting the best, to active eugenics or the creation of new beings hybrid, monstrous, dwarf or giant, subhuman or superhuman. To be sure, one might ask on the basis of what principles such developments must be considered alarming. The human race has already evolved and will continue to do so due to the influence of food, health or social factors. Some diseases have disappeared or can be controlled, the duration of life has lengthened, the average height has grown and the cultural level has risen. Yet all these changes, which are improvements, do not bring into question the very essence of the human person. The possibility of damaging it through voluntary action, on either the individual or collective level, would be as dire as the power to destroy the human race itself by triggering a nuclear disaster.

C. Protection of human rights

The authors of the Declaration of the Rights of Man and the Citizen of the French Revolution, of which the bicentennial is being celebrated this year, and even those of the Universal Declaration of Human Rights, which had its fortieth anniversary last year, could not foresee and take into account these scientific and technical developments and the risks inherent in them. It is therefore necessary to embark on new reflections, without delay, for science today moves faster than law.

This reflection is already under way in national and international institutions; drafts of laws and conventions have been prepared and in some cases adopted.

In the initial phase, the reactions were in the area of social morals, ethics. Ethics committees were set up in hospitals or research centres for the purpose of containing the work and experiments within reasonable bounds. In some cases, they have been institutionalized, as in France, where a decree of 1983 created the Comité consultatif national d'éthique pour les sciences de la vie et de la santé (National Consultative Committee on Ethics for the Life and Health Sciences). This committee, which has a pluralistic composition from the points of view both of opinions and of expertise, has issued important public statements over a span of several years, following in-depth studies of these different topics. Codes of good professional conduct have also been established by the representatives of the practitioners or the authorities. Recommendations have been made within the framework of international organizations, such as the Council of Europe.

It seems today that this effort is not enough and that one must move, as the title of a study done by the French Council of State at the request of the Government has it, "from ethics to law". For indeed, it is no longer possible to let dangerous practices develop without any check or control or to give free rein to the laws of scientific progress and those of the market. The political and financial stakes are enormous: in certain countries, or between certain countries, trafficking in organs or embryo banks has already appeared; surrogate motherhood has resulted in dramatic conflicts between the mother who bore the child and became attached to it and the couple who placed the order and was eager to accept delivery. Even research can no longer be left to the free appraisal of scientists and to their conscience alone. In order to put an end to bad practices and prevent them from developing further, it is important to establish principles and state rules and set up guarantees.

1. Principles

To answer these new questions, the best solution is no doubt to refer to fundamental, traditional principles.

The distinction between persons and objects or commodities must be maintained uncompromisingly. On the one hand, persons should retain their body's organs and its vital products from before birth until after death. It is not only the global, living being but all the elements, as well as the embryo and the corpse, that make up the person. On the other hand, there are commodities that belong to everyone, such as the air one breathes, and those which belong to the community or to individuals. Persons, within this broad definition, must not be the object of ownership or of commerce: they must not be brought, sold or leased; they are neither assets nor pieces of merchandise.

A person is made up indivisibly of the body and the spirit. The body cannot be detached from the person either physically or juridically. Respect for the human person thus implies respect for the body and all its components. It results from this that the human body cannot be violated or disposed of; no one can harm the body of another without legitimate grounds and, whenever possible, without first obtaining the consent of the person concerned or those qualified to represent that person, except in cases of medical emergency or legal obligation.

Other principles must also serve as references for the construction of this new area of law: proportionality between acts, the benefit that one expects from them and the risks that they involve; transparency of scientific progress and medical actions; respect for privacy; freedom of research.

2. Rules

In this way a set of laws on the human body will be created. It might rest on three fundamental rules: consent; gratuitousness; therapeutic or scientific aim of treatments carried out in a person.

The requirement of consent is very general in character. It applies to all forms of medically assisted reproduction, pre-natal diagnosis and the fate of embryos, as well as to the transmission of data to epidemiological records and to experiments carried out in humans. Such consent must be free and enlightened. The person who gives it must be fully informed of the actual and possible consequences of the decision and must not be in a situation of dependency, such as detention. Those who are not in a position to give it themselves, such as children, must be represented by persons qualified by law. In some cases, the intervention of a judicial authority may be recommended for reasons of impartiality and independence with respect to the various interests involved. Today, this condition of consent is universally acknowledged. The same is not true of the other two rules.

The second condition is related to the non-commercial, non-marketable, non-asset character of the human body, i.e., gratuitousness, not, of course, as relates to medical acts, surgery, pharmaceuticals or analyses, but to the organs and vital products of the human body. Gametes, embryos or organs may be donated but not sold; experiments done or information collected must not entail any remuneration, for otherwise they are likely to vitiate consent, facilitate trafficking and develop the exploitation of the poor; no one may derive profit from the elements of his or her own body, nor, with all the more reason, the body of another. The notions of consent and gratuitousness are thus closely tied together and are both connected with the principles of liberty and equality. It is true, however, that in certain countries a commercial conception of these questions currently prevails, in the name of efficiency and freedom.

Thirdly, the uses of the human body and its components and inroads into its integrity must be justified by a therapeutic or scientific purpose. They should be possible only for treating the person concerned or a third person or for bringing about progress in the knowledge of the human persons and human diseases, and thus the biological and medical sciences. Here again, however, divergences arise: some contend that the organs and vital products of the human body may be used for industrial and commercial purposes, within a market system based on profit; and they apply these practices even in the area of reproduction and genetics.

These general rules, if adopted, would have to be completed with specific rules in certain sectors. Thus, in the area of assisted reproduction, surrogate motherhood should be banned, owing to the abuses and the dramas to which it has given rise in those places where it is practised. It would seem preferable for donations of gametes and oocytes to be anonymous and confidential and for the technique of medically assisted reproduction to be reserved for stable couples, whether married or not, who are barren. Here, again, the opinions are not unanimous. Some assert that artificial reproduction should not exclude the search for paternity and everyone's right to know his origins, for both medical and psychological reasons. Others, or the same persons, accept that it should be extended to single mothers and even to homosexual couples.

The rules pertaining to embryonic studies are without doubt the most difficult to establish and to apply. Three solutions are possible. At one extreme is authorization pure and simple, without any restrictions. At the other is absolute, final prohibition. In the middle is a more reasonable position that reconciles the benefits of the study with the protection of the human species: total prohibition of certain particularly dangerous studies that might lead, in particular, to genetic manipulation, cloning or the fabrication of chimeras; permission for other studies, under the supervision of the authorities competent in matters of ethics and science.

3. Guarantees

Compliance with these rules must be guaranteed by a system of supervision and sanctions.

Activities subject to requirements of a moral and scientific nature, such as assisted reproduction or pre-natal diagnosis, must be carried on only in qualified centres, subject to the approval and supervision of the public powers. Authorities of a new type, such as ethics committees, made up of personalities representing the scientific and medical disciplines and philosophical and religious sensibilities, would have the mission of supervising the application of the rules in particularly delicate areas, such as experimentation in man and embryonic studies. Lastly, violations of the new rules must be punishable by sufficiently severe penal sanctions.

To be truly effective, the principles, rules and controls should rapidly take on an international character. Otherwise, the most dangerous activities will be carried on in the countries that are the most lax, and international trafficking will develop. It is for this reason that the actions of regional organizations, such as the Council of Europe, and of international organizations, such as the United Nations, are of such great importance in this area.

Defining international standards is at the same time indispensable and difficult. It is indispensable if one is to avoid distortions from one country or one region to another. One must avoid a situation where, for example, certain studies are permitted here, prohibited there and encouraged elsewhere. One must avoid having the same products of the human body free of charge on one side of the border and paid for on the other side; one must not encourage "medical tourism", which enables some, generally the more affluent, to go to other countries to get what they cannot find at home. This search for international standards, however, is made difficult by differences in culture, civilization, religion and level of development; the concepts of humanism and social efficiency are not the same everywhere, any more than are scientific and medical traditions.

The new biotechnologies must not, in any circumstances, serve demographic policies, under penalty of infringing upon human rights. Artificial reproduction and pre-natal diagnosis must be used only for resolving individual cases of a medical character and not for increasing or decreasing the birth rate. Embryo studies must not lead to eugenic practices. These new technologies must have only scientific or technological purposes, to the exclusion of objectives of a political or demographic nature.

Thinking must continue in these fields, especially within the United Nations. Even now it can be said, however, that beyond these divergences, which still exist, there is agreement concerning the idea that it is time to subject these practices to texts — in a word, to legislate.

References

American Fertility Society, Ethics Committee (1986). Ethical considerations of the new reproductive technologies. Fertility and Sterility (Birmingham, Alabama), vol. 46, No. 3 (September).

Australia, Committee to Consider the Social, Ethical and Legal Issues Arising from in vitro Fertilization (1984). Report on the Disposition of Embryos Produced by in vitro Fertilization. Melbourne, Victoria.

Baudoin, J. L., and C. Labrusse-Riou (1987). Produire l'homme: de quel droit? Les voies du droit. Paris: Presses universitaires de Paris.

Canada, Law Reform Canada Commission (1985). Report on Human Artificial Reproduction and Related Matters. Toronto, Ontario.

Conseil de l'Europe (1988). Projet de recommendation relative à la procréation artificielle humaine.

__________ (1989). Recommandation sur l'utilisation d'embryons et foetus humains à des fins diagnostiques, thérapeutiques, industrielles et commerciales. Recommandation 1046 of 1986. In Recommandations adoptées par le Comité des ministres et par l'Assemblée parlementaire. Strasbourg: Direction des affaires juridiques, p. 30.

Dufresne, J. (1986). La reproduction humaine industrialisée. Montreal, Canada.

France (from 1984). Rapport annuel du Comité consultatif national d'éthique pour les sciences de la vie et de la santé. Paris.

__________, Conseil d'Etat. De l'éthique au droit. Paris.

Génétique, procréation et droit (1985). Actes du colloque organisé à l'instigation du Président de la République et du Gouvernement. Paris: Nyssen.

Institut suisse de droit comparé (1986). Procréation artificielle, génétique et droit. Colloque, Lausanne, 1985. Zurich: Schultess.

Roy, D., and M. de Wachter (1986). The Life Technologies and Public Policy. Montreal: The Institute for Research on Public Policy.

United Kingdom Department of Health (1984). Embryology and Human Fecundation. Report of the Committee of Inquiry into Human Fertilisation and Embryology. London: Her Majesty's Stationery Office.

United States Department of Health, Education and Welfare, Ethics Advisory Board on Protection of Human Subjects (1971). Support of Research Involving Human in vitro Fertilization and Embryo Transfer. Washington, D.C.: Government Printing Office.

X. HEALTH CARE AND HUMAN RIGHTS, INCLUDING THE SPECIAL ISSUE OF AIDS

M. A. El-Badry*

A. The setting

The approach to the concept of "rights" adopted in this paper is pragmatic. It is based on the premise that society should do all it can to prevent premature death, to alleviate or control the suffering of the sick and the disabled and, above all, to enable the population to enjoy a healthy and productive life. Generally speaking, human rights have a wider foundation than that provided by legislation. Some of the rights discussed here are guaranteed by the constitution and legislation in some countries. Some others are set forth in covenants and other international instruments of the United Nations and its specialized agencies. 1/ An important role in supporting these rights, however, is played by the moral values, ethics and sense of justice and equity within the society and among the countries of the world community. The sections of this paper discuss rights in the field of health, with emphasis on what is being done and what should be done about them. It should be noted, nevertheless, that the text does not cover many philosophical aspects, an adequate discussion of which would be beyond the scope of this paper.

Unfortunately, human rights are often perceived as political and civil rights, although social rights are equally important. There is a basic difference between the two, namely, that the fulfilment of social rights is usually limited by the extent to which society can provide the needed services: financially; technically; or otherwise. Budget limitations in all societies, developed and developing, are bound to impose constraints; and some health programmes cannot be put into effect in rural areas even if funds are available, simply because the needed professionals are not available to carry them out. Such constraints render it essential for decisions to be based on priorities. In the health sector, priorities are decided upon taking into consideration such important factors as local health conditions and needs, cost efficiency, ability of the public to finance certain services and the essential need to guarantee certain health services to all members of the society, regardless of their ability to pay, their geographical location or any other demographic characteristics.

---

*Former Assistant Director for Research, Population Division, Department of International Economic and Social Affairs, United Nations Secretariat; and former Director, Cairo Demographic Centre, Egypt.

Equity is thus a fundamental criterion of human rights in the social fields. It is missed when different sectors compete over limited resources. It is also missed, despite the proliferation of legislation and declarations, because of political pressure exerted by some population groups promoting their own interests. Consequently, rights that should be universal are often observed in proportion to the awareness among different classes of their rights, and in proportion to their ability effectively to demand these rights for themselves, as, for instance, in the case of public sanitation or medical facilities. This all too familiar situation culminates in differential allocation of public funds and in uneven observance of human rights among the different strata of the society, with those who should be the focus of a human rights approach in decision-making, namely, the poor and people living away from the centre of power, getting far less than their share of attention.

Human rights in all social sectors are so closely linked that reaching a satisfactory level of fulfilment in one field is often dependent upon achieving a corresponding level of success in another. In the field of health, for instance, the rights to education, food and housing are highly significant in a plan of action that includes provision of pure water and medical care. The importance of co-ordinated efforts in the social and economic sectors is very clear: unless the benefits of development reach the poor, it would be very difficult for them to attain a health level that is their human right.

The following discussion is presented in two parts. The first deals with the basic human rights in the field of health, namely, the rights to life, nutrition and health care. Although these rights apply universally, the focus is mainly on the developing countries, whose populations are lagging in the enjoyment of these rights. The second part deals with considerations of social justice in health care, with emphasis on justice to special groups which are unable to obtain an equitable share commensurate with their particular health problems, including the chronically ill, the disabled and the aged. Naturally, such considerations are of universal applicability, but the discussion has more relevance to developed countries where some services to these groups are already provided and issues of adequacy and justice are widely debated. The last section is devoted to patients with acquired immunodeficiency syndrome and those with human immunodeficiency virus infections, whose human rights have been widely violated due to ignorance about the disease, fear of catching it or sheer bias against some of the groups, such as homosexuals and drug addicts, whose behaviour exposes them to the deadly disease. 2/

B. Basic human rights concerning health

1. Right to life

The most basic human right to life is conceived in two senses: the right to preserve life against violent action; and the right to live as long as possible. The first of these two aspects entails rights against politically motivated arbitrary execution and the right of the mentally ill and those with other serious chronic illness not to be killed because of the incurable nature of their illness. Also included is genocide, or the systematic destruction of a population group for ethnic, racial or religious reasons, whether committed directly or indirectly through starvation, servitude or deliberate neglect under serious health conditions. Another flagrant violation is infanticide, whether motivated by poverty or sex bias or for any other reason.

The right to live as long as possible embodies other rights, notably the rights to adequate nutrition, good health and decent shelter. Since the length of life is highly dependent upon the environment, particularly the social and economic conditions in the society, it would only be realistic to envisage this right in terms of: (a) what can feasibly be done to lower morbidity and mortality as much as possible; and (b) equity or at least narrowness of the differentials between different classes.

Although it would not be realistic to claim for the present or the near future that developing countries should have among their populations the life expectancy prevalent in developed countries, it is indeed realistic and a human right that countries in the third world should work towards that end and narrow the gap, as many are currently doing. However, if one takes as standard in this regard the life expectancy at birth of 50 years set forth by the World Population Plan of Action (para. 23) as a minimum to be achieved by high-mortality countries by the year 1985, one finds that virtually all of sub-Saharan Africa, except for Southern Africa, and 10 countries in Southern and Western Asia fell short of that goal (United Nations, 1986, pp. 40-41).

Child mortality

As is well known, highly premature child mortality (below five years of age) is a main contributor to the low average length of life still prevalent in developing countries. It is thus estimated that of the 75 million child deaths that took place between 1980 and 1985, as many as 98 per cent were among children in developing countries. Because a large proportion of these deaths are preventable, child mortality in those countries, particularly in Africa and South Asia, is a matter of serious humanitarian concern. It is true that the level of mortality at those young ages has declined by more than half in the past 30 years, even in developing countries, but the relative gap between the two groups of countries is unfortunately widening: child mortality was four times as high in the developing countries as in the developed countries in 1950-1955; it became seven times as high in 1980-1985. 3/

Disparities are also increasing among the developing countries. In Africa, child mortality during the period 1950-1955 was only 15 per cent higher than that in all developing countries taken together. However, due to a much slower mortality decline in Africa in subsequent years, the relative gap became 36 per cent in 1980-1985. The seriousness of the difference with what it entails in terms of wasted lives and human suffering is reflected in the observation that in the period 1980-1985, the excess child mortality in relation to all developing countries taken together was about 50 per cent in Eastern, Middle and Western Africa, and in Southern Asia, this relative gap was also nearly one third (United Nations, 1988a, p. 12, table 1).

The situation is similar, though more dramatic, in the case of infant mortality: the level is still more than five times as high in the developing countries as in the developed countries, despite substantial declines in the former group. United Nations estimates show that, except for Southern Africa, all other African subregions, including Northern Africa, are far behind other regions of the world. 4/ Estimates for countries show much wider discrepancies in both infant and child mortality levels. By 1980-1985, the level of infant mortality in 33 countries, of which 23 are in Africa, was still higher than the 120 recommended by the World Population Plan of Action as a maximum to be achieved by 1985. There were also 12 countries, nine in Africa and three in Asia, whose infant mortality levels were 150 or more (United Nations, 1988a, pp. 36-41, table A.2).

As the recent experience of many countries shows, the levels of infant and child mortality can be reduced considerably and rapidly by campaigns against diarrhoeal disease and respiratory infections and by immunization. International and bilateral assistance in this field can substantially relieve humanity of one of its serious illnesses, as it already has in some countries. "Nevertheless, a surprisingly substantial proportion of the world's population is without knowledge of, or access to, these control measures" (Walsh, 1988, p. 2).

Female mortality

Another clear incidence of neglect of human rights exists in societies with prevalent preferential treatment of males and relative neglect of the nutrition and health of females. As is well known, females generally enjoy lower mortality than males and consequently have a higher life expectancy, which in developed countries exceeds that of the males by six years or more. It is presumed that this difference is in part biological. In some developing societies with high mortality, however, female children and women of reproductive age experience higher mortality than males in the same ages. This situation has drawn the attention of demographers during the past two decades (see, for instance, El-Badry, 1969). A recent study based on 78 relatively reliable life tables of developing countries for the period 1945-1981 found that females are most disadvantaged in relation to males in Southern and Western South Asia, and, to a much smaller extent, in Northern Africa. It also concluded that the difference was mainly or partialy due to a higher than expected level of female mortality in those countries (United Nations, 1988c).

Higher female than male mortality, where it exists, is attributed to the health consequences of socio-cultural behaviour which discriminates against females, particularly at childhood ages; in some areas, however, such as rural South Asia, this behavioural bias continues throughout the child-bearing years and the rest of the woman's life. Several studies have pointed at less frequent medical attention to female children and longer delay in seeking this attention, and at care sought from less competent practitioners when a female child is seriously ill. Studies have also attributed the presence of excessive malnutrition among female children to the existence of marked differences in the allocation of food between male and female children. There is also evidence that nutritional discrimination may pursue a woman into older ages (see, for example, El-Badry, 1969; D'Souza and Chen, 1980; Chen, Huq and D'Souza, 1981; Bhatia, 1983). Indeed, the ill effects of female undernutrition are not confined to mortality. They include inhibited growth, continuous vulnerability to sickness and lack of adequate strength to function and work normally.

A main issue in this regard is the higher level of maternal mortality, or mortality due to complications of pregnancy and delivery among women of reproductive ages, in developing countries. Disparity in mortality due to this cause is so high that while maternal mortality rates are mostly less than 10 deaths per 100,000 births in developed countries, 5/ these can be as high as 1,000 or more in some developing countries. With the higher levels of pregnancy and birth existing in developing countries, women of reproductive ages in those countries are thus highly exposed to the risk of dying during pregnancy and delivery. Thereafter, their dependent children undergo all the suffering caused by maternal orphanhood.

Maternal deaths have their roots in poverty and malnutrition. Major direct causes are lack of competent health services during pregnancy, primitively induced abortion, poorly trained birth attendants and lack of rapid transport and access to health facilities in cases of delivery complications. Responsibility for all these environmental factors lies mainly with the community. Moreover, it goes without saying that family planning practice, which is substantially the responsibility of the woman together with her husband, can help the woman to avoid the risks caused by pregnancy in the young and old ages of the reproductive period, the ill effects of short birth intervals on the woman's health and the danger of poorly performed abortions.

2. Right to food security

Although access to adequate nutrition is a basic human right, one third of the population in the developing countries, excluding China, cannot obtain enough food to lead active productive lives and avoid serious health risks, low birth weight among infants and stunted growth among children. About two thirds of these unfortunate human beings live in South Asia and one fifth in sub-Saharan Africa. Most of them, four out of every five, live in poor countries with income per capita below $400 in 1983. 6/ The implications of this serious situation go even beyond failure to satisfy the human right of those persons to adequate nutrition: they obviously imply vulnerability to morbidity and mortality, inability to learn from schooling and training, massive waste of manpower and reluctance to meet the challenges of development, and disruption of the political fabric of the society. This situation is all the more unfortunate when one realizes that in most cases the food deficit required to meet the standard consumption per capita is far less than 10 per cent of the national food supply and may well be below 5 per cent (World Bank, 1986, p. 20, table 2-5).

A highly pertinent question arises then as to why this degree of undernourishment exists when the world has a more than adequate food supply and the growth of global food production has generally been faster than the unprecedented world population growth. From 1974 to 1983, world food production, weighted by national prices, increased annually by 2.2 per cent, or by 0.5 per cent more than the rate of population growth. Developing countries expanded their food output during this period at a rate nearly three times that of the developed countries; but because of their much higher rate of population growth, the growth rate per capita was only a little more than double that of the developed countries. It has also been observed that in 90 developing countries, food energy supplies per capita increased during the 1970s, from 2,140 to 2,350 calories per day (Food and Agriculture Organization of the United Nations, 1984, p. 26, table 1.11; United Nations, 1988e, p. 286). Moreover, between 1980 and 1984, the same supplies per capita increased in countries accounting for 73 per cent of the total population of 102 developing countries (FAO, 1987). Why, then, do these hundreds of millions suffer from undernourishment?

The truth is that global averages misrepresent the actual situation in many countries, and food insecurity does not necessarily result from inadequate food supplies, as is widely believed, but from a lack of purchasing power among countries and households that cannot produce their own. Economic growth and a more equitable distribution of income are obviously primary policy goals in this regard.

There are some low-income countries, particularly in Africa, that do have national food supply problems. A World Bank study estimates that in order for the national food supply to provide by 1990 the FAO/WHO requirement for adequate individual diet, a country like Ethiopia would have to spend on cereal imports in that year about 86 per cent of its exports earnings; and in the United Republic of Tanzania, the corresponding percentage expenditure would be 49. Not only is it clear that such imports of cereal cannot be afforded, it is obvious that countries in similar situations would need large amounts of food aid. In the case of Ethiopia, the needed aid amounts to almost 3 million tons in 1990 if its cereal imports are held to 10 per cent of its export earnings (World Bank, 1986, pp. 20-21, table 2-6 and figure 2-3).

For most developing countries, however, the cost of providing an adequate food supply is not a main obstacle to achieving food security. At the national level, the food gap, if it exists, is small in relation to total supply and can easily be filled by expanding domestic production and/or imports of food. Here again, the national averages are presenting a defective picture: even when the food supply is sufficient, a deficiency still exists because the poor do not have the necessary purchasing power. Hence, apart from temporary food shortages caused by serious increase in prices, droughts, floods etc., food insecurity is essentially a problem of poverty: the inability to acquire the needed food even when it is available.

Infants and children are the most seriously affected by malnutrition. It is estimated that 12 per cent of children under age 5 in developing countries are suffering from acute malnutrition and that one tenth of those malnourished children are suffering from the severe form that is normally fatal if not treated. It is also estimated that almost 40 per cent of children under age 5 in those countries are living in a chronic state of insufficient nutrition and associated illness that is hampering their growth. 7/ Low food intake by pregnant women is among the main causes of foetal growth retardation culminating in low birth weight--a most important determinant of the chances of the new-born for survival and healthy growth. An estimated 17 per cent of infants born in 1985 in developing countries (25 per cent in South Asia) had low birth weight, compared with 7 per cent in the industrialized countries (World Health Organization, 1987, pp. 88-90).

Malnutrition can also lead to serious diseases. Nutritional anaemia is a devastating specific nutritional deficiency that has a profound effect on physical and psychological behaviour and contributes significantly to morbidity and mortality. A recent review estimates the prevalance of this disease to be about 36 per cent in the developing countries and 8 per cent in the developed countries. Pregnant women and pre-school children are the most affected groups, with estimated global prevalence of 51 and 43 per cent respectively. It is also estimated that in the developing countries nearly two thirds of the pregnant and half the non-pregnant women are suffering from nutritional anaemia. Another serious nutritional deficiency, namely, that of vitamin A, causes nutritional blindness among more than half a million children every year, two thirds of whom die within weeks of becoming blind. Vitamin A deficiency is in fact the single most frequent cause of blindness among young children in developing countries (WHO, 1987, pp. 91-92).

Clearly, no attempt can be made here to cover the ills of undernutrition. The purpose of the preceding two paragraphs is to illustrate aspects of the suffering of those who do not have sufficient income to acquire enough food. It is obvious that there is no quick approach to fulfilling their human rights because the solution, which lies in production, trade and poverty alleviation, will take time and effort. Accelerating the growth of agriculture in Africa and South Asia will contribute to nutrition and help to alleviate poverty. As an immediate measure, some countries may favour interventions that provide food security for the groups most affected, particularly pregnant women and young children. Such measures include targeted food-price subsidies, food rationing for the poor or direct assistance as part of welfare schemes.

3. Right to health

Every person has a right to the highest attainable level of physical and mental health that would enable him or her to carry out a productive life, without any distinction. This fundamental human right is asserted in a large number of declarations and covenants, some of which are referred to at the beginning of this paper, 8/ as well as in the constitution of the World Health Organization. It was also highlighted by the two symposia on population and human rights held by the United Nations in 1974 (see United Nations, 1975, annex IV) and 1981 (United Nations, 1983).

Equity in ensuring essential health services, particularly as it relates to such vulnerable groups as infants, children, women, the elderly, the disabled and the poor, is the primary concern of all those interested in the fulfilment of this human right. In many countries, rich and poor, although sophisticated medical services are currently available to those who can afford them, some of the basic services are not available to the rural population or to the urban poor to whom available health facilities are so overcrowded that they cannot always be accessible. The extent of the shortage of the basic services required for fulfilment of this human right is discussed below, leaving to the next section the discussion of considerations of social justice and morality.

Although all countries recognize the need to provide the essential components of primary health care, in most of the developing countries such services are not available on a uniform basis, as can be seen in table 13. This table presents, in so far as available information permits, the extent of availability of the basic components of primary health care to the whole population in some regions. Sub-saharan Africa stands out as the region where the most serious deficiencies and striking internal differences exist. Among the 39 countries for which information is provided on availability of safe water in the home or within a 15-minute walking distance, 31 have this service available only to fewer than 40 per cent of their rural populations; and in 15 countries, coverage is under 20 per cent of the rural population.

Accessibility is much better in urban areas, although there are still six countries in which safe water is available only to fewer than 40 per cent of the urban population. The situation is similar in the case of availability of adequate sanitary facilities in the home or immediate vicinity: in 20 out of the 29 countries for which information is provided, this service is available only to fewer than 20 per cent of the rural population; and even in the urban areas of 16 out of 33 countries, fewer than 40 per cent of the population are covered. Furthermore, in substantial numbers of countries, immunization of infants is unavailable to most of the population, as table 13 indicates. Immunization against diphteria/pertussis/tetanus (DPT) and polio is unavailable to 60 per cent or more of the population in 22 out of 37 countries; and immunization against measles, in 16 out of 37 countries.

Information given in table 13 concerning the remaining components of primary health facilities should be interpreted with caution because of the large number of countries from which no information is available- which probably means that the situation is worse than indicated by the data for the countries that provided information. Nevertheless, it is highly indicative that immunization of pregnant women against tetanus is not available to more than 80 per cent of the population in 5 out of 11 countries. Likewise, it will be noticed in table 13 that attendance of trained personnel is not available to more than 60 per cent of the population in 9 out of 21 countries in the case of delivery and in 8 out of 16 countries in the case of infant care, although such services are usually provided by peripheral health workers. Lastly, as concerns the accessibility of health care, more than 60 per cent of the population are not covered by a health-care unit located even within an hour's walk or travel in 6 out of 25 countries.

Table 13 also shows that unfortunately serious deficiencies in primary health care exist in other developing regions. In South-east Asia, 9/ this is true for availability of safe water in rural areas, availability of adequate sanitary facilities in both rural and urban areas, immunization of infants against measles and polio, and availability of trained personnel for delivery. The Eastern Mediterranean region 10/ shows serious shortages in

Table 13. Coverage of population with primary health facilities, some World Health Organization regions

Percentage of population covered	Number of countries												
	Safe water a/		Adequate sanitary facilities b/		Immunization of infants against				Tetanus immunization of pregnant women	Trained personnel attendance in			Health care available locally c/
	R	U	R	U	DPT	Measles	Polio	Tuberculosis		Pregnancy	Childbirth	Infant care	
Africa d/													
Under 20	15	-	20	5	10	7	12	7	5	2	3	6	1
Under 40	31	6	24	16	22	16	22	12	6	5	9	8	6
Under 60	35	18	25	22	30	28	29	18	7	10	13	9	13
Under 80	38	26	28	26	33	33	34	29	10	14	17	11	20
Subtotal	39	40	29	33	37	37	37	39	11	23	21	16	25
No information	5	4	15	11	7	7	7	5	33	21	23	28	19
South-east Asia e/													
Under 20	3	-	5	1	4	9	6	1	1	2	2	1	-
Under 40	6	2	6	5	6	10	7	5	2	3	5	2	-
Under 60	8	5	7	6	8	10	8	7	4	5	5	2	3
Under 80	9	8	7	7	10	10	10	10	4	6	5	3	4
Subtotal	11	11	8	8	11	11	11	11	4	9	9	5	8
No information	-	-	3	3	-	-	-	-	7	2	2	6	3
Eastern Mediterranean f/													
Under 20	2	-	5	-	5	6	5	8	13	4	4	1	-
Under 40	7	1	11	1	7	12	7	9	19	8	8	4	3
Under 60	10	2	12	3	14	16	13	15	19	12	9	4	4
Under 80	15	6	12	10	19	21	19	18	19	17	15	7	8
Subtotal	21	21	16	20	22	22	22	20	19	22	20	12	21
No information	1	1	6	2	-	-	-	2	3	-	2	10	1

.../...

Table 13 (Continued)

Percentage of population covered	Number of countries													
	Safe water a/		Adequate sanitary facilities b/		Immunization of infants against				Tetanus immuni-zation of pregnant women	Trained personnel attendance in			Health care available locally c/
	R	U	R	U	DPT	Measles	Polio	Tuberculosis		Pregnancy	Childbirth	Infant care	
							Americas						
Under 20	6	-	10	-	1	6	1	-	2	-	-	-	-
Under 40	13	-	14	1	9	13	4	7	5	1	4	-	-
Under 60	17	2	17	12	16	18	11	13	9	5	7	3	2
Under 80	21	7	18	16	23	24	20	19	10	11	9	8	2
Subtotal	24	25	23	25	34	32	34	23	12	18	28	15	15
No information	10	9	11	9	-	2	-	11	22	16	6	19	19

Source: World Health Organization, Evaluation of the Strategy for Health for All by the Year 2000, vol. I (Geneva, 1987). This table is compiled from tables 7-13 of that source. Although no time reference is given in those tables, the report covers the period 1978-1984 and was based largely on information collected from Governments during 1983.

Note: R = rural; U = urban; DPT = diphtheria/pertussis/tetanus.

a/ In the home or within a 15-minute walking distance.
b/ In the home or immediate vicinity.
c/ Within one hour's walk or travel.
d/ Sub-Saharan Africa.
e/ Including Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand.
f/ Northern Africa, Arab countries of Western Asia, the Islamic Republic of Iran, and Pakistan.

availability of adequate sanitary facilities in rural areas, in immunization against measles and tuberculosis and in immunization of pregnant women against tetanus. The rural areas of Latin America and the Caribbean 11/ also indicate serious shortages of safe water and adequate sanitary facilities reflecting, as they do in developing countries in general, the much more limited attention paid to the basic needs of rural areas.

The foregoing discussion clearly demonstrates that the basic right to health is far from being enjoyed on a wide basis. It is true that the political will to improve health as a key element in quality in life has not always been strong enough. It is also true that lack of tangible short-term economic returns of health programmes may have delayed the realization of the value of health as an important determinant of economic productivity. Furthermore, health research is generally accorded a low priority in the third world, and consequently insufficient attention is paid to finding affordable solutions to the unique health problems of those countries.

It should always be remembered, however, that the problems involved, economic, social and technological, are too serious to be taken care of as short-range targets. The economic hardships that prevailed in the late 1970s and early 1980s made it difficult for most developing countries to give the public health sector its proper share of national wealth and attention. For instance, some of those countries could not meet the minimum financial standard of 5 per cent of the gross domestic product allocated to health services, as recommended in the Global Strategy for Health for All by the Year 2000. 12/ In the 37 poorest countries, spending per capita on health care has fallen by 25 per cent in the past 10 years. During the same period the proportion of government expenditure devoted to health has declined in most countries of sub-Saharan Africa, in more than half the countries of Latin America and the Caribbean, and in one third of the countries of Asia (United Nations Children Fund, 1989, p. 17). One should also bear in mind that progress in health conditions is contingent upon progress in other socio-economic sectors, without which improvements in the health of the rural populations or the urban poor would be very difficult to achieve.

C. Social justice in health care

1. Equity and accessibility

Issues of social justice arise in health care because differences in accessibility of health services usually exist within the society. Such differences, whether in the kinds of services available or in their distribution, will directly affect the people's well-being through influencing their chances of falling sick, of being cured or of getting rehabilitated and supported if they become impaired. Indeed, in affluent societies that spend nearly one tenth (or more) of their gross national product (GNP) on health-care, serious questions about justice arise when a sizeable proportion of the population, over 10 per cent in some cases, has little health care coverage. 13/ These are usually the poor and some rural residents who, because of their circumstances, have little access to regular health services and seek help only late in illness.

Principles of justice would guarantee, as already emphasized, the provision of certain health-care services to all, regardless of ability to pay or geographical location. They would also provide guidelines for setting public health policy within budgetary limitations: what services should be fully or partially paid for from public funds; who should be covered by social health insurance schemes and at what cost; the allocation of health centres; efforts to place physicians and other health personnel in underserved areas. Principles of justice are also essential in resolving the conflicts of interest between groups that have different claims and different degrees of readiness to contribute to the cost, as well as conflicts of interest between consumers and providers of medical care. Principles of justice are also important in dealing with questions concerning proportionate allocations to preventive health services, including sanitation, immunization, nutrition to vulnerable groups and environmental protection; to acute care, where some systems have been accused of bias in favour of using expensive high-technology procedures; and to the care of the chronically ill and the elderly. This third aspect of health care, which is being given increasing attention in developed countries, particularly in view of the current aging trends, is discussed in the next section.

The importance of giving preventive care a fair share of health expenditure is clear on cost-effectiveness grounds because, as old wisdom has it, it is often more effective to prevent disease and disability than to cure or to rehabilitate and support after the illness: some diseases are not detected in time for them to be cured; and others are not curable. Apart from cost effectiveness, justice and equitable opportunity considerations would also favour paying due attention to preventive measures. Such measures, if distributed evenly, would reduce the general level of morbidity, particularly among the population sectors with relatively high risks of avoidable disease, and would accordingly reduce differential mortality.

These considerations apply to the above mentioned areas of preventive care. They apply, moreover, to regulation of workplace hazards, whether these are resulting from general health conditions, from pollution or from occupational injuries. The employer should take all the necessary measures on grounds of both prevention and justice: equality of opportunity requires that increased risks of disease faced by particular groups are to be avoided or minimized. Considerations of cost efficiency in this regard do not override the requirement of justice: the worker should not bear the cost in the form of morbidity and disability, and society should not bear this cost in the form of increased health expenditures. It goes without saying that society cannot be satisfied with workers' consent to work in risky circumstances. Such consent is obtained in contract negotiations where workers' choices are unjustly limited or through the temptation of higher wages (Daniels, 1988, chaps. 7 and 8).

Similarly, in curative medicine, priorities have to be set in the light of local conditions and needs, on the basis of cost effectiveness and in full compliance with justice, which implies the provision of a certain amount of basic medical services to all. Such priorities are not observed when a developing country spends substantial sums on establishing specialized centres for cardiology or haematology while its infant and child mortality rates are high due to high levels of diarrhoeal and respiratory diseases and low birth weight. Nor are priorities well determined when a poor country sends considerable numbers of its citizens abroad for treatment while women and infants die for lack of maternity care, or when public funds are used to build expensive central hospitals and provide them with sophisticated equipment while large sectors of the population have no access to any health-care facility within a reasonable distance.

In the context of priorities, it should be emphasized that health research ought to be given high priority in developing countries. What is needed here is to add to the Western-oriented skills more knowledge about local health problems and diseases, which are substantially due to poverty and malnutrition. More knowledge is also needed about how to deal with those diseases, economically and effectively, whether by prevention or treatment, taking fully into consideration local circumstances and the need to offer services acceptable to the community. These research priorities include the relevant areas in epidemiology, therapy, pharmacology, operations and management (Walsh, 1988).

As already discussed, issues of coverage and of accessibility and priority setting also exist in developed countries. One more issue that has been raised is whether transplants and other high-technology, very expensive operations could be financed from public funds or by contributory health insurance schemes. At issue here is not the importance of the operation nor the extent of its benefit to the patient, but rather whether society at large should bear the very high cost of medical care given to a very small number of its members whose unfortunate health circumstances have made such operations necessary for them. Under the prevalent conditions where health care is allocated a substantial share of public funds and of individuals' expenses and where there is considerable competition for funds among the various health programmes, the question becomes one of priorities based on cost effectiveness and justice: whether highly costly programmes that will benefit a very small minority should be placed in competition with others that are also life saving but within much larger groups, like maternity and infant care (Daniels, 1988).

The requirements of justice can conflict with the traditional autonomy and paternalism of health-care providers. If there are alternative approaches to diagnosis and therapy, shouldn't the most cost-effective procedures be adopted? If the indigent and those who have no medical insurance are to be provided with essential health care, shouldn't the providers, including hospitals, make appropriate arrangements in this connection? In a developing country where the cost of medical training is paid fully or substantially from public funds, would physicians, nurses or technicians be justified in refusing to serve for a limited period in rural areas at least as part of their post-graduation training?

Donating medical care to the poor is, of course, an old tradition which physicians have maintained since Hippocrates and perhaps earlier. Many are still generously doing so by volunteering in one or more of the medical services provided to the poor. However, some top medical leaders are expressing concern about the decline of this public spirit and urging physicians to provide more free care. In the United States of America, the editor of the Journal of the American Medical Association, for example, said recently that physicians should donate at least 50 hours each year. The medical association's president told physicians that taxpayer subsidies of their education have added to "a basic responsibility to see that they take care of the poor and needy of their community" (The New York Times, 1989).

2. The challenge of chronic illness and frailty in an aging world

This section deals with justice for those whose incapacitating illness is not fully curable, either permanently or for a long period of time, and who consequently need both specialized medical treatment, rehabilitation and support. This group includes the chronically ill, those whose disability has caused substantial loss of function and the very elderly who have become too frail to live normally without help. The increasing sizes of those groups in an aging society, in the developed countries at present and in the whole world soon, is an ever-growing problem of modernization. With the advances in medical life-saving technologies, larger numbers of patients survive: new-born infants, children and adults survive illnesses or injuries that would have once proved fatal, with many of them developing a certain degree of disability in the process. As the general aging trend continues, 14/ they continue to live longer into the old ages. 15/

Although most of the care for the chronically ill, the disabled and the frail elderly takes place outside hospitals, they usually still need relatively large numbers of hospital days and physicians' visits. They also require some assistance with their normal functions and eventually a substantial amount of nursing and care, possibly in a specialized institution.

The ethical challenge faced by society in dealing with these groups is to satisfy their needs and at the same time treat them with dignity- rights to which they are fully entitled as members of the society. The challenge is to enable them to make the necessary adjustments in their lives with as little loss of purpose and coherence as possible in the face of communities that place great value on youth and vigour and may undervalue the frail elderly, the handicapped and those who lack full self-support.

There is also the challenge of who is to provide the needed support--physical, moral and financial--in competition with other pressing obligations of families, community organizations and the State. In many societies, developing and developed, individual patients, their families and charitable organizations bear a heavy share of the costs and services involved; and the burden falls most heavily on the low-income elderly, the poor and the uninsured. Public funds in developed countries contribute part of the costs, but such contributions are made under the pressure of competition over resources with all other public programmes and the pressure of the accelerated increase in the sizes of those groups.

Thus, in general, social policies towards the chronically ill, the disabled and the frail should be directed towards justice, compassion and a due sense of public responsibility without putting undue pressure on public funds. Policy formulation should be guided by their right to satisfaction of their distinctive needs without treating them as a special class. Their needed health-care services should be provided without turning them into dependants of the health-care systems. The important role played by families and community organizations should be supported by public funds, without eroding the special sense of familial obligation that is still powerful despite changing life-styles and without transforming personal care into an impersonal commercial enterprise (Jennings, Callahan and Caplan, 1988).

A right of kinship for these groups, vis-à-vis their close relatives, is now taken for granted in most developing societies and to some extent also in developed societies. Those with chronic impairment, in addition to needing to regain their physical abilities, badly need emotional attachment, which can only be provided by families and friends. However, changes in patterns of living are making it questionable whether family members can take full responsibility for the agonizing and time-consuming care--although many of them still do even if they are not sharing the same household with their incapacitated relative. Seeking alternative solutions in the developing countries currently or in the near future, besides being culturally undesirable, would be economically unrealistic. However, those countries should, as a right of the patients, assist the needy families medically and financially whenever possible. Even more important, they should act now on organizing or expanding their social security schemes that will be effective in covering part of the medical and living expenses of the incapacitated and the frail elderly as their numbers increase in the coming years.

On the other hand, a main question concerning rights in affluent societies is how much social support the families can expect to get from the community and the State. There is a clear and compelling need to support the non-affluent families, as many developed countries do. This assistance not only takes the form of publicly subsidized medical institutions and programmes to facilitate independent living but also includes professional home-care services provided with some public support. Cost containment is expected to put increasing limitations on those programmes as populations continue the aging process (obviously, a problem will be posed when the "baby boom" cohorts reach the elderly ages beginning in the decade of the 2010s), but considerations of equity and justice will always necessitate public support for poor families.

In normal circumstances, a patient with acute illness has two main rights vis-à-vis the health care providers--privacy and autonomy. These rights still apply in the case of the chronically ill, the disabled and the elderly frail, with some modification arising from the nature of their illness. Thus, issues of privacy and confidentiality are complicated by the need to involve family members or friends in the provision of care, which may well require the disclosure to them of information about the illness. Similarly, strict adherence to the patient's autonomy obliges the physician to provide only such care as is desired or consented to by the patient, even against his own best judgement and in situations where a decision can affect the patient's future life and abilities. There is also the moral challenge here as to what extent the physician can take seriously the ability of severely disabled or very old patients to make responsible choices concerning the risks and benefits of treatment (Caplan, Callahan and Haas, 1987). Therefore, it can be concluded that the impaired have rights to privacy and autonomy, the first in the sense of giving information only when necessitated by the patient's interest, and the second in the sense of professional compromise between justifiable paternalism and the patient's interest as an active partner in the process of caring for his or her health.

A particularly important ethical challenge facing health-care providers is to obtain agreement from the patients and their families as to what abilities would constitute an acceptable quality of life, having in mind the technical and financial limitations. In the process, they have to be educated and convinced to accept changes in life-styles imposed by irreversible impairments. Although health professionals should be careful not to overestimate the contribution which family members can make, they have a duty to explain to them the unique capability they possess.

Ethical issues connected with the rights of these patients also arise with regard to institutionalization. Questions arise not about the need for this service but with respect to its timing. Apart from considerations of cost, home care is preferable because it enables the elderly and the disabled to live a closer to normal life, to have autonomy, dignity and freedom of choice and to enjoy the emotional support of family and friends. Even when family care is not available, many of those patients would prefer to live in their homes if home-care services could be provided by the community. Institutionalization can then be a last and necessary resort. Even there, the resident has rights to have as much privacy as possible, to have access to medical attention, to receive visitors and be free of restraints and to be treated with dignity without physical or verbal abuse.

D. AIDS and human rights

The terrifying experience with the acquired immunodeficiency syndrome is unprecedented in human history. Since its recognition in 1981 and the isolation of the causative human immunodeficiency virus in 1983-1984, no means of effective control has been found, and the disease is spreading rapidly and globally; morever, further spread appears inevitable, at least in the short term. 16/

On the basis of available evidence, it can be said that AIDS is occurring world-wide, and the number of cases is increasing at the same general rate in all major regions, although in the developing countries there is still relatively much more underrecognition, underdiagnosis and underreporting of the disease. WHO estimates the number of AIDS cases at about 250,000 as of late 1988. Based on an estimated number of HIV infections for 1987, over 1 million AIDS cases can be expected by the early 1990s and over 3 million by the late 1990s (Chin, Lwanga and Mann, 1989). 17/ Pending a medical breakthrough, available estimates clearly indicate the potential tremendous threat of the disease.

Although the concern here is with the human rights of the patients, it should be emphasized that societies' interests, those of Governments, communities and families, are much wider than the important issue of safeguarding the dignity and welfare of the patients and their families. If unchecked, the disease has the potential to impose a particularly damaging effect on the social and economic life of the society because, unlike other diseases that mainly affect children and the elderly, AIDS victims are mainly in the most productive and the most socially active age groups. It is estimated that 90 per cent of those with AIDS are between 20 and 49 years of age. Their serious illness or death means loss of support for their families, loss of productivity for the economy and loss of vitality for the social and political life of the community. It has been estimated that by 1995 some countries could lose as much as 8 per cent of their GNP due to AIDS-related losses. When added to the direct treatment costs of the disease, the resulting devastating impact on the infrastructure is obvious (United Nations, 1988b).

To place the discussion of the human rights of HIV/AIDS patients in the proper context, it should be clear that epidemiological studies throughout the world have consistently shown that the virus cannot be transmitted through casual contact; a healthy person cannot catch the virus through water, food, clothes, toilet, insect bites, handshake, cough or sneeze. 18/ There is definitely no evidence of person-to-person spread in schools or workplaces. Therefore, given the restricted modes of transmission, there is no public health reason for imposing restrictions on the daily social interaction of infected persons.

Along with the continuing spread of HIV/AIDS, however, prejudice against the infected persons has also been spreading, mostly based on wrong or incomplete information about the disease. Such unwarranted prejudice is not only infringing the basic human rights of harmless members of the society but, unfortunately, it may accelerate the spread of the disease and worsen the global crisis by forcing possible carriers to refrain from coming forward for blood-screening and forcing infected persons to refrain from seeking treatment and counselling. They may well find such negative action necessary in order to avoid ostracism for themselves, their children and their spouses.

Despite convincing evidence that there is no risk of transmission through normal contact, people with HIV/AIDS are discriminated against in housing, in employment, in the workplace and even in hospitals and in the provision of medical services. Even children who were born with HIV infection or who contracted the disease through infected products administered to treat their haemophilia have been discriminated against in schools through either complete barring or isolation. There have also been cases of quarantine, ostracism, detention and deportation of AIDS victims. Even old tones of racism blaming people of different colour and foreigners have been raised in several parts of the world 19/ (Breum and Hendriks, 1988; Panos Institute, 1989; and Fox, 1986).

All such acts are unwarranted, as stated above, and are therefore violations of the basic human rights of the patients and their families to be treated with dignity and without discrimination and to have access to schooling, housing, employment, health care and other community services like everyone else. Society is showing all this prejudice and paying the cost of detention, comprehensive compulsory screening, compensation to employees separated from work, recruiting and training new employees etc. when the funds could be put to much more effective and humanitarian use by channelling them to pertinent educational and counselling programmes, health care or blood-testing before transfusion.

Some arguments implicating moral values are made in this regard. The first is preserving the health rights of the majority against the infected minority. Justifying discrimination on the basis of this argument, which is valid in the cases of communicable diseases, is groundless in the case of a disease like AIDS, whose virus cannot be transmitted through normal casual contact. On the contrary, the moral issue here is protecting the harmless minority from the ill-informed majority.

A second argument justifies a negative attitude on the moral premise that the patients are "irregulars"--homosexuals and drug addicts--and have only themselves to blame. Obviously, infected children "inherited" the virus; and blood transfusion or administration cases are innocent victims of ignorance about this process being a mode of transmission (before 1982 when the possibility was documented), neglect by others (after 1985 when a test became available) or lack of a method of screening between those years. Many heterosexual victims simply had the virus passed on to them by their spouses. Even among those who contracted the disease through irregular sexual behaviour or through needle-administered drugs, many did not know about the risk involved when they exposed themselves and many were infected before the virus was identified. Moreover, it would be difficult to agree that people deserve punishment for a condition arising from poverty and ignorance. 20/

There can be no doubt, therefore, that societies should safeguard the human right of HIV/AIDS patients to be treated with dignity and without prejudice in all the basic services provided by the community. There are several other rights that society should ensure in order to support these patients and their families in their very unfortunate circumstances and also in societies' own interest as measures towards controlling the spread of the disease. These are the rights to confidentiality, public education about the disease, research enhancement and treatment with compassion and support.

Since a person's HIV status is potent information which can have drastic repercussions, such information should be kept confidential in order to contain the prejudice from which the patients and their families are suffering unnecessarily. Confidentiality is also an essential preventive measure without which many patients would not come forward for screening and treatment. The controversy here is about who is to have access to the information besides those who follow up and study the epidemiology of the disease, to whom the information provided should be anonymous. There are obvious reasons for informing the sex partners or the needle-sharers, or both, of the patients, but here again there is the fear that such measure would be a deterrent to persons who do not want their spouses or lovers to know if they have the virus. The opinion has been expressed in this regard that it would be best (and more feasible) if the physician could persuade the patient to inform such vulnerable persons voluntarily. On the other hand, the need to reach out for these exposed persons may well justify contacting them directly in order to educate them and to provide those among them who are found to have the disease with available services and therapies.

Educating the public about the nature of the disease and how it is transmitted is the most effective way of reducing and eventually eliminating unwarranted discrimination, which, as society knows from experience, cannot be eliminated by penal law. Beside the necessity of this measure as a right of the patients, education is in fact society's main defence against AIDS. It is a costly enterprise in terms of the needed strong mass communications, health education programmes in schools, competent social organizations and efficient community services. However, it should be looked upon, inter alia, as a necessary measure of social justice, promoting public health and at the same time putting to rest some of the anxiety and fear caused by the lack of more effective health measures against the disease. Even at the legislative level, it is this fear based on wrong information which has led to unwarranted legislation in some instances. Lastly, it should be emphasized that human rights work in both directions: every individual must know how to behave in order to avoid infection; and every patient must know how not to expose others to the risk.

The world is waiting patiently for the outcome of research directed to preventing the disease, whether that will be in the form of a vaccine or anything else, and relieving humanity of the horrors, current and perspective, caused by the spread of the disease. It is clear that research efforts have to be intensified towards developing a cure for the victims to whom all that is available now is a drug that delays the development of AIDS among some of the HIV-infected persons and treatment for some of the illnesses that accompany AIDS. Because AIDS is a world-wide disease that can spread everywhere if it exists anywhere, the main aim of research should be a treatment that can be afforded in poor countries and can be administered in less developed localities. Research oriented to high-cost drugs and sophisticated facilities will not be very effective. As this battle against HIV/AIDS may take decades, research is needed to enlighten and support current efforts at containing the disease: reaching better understanding of its spread; monitoring its prevalence among different groups at risk and by different means of infection; and devising more effective tactics for changing risky sexual behaviour and countering drug addiction.

The fate of the victims, their helplessness, their suffering and their financial ruin, should bring about within their societies understanding, appreciation, compassion, all possible help and, above all, determination not to allow prejudice against them. A basic need, one where they need a lot of sympathy and support, is health care at the primary medical level, in hospitalization, in home care and in counselling. They also need sympathy and support in meeting the heavy financial burden which only the rich can afford and which will be increasingly harder to meet from public or charity funds even in affluent societies as the numbers multiply. Obviously, there will be an increasing demand for voluntary contributions at all levels of health care in the coming years.

Although there is virtually no disagreement about the right of persons with AIDS or HIV infection to proper health care provided by competent health care workers, some controversy has arisen over the refusal of some surgeons, other physicians, dentists and nurses to work with those patients because of the risk of virus transmission. It is documented that transmission can happen through accidental injury from a needle that was used on a patient and in a limited number of cases through accidental exposure to a patient's blood or other infectious body fluids. Data accumulated so far show that the chance of infection is very small, probably less than half of 1 per cent among those who have already accidentally been exposed. This small, but none the less distressing risk, can be reduced even further if universally applied blood and body fluid precautions are rigorously adhered to (Allen, 1988).

The refusal of some medical personnel to treat AIDS or HIV-infected persons raises an old bio-ethical question regarding the moral obligation to carry out professional duty in hazardous circumstances. Are the members of the medical profession duty-bound or ethically bound to render the needed service, particularly since the risk involved is so small compared with the risks run by previous generations of physicians and other health-care personnel? Or is the responsibility really that of the society which has a kind of social contract with the medical profession? Is it adequate to have a voluntarist system with special incentives for those willing to treat? What if this approach caused lack of access or substandard care? Would society then be justified in imposing a duty on the part of the health-care worker to treat in conformity with the social contract, or is the risk involved still above the level of duty? (Arras, 1988; and Freedman, 1988).

These issues have been debated in developed countries, sometimes with undertones reflecting points of view of human rights activists, philosophers or health-care workers. Suffice it to give here the position of the American Medical Association's Council on Ethical and Judicial Affairs, included in a statement issued in December 1987:

> "A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive. The tradition of the American Medical Association, since its organization in 1847, is that: 'when an epidemic prevails, a physician must continue his labors without regard to the risk to his own health'... Physicians should respond to the best of their abilities in cases of emergency where first aid treatment is essential, and physicians should not abandon patients whose care they have undertaken...
>
> "...
>
> "A physician who is not able to provide the services required by persons with AIDS should make an appropriate referral to those physicians or facilities that are equipped to provide such services." (Freedman, 1988, p. 24)

The United States Surgeon-General, in a statement regarding physicians who refuse to care for HIV-infected persons, characterizes them as "a fearful and irrational minority" (The New York Times, 1987).

Nobody questions the usefulness of promoting voluntary testing for HIV, particularly among the groups at high risk. There is strong objection to mandatory testing because of its prohibitive cost, its negative impact on those who are afraid of community prejudice and its incompatibiity with a citizen's rights to privacy and dignity. There are still some issues in this connection, the clarification of which would benefit from further discussion of their pros and cons. One is the application of routine screening before marriage, which would give society a chance to counsel in case of a positive result and save considerable misery and death. A second arises in communities where prostitution is permitted: should a prostitute be required to take periodic screening? And if she/he is found seropositive, should the practice be allowed to continue? The third concerns health-care professionals who have HIV/AIDS: should such persons continue to practise even if the risk of transmission of the virus to the patients is small?

Notes

1/ Of particular relevance to the issues discussed here are the following instruments: 1948: Universal Declaration of Human Rights (General Assembly resolution 217 A (III); 1966: International Covenant on Civil and Political Rights (General Assembly resolution 2200 A (XXI); 1968: Resolutions and Final Act of the International Conference on Human Rights (Teheran, 23 April - 13 May); 1969: International Convention on the Elimination of All Forms of Social Discrimination (4 January); and Declaration on Social Progress and Development (General Assembly resolution 2542 (XXIV); 1971: Declaration on the Rights of Mentally Retarded Persons (General Assembly resolution 2856 (XXVI); 1974: Universal Declaration on the Eradication of Hunger and Malnutrition (World Food Conference, Rome, 16 November); 1978: Declaration of Alma-Ata (International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September); 1980: International Development Strategies for the Third United Nations Development Decade (General Assembly resolution 35/36); 1981: Global Strategy for Health for All by the Year 2000 (World Health Assembly resolution WHA34.36 of 22 May; and General Assembly resolution 34/38 of 19 November); 1987: Global Strategy for AIDS Prevention and Control (World Health Assembly resolution WHA40.26); 1988: Resolution on Avoidance of Discrimination in Relation to HIV-Infected People and People with AIDS (World Health Assembly resolution WHA41.24). The constitutions of the Food and Agriculture Organization of the United Nations (FAO) and the World Health Organization (WHO) also belong to this group of international instruments.

2/ This paper does not discuss the rights concerning the health aspects of family planning, the rights of the elderly vis-à-vis younger generations with regard to health care or the ethical aspects of care of the terminally ill. These topics are dealt with in separate papers presented to this Meeting.

3/ For the developed countries, the estimate of child mortality (probability of dying before age 5) was 75 per 1,000 in 1950-1955 and became 19 per 1,000 in 1980-1985. The corresponding figures for the developing countries were 281 and 134, respectively (see United Nations, 1988a, pp. 1-3).

4/ The infant mortality rates for 1980-1985 are: developed countries, 16; developing countries, 88; Eastern Africa, 120; Middle Africa, 117; Western Africa, 123; Northern Africa, 100; Southern Asia, 115 (United Nations, 1988a, p. 23, table 2).

5/ A recent United Nations publication (1989), quoting World Health Organization (WHO) and Demographic Yearbook figures, shows clearly that it is mainly in Eastern Europe, and presumably mainly due to abortion complications, that the maternal mortality rate in developed countries exceeds 20. The same report quotes WHO estimates indicating that around 1983 the maternal mortality rate was 30 in the more developed regions and 450 in the less developed regions.

6/ Based on the results of a study conducted in 1980 in 87 developing countries with 92 per cent of the total population in developing countries, excluding China. The level of food intake used is equivalent to 90 per cent of the FAO/WHO requirement (see World Bank, 1986, p. 17, tables 2-3).

7/ A recent report by the United Nations Children's Fund (UNICEF) estimates that at least 500,000 young children died in the past 12 months, as a result of the slowing-down or reversal of progress in the developing countries (UNICEF, 1989, p. 1).

8/ See note 1/.

9/ This WHO region includes Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand.

10/ Northern Africa, the Arab countries of Western Asia, the Islamic Republic of Iran and Pakistan.

11/ The WHO region, Americas, includes Canada and the United States in addition to Latin America and the Caribbean. However, the low coverage in the facilities shown in table 14 obviously does not involve the two developed countries.

12/ In Africa, for example, only 3 out of 24 reporting countries met this minimum standard, and in the regions of South-east Asia and the Eastern Mediterranean, the corresponding figures were out of nine and 5 out of 20, respectively.

13/ In the United States of Americas, it is estimated that 37 million persons have no health insurance.

14/ The 1988 projections of the United Nations show that in the developed countries the population aged 65 and over in 1980 is expected to increase by 28 per cent by the end of the century and by 89 per cent by the year 2025. The corresponding percentage increases in the developing countries are 54 and 251, respectively (United Nations, 1988d).

15/ In the United States, among those aged 65-69 in 1984, 17 per cent were unable to carry on a major activity and 32 per cent had a limitation in a major activity (Jennings and others, 1988).

16/ Infection with HIV can be without any noticeable symptoms, and the disease is detectable only through the antibodies which are found from two to three months after infection. The patient then goes through a period of some years, perhaps eight or nine, with much shorter durations in some cases, after which the life-threatening symptoms of AIDS appear, followed by death after about 18-36 months in most cases. It is now estimated that the proportion proceeding to AIDS may be 40 per cent within eight years after the infection, and the future progression is as yet unknown.

17/ These estimates may be conservative, as they are based on the assumption that the number of HIV infections was 5 million in 1987, while WHO estimated that in 1986-1987, the number was between 5 million and 10 million.

18/ Transmission is limited to sexual intercourse, injection with or administration of infected blood (usually through blood transfusion or sharing an infected needle) or transmission from an infected mother to her baby during pregnancy or delivery. Infection through blood can effectively be avoided by screening before transfusion and by use of sterile needles and syringes.

19/ See Breum and Hendriks (1988). This book includes contributions from 14 industrialized countries in all regions of Europe, the Union of Soviet Socialist Republics and the United States of America. Each contribution describes AIDS policies and legislation and puts the facts provided in a human rights perspective.

20/ For elaborate discussions relevant to the issues raised in paras. 57 and 58, see Gostin and Curran (1986), and Beauchamp (1986).

References

Allen, James R. (1988). Health care workers and the risk of HIV transmission. Hastings Centre Report (Hastings-on-Hudson, New York), vol. 18, No. 2 (April/May), Special Supplement, pp. 2-5.

Arras, John D. (1988). The fragile web of responsibility: AIDS and the duty to treat. Hastings Centre Report (Hastings-on-Hudson, New York), vol. 18, No. 2 (April/May), Special Supplement, pp. 10-20.

Beauchamp, Dan E. (1986). Mortality and the health of the body politic. Hastings Centre Report (Hastings-on-Hudson, New York), vol. 16, No. 6 (December), pp. 30-36.

Bhatia, S. (1983). Traditional practices affecting female health and survival: evidence from countries in South Asia. In Sex Differentials in Mortality: Trends, Determinants and Consequences, Alan D. Lopez and Lado T. Ruzicka, eds. Miscellaneous Series, No. 4. Canberra: Australian National University, Department of Demography.

Breum, Martin, and Aart Hendriks, eds. (1988). AIDS and Human Rights: An International Perspective. Copenhagen: The Danish Centre of Human Rights.

Caplan, Arthur L., Daniel Callahan and Janet Haas (1987). Ethical and policy issues in rehabilitation medicine. Hastings Centre Report (Hastings-on-Hudson, New York), vol. 17, No. 4 (August/September), pp. 1-20.

Chen, Lincoln C., Emdahul Huq and Stan D'Souza (1981). Sex bias in the family allocation of food and health care in rural Bangladesh. Population and Development Review (New York), vol. 7. No. 1 (March), pp. 55-70.

Chin, James, S. Lwanga and Jonathan M. Mann (1989). The global epidemiology and projected short-term demographic impact of AIDS. Population Bulletin of the United Nations, No. 27. Sales No.E.89.XIII.7, pp. 54-68.

Daniels, Norman (1988). Just Health Care. Cambridge: England; and New York: Cambridge University Press.

D'Souza, Stan, and Lincoln C. Chen (1980). Sex differentials in rural Bangladesh. Population and Development Review (New York), vol. 6, No. 2 (June), pp. 257-270.

El-Badry, M. A. (1969). Higher female than male mortality in some countries of South Asia: a digest. Journal of the American Statistical Association, vol. 64, No. 328 (December), pp. 1234-1244.

Food and Agriculture Organization of the United Nations (1984). The State of Food and Agriculture, 1984. Rome: FAO.

__________ (1987). *The State of Food and Agriculture, 1986*. Rome: FAO.

Fox, Daniel M. (1986). From TB to AIDS: value conflicts in reporting disease. *Hastings Center Report* (Hastings-on-Hudson, New York), vol. 16, No. 6 (December), pp. 11-16.

Freedman, Benjamin (1988). Health profession, codes and the right to refuse to treat HIV-infectious patients. *Hastings Centre Report* (Hastings-on-Hudson, New York), vol. 18, No. 2 (April/May), Special Supplement, pp. 20-25.

Gostin, Larry, and William J. Curran (1986). The limits of compulsion in controlling AIDS. *Hastings Centre Report* (Hastings-on-Hudson, New York), vol. 16, No. 6 (December), pp. 24-29.

Jennings, Bruce, Daniel Callahan and Arthur L. Caplan (1988). Ethical challenges of chronic illness. *Hastings Center Report* (Hastings-on-Hudson, New York), vol. 18, Special Supplement (February/March), pp. 1-16.

The New York Times (1987). Doctors who shun AIDS patients are assailed by Surgeon-General. 10 September, p. A1.

__________ (1989). Doctors are urged to donate more medical care to the poor. 31 January, p. C3.

The Panos Institute (1989). *World AIDS* (London), No. 1 (January).

United Nations (1975). *The Population Debate: Dimensions and Perspectives*, vol. II. Sales No. E/F/S.75.XIII.5.

__________ (1983). *Population and Human Rights*. Non-sales publication, ST/ESA/SER.R/51.

__________ (1986). *Review and Appraisal of the World Population Plan of Action: 1984 Report*. Population Studies, No. 99. Sales No. E.86.XIII.2.

__________ (1988a). *Mortality of Children Under Age 5*. Population Studies, No. 105. Sales No. E.88.XIII.4.

__________ (1988b). Note elaborating upon issues addressed by the Secretary-General in his statement on World AIDS Day. New York: 30 November.

__________ (1988c). Sex differentials in survivorship in the developing world. *Population Bulletin of the United Nations*, No. 25. Sales No. E.88.XIII.6, pp. 51-64.

__________ (1988d). *World Population Prospects, 1988*. Population Studies, No. 106. Sales No. E.88.XIII.7.

__________ (1988e). World Population Trends and Policies: 1987 Monitoring Report. Population Studies, No. 103. Sales No. E.88.XIII.3.

United Nations Children's Fund (1989). The State of the World's Children, 1989. Oxford: Oxford University Press.

Walsh, Julia A. (1988). Establishing Health Priorities in the Developing World. New York: United Nations Development Programme.

World Bank (1986). Poverty and Hunger. Washington, D.C.

World Health Organization (1987). Evaluation of the Strategy for Health for All by the Year 2000. Vol. I. Geneva.

XI. HUMAN RIGHTS, TERMINAL ILLNESS AND EUTHANASIA

Dirk J. van de Kaa*

The right to die, casus quo the right to die with dignity, casus quo the right to a personal death, is not covered by existing international human rights instruments, such as the Universal Declaration of Human Rights of 1948 or the European Convention for the Protection of Human Rights and Fundamental Freedoms of 1950. This is no doubt understandable because those instruments, and versions of the bills of rights which preceded them, were largely inspired by the need to protect the right to life and, more generally, by the need to assure people an existence free from the fear of slavery, coercion or the misbehaviour of capricious rulers. Moreover, those international instruments were formulated with the atrocities and genocide of the Nazi period fresh in mind, atrocities which have so stigmatized and coloured the term "euthanasia" that even now it can scarcely be used in its original sense of "good death" (the term was derived from the Greek words eu, good and thanatos, death). Significantly, the telephonic request for a paper on "Human rights and euthanasia" later took the form of a written request to write on "Human rights and terminal illness", which, although clearly related, is a rather different topic and can possibly best be approached in terms of the right to life and the right to health care. This author has assumed, therefore, that the context of the original request had not changed fundamentally and has thus included euthanasia in the title.

A. Demographic dimensions and definitions

1. Terminal illness

In the world as a whole, about 50.1 million men and women die (United Nations, 1988b) each year. The causes of death are very numerous--no fewer than 4,000 causes of death are distinguished in the International Classification of Diseases of the World Health Organization--and the main causes of death vary from region to region. In developed countries malignant neoplasms, ischaemic heart disease and diseases of the circulatory system predominate, particularly at older ages. In the countries of the European

---

*Director, Netherlands Institute for Advanced Study in the Humanities and Social Sciences (NIAS), Wassenaar, Netherlands; and Professor of Demography, University of Amsterdam. The author would like to express his gratitude to Dorien Manting of NIAS for research assistance, and to his colleagues, Ch. J. Enschedi and G. A. van der Wal, for comments on the first draft of this paper.

Economic Community (EEC) (excluding Denmark), for example, 2.4 million men and women aged over 65 die each year, about 19 per cent from malignant neoplasms and 52 per cent from diseases of the circulatory system. 1/ In a substantial fraction of cases death will occur some time after a diagnosis of fatal illness. But although the concepts "fatally" or "terminally" ill might appear to be self-evident and certain illnesses might seem much more likely to prove fatal than others, a generally accepted list of "fatal" illnesses or illnesses likely to be "terminal" does not exist. In fact, the prognosis of the outcome of a given disease, e.g., leukaemia, may well change over time, while on occasion a new disease, such as the acquired immunodeficiency syndrome, will have to be added to the group of diseases for which is no cure.

It should further be noted that many years may pass between an infection or the onset of a disease and its outcome. In some cases (e.g., multiple sclerosis, emphysema) a very prolonged period of illness may be characteristic; in others (e.g., brain tumour) the fatal outcome will normally occur within a few months. Thus, it is not an easy matter to quantify the frequency of terminal illness in a population, nor is it easy to arrive at satisfactory estimates of the numbers requiring terminal care or assistance towards death.

It would appear that there is, again, no generally accepted definition of terminal care, although it is normally understood to relate to care given to patients whose death is expected within months rather than years. The concept can be approached from three different angles: from the point of view of the organization of the care; from the point of view of the phase of the illness; and from the point of view of the type of care the patient needs or is given (Cleton-van de Dikkenberg, 1989). In the first case it refers to an integrated form of nursing, medical and pastoral care given either at home or in an institution to a terminally ill patient. In the second it refers to the care given to a fatally ill patient from the moment that he or she experiences the approach of death as a reality.

Different phases in that process are usually distinguished, the main criterion being whether the emphasis falls on assistance to lead an acceptable life to a predictable end or on assistance when the process of dying has clearly begun. The type of care given is clearly related to the phase the patient is in. Nursing and medical care tend to predominate when the disease can to a certain extent still be controlled and the patient may live for a good while. Pastoral and emotional care will play a central role when the disease can no longer be controlled and the patient has to prepare for approaching death. The care given then is, to some degree, still meant to let the patient lead an acceptable life but is also given to facilitate the course to the inevitable end. The relief of pain and other physical complaints, such as nausea, choking, thirst and powerlessness, then predominates while psychopharmaca and sedatives may be given to reduce anxieties and fear. In the final stages, when the process of dying has clearly begun, this type of care becomes increasingly important; and the needs and wishes of the patient increasingly determine the type of assistance given. It is usually at this stage that requests for a good death occur and the issue of euthanasia arises.

Table 14. Life expectancy at birth, by sex, European countries, 1950-1986

Region and country	Live expectancy in years at birth													
	Male							Female						
	1950	1970	1975	1980	1985	1986	Gain a/	1950	1970	1975	1980	1985	1986	Gain a/
Eastern Europe														
Bulgaria	64.2	68.8	68.7	..	..	..	4.5	67.7	73.5	73.9	..	..	..	6.2
Czechoslovakia	60.9	66.2	66.9	66.8	67.3	67.4	6.5	65.5	72.9	73.9	74.2	74.7	74.3	8.8
Germany, Democratic Republic of	65.1	68.9	68.5	68.7	69.5	..	4.4	69.1	74.2	74.0	74.6	75.4	..	6.3
Hungary	58.8	66.3	66.8	66.0	65.6	65.3	6.5	63.2	72.1	73.0	73.2	73.6	73.2	10.0
Poland	55.6 f/	66.8	67.8	66.9 b/	66.5	..	10.9	64.2 f/	73.8	74.3	75.4 b/	74.8	..	10.6
Romania	61.5 g/	66.3	67.4	..	67.0	..	5.5	65.0 g/	70.9	72.0	..	72.6	..	7.6
Northern Europe														
Denmark	67.8	70.7	71.1	71.2	71.6	..	3.8	70.1	75.9	76.8	77.3	77.5	..	7.4
Finland	62.9	65.9	67.4	69.2	70.1	..	7.2	69.1	74.2	75.9	77.6	78.5	..	9.4
Iceland	66.1	70.7	..	73.7	74.7	75.0	8.9	70.3	76.3	..	79.7	80.2	80.4	10.1
Ireland	64.5	68.8	..	70.1 b/	..	..	5.6	67.1	73.5	..	75.6 b/	..	..	8.5
Norway	70.8	71.2	71.7	72.3	72.8	..	2.0	74.4	77.4	78.0	79.0	79.5	..	5.1
Sweden	70.0	72.0	72.1	72.8	73.8	74.0	4.0	72.7	77.0	77.9	78.8	79.7	80.0	7.3
United Kingdom	66.2	68.7	..	..	71.4 c/	..	5.2	71.2	75.0	..	..	77.2 c/	..	6.0
England and Wales	..	..	69.6	70.8	71.8 d/	..	2.2 h/	..	..	75.8	76.9	77.6 d/	..	1.8 h/
Southern Europe														
Greece	63.4	72.0	..	72.2	..	..	8.8	66.7	76.1	..	76.3	..	..	9.6
Italy	63.9	69.0	..	70.6	71.1 b/	..	7.2	67.5	75.0	..	77.4	..	..	9.9
Malta	60.7	68.2	68.6	..	70.7 d/	..	10.0	63.3	72.7	72.7	..	75.0 d/	..	11.7
Portugal	56.3	63.7	65.2	68.9 b/	69.3 d/	..	13.0	61.5	70.3	73.0	..	76.6 b/	76.2 d/	15.7
Spain	59.8	69.7	70.4	72.6 b/	..	..	12.8	64.3	75.0	76.2	78.6 b/	..	..	14.3
Yugoslavia	62.2	65.6	66.9	67.8 c/	..	..	5.6	65.3	70.4	71.7	73.5 c/	..	..	8.2
Western Europe														
Austria	61.9	66.6	67.7	69.0	70.4	71.0	9.1	67.6	73.7	74.7	76.1	77.4	77.7	10.1
Belgium	65.2	67.8	..	70.0 b/	..	..	4.8	70.3	74.2	..	76.8 b/	..	..	6.5
France	63.6	68.3	69.0	70.2	71.3	71.5	7.9	69.3	75.8	76.9	78.4	79.4	79.6	10.3
Germany, Federal Republic of	64.6	67.4	68.3	69.9	70.8 c/	..	6.2	68.5	73.8	74.8	76.6	77.5 c/	..	9.0
Luxembourg	61.7	67	..	70.0 b/	..	..	8.3	65.8	73.9	..	76.7 b/	..	..	10.9
Netherlands	70.6	70.8	71.4	72.4	73.1	..	2.5	72.9	76.8	77.6	79.2	79.7	..	6.8
Switzerland	66.4	70.2	71.4	..	73.1 d/	73.6	7.2	70.9	76.2	77.6	..	79.7 d/	80.3	9.4
USSR	61	65	..	..	63.0	64.2	3.2	67	74	..	..	73.0	73.3	6.3

Source: D. J. van de Kaa, The Second Demographic Transition Revisited: Theories and Expectations, No. 109 (Amsterdam, PDI-Werkstukken, 1988).

a/ Gain between 1950 and most recent available date.
b/ 1981.
c/ 1983.
d/ 1984.
e/ 1982.
f/ 1949.
g/ 1956.
h/ Gain between 1975 and 1984.

Although it is not possible to indicate the frequency of terminal illness or the need for medical care with any sort of precision, there are numerous indications that recent, current and future demographic trends will almost certainly lead to a considerable increase. The life expectancy at birth for men and women has risen significantly over the past 35 years or so, gains in the order of 10 years having occurred in many countries (table 14).

In Japan and in some European countries, the life expectancy at birth of women now exceeds 80 years, while further rises are expected (Van de Kaa, 1988). Similar developments took place or are postulated for other parts of the world, most notably other developed countries. United Nations projections assume that by 2020-2025 all more developed countries will have a life expectancy at birth in the high seventies, while that figure could reach 70 years for the world as a whole (table 15).

In such circumstances, the proportion of all deaths occurring at very advanced ages will continue to increase--in developed countries more than 80 per cent of all deaths already occur at age 65 and older--and so, most probably, will the proportion of all persons dying after a long terminal illness and after having reached a stage where they long for the end. This and other developments in society will make the problem of euthanasia even more important than it already is. It is thus reasonable to explore whether "a right to die (with dignity)" can be justified.

2. Euthanasia

Definitions

The State Commission on Euthanasia, which presented its report to the Government of the Netherlands in 1985, described euthanasia as follows: "Euthanasia is the deliberate act of ending life by another than the person concerned, at his request" (Netherlands, 1985).

It is of interest to note here that this definition does not indicate any specific circumstances; it does not specify that the act will have to occur in the dying phase, that the person has to be incurably ill or that he has to suffer unbearably. Such restrictions were obviously not considered appropriate for inclusion in a definition, although they may well form part, or should form part, of any set of rules governing the practice of euthanasia.

It should further be noted that the Commission used the phrase "at his request" rather than "in his interest", the terminology frequently adopted elsewhere. The Commission clearly wanted to exclude from the definition any procedures whereby the prior consent of the person was not or could not be obtained.

The Commission further considered that the concept of euthanasia does not include:

(a) Ending treatment if, according to current medical standards, its significance can be no other than to slow down the process of dying;

Table 15. Life expectancy at birth, both sexes, United Nations medium variant, 1950-2025

Period	World	More developed countries	Northern America	Europe	USSR	Australia-New Zealand	Canada	Japan
1950-1955	45.9	65.7	69.0	65.3	64.1	69.6	69.1	63.9
1975-1980	58.1	71.7	73.3	72.3	67.9	73.3	74.2	75.5
1980-1985	59.6	72.3	74.6	73.2	67.9	74.9	75.9	76.9
1995-2000	64.5	75.4	77.0	75.9	72.1	77.4	78.0	79.3
2020-2025	71.3	78.7	79.7	79.1	76.7	80.0	80.4	81.3
Gain between 1980-1985 and 1950-1955	+13.7	+6.6	+5.6	+7.9	+3.8	+5.3	+6.8	+13.0

Source: World Population Prospects, 1988, Population Studies, No. 106 (United Nations publication, Sales No. E.88.XIII.7), table 15.

(b) Giving that form of terminal care which is primarily intended to reduce pain but which may, as an unintended but accepted effect, reduce the length of life;

(c) Giving that form of terminal care which is intended to aid patients in the last phase of their life without intention to reduce or end life;

(d) Not proceeding with a treatment if the patient so wishes and persists in that wish.

The Commission was of the view that all four courses of action form part of proper medical practice. The Commission also distinguished between euthanasia and providing assistance to commit suicide: in the first case, the act of ending life is performed by someone other than the person concerned; in the second case, it is the person concerned who acts, albeit with means made available to him. It should also be recognized that the person concerned need not necessarily be in the last stages of life.

In other existing literature, the term "euthanasia" is frequently combined with various adjectives to describe differences in the way "the gentle and easy death" is realized. The most common probably are: (a) active euthanasia, subdivided into (i) active direct euthanasia, active indirect euthanasia and (ii) passive euthanasia; (b) voluntary euthanasia and non-voluntary euthanasia; and (c) involuntary euthanasia.

Active euthanasia and active direct euthanasia are essentially equivalent in meaning to the definition of the State Commission in that they involve a deliberate act to end life at the request and in the interest of the person concerned. Active indirect euthanasia refers basically to the description given under (b) above, while passive euthanasia refers to (a). Albeit that, as just indicated, the Commission did not classify such acts as cases of euthanasia, this was possibly because it need not be done at the request of the patient. And indeed, if situations (a) and (b) occur, the question whether a request was made is theoretically irrelevant. In everyday practice, however, the situation will usually be more complicated. The reality is that the patient may well have expressed a wish to see his life ended to the physician concerned, and such a request inevitably alters the relation between patient and medical practitioner. In fact, it may be precisely such a request which will bring the physician to the conclusion that a situation as described under (a) or (b) exists and that he should act accordingly. If one follows the definition of the Commission, one would, strictly speaking, have to distinguish between ending life upon request and after request.

It should further be noted that case (a) may also include "letting die", e.g., a new-born child with serious mental or physical defects. Thus, these terms relate to procedures that in the view of the State Commission form part of proper medical care and practice.

Voluntary euthanasia occurs in all cases in which life is ended with the explicit permission or at the explicit request of the patient concerned, while the term "non-voluntary euthanasia" is sometimes used in cases where the person concerned never had an opportunity to make his or her views known, as in the case of seriously handicapped new-born children or patients in coma. The term "involuntary euthanasia" then would be applicable in situations in which euthanasia is performed in the person's interest, to save him further suffering. The assumption is that a person cannot always see his own best interests clearly; a paternalistic attitude should then prevail. The question whether use of the term "euthanasia" is appropriate in all of these definitions is not dealt with here.

Dimensions

Because no country in the world has legalized euthanasia by statute law, there are no national, systematically collected official statistics available to gauge the frequency of demand for it, nor are data available on its occurrence. However, the practice of euthanasia has become sufficiently accepted in a number of countries to elicit reasonably reliable data in special surveys or in well-designed registration systems. The Netherlands is a case in point; and as this country has probably advanced furthest on the road towards some form of legalization by statute law, data from the Netherlands are likely to indicate the maximum levels currently achieved.

Data collected from a representative group of general practitioners in The Hague suggest that each practitioner will, on average, receive two requests for euthanasia every three years. The 17 requests received showed the distribution by age, ground and medical diagnosis given in table 16. Malignancies, suffering without perspective for improvement and unbearable pain clearly rank high among the reasons for the requests.

Information on requests for euthanasia was collected from a nation-wide representative sample of medical practitioners covering 1 per cent of the population of the Netherlands as part of a system of continued registration of morbidity from 1977 to 1986. The total number of requests over the period was 280, of which 149 were made by men and 131 by women; the requests cover the direct (265 patients) as well as indirect form of euthanasia (15 patients). Most requests relate to the direct form and most occurred in situations where the patients were suffering from cancer (usually metastasized). Table 17 shows the distribution by age for the two five-year periods 1977-1981 and 1982-1986, together with the frequency of occurrence among the population of the Netherlands.

If the frequencies found during 1982-1986 are extrapolated to the Netherlands as a whole and to the EEC countries, the resultant totals are 3,300 and about 74,000 per annum, respectively. Thus, if the frequency of requests to general practitioners elsewhere were of the intensity currently observed in the Netherlands, the numerical dimensions of the euthanasia problem would be significant, implying, for example, 270,000 requests a year in the developed countries. Obviously, requests made to general practitioners form only part of all requests. Thus, requests made to medical personnel in hospitals and other institutions would have to be added to obtain an overall estimate. As against this, it should be evident that the underlying assumption that all countries would reach the situation that now obtains in the Netherlands may well be unrealistic, while it is similarly clear that not all requests are honoured: the frequency of euthanasia is almost certainly much lower than that of requests.

Table 16. Distribution of 17 requests for euthanasia among 25 general practitioners, The Hague

Age of patient		Diagnosis		Grounds	
< 60	3	Malignancy	8	Suffering without perspective	14
60-64	7	Other	9	Pain	5
70-79	5			Breathing problems	5
80+	2			Anxiety / loneliness	4
Total	17		17		

Source: A. P. Oliemans and H. G. J. Nijhuis, Euthanasie (verzoek) (Euthanasia (request)), Epidemiloqisch Bulletin, vol. 21, No. 2 (1986).

Table 17. Number of patients who requested active euthanasia from their medical practitioner, absolute and relative figures, Netherlands, 1977-1986.

	Age group					
Period	0-54	55-64	65-74	75-84	85+	Total
	<u>Number of reported requests</u> a/					
1977-1981	18	21	27	23	10	99
1982-1986	23	40	49	41	13	166
	<u>Relative annual figures (per 100,000 population)</u> b/					
1977-1981	3.32	32.41	55.25	91.45	169.63	14.10
1982-1986	4.06	58.03	97.61	143.75	179.43	23.01
	<u>Estimated absolute annual figures 1982-1986</u> c/ <u>(in thousands); annual average in 1982-1986</u>					
The Netherlands	0.46	0.8	0.98	0.82	0.26	3.3
European Economic Commission	0.98	20.4	23.9	22.0	5.8	(73.9)
Developed countries	37.5	69.0	75.8	-- 84.3 --		(270.0)

<u>Sources</u>: <u>World Population Prospects, 1988</u>, Population Studies, No. 106 (United Nations publication, Sales No. E.88.XIII.7); <u>Peilstations Nederland, Continue Morbiditeits Registratie, 1986</u> (Continuing registration of morbidity, Netherlands, 1986) (Uitgever Stichting Nederlands Huisartsen Institut, 1986).

<u>a</u>/ These figures correspond to the number of requests of the sample of medical practitioners covering 1 per cent of the population of the Netherlands.

<u>b</u>/ Relative annual figures were obtained by dividing the quinquennial number of requests by five and then by the mean population of the Netherlands in 1979 and 1984, respectively, for each age group.

<u>c</u>/ Estimated absolute annual figures correspond to the annual averages for the period 1982-1986. These figures were obtained by multiplying the mean population of the European Economic Community (EEC) in 1984 or the population of the group of developed countries in 1985 by the relative figures of the Netherlands for each size group. Note that the figures in brackets are slightly different from the sum of the values for each age group because they were obtained directly by applying the relative figures to the total population.

The proportion of requests honoured is likely to remain unknown for as long as a legal basis for euthanasia does not exist. In the study of general practitioners at The Hague, just referred to, 9 of the 17 requests had been honoured; in two cases, the patient died before steps were taken. In all, those nine cases probably represent about 2 per cent of the total annual number of deaths in the medical practices concerned, which would yield about 2,500 cases at the national level. If the cases of euthanasia in hospitals, nursing homes and so on are added, a doubling will perhaps occur; and a total number on the order of 5,000 comes close to the estimate of about 6,000 provided by an official governmental body (Medical Health Inspection) in 1985. It is, however, less than one third of the estimate of 20,000 arrived at by Vos using an approach based on a 1983 survey result which showed that 50 per cent of the population intended to request euthanasia if they were to suffer from cancer (Vos, 1985). Whichever is correct, each figure suggests a situation where the penal code is no longer strictly enforced.

However, although the frequency of an event in the population is not without significance when it comes to its acceptability, for its legalization and its recognition as a right, questions of principle are even more important. Further exploration of the demographic dimension is therefore unnecessary, particularly because the effects on life expectancy and other demographic measures are likely to be negligible.

B. Human rights dimensions

1. Rights to life, health care and liberty

The main human rights aspects involved in a discussion of terminal illness and euthanasia are: the right to life; the right to health care; the right to liberty; and the right to die (with dignity). The first two are covered by international instruments.

International standards on the right to life are contained in article 3 of the Universal Declaration of Human Rights and article 6 of the International Covenant on Civil and Political Rights (see United Nations, 1988a), in article 2 of the European Convention on Human Rights and Fundamental Freedoms (see Council of Europe, 1955), in article 4 of the American Convention on Human Rights (see Organization of American States, 1970) and in article 4 of the African Charter on Human and People's Rights (see Organization of African Unity, 1981).

Article 3 of the Universal Declaration states: "Everyone has the right to life, liberty and security of person" (United Nations, 1988a, p. 2). The International Covenant, in article 6.1, affirms: "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life" (United Nations, 1988a, p. 21).

The European Convention for the Protection of Human Rights and Fundamental Freedoms states in article 2.1: "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law" (Council of Europe, 1955).

International society has evolved considerably since these formulations were agreed upon and the concept of the right to life has been extended in various directions, for example, the right to peace, the right to a safe environment and the duty to ensure the right to life. What emerges from an extensive analysis (see Ramcharan, 1985) is that the right to life, although imperative, is not absolute and that certain carefully controlled exceptions are permitted. It should be noted that the formulations adopted in international instruments clearly have the basic aim of protecting individuals and groups from being killed arbitrarily. They do not deal with the right of non-interference if one wishes to take one's own life or the right to refuse medical treatment necessary to prolong life. Neither do they refer to situations where life is terminated with that person's consent. It is further evident that the duty to ensure the right to life, requires "the State to guarantee access to the material conditions necessary for supporting life; to take all possible measures to prevent violations of the right to life by others" (Ramcharan, p. 17) and that euthanasia is not included in those deprivations of life about which an international consensus exists that they are manifestly arbitrary (Ramcharan, p. 20).

The right to health care is, inter alia, embodied in the International Covenant on Economic, Social and Cultural Rights (article 12) and the European Social Charter (part 2, article 11), which declare that everyone has the right to the highest possible standard of health. Macfarlane (1984) argues that the meaning to be attached to the concept of the highest possible standard should take various limitations into account. In his view, the highest possible can never be the right of everyone to the best possible available in a particular area of health provision or treatment. It may be argued, however, that where a claim is unquestionably within the capacity of the State, a Government has the obligation to assure, as article 12 states, "all medical service and medical attention in the event of sickness" (United Nations, 1988a, p. 12). Where a request for euthanasia would result from a lack of care or medical attention, while the Government would have the capacity to provide it, it would fail in the obligation stated in article 12 of the International Covenant.

The last-mentioned international human rights instruments do not include a general right to liberty, although a number of specific freedoms are normally defined (freedom not to marry without consent, freedom of movement and residence, freedom from slavery etc.). There is clearly no consensus about the concept of liberty, even though it is central to the concept of basic human rights. Nevertheless, it has frequently been argued that people have the right to forbearance on the part of others from the use of coercion or restraint, and that a person is at liberty to act in any way that does not coerce, restrain or is designed to injure other persons. Such rights to non-coercion and to non-interference can obviously not be absolute and are limited through the legitimate role of Governments. In the present context, however, they are significant in that they may be relevant for the relationship between (terminally ill) patients and their physicians and for the rights of patients. Macfarlane states in this regard:

> "The would-be patient must have the negative liberty right not to be prevented from going to the doctor of his or her choice, or required to go to some other doctor. For his part the doctor has the right not to have a particular patient forced upon him... The positive form of the liberty right is the patient's right not to be forced to have medical treatment against his will or without his consent,..." (1984, p. 124)

Thus, it would seem that a patient certainly has the right to refuse further treatment and the right to choose a doctor who is, at least in principle, willing to assist if at any time the patient should request euthanasia. Set against this, a doctor should be free not to accept such a patient.

2. Right to die (with dignity) or right to a personal death

Content and justification

Those speaking or writing in favour of euthanasia have for a long time advanced humanitarian reasons. They have argued that individuals undergoing the terrible suffering, helplessness and loss of dignity sometimes associated with certain diseases deserve mercy and should be allowed to have a gentle death if they so desire. There is, in fact, little doubt that even now those who state in opinion polls that they find euthanasia acceptable are mainly moved by humanitarian considerations. In the Netherlands, for example, where six surveys that included questions on euthanasia were taken between 1966 and 1986, the overall proportions who agreed that euthanasia was permissible ranged from 40 per cent in 1966 to 57 per cent in 1983. However, a further breakdown of replies invariably shows much higher proportions accepting euthanasia if its purpose is to end the unbearable suffering of a person on the point of death (76 per cent in the Stimezo survey of 1975) than if the request comes from an elderly person who can no longer look after himself and prefers to die (19 per cent in the same survey).

In recent times, however, the emphasis has changed perceptibly. The attempts now clearly point in the direction of trying to establish a right to die (with dignity) which is vested in each individual. It would then only be that person in whom the right is vested who could relinquish it and who could free others from the obligation to grant him that right.

In a very stimulating paper, van der Wal (1987, p. 142) stresses that when a right to die is postulated, it is in essence a right in the moral sense. It is, however, usually postulated because of the intention to give it legal effect. Moral rights are rights of individual subjects; claims based on such rights are particularly strong because they no longer depend upon obligations of a humanitarian nature but upon the rule that justice should be done. He who does not honour such a right is at fault. For this reason, defining the right to die (with dignity) as a legal right, <u>casus quo</u> as a basic or fundamental human right, has such far-reaching consequences.

The discussion in the section on definitions of euthanasia and the use of the double phrase "right to die or right to die with dignity" have demonstrated that the possible content of a right to die is not immediately clear. It would seem that in the cases of passive euthanasia and active indirect euthanasia, in fact, in all instances that the State Commission on Euthanasia did not classify as euthanasia, the right to die is simply the right to be spared measures that others might take to prolong one's life beyond its natural course. The right sought is no other than that treatment not be continued nor commenced beyond what is reasonable and makes medical sense. In other words, at a given moment enough is enough; and one can then die "one's own natural death at one's own time", without interference and without being subjected to an artificially prolonged period of dying and suffering. Here the right to die gains the meaning of a right to die in a specific way.

The right to die with dignity differs from the right to die as just discussed, in that the emphasis lies on the right to have a specific type of death--a death worthy of a human being, worthy of the person one was during life. In this approach it is not biological death, the death of an organism, which is the focus of attention, but the end of a person's life as a human being. Van der Wal (1987, p. 146) rightly observes that this approach is founded on a certain idea about what it means to be a human being: an individual with a certain, very specific identity, with very personal experiences; with well-established norms and opinions on what is good, proper and valuable; with discernment, a will and capable of making a personal choice. The basic thought is that in life as well as in death, the essential characteristics of being human have to find their expression and have to be safeguarded; there are minimum standards below which a human existence should not have to fall, and certainly not in the final stages of a terminal illness. The right to die with dignity then gains the meaning of a right to a personal death and is no longer chained to the subjective term "dignity". Such a right should make it possible that at the end of a life, pain, suffering and horror do not dominate the process of dying. Instead, the last decision made should allow one to end and round off a life in a meaningful way.

It should be noted that in this approach dying as a physiological process is not considered central, but that dying or having died as a human, a person, is decisive.

With the possible content of a right to die and a right to die with dignity, i.e., the right to a personal death, thus briefly sketched and contrasted 2/, the question whether the existence of such a right or rights can be justified needs to be considered. The most instructive way of proceeding is probably to follow van der Wal's line of argument towards a conclusion that such (a) right(s) can be justified and then to review the arguments against it.

Van der Wal (1987, p. 150) first argues that thinking about euthanasia in terms of rights implies that such a claim right is vested in someone. The whole idea of a right only has significance when such a right relates to subjects or persons, endowed with discernment, a will of their own and capable of giving direction and meaning to their existence. Having rights and being a person are therefore directly related. Where morality uses the concept of a right, the idea of safeguarding the integrity of a human being as a person is always central. In the perspective of rights, van der Wal observes, all moral statements are concrete manifestations of that central thought. Slavery, exploitation, rape and so on are all considered immoral because they constitute an attack upon the true nature of the subject concerned. Where one speaks of rights, this implies a specific view of what it means to be a human being and, consequently, of the development of that human being as a person, an individual. What rights do is to protect people from infringements (negative rights) and to create circumstances and conditions that allow the best possible development of the human being so understood (positive rights).

Seen in this light, van der Wal finds no reason for making a distinction between, on the one hand, a right to die and, on the other, a right to die with dignity. In fact, he considers postulating a right to a natural death that would reach no further than a natural death an inconsistent construction. For, from a moral point of view, and at any rate from a rights perspective, the natural characteristics of a human existence (talents, even life itself) have no value in themselves but derive their meaning solely from being a medium and necessary condition for human self-expression, that is to say, because of their unique, personal qualities. Van der Wal argues then that life is not an inherently valuable good and also not the highest of all goods. Its value is that it forms the medium through which being a person finds expression. He concludes that the reason to protect life ends when a person is brain-dead because the conditions for leading a personal existence have irrevocably ended. The content of a right to die can, in van der Wal's view, be no other than the right to die with dignity, worthy of a human being.

Van der Wal (1987, p. 157) is positive about the justifiability of such a right to die. He feels that consideration of the problem in terms of a right matches current practice and opinions in a broad area of human activity. Central to this rights concept is the vision that what is valued most in man is his existence as an individual person; this is what is protected by morality and law. Safeguarding the existence of someone as a person, in a situation where immense suffering occurs and loss of identity and depersonalization threaten, is precisely what a right to a personal death entails.

It should be noted here in passing that this discussion does not explicitly deal with the possibility that people could claim to have or would have the right to end their life whenever they see good reason to do so. While existing legal systems do not explicitly recognize a right to self-determination in this regard, neither do they usually forbid it. Hence, suicide is permissible in such circumstances and attempts to commit suicide will not be punishable. It is quite probable that terminally ill patients, as long as they are able to do so, will prefer, or will be advised, to follow that course of action instead of asking a third party to act on their behalf. A practical problem in such cases may be that he who encourages or assists someone to commit suicide may be punishable by law (see the last section of the paper); this is why assisted suicide is frequently dealt with in discussions about euthanasia.

Objections and problems

Van der Wal's theoretical analysis and carefully phrased conclusions have not gone unchallenged. In his paper he has already tried to refute the most commonly voiced objections, but this is not the purpose of listing a number of important issues and objections here. Rather, the idea essentially is to ascertain to what extent a moral right to die a personal death could also become a human right. In this regard it is salutatory to recall what Macfarlane says about the nature of human rights:

> "Human rights are those moral rights which are owed to each man or woman by every man and woman solely by reason of being human. Human rights are distinguished from other moral rights in possessing the following inherent characteristics: (i) universality; (ii) individuality; (iii) paramountcy; (iv) practicability; (v) enforceability." (1985, p. 3)

The question of universality immediately causes problems. Although one could in principle envisage a situation in which the right to die a personal death would be universally accepted (without any obligation, of course, to use that right), it is quite unlikely that a proposal to that effect would meet with consensus. Large segments of the world population find the idea of the right to die totally unacceptable. Religious objections are basically that life is a gift of God and that only God has the right to decide about life and death.

In the secularized societies of the developed world, such a view of life is not a necessary correlate of being religious, and majorities in favour of some form of legalization of euthanasia are thus conceivable even in situations where religiously inspired political parties have a significant influence on public life. Nevertheless, it is obvious that the (human) rights perspective on the issues concerned lies outside the concept of life of the more orthodox segments of society or in such societies as a whole and therefore cannot play a role in the discourse on euthanasia.

A second objection of a philosophical nature poses the following questions. Is it not inappropriate to discuss the relation between an individual human being and his life in terms that suggest that he owns his life? Can one really possess one's life, can a life be one's property, something one can dispose of at will, or are "having" and "being" identical in this relation? If life is something one is, it is difficult to see how one can have a right over it. Thus, the rights concepts assumes that human beings are capable of creating a certain distance between their life and themselves, and that while doing so, their identity as a person remains intact.

A third objection questions the rights approach on juridical grounds. In this view, life is seen as an objective good which has a specific value independent of whether the person concerned values that life or is ready to give it up. Whatever the attitude or opinion of the person concerned, his life has a value which society and other persons have to safeguard. Again, independent of what the person concerned wishes or requests and independent of the altruistic motives of those who aid him, taking his life remains unlawful and has to be considered an illicit act. This approach is quite evidently at variance with the attitude of those who do not recognize an objective right to life in a moral or legal sense and consider that no injustice can be done to those who give their consent.

From a human rights point of view, two interrelated objections are sometimes voiced. Both relate to the nature of the right to life. The first of these stresses the non-derogatable character of that right. The argument is that the right to life may not be impaired or detracted from by any authority: that it is paramount. To quote Ramcharan's review of the right to life: "As a norm of jus cogens..., the right to life may not be derogated from in any circumstances whatsoever. As a norm of jus cogens, no government may deny the existence of the right to life and a higher duty and standard of protection of the right is imposed upon governments" (1985, p. 15).

The second of the objections which can be raised from a human rights perspective is that the right to life is a mandatory right, an inalienable, indefeasible and imprescriptible right. If it is mandatory and not discretionary, "a human being has only one way of exercising this right, and a duty not to take his or her own life and not to co-operate with others in taking his or he(r) own life" (Redelbach, 1985, p. 199). Thus, in justifying a right to die a personal death, one implicitly or explicitly recognizes and accepts that there is no inconsistency between seeing the right to life as on inalienable right--in the sense that it is a right one cannot give up--and not using that right in exceptional circumstances where living has become an unbearable burden.

The last and possibly most powerful objection against recognizing and legalizing a right to die has a fairly strong practical component. This is the so-called "wedge" or "slippery slope" argument. The essence of this argument, sketched lucidly by de Beaufort (1987, p. 10), is that accepting a morally justifiable or at least neutral point of view A leads to the morally unacceptable point of view B, or to morally unacceptable consequences B. Thus, if one does not want to justify B, one should not accept or do A. This argument, which is voiced not only against euthanasia but also against abortion, in vitro fertilization, gene therapy and other new biological and medical techniques, has in its relation to euthanasia two different versions: the conceptual or logical version; and the empirical or causal version.

The heart of the logical version is that those in favour of recognizing and of legalizing a right to die a personal death logically will have to justify more than they want. De Beaufort (1987, p. 13) poses several problems in this regard, mainly concerning the conditions under which euthanasia is admissible and the grounds on which it is justified. Is the discussion between voluntary, non-voluntary and involuntary euthanasia in everyday practice sufficiently clear, or is there likely to be a grey zone which would make it impossible to enforce legally specified criteria of admissibility? If, for example, euthanasia were legally possible in an emergency situation without prospect for improvement or where there is a concrete expectation that death is imminent, are such criteria not too vague and subjective? Do they not exclude important cases; do they not give too much power to medical doctors? Although such arguments may have validity, in de Beaufort's view they do not support a logical version of the wedge argument, since they do not suggest conceptual inconsistencies.

In her perception, the wedge argument offers better prospects if the issues of self-determination and non-voluntary euthanasia are scrutinized. Conceptual inconsistency may arise where those in favour of a right to die largely follow the argument that people should have a choice in this matter and have the right to self-expression, while at the same time defending non-voluntary euthanasia in certain cases, for example, in cases where there is no prospect for improvement so that it would be in that person's interest and would prevent much grief. But which criteria should be used if a person cannot or can no longer express himself and make his wishes known? Would it be sufficient to make an assumption about what he would have wished others to do?

The empirical version of the wedge argument postulates a gradual process of shifting norms after the legalization of euthanasia, beginning with a reduction in concern for and funding of terminally ill patients, to increased pressure on handicapped and chronically ill patients to request euthanasia. They will feel that they are a burden to society and it will no longer be their interests alone that will motivate the seeking of euthanasia. Medical practitioners become accustomed to killing patients; these, in turn, will lose confidence in their physicians.

The essence of the argument is that the borderline between voluntary, non-voluntary and involuntary euthanasia will become increasingly blurred with disastrous effects. De Beaufort (1987, p. 22) reviews four arguments in favour of the empirical version: (a) vagueness of the criteria for admissibility; (b) practical problems in their application; (c) comparisons with the past; and (d) current examples of misuse. She finds no grounds to assume an "apocalypse later" development, but sees a number of specific dangers in legalization. Whether these dangers are greater than those inherent in a situation where the problem of terminal illness and euthanasia are ignored is, however, a moot point. The current, unlegalized practice of euthanasia is not controllable and not transparent. Medical doctors who fear prosecution will declare on the death certificate that the patient has died a natural death, even though euthanasia was practised. The risk of improper practices always exists. Thus, so argues de Beaufort, whether one legalizes or not, the really important issue is to take appropriate action and begin corrective measures as soon as undesirable developments become apparent.

C. Current practice, alternatives and proposals

Until fairly recently the penal codes of most countries made it possible to prosecute someone who had attempted suicide, but failed to do so successfully. Presumably, the grounds for this provision were that the right to life was an inalienable right and that suicide therefore constituted an essential violation of that right. Suicide is now usually no longer forbidden by law nor is it a crime to provide pertinent information to someone who contemplates ending his life. However, the penal codes invariably contain articles (see Netherlands, 1985, part 3) stipulating in essence that: (a) a person who intentionally kills someone is guilty of manslaughter; (b) a person who intentionally or premeditatedly kills someone is guilty of murder;

(c) a person who kills someone at his or her explicit and serious request will be punished; (d) a person who intentionally encourages someone to commit suicide, assists him or her with it or provides him or her with the means thereto will be punished if the suicide follows.

The codes may, moreover, contain other relevant articles. For example, they stipulate that a person will be prosecuted if and when that person: (a) can be blamed for someone's death; (b) intentionally brings or leaves someone in that person's care to or in a helpless position; (c) does not provide assistance to someone who is in direct mortal danger. Such provisions suggest that in a legal sense, the difference between passive and active euthanasia may not be very great; and also, that in countries where the practice of euthanasia has become accepted, solutions must have been found to circumvent the law or to interpret the articles in such a way that, in certain instances, prosecution does not have to follow.

An important condition for preventing prosecution is always that euthanasia is performed only by the physician who attends the patient and that this doctor has acted carefully and in accordance with proper medical practice. In the Netherlands, the first set of criteria of carefulness were formulated in 1981 by a court in Rotterdam, when passing sentence in a case of "assistance with suicide" (Feber, 1987, p. 54). Most of them have later found their way into jurisprudence on euthanasia and into medical practice. It would appear that the criteria mostly comprise the following elements:

(a) Voluntariness. The request has to be made voluntarily and the physician has to discuss it on several occasions with the patient alone, as well as with members of the family;

(b) Informed request. The request has to be informed, that is to say, the patient should have a clear understanding of his medical situation and the prognosis. Euthanasia should not be resorted to if an alternative solution can be found;

(c) Lasting desire to die. The request has to result from a persistent desire to die and should not be associated with temporary depression;

(d) Unacceptable suffering. The medical practitioner has to evaluate the chances that new therapies will become available to improve the situation of the patient and has to consider whether further steps could be taken to make the suffering and the life of the patient in his own eyes more bearable;

(e) Consultation with colleagues. The medical doctor should consult an experienced colleague;

(f) Good record-keeping. Good records have to be kept which document the procedure and which may comprise a written declaration of the patient and a report on the consultation with the colleague.

It may be noted in passing here that the patient may well have had such a declaration prepared in advance, possibly through a public notary (see annex) or through a special association. In the Netherlands, about 85,000 such declarations are in circulation. Similarly, it is possible that the person concerned has signed a request not to be reanimated if found unconscious (Cleton-van de Dikkenberg, 1989, p. 31).

Even where a doctor has acted carefully, special problems may arise around the cause of death which, in developed countries, the physician customarily has to declare. It is frequently argued that euthanasia is not a natural cause of death and that this should be made clear by the medical doctor concerned. In the Netherlands, it is not uncommon for a doctor contemplating euthanasia, and intending to report that, to consult the appropriate authorities, i.e., the public prosecutor, beforehand. That person cannot give permission, but may point out relevant factors and thus in certain cases ensure that proper procedures shall be followed (Cleton-van de Dikkenberg, 1989, p. 61).

Where the medical doctor has observed criteria of the type sketched above, the public prosecutor may decide not to press charges. And, if he does, the verdict may well be that the doctor should go free, the two main grounds for such a decision being the exclusion of guilt and the absence of illegality. In the first case, the argument will be that although the act fits the description of an offence in the penal code, the circumstances justified the act (*force majeure*, situation of emergency, medical exception etc.). In the second, it will be that although the act fits the description of an offence in the penal code, the person who committed the act is excluded from being guilty because of his special function. Thus, although an offence was committed, there is no offender (conflict of conscience, *force majeure*).

It is understandable that in countries where the practice of euthanasia has become fairly common and is generally accepted by the public at large, the question of its legalization arises. The views on the desirability of such a formal step differ widely.

It is sometimes, and then rather convincingly, argued that legislation is unnecessary and that regulation should take place through recognizing euthanasia as justifiable on the grounds of medical exception (Langemeijer and others, 1986). In that case, all that might be required is to amend the rules by which the medical profession works and is disciplined. This view has not gone unchallenged, in part because it is felt that such an important issue should not be regulated by the normative standards in that particular profession.

Others feel that legislation is (urgently) necessary. In the Netherlands, three different proposals to that effect have already been made: one in August 1985 by the State Commission on Euthanasia; one through a Private Member's Bill presented in amended form by Wessel-Tuinstra (Democrats, 1966) to the House of Commons in December 1985; and the last one by the Cabinet in January 1986. The latter proposal was meant to reflect current thinking in the Cabinet and was presented to the public as a test and as a basis for discussion.

On 27 April 1989, two different proposals to resolve the issue were discussed by the Parliament. The first was a somewhat amended version of the Private Member's Bill originally proposed by Wessel-Tuinstra and now defended by her party colleague, Kohnstamm. It proposed to change two important articles of the Penal Code. The first of those two articles (293) would be changed in such a way that he who takes the life of someone at that person's explicit and serious request, would, in principle, remain punishable (maximum penalty reduced to four years). In further clauses of that article, however, it is stipulated that the person would not be punished if the act occurred as part of the provision of proper (medical) care, if the patient was in the dying phase or if the patient experienced unbearable physical or mental suffering. It also specified the criteria which would qualify the act as being part of proper (medical) care. The second article (294) would be changed in such a way that he who encourages someone to commit suicide or assists someone in committing a successful suicide would, in principle, remain punishable. However, such an act would not be punished if performed as part of proper (medical) care and according to the criteria stipulated in article 293.

The second Bill for an Act was formulated by the Cabinet. It specified the rules that a medically qualified person would have to follow when performing euthanasia at the explicit and serious request of a patient if he intended to claim that he faced a conflict of choice and acted in a force majeure situation. In this proposal, article 293 of the Penal Code would also be changed slightly, but euthanasia would in principle remain punishable, although the maximum penalty would be reduced to four and a half years or a fine of the "fourth category". The proposal further suggested the insertion of two new articles (6a and 6b) into the Law on Medical Practice. Article 6a, as proposed, stipulates that certain acts would not be considered to be ending someone's life (i.e., ending treatment, not commencing treatment where that would be considered to be without purpose according to current medical practice and acts intended to alleviate suffering but with the additional effect that the end of life would come sooner). Article 6b, as proposed, states that a medically qualified person who reacted positively to an explicit and serious request to end a patient's life would remain responsible for his actions according to the Penal Code and should, when acting on the request, conform to the criteria of proper medical practice. In the second part of this proposed article, the criteria of what constituted proper medical practice in such circumstances were, in fact, listed.

The discussions devoted to these two proposals showed that the political parties were seriously divided. It never came to a vote; almost immediately after the debate the Cabinet fell.

From the way in which the two proposals were formulated, it is evident that they tried to take political realities into account. In particular, the Bill for an Act proposed by the Cabinet showed every sign of being a very uneasy compromise between two coalition partners (Christian Democrats and Liberals). It has come under serious attack from people in the legal profession for its flaws in consistency (Feber, 1989, pp. 21-23). The likelihood that the Netherlands would become the first country in the world with a legalized practice of euthanasia has, as a consequence of those events, declined substantially. For the time being, this does not affect a practice which is well grounded in jurisprudence. And since the medical profession now knows full well "how to sin in order to be forgiven", this situation is most probably to be preferred to one in which new, controversial legislation would have been passed by a very slender majority.

Conclusion

Past and current demographic trends coupled with important normative changes have made terminal illness and euthanasia important issues in many developed countries. Future demographic trends are likely to make those problems even more serious. Good arguments can be advanced for a theoretical justification of a right to die with dignity, interpreted as a right to die a personal death, but the arguments in favour do not go unchallenged. There is, similarly, no agreement on the question whether the current liberal practice of euthanasia in some countries should be legalized. Recognition of a right to die a personal death as a (basic) human right appears to be far away: this becomes very clear if such a right is tested for the usual human rights criteria of universality, individuality, paramountcy, practicability and enforceability.

Notes

1/ Deaths by cause, classified according to the Abbreviated International List, 1975 revision (United Nations, 1986).

2/ A third way of defining the content of such a right would be to consider it an absolute right of self-determination, which would allow everyone to end his life at any moment considered appropriate. However, such a right is seldom claimed even in discussions about suicide and will not receive further attention here.

Annex

DECLARATION FOR EUTHANASIA THROUGH NOTARY

I hereby witness that Mr. .... has appeared before me as testator of this document. The testator declares that this document will hold legal value only in as far as he is not of sufficiently sound mind to declare himself in any other way. The testator has stated the following:

1. Should I at any future date, through illness etc., be in an irreversible condition (either physically or mentally) which denies me a reasonable quality of life, then I state my wishes in the strongest possible terms:

(a) that no means should be used to lengthen my life, nor to prevent my death. I should be allowed to die while receiving treatment which, for instance alleviates pain, and which treatment should be continued until my death.

(b) that in as far as under (a) above any medication (or treatment) in use does not give sufficient results while other possibilities might lead to a comfortable death, then such alternatives may be used.

2. Should the medical practitioner in attendance not have access to, or be unwilling to implement, the right means, then I require that he transfer me to another practitioner. Should the medical practitioner in attendance be unwilling to agree to such a transfer, then my next-of-kin (or executor) is hereby authorized to give the order for this to be done.

3. I authorize the holder of this document (notary) to give a copy to any medical practitioner who treats me, if and when he requests it.

4. This declaration shall remain valid for a maximum of five years unless it has been impossible (on grounds of mental, or any other, impairment) for me to renew same.

In the capacity of notary, the testator of this document is known to me.

I hereby declare the original document was drawn up on this ____ (date) __ in a professional way. A summary of the contents has been read to the testator who declares that he is conversant with its contents and has signed it in my presence, to which my own signature herein testifies.

Notes:

(a) It is agreed here that no single medical practitioner can be forced to give euthanasia against his will.

(b) Where possible, the notary should be informed in writing if any changes are made to this document, or if the intention of this document is withdrawn.

References

Cleton-van de Dikkenberg, E. C. (1989). Terminale zorg en Euthanasie (Terminal care and euthanasia). Utrecht, Netherlands: G.G. en G.D.

Council of Europe (1955). European Yearbook. Vol. I. The Hague: Martinus Nijhoff.

__________ (1987), Recent Demographic Developments. Strasbourg.

de Beaufort, I. (1987). Op weg naar het einde? (On the way to the end?). In Euthanasie: Knelpunten in een discussie (Euthanasia: issues in a discussion), G. A. van der Wal, ed. Baarn, Netherlands: Ambo.

Eurostat (1987). Demographic Statistics. Luxembourg.

Eurostat (1988). Demographic Statistics. Luxembourg.

Feber, H. R. G. (1987), De wederwaardigheden van artikel 293 van het Wetboek van Strafrecht van 1981 tot heden (The vicissitudes of Article 293 of the Penal Code from 1981 till now). In Euthanasie: Knelpunten in een discussie (Euthanasia: issues in a discussion), G. A. van der Wal, ed. Baarn, Netherlands: Ambo.

__________ (1988). De Gezondheidszorg en het Strafrecht. Het beleid van het openbaar ministerie bij de behandeling van strafzaken met medische aspecten. Preadvies voor de Vereniging van Gezondsheidsrecht. (Health Care and Penal Law. The policy of the Office of Public Prosecution in the treatment of criminal cases with medical aspects. An Advice to the Society for Health Law) (February).

Langemeijer, G. E., Ch. J. Enschede and Th. W. van Veen (1986). Euthanasie heeft geen wetgeving nodig (Euthanasies doesn't need legislation) Netherlands Tijdschrift voor Geneeskunde (Amsterdam), vol. 130, No. 5 (February), pp. 223-225.

Macfarlane, L. J. (1985), The Theory and Practice of Human Rights. Southampton: The Camelot Press; New York: St. Martin's Press.

Netherlands (1985). Rapport van staats-commissie euthanasie (Report of the State Commission on Euthanasia). The Hague: Staatsuitgeverij.

Oliemans, A. P., and H. G. J. Nijhuis (1984). Euthanasie (verzoek) (Euthanasia (request)). Epidemilogisch Bulletin, vol. 21, No. 2.

Organisation of African Unity (1981). African Charter on Human and People's Rights.

Organization of American States (1970). Treaty Series, No. 36. Washington, D.C.

Peilstations Nederland (1986). Continue Morbiditeits Registratie 1986 (Continuing registration of morbidity, 1986). Uitgeser Stichting Nederlands Huisartsen Instituut.

Ramcharan, B. G. (1985). The concept and dimensions of the right to life. In The Right to Life in International Law, B. G. Ramcharan, ed. International Studies in Human Rights. Dordrecht, Netherlands: Martinus Nijhoff, pp. 1-32.

Redelbach, A. (1985). Protection of the right to life by law and by other means. In The Right to Life in International Law, B. G. Ramcharan, ed. International Studies in Human Rights. Dordrecht, Netherlands: Martinus Nijhoff, pp. 182-220.

United Nations (1986). Demographic Yearbook 1985. Special Topic: Mortality Statistics. Sales No. E/F.86.XIII.1.

__________ (1988a). Human Rights: A Compilation of International Instruments. Sales No. E.88.XIV.1.

__________ (1988b). World Population Prospects, 1988. Population Studies, No. 106. Sales No. E.88.XIII.7.

Van de Kaa, D. J. (1988). The Second Demographic Transition Revisited: Theories and Expectations, No. 109. Amsterdam: PDI-Werkstukken.

Van der Wal, G. A. (1987). Bestaat er een recht op sterven? (Does a right to die exists?). In Euthanasie: Knelpunten in een discussie (Euthanasia: issues in a discussion), G. A. van der Wal, ed. Baarn, Netherlands: Ambo.

Vos, M. (1985). Toetsing bij Euthanasie (Testing euthanasia). Medisch Contact, vol. 40, No. 35, pp. 1059-1060.

X. HUMAN RIGHTS, POPULATION AGING AND INTERGENERATIONAL EQUITY

Norman Daniels*

A. The aging of populations and welfare rights

The aging of society forces major changes in the institutions responsible for social well-being. As the age profile of a society--the proportion of the population in each age group--changes, social needs change. 1/ As society ages, proportionally fewer children need education and fewer young adults need job training, but more elderly persons need employment, income support and health care, including long-term care. Changing needs find political expression. Strong voices press for reforms of the institutions that meet these needs. At the same time, advocates for existing institutions and their beneficiaries resist change. The result is a heightened sense that the old and the young are in conflict, competing for a critical but scarce resource, public funds that meet basic human needs.

Underlying this common perception of competition between the old and the young, underlying the call for intergenerational equity being voiced in some industrialized societies, there lurk two challenging new problems of distributive justice. 2/ First, what is a just or fair distribution of social resources among the different age groups competing for them? The approach to this problem taken here--the prudential life-span account--involves imagining that one can prudently allocate a lifetime fair share of a particular resource, such as income support or health care, over the whole life span. Then, what counts as a prudent allocation between stages of a life will be the guide to what counts as a just distribution between age groups. But an institution that solves the age group problem must also solve the second problem, the problem of equity between birth cohorts: what is fair treatment of different cohorts as they age and pass through transfer and savings schemes that solve the age group problem? This paper distinguishes those two problems and suggests how they can be simultaneously solved for schemes that transfer such goods as income support and health care over the life span. As is shown, somewhat different issues arise in developed and developing countries.

---

*Professor, Department of Philosophy, Tufts University, Medford, Massachusetts, United States of America. This paper is based in part on material contained in Daniels (1988). The author is grateful to the publishers for permission to draw on that material for this paper. Another version of this paper will appear in Meaning and Method, George Boolos, ed. (Cambridge University Press, forthcoming), a Festschrift in honor of Hilary Putnam.

Solving the age group and birth cohort problems is necessary if one is to understand the human rights implications of the aging of society. Articles 23-26 of the Universal Declaration of Human Rights (United Nations, 1988, pp. 5 and 6) affirm that people have what is here called "welfare rights"--rights to decent jobs, to rest and leisure, to a standard of living adequate to assure health and well-being and to education. In a general and abstract way, these articles assert that countries have obligations to ensure that certain basic human interests and needs shall be met.

Just what Governments are required to do and just what individuals are entitled to claim in light of those rights--that is, just what the content of those rights really is--depends fundamentally upon the types of needs that must be met and on their distribution in the society. In a rural, agricultural society, the needs of the small number of elderly may be met through part-time employment and family support. The rights of those elderly to a decent standard of living may thus be met through traditional employment patterns and the discharge of familial obligations, without any governmental intervention. 3/ But industrialization and urbanization, combined with a major demographic shift that produces many elderly, may mean that the basic economic needs of the elderly are no longer met. New social transfer mechanisms must be forthcoming or the welfare rights of the elderly will be violated.

Similarly, what a Government is obliged to do to meet the health-care rights of its citizens depends upon the profile of medical needs in that society and upon the resources that can be made available to meet those needs. In the same way, what individuals are entitled to claim by way of medical services depends upon what counts as a fair distribution of medical services, given those needs and the limitations on resources available to meet them. For example, when there are very few aged people with partial disabilities; and when there are typically many children per aged parent, including adult daughters not in the work-force; and when medical technology can rarely prolong the lives of the frail elderly, then their right to long-term health care (which seems to be implied by article 25 of the United Nations Declaration on Human Rights) appears to be satisfied by the discharge of family obligations. But as all those conditions change, social resources for long-term care, including personal services at home, become an important way of meeting health-care needs and discharging health-care rights. 4/

The problem is not as simple as those examples suggest. As the profile of needs changes with societal aging, new disputes arise about the priorities for meeting those needs. These are especially difficult problems to solve. The needs of the elderly for employment opportunities and income support compete with the needs of younger workers for the same goods. The rights of the young and the old to a decent level of living are in conflict under conditions of limited resources. Similarly, the old and the young both need health care. If resources are scarce and not all needs can be met, there still is a serious problem of distributive justice. This is not a case in which the basic needs of one group are not being met while another group enjoys special privileges or affluence. In that case, one can justify redistribution by appealing to the greater urgency of the needs of the less fortunate group.

Indeed, that is when an appeal to their welfare rights seems most compelling. But what does one do when the competition between the old and the young is for life-extending health care or for income support necessary to meet other basic needs? Here, claims of comparable importance, based on appeals to the same rights, conflict. To resolve such disputes about the content of welfare rights, one must determine what counts as a fair distribution of social resources among the different age groups and birth cohorts competing for them. 5/

Those examples also point to another implication of societal aging for human welfare rights. Demographic changes combine with other economic and social forces to raise complex questions about who is responsible for guaranteeing those rights. Under some conditions, those rights may be protected largely through private, non-governmental systems of support. But under other conditions, formerly limited to the industrialized countries but now quite general throughout the world, co-ordinated public action is required to guarantee welfare rights. The aging of society further advances the need for public responsibility. Nevertheless, it remains a complex question of how to mesh public obligations with private or familial obligations and systems of support. For example, heated debate in the United States of America still focuses on the degree to which traditional family values will be undermined by enlarging government programmes for long-term care. In developing countries, the problems are even more complex, as is shown below.

In the following sections, age group and birth cohort problems are first distinguished and the author's approaches to them are sketched. The discussion then returns to further consideration of the implications of societal aging for human welfare rights in both developed and developing countries.

B. Age groups and birth cohorts

In the United States, the call for intergenerational equity has been confusing. Some complain that in recent years too much has been spent on the old and too little on the young (see Preston, 1984; Longman, 1987), in effect removing many elderly from poverty while pushing many children into it. They refer to this as "intergenerational inequity". Others argue that the current young will never benefit as generously from social security as the current elderly, and these authors refer to this as "intergenerational inequity". There are really distinct issues of distributive justice here. The first complaint concerns justice between age groups; the second is about equity in the treatment of different birth cohorts.

It is easy to confuse those notions. The term "generation" is ambiguous. One can speak of the perennial struggle between the generations, meaning the conflict between the old and the young, or one may speak about the generation of the 1960s, meaning a particular birth cohort. The notions are also easily confused because, at a given time, people in a given age group, say the elderly (those over 65), are also members of a particular birth cohort (those born prior to 1924).

Nevertheless, age groups and birth cohorts are different notions and give rise to distinct problems of distributive justice. Over time, an age group includes a succession of birth cohorts. Twenty years ago, the elderly included only pre-1924 birth cohorts. Today, they include all pre-1924 cohorts. Age groups do not age. Over time, new and different birth cohorts simply move into other age groups. In contrast, birth cohorts do age. They pass through the stages of life, and so, at different times, fall into different age groups.

A birth cohort is a distinct group of people with a distinctive history and composition. The question what is a just distribution of social goods between birth cohorts thus carries with it the assumption that one is focused on the differences between distinct groups of people. For example, special questions of fairness may arise because of particular facts about the socio-economic history and composition of particular birth cohorts. The notion of an age group abstracts from the distinctiveness of birth cohorts and considers people solely by reference to their place in the life span. Consequently, the question about justice between age groups also abstracts from the particular differences between the current elderly and the current young that arise because of the distinctive features of the birth cohorts that happen to make up those age groups. The concern is with a common problem about justice between the old and the young that persists through the flux of aging birth cohorts. 6/

Age groups and birth cohorts are not only conceptually distinct, but distinct issues of justice concern them. Insisting, for example, that different cohorts should be treated equitably or fairly does not indicate just what transfers society ought to guarantee between the young and the old. Knowing that what one does for one cohort must be equitable compared with what is done for another does not help one to learn what should be done for either as they age. Answering the age group question properly, however, may teach what to do for each birth cohort over time.

Another point suggests that those problems are distinct. The question about age groups is centrally connected to certain other issues of justice in a way that the question about birth cohorts is not. For example, worries about age bias and age discrimination abstract from any consideration about birth cohorts. In asking whether people over 65 should be required to retire or whether they should be denied access to life-extending medical services, such as dialysis, as they are in the United Kingdom of Great Britain and Northern Ireland (Aaron and Schwartz, 1984), one is not asking a question that in any way turns on differences between birth cohorts. One is asking a question about the treatment of different age groups. Similarly, other moral issues, such as questions about filial obligations, are raised about the young and the old in general. Those issues are too abstract from questions about particular birth cohorts.

The following discussion adresses two problems of "intergenerational equity". The age group problem asks what is a fair distribution of resources between the old and the young. The birth cohort problem asks what is fair treatment for different birth cohorts as they pass through institutions that distribute goods over the life span. The justice of transfer schemes, such as health-care and social security systems, depends upon answers to both questions. Although there has been some tendency in industrialized countries to be most alarmed about the birth cohort problem, because the solvency of social welfare systems is a matter of concern, this discussion begins with the age group problem. One must, in any case, solve it, as every birth cohort has an interest in knowing how resources should be distributed across the life span.

C. The prudential life-span account

What is a just distribution of resources between the young and the old? The key to answering this question lies in the humbling fact that everyone ages. In contrast, one does not change sex or race. The relevance of those banal observations needs some explanation.

If one treats blacks and whites or men and women differently, then one produces an inequality between persons; and such inequalities raise questions about justice. For example, if one hires and fires on the basis of race or sex rather than talents and skills, then one creates inequalities that are objectionable on grounds of justice. (Article 2 of the Universal Declaration of Human Rights bears on this issue.) If one treats the old and the young differently, however, one may or may not produce an inequality between persons. If one treats them differently just occasionally and arbitrarily, then one would be treating different persons unequally. But if one treats the young one way as a matter of policy and the old another, and does so over their entire life, then one treats all persons the same way. No inequality between persons is produced because each person is treated both ways. Thus, the banal fact that everyone ages means age is different from race or sex for purposes of distributive justice.

This account of justice between age groups builds on this basic point: unequal treatment at different stages of life may be exactly what one wants from institutions that operate over a lifetime. Since needs vary at different stages of life, one wants institutions to be responsive to those changes. For example, in many industrialized countries, people defer income from their working life to the post-work retirement period through some combination of individual savings and employee or government pension or social security plan. In many such schemes, there are no vested savings, but a direct transfer from the working young to the retired old. Viewed at a moment, it appears that "we" young workers are taxed to benefit "them", the old. If the system is stable over the life span, however, it appears that people's needs for income vary through the different stages of life; and a system has been designed that treats people appropriately-- and differently-- at different ages.

The same point holds for health care. When one reaches age 65 in the United States of America, one consumes health-care resources at about 3.5 times the rate (in dollars) that one does prior to age 65. But one pays, as young working people, a combined health-care insurance premium-- through private premiums, through employee contributions and through social security taxes--which covers not just one's actuarially fair costs but also the health-care costs of the elderly and of children. Age groups are treated differently. The old pay less and get more; the young pay more and get less. If this system continues as one ages, others will pay "inflated premiums" which will cover the higher costs when one is elderly. In effect, the system allows one to defer the use of resources from stages of life when one needs them less into stages at which one needs them more. In general, budgeting those transfers prudently enables people to take from some parts of their life in order to make their life as a whole better.

Thus, one learns two important lessons about the unequal treatment of different age groups. First, treating the young and old differently does not mean that persons are treated unequally over their life span. Secondly, unequal treatment of the young and old may have effects that benefit everyone. Those two points provide the central intuition behind what is here called the "prudential life-span account" of justice between age groups: prudent allocation among the stages of life is the guide to what is just between the young and the old.

The life-span account involves a fundamental shift of perspective. One must not look at the problem as one of justice between distinct groups in competition with each other, for example, between working adults who pay high premiums and the frail elderly who consume so many services. Rather, one must see that each group represents a stage of life. One must view the prudent allocation of resources through the stages of life as the guide to justice between groups. From the perspective of stable institutions operating over time, unequal treatment of people by age appears to be budgeting within a life. If one is concerned with net benefits within a life, one can appeal to a standard principle of individual rational choice: it is rational and prudent that a person take from one stage of his life to give to another in order to make his life as a whole better. If the transfers made by an income support or health-care system are prudent, they improve individual well-being. Different persons in such schemes are each made better off, even when the transfers involve unequal treatment of the young and the old. This means that neither the old nor the young have grounds for complaint that the system is unfair.

The contrast of age with race or sex should now be clear. Differential treatment of people by age, when part of a prudent lifetime plan, involves treating people equally and benefiting them over their entire life. There are no losers. Differential treatment by sex or race always creates inequalities, benefiting some at the expense of others. Losers will have legitimate complaints about unfairness or injustice.

Because it will help to have an example in mind, a prudential life-span account for the case of health care is first developed. Some elements of the problem of social allocation can be brought out by considering an individual--who may be called Prudence--who is trying to design a lifetime health-care insurance package for herself. Prudence is willing to spend only a certain amount of her lifetime resources to insure herself against health-care risks; health care, however important, is not the only good in her life. She quite realistically accepts the fact that the benefits she can buy with that lifetime premium will not meet every conceivable medical need she will have. Therefore, she must be willing to trade coverage for some needs at certain stages of her life for coverage at others. Prudence also believes that she should give equal consideration to her interests at all points in her life. Unfortunately, if she knows how old she is and thinks about things only from the perspective of what she considers important at that point in her life, then she risks biasing the design of her insurance package, for example, by underestimating the importance of things she will need much later in life. To compensate for this bias, she may pretend that she does not know how old she is and will have to live through all the trade-offs she imposes at each stage of her life.

Just as the individual, Prudence, sets a reasonable limit on her lifetime insurance premium, prudent planners acting on behalf of society in general are limited by what counts as a fair share of health care (this concept will be raised again shortly). Their problem is to find the distributive principle that allocates this fair share over the entire life span. Their goal is a distribution that people in each age group would think is fair because they would all agree it makes their life as a whole better than alternatives. To ensure that the planners avoid biasing the design in favour of their own age group, they will be forced to pretend that they do not know how old they are, and it is required that they accept a distribution only if they are willing to live with what it does to them at each stage of their life. Each stage of their own life thus stands in as proxy for an age group, and they will age from conception to death in the system of trade-offs to which they agree. (For a more detailed statement of those and some other qualifications on the concept of "prudent deliberation" appropriate for solving the age group problem, see Daniels, 1988, chap. 3.) 7/

The notion of a lifetime fair share of health care requires clarification. This share is not simply a dollar allotment per person. It consists of entitlements to services that are contingent on people having certain medical needs. More must be said about which contingent entitlements form a fair share.

It is argued elsewhere (Daniels, 1985) that a central, unifying function of health care is to maintain and restore functioning that is typical or normal for the human species. Health care derives its moral importance from the following fact: normal functionning has a central effect on the opportunity open to a person. It helps guarantee people a fair chance to enjoy the normal opportunity range for their society. The normal opportunity range for a given society is the array of life plans reasonable persons in it are likely to construct for themselves. An individual's fair share of the normal opportunity range is the array of life plans he or she may reasonably choose, given his or her talents and skills. Disease and disability shrinks that share from what is fair; health care protects it. Health care lets people enjoy that portion of the normal range to which their full range of skills and talents provide access, assuming those, too, are not impaired by special social disadvantages. The suggestion that emerges from this account is that one should use impairment of the normal opportunity range as a fairly crude measure of the relative moral importance of health-care needs at the macrolevel.

Some general theories of justice, most notably that of Rawls (1971), provide the foundations for a principle protecting fair equality of opportunity, and equality of opportunity underlies articles 21, 23 and 26 of the Universal Declaration on Human Rights. If such a principle is indeed a requirement of an acceptable general theory of justice, then there is a natural way to extend such general theories to govern the distribution of health care. Health-care institutions should be included among those basic institutions of a society which are governed by the principle of fair equality of opportunity. 8/

Because one has obligations to assure people fair equality of opportunity, one has social obligations to provide health-care services that protect and restore normal functioning. This account implies that there should be no financial, geographical or discriminatory barriers to a level of care that promotes normal functioning, given reasonable or necessary limits on resources. Hard public policy choices about which services are more important to provide can be guided by considering their relative impact on the normal opportunity range. Rights to health care are thus system-related: entitlements to services can only be specified within a system that works to protect opportunity as well as possible, given limited resources.

Prudent planners can solve the age group problem if they can clarify what the right to health care means for each age group. To do this, they must agree to a principle for allocating their lifetime fair share to each stage of life. Remember, these planners do not know how old they are. This means that it is especially important for them to make sure social arrangements give them a chance to enjoy their fair share of the normal range of opportunities open to them at each stage of life. This protection of opportunity at each stage of life is particularly important, because they are planning for their entire life and must keep in mind the importance of being able to revise their views about what is valuable in life as they age. But impairments of normal functioning by disease and disability clearly restrict the portion of the normal opportunity range open to individuals at any stage of their life. Consequently, health-care services should be rationed throughout a life in a way that respects the importance of the age-related normal opportunity range. In effect, all specific allocation decisions must be constrained by this principle. Its implications for health-care rights in developed and developing countries are considered below.

This approach to solving the age group problem is quite general and will help one to think about other welfare rights as well. For example, article 25 of the Declaration includes the right to income support during periods of unemployment, including retirement in old age. The young and the old appear to be in competition here just as much as in the case of health care. The prudential life-span account asks one to think about how planners who do not know their age would allocate a lifetime fair share of such entitlements to each stage of life. Here, too, the lifetime fair share is not some lump sum in dollars, but a range of contingent entitlements to support. Those entitlements are specified in relation to what justice in general permits in the way of economic inequalities between persons.

Prudent planners, operating under the constraints sketched above, would have to reason as follows. They cannot expand their lifetime income share by allocating it in certain ways, for example, by setting aside income early in life and investing it heavily in their own human capital or otherwise. Such investment strategies are already accommodated within the notion of a lifetime fair income share, or so it is supposed when one is imagining them budgeting a fixed but fair lifetime share. 9/ These planners do not know how old they are, and they must allow for the fact that their preferences or views about what is good in life will change over the life span. The prudent course of action would be to allocate their fair share in such a way that their standard of living would remain roughly equal over the life span (call this the "standard of living preservation principle"). They would want institutions to facilitate income transfers over the life span in such a way that the individual would have available to himself, at each stage of life, an adequate income to pursue whatever plan of life he or she may have at that stage of life. Of course, the term "adequate" is here used in relation to that person's fair income share, as determined by the acceptable inequalities of the society. This principle has implications for income support in old age, an aspect discussed below.

The general rights to education described in article 26 also must be refined to solve the age group problem. People are used to thinking of education as a process early in life, one that helps set the trajectory for the quality of later life. But as more and more people live longer in the context of rapidly changing technologies, and as societies age, it is necessary to think anew about the role of education throughout the life span. Education, like health care, is important for protection of fair equality of opportunity; and prudent planners would probably want the education system to be designed so that it would protect the normal opportunity range at each stage of life. Later, the discussion covers in somewhat greater detail how one must think about welfare rights, given the aging of society in developed and developing countries. First, it is preferable to describe quite briefly how the problem of equity between birth cohorts should be addressed. The solution to this problem also places constraints on the specific entitlements that can be granted through a system of welfare rights under different conditions.

D. Equity between birth cohorts

In the United States of America, many people have pointed to the fact that benefit ratios--the overall ratio of benefits to contributions--have been falling for successive cohorts entering the social security system, and there is considerable concern that those ratios will continue to fall. A special instance of the problem of equity between birth cohorts concerns the question what inequalities in benefit ratios are fair or equitable. More generally, one may ask what inequalities in the treatment of different cohorts are just or fair as those cohorts pass through institutions intended to meet the requirements of justice between age groups.

Each birth cohort has an interest in securing institutions that solve the age group problem effectively. This is true because each cohort ages and has an interest in solving the age group problem. But institutions or transfer schemes that solve the age group problem operate under considerable uncertainty. There is uncertainty about population and economic growth rates, as well as about technological change, which further affects productivity. Errors are likely to abound, and inequalities in benefit ratios between cohorts will arise as a result. But institutions that can solve the age group problem must remain stable over time. They must weather the political struggle that will be a result of unjustifiable or unacceptable inequalities in benefit ratios. Such institutions will be able to survive the struggle among coexisting birth cohorts only if each feels it has a stake in preserving them. Each will feel it has such a stake only if it believes those institutions work to its benefit within the limits of fairness.

The practical target for this commitment can be taken to be approximate equality in benefit ratios. Nevertheless, uncertainty obtains. Productivity can increase or decrease under certain economic conditions. How should the benefits of increasing productivity be shared? Some argue that the concept of desert should play a role here. Rewards or entitlements should be proportional to the contributions one--or one's cohort--has made. But this would imply that benefit ratios should depend upon disentangling the many sources of change that contribute to rising or falling economic fortune. It is hard to see how a stable system could incorporate such factors in its scheme of benefits.

One might try to cut through some of the complex issues raised by the concept of desert by appealing to the interest each cohort has in providing for stable institutions that solve the age group problem. Cohorts must co-operate to achieve such stability. But co-operation will require some sharing of risks across cohorts. In general, the burdens of economic declines and of living through unfavourable retiree/employee ratios must be shared, as must the benefits of economic growth and favourable retiree/employee ratios. This suggests again that approximate equality in benefit ratios should be the practical target of public policy, if not a hard and fast rule. This may mean, for example, that transfer schemes may have to build cushions of reserves, which are not spent on the current elderly, if cohorts that will retire under less favourable conditions are to enjoy equity of treatment. In the United States, building such reserves creates considerable political tension, for the reserve funds are targets of convenience for those who want to use those resources for other purposes.

The present author's solution to the birth cohort problem, that one should strive for approximate equality of benefit ratios because that will help ensure stability, is open to an important objection. The objection is that birth cohorts cannot be trusted to abide by a transfer scheme that ideally solves the age group problem through intercohort transfers, because, as they age, they may use their increasing political power to revise the scheme in favour of their old age, benefiting heavily at both ends of the life span. Thomson (1989) suggests that a particular cohort has been greedy in just those ways in New Zealand, and that similar distortions have occurred in transfer schemes elsewhere. His argument is compatible with the view that this behaviour is just the result of the special circumstances or opportunities that faced a particular cohort. But a stronger version of this objection might claim that the pattern is general or invevitable. For example, some public choice theorists (e.g., Epstein, 1988) have argued that large-scale, State-managed transfer schemes are sitting ducks for the self-interested behaviour of aging cohorts, as their political power increases.

The present solution to the birth cohort problem rests on the claim that each cohort has an interest in providing itself with a stable solution to the age group problem. The objection just noted says that sometimes or even generally, given the opportunity, self-interest will drive a cohort to undermine a fair scheme, leading it to take unfair advantage of the less powerful cohort that follows it.

It should be noted that not all cohorts behave in this way. More important, it is not obvious what the alternative is. If one avoids schemes that depend upon intercohort transfers of the type that occur in the United States Social Security system, then one still must answer the question how social institutions can facilitate adequate types and rates of savings. That is, one goes back to the age group problem, but it must now be solved by relying only upon the resources of one cohort. Moreover, one is ruling out an important adventive offered by a system involving intercohort transfers, namely, that it tends to share risks more widely over time. One cannot take advantage of the fact that an equitable form of risk-sharing would be much more desirable than the results of privatizing the age group problem for each cohort.

Avoiding schemes that involve intercohort transfers in order to avoid unequal benefit ratios does not mean that different cohorts will fare equally well once each is solely responsible for its own well-being over the life span. In fact, inequalities will come about because of uneven economic growth rates. It is not at all obvious that inequalities of benefit ratios in intercohort schemes will generate more intolerable forms and degrees of inequality than the inequalities that result when each cohort must depend upon its own resources and good luck. Co-operation may be a better strategy than going it alone, and the problem becomes one of institutional design and of securing a long-term commitment to schemes that are fair.

The ideal solution being sketched for both age group and birth cohort problems, then, is not merely utopian. It can serve as a basis for moral and political criticism of attempts by particular cohorts to undermine just transfer schemes. There is more than one way to learn from history. Rather than learn that no cohort can trust another, one should seek to make more explicit the principles around which cohorts can seek the benefits of co-operation.

E. Welfare rights and family obligations

The account thus far has skirted a very important issue concerning societal aging and welfare rights, namely, whose responsibility it is to assure that welfare rights of the elderly are met. Specifically, the question is how this responsibility is to be divided between the Government and individuals or families. The position taken here is that those welfare rights are ultimately the responsibility of society to assure through government authority, but this ultimate responsibility does not preclude dividing the burden of meeting those rights in various ways among families and the Government, depending upon important facts about the given society. This paper touches only briefly on several related points.

There are obvious reasons that the ultimate responsibility for assuring those welfare rights of the elderly must be societal. Many elderly will have no families who can be assigned specific responsibility. The economic policies and social structures that affect employment, health status and health services are all beyond the immediate control or responsibility of individuals or families. Even if the burden of providing economic or personal support falls on families for the care of some elderly, it is society which must co-ordinate (through incentives or sanctions) that individual behaviour and supplement it where necessary.

This general point about societal responsibility is sometimes lost in the controversy--and rhetoric--about who should bear the costs of meeting the needs of the elderly. In the United States, for example, recent appeals in the political arena to return to "traditional family values" provided a background for some (unsuccessful) state initiatives to make adult children legally responsible for some of the costs being incurred by state governments for nursing-home care of the elderly. This appeal to filial or family obligations warrants making several points.

First, in a culturally diverse country like the United States, there is no shared cultural tradition that selects out just one, well-defined set of filial obligations. The attempt to elevate some mythical set of traditional values into a shared tradition should be avoided, for it is an unsound basis for public policy. It risks failing to respect the cultural diversity that exists in the United States and in many larger countries. In some countries, where a set of filial obligations is widely recognized as a shared heritage, public appeal to such tradition may be less objectionable, but it still risks doing an injustice to some minorities.

Secondly, even where there is a widely shared tradition of family support for the elderly, it may be very difficult to extrapolate from the obligations that held under past demographic, social and economic patterns to the obligations it would be appropriate to consider binding under current conditions. After all, very few adult children had to support frail elderly parents in past generations; many do now and more will in the future. And support provided in traditional agricultural settings, where the elderly controlled the land, is not necessarily the same thing as support provided under quite different social and economic conditions in urban settings today. Even a well-defined tradition may not indicate just what a comparable burden is today. Consequently, in the context of rapid demographic and social change in developing countries, the insistence that traditional family values must prevail and that the support of the elderly is entirely a family responsibility can be demanding either the unfair or the impossible. Families in those circumstances should not be asked to shoulder a much larger burden in the name of tradition than families ever had to shoulder in the past. And they should not be asked to do so when social and economic change leaves them completely incapable of shouldering that larger burden. Appeals to traditional values should not be a cynical way of avoiding the development of public policies that help families provide support to the elderly or of avoiding the necessity of picking up the slack when families cannot help the elderly.

Thirdly, even in culturally diverse, yet highly developed societies, such as the United States, a substantial proportion of support services and care for the partially disabled elderly is provided by families (up to 80 per cent according to some estimates). It is unlikely that any purely public system of social support could provide an adequate substitute for the quantity and quality of care provided by families. So the real task for public policy is to facilitate family support wherever possible, by providing incentives and supports for families that offer such care. It is quite inappropriate for Governments to insist that the obligations to provide such care are really individual and, at the same time, to avoid providing a climate in which such obligations can be met without undue strains on moral commitment. Of course, changes in family structure and geographical mobility mean that many elderly have no adult children who are in a position to help them at all. As society ages, in both developed and developing countries, some supplementary system of public supports will have to be provided.

In developing countries, the challenge to protect the welfare rights of the growing numbers of elderly is very great because resources for social transfer schemes are hard to come by. The option of appealing either to individual savings or to tax-based transfer schemes from younger to older cohorts may not be open to the poorer developing countries. Many commentators have therefore noted that government policy may have to make up for inadequate social transfer schemes by developing various incentives to continue the provision of family support. Policies that focus on employment and housing may be crucial to maintaining family and community networks capable of meeting the welfare needs of the elderly under rapidly changing economic and social conditions (Binstock, Chow and Schulz, 1982). Even where the focus of public effort must remain on creatively encouraging private and family transfers of support, the ultimate responsibility for assuring welfare rights remains a societal one. What cannot be done, as noted above, is simply to insist that traditional family values must prevail. Under new conditions and with a much greater burden of elderly to support, traditional family structures must be supplemented by novel government policies.

Those remarks suggest that public policies can successfully assure welfare rights to aging societies in a variety of ways, dividing the burden in various ways between public and private systems of support, depending upon local economic conditions and cultural traditions. Thus, one again sees that the actual content of welfare rights will be quite system-related. In some contexts, entitlements to care will mainly be correlated with family obligations to provide support; in others, entitlements will be to public systems of support. There does not appear to be any one model that best assures those rights in all existing conditions. Unfortunately, there also does not seem to be any one, easy solution to the problem of supporting a much larger elderly population in the poorer developing countries, and Governments will have to develop novel policies if the welfare rights of the elderly are not to be seriously threatened.

F. Current controversies and welfare rights

Because the aging of society alters the content and distribution of welfare needs, it has important implications for welfare rights. Conflict about those implications has surfaced as concerns about intergenerational equity, especially in some developed countries with extensive social welfare systems. It has been argued here that the content of those welfare rights can be clarified if two distinct problems of distributive justice--the problem of justice between age groups and the problem of equity between birth cohorts--can be solved. To solve the age group problem, one must imagine prudent planners (who do not know how old they are) budgeting a lifetime fair share of an important good, such as health care or income support, among the stages of life. What is prudent between stages will count as what is fair between age groups. Distinct birth cohorts will be treated equitably if they receive approximately equal benefit ratios as they pass through institutions that solve the age group problem appropriately. Lastly, depending upon complex facts about a given society, there may be various ways to distribute the burdens of meeting welfare rights among families, employers and governmental programmes, although the ultimate responsibility for assuring those rights is societal, not individual.

A few implications of this general approach to problems of intergenerational equity can be developed by considering several issues of current controversy. Though those controversies have arisen first in developed countries where the aging process is well advanced, they have implications for welfare rights in developing countries as well. Specifically, the following questions which concern the design of health care and income support systems, are considered: (a) whether rights to long-term care are of comparable importance to rights of acute care; (b) whether rationing of high-technology medicine by age is a violation of welfare rights; (c) whether current levels of income support benefits, including early retirement incentives, mean that the welfare rights of future generations will be compromised.

1. Long-term care

Are rights to long-term care of comparable importance to rights to acute care?

Because the likelihood of needing long-term care increases with age, the aging of society raises urgent questions about the long-term care systems in many developed countries. Some experts suggest that long-term care "may well be the major health and social issue of the next four decades, polaraizing society over the next 20 to 40 years" (Vogel and Palmer, 1982, p. v). By 2040, there is likely to be a fivefold increase in the number of people aged 85 or over in the United States and in some European countries, and similar increases in the numbers of very old who are nursing-home residents or are functionally dependent upon the community (Soldo and Manton, 1985, p. 286). Those trends are present in many developing countries as well.

The problem will not be that of merely expanding a basically adequate system. The system in the United States, for example, is by no means adequate to handle current needs. Criticisms of the United States long-term care system focus on the following central faults:

(a) It is very difficult for poor patients who need high levels of care, specially Medicaid recipients, to find nursing-home placements;

(b) The cost of nursing-home care and the eligibility requirements for Medicaid reimbursements drive spouses into poverty, often reducing their ability to maintain independence;

(c) There is premature institutionalization of many people who could be sustained in less restrictive settings if services were available;

(d) There are many unmet needs for personal care and social support services for frail elderly people trying to maintain independent living arrangments;

(e) Care in institutions for the elderly is often not directed to rehabilitation, even though some would be possible;

(f) Families providing long-term care are given few services intended to relieve their burdens.

Two issues are central to explanations of those problems in long-term care systems. First, there is confusion about the moral importance of long-term care services, that is, about their relative importance compared with acute medical services. Secondly, there is controversy about how to mesh public obligations to provide long-term care with the belief that families are responsible for caring for their elders. The prudential life-span account gives a unified view of both issues.

The moral importance of personal medical services derives not from their glamour or prestige but from the purpose and function, which is to maintain or restore or compensate for the losses of normal functioning. Keeping people normal in those ways is of importance because it affects an individual's share of the normal opportunity range at each stage of life. The moral importance of long-term care services also derives from their general purpose and function, which is identical to that of medical services. Their importance for purposes of distributive justice is also measured by their impact on the normal opportunity range at each stage of life. Because the disabilities that require long-term care affect such a substantial portion of the elderly population at the very late stages of life, it is imprudent to design a system that ignores them and meets only the acute-care crises of the elderly. That long-term care should be so seriously neglected in the United States and in some other developed countries is morally indefensible and constitutes a violation of welfare rights of the elderly.

Many advocates of increased home-care services, including personal care and social support services, have emphasized the importance of independent living. They have sometimes cited a principle calling for care in the "least restrictive environment" (see Callahan and Wallack, 1981). Similarly, others have discussed the loss of dignity that accompanies premature or inappropriate institutionalization. The underlying issue, however, is the loss of opportunity range, which has a direct effect on autonomy and dignity, as well as self-respect. The moral issues here thus go beyond comparing the costs of institutionalized and home-based services.

In improving the long-term care system, however, attention should be paid to building on the high level of home care already provided by families. Providing support for families that give such care, through economic incentives and through facilities that give temporary relief to the burdens of providing care, will improve conditions both for the recipients of the care and for the providers. That is, it will improve things at two stages of life, not just one. The prudent planners of a health-care system should thus assist family provision of care, wherever possible.

There are lessons to be learned here for use in developing countries. Those countries can avoid the bias that exists in many developed countries in favour of high-technology acute care and against long-term care services. A properly designed health-care system will better protect the welfare rights of the elderly if it gives appropriate importance to long-term care, which may be of greater value than the provision of high-cost, high-technology interventions that marginally extend the lives of the dying elderly. Of course, some level of institutional care will have to be provided for those elderly who have no other alternatives. A number of commentators have emphasized the importance of facilitating the care of the elderly by paying attention to housing and other community policies that allow families to preserve support relationships in non-traditional settings (see Lawton, 1982). Those are promising alternatives, but they require positive steps to be taken by the Government, and they are not to be confused with simply allowing traditional family supports to continue, for the economic and social fabric surrounding that support has been altered.

2. Rationing by age

Is rationing by age a violation of the health-care rights of the elderly?

In the United States, there is considerable concern that the increasing numbers of elderly will intensify the already acute problem of health-care costs that rise at rates much higher than the rate of inflation. Much of this rate of increase is due to the rapid dissemination of high-cost medical technologies, many of which are directed to conditions that are prevalent among the elderly. In this context, there is a growing discussion about the need to ration beneficial medical treatments. In the United States, the greatest threat to health-care rights will come from the temptation to use ability to pay as a criterion for rationing, but there is a growing discussion of the relevance of age as a basis for rationing some high-cost medical technologies. Callahan (1987) has drawn considerable critical comments for his proposal that consideration should be given to rationing life-extending medical services explicitly by age. Less hypothetically, there is evidence that the British National Health Service already uses age as a basis for rationing some expensive technologies, such as renal dialysis (Aaron and Schwartz, 1984).

Some critics of rationing by age consider it morally impermissible in exactly the way that rationing by race or sex would be. They consider age, as opposed to medical suitability, a "morally irrelevant" basis for distributing medical services. Others (see Callahan, 1987) argue that rationing by age is permissible because the elderly have a duty to step aside and sacrifice for the young; or that it is fair for the elderly, who have had the opportunity to live a long time, to improve the chances of the young, who have had less opportunity to live (see Veatch, 1988).

The prudent life-span approach to the age group problem provides a way to resolve this dispute (see Daniels, 1988, chap. 5). A policy will be fair to different age groups if prudent planners who did not know how old they were would choose it as a way of allocating a lifetime fair share of health care among the stages of life. Under certain conditions of resource scarcity, the following might happen: providing very expensive or very scarce life-extending services to those who have reached normal life expectancy can be accomplished only by reducing access by the young to those resources. That is, saving those resources by giving oneself claim to them in old age is possible only if one gives oneself reduced access to them at earlier stages of life. A central effect of this form of saving is that one increases the chance of living a longer than normal life span at the cost of reducing the chances of reaching a normal life span. Under some conditions, it would be prudent for planners to agree to ration such technologies by age, making them more available to the young than to the very old. If that is true, then such a rationing policy would be fair to each person. Each person would have maximized the chances of reaching a normal life expectancy and these would benefit from the rationing. Each person would be treated equally--judging from the perspective of a whole life. This argument turns on no prior moral assumptions that life at one age is more valuable than life at another; nor does it turn on prior moral views about the duties of the elderly to the young or vice versa.

It is very important to understand that this argument is not an endorsement of rationing by age as a general strategy for reducing health-care costs. Rationing by age would not be the preferred strategy except in very special circumstances of resource scarcity. Also, such rationing would have to be constrained by other considerations of justice. For example, the criteria for rationing and its rationale would have to be public, and people would have to consent to such a scheme through some democratic means. In a broad range of circumstances, it seems quite likely that other criteria for rationing medical services would appear preferable to rationing by age. When it would be prudent to ration by age, however, age becomes a morally relevant basis for distribution. In general, nevertheless, it is very likely that there are better strategies for rationing health care than rationing by age--ones that would be judged preferable by the prudential life span account.

3. Income support policy

Do current levels of income support benefits, including early retirement incentives, mean that the welfare rights of future generations will be compromised?

Some of the loudest complaints about intergenerational equity come from critics of social security policies in developed countries. The complaint is that relatively high levels of benefits enjoyed by current elderly cohorts cannot be sustained as the aging of society proceeds and there is a reduced ratio of employed to retired workers. The complaint is that current cohorts of workers will never be able to enjoy comparable benefit ratios when they retire. In the United States, some of the shrillest proponents of intergenerational equity call for dismantling the social security scheme and forcing each cohort to rely upon its own resources for income support in old age.

The approach to the birth cohort problem given here has important implications for this issue. In general, it is necessary to secure stable solutions to the age group problem, solutions that will earn the support of successive cohorts. This suggests that approximate equality in benefit ratios should be a target for public policy. Several strategies are available for adjusting benefits so that this target is achievable despite demographic shifts, such as the aging of society. One strategy is to build a cushion of unexpended benefits while the ratio of workers to retirees is still relatively high. This strategy has been adopted in some recent financing reforms of the United States social security system, though there is always a risk that those benefits will be a target of convenience for politicians seeking to relieve budget deficits.

A second strategy is more basic, for it involves rethinking some of the policies towards retirement that have dominated developed welfare systems in recent decades. Many current policies provide considerable incentives for older workers to withdraw from the work-force well before any disability actually makes such withdrawal necessary. It is also quite difficult for older workers to find flexible, part-time employment that can reduce the need for drawing on income support benefits. Underlying those incentives and policies are both economic and moral considerations. Pushing older workers out of the work-force in periods of unemployment, when there are large numbers of young workers seeking employment opportunities, may have seemed an acceptable way to ration jobs by age; or it may have seemed an appropriate way to make room for better educated and potentially more productive workers in technologically advancing economies. Those economic considerations may have been reinforced by the view that the elderly want to enjoy more leisure time. The question now arises whether those underlying considerations should be reassessed.

Health status for the elderly remains quite good well into their mid-seventies. Millions of elderly who would be happier with some form of meaningful work, at least on a part-time basis, find themselves facing forced withdrawal from the work-force. At the same time, many European economies will actually face a shortage of workers in the next few decades. Under those conditions, it may well be wise to consider revising the existing benefits and incentives that lead workers to withdraw from the work-force early. The new shape of a life, with many vigourous and healthy years extending well beyond standard retirement age, means that society may be in the grip of an antiquated conception of the typical course of life.

In the United States, compulsory retirement ages have been raised or eliminated, at least for large categories of employment, and this may encourage some reassessment of the employability of older workers. It may not be enough, however, simply to eliminate legal or quasi-legal barriers to the employment of willing, elderly workers. Rather, it may be necessary to encourage the emergence of flexible employment practices that accommodate the needs of older workers. Such practices may become an increasingly important way of assuring the welfare rights of an aging population.

Developing countries may have a chance to avoid what are now appearing to be mistakes in the design of income support systems in some developed countries. Given the scarcity of resources in developing countries, a policy that recognizes the growing absolute numbers of healthy, employable elderly people would be highly advisable. Such policies may make it possible to target income support for the elderly so that it meets the needs of those without family or work-based support.

4. The new shape of a life

Increased life expectancy, especially for the elderly, combined with the demographic shift to an older society, changes the typical shape of a life. One can no longer look at the problems of the old as exceptional problems. Each person faces the prospect of planning for life through its expanded late stages. But collectively, society must adjust institutions and policies to accommodate this new shape. Here, quantity changes to quality. When enough lives have the new shape, there is a critical mass of people who have a common interest in making the later stages of life meaningful and productive. The social task--and this involves issues of distributive justice and welfare rights--is to provide an adequate framework of opportunities and means through which diverse individuals can pursue their own views of the good life. The prudential life-span perspective can help people to understand some of the distributive issues that are involved.

One issue that has been frequently discussed by gerontologists is the standard expectation that the elderly, even the energetic and active majority of the elderly, will face the later stages of life without meaningful work. For many people, including the elderly, being productive or pursuing meaningful work is a central element of well-being--one clearly singled out by article 23 of the Universal Declaration on Human Rights. Work is much more important than a mere means to acquire income. Protecting fair equality of opportunity in the later stages of life will require that the development of flexible policies regarding employment of the elderly, as well as many community programmes using volunteers. This argument for the importance of such policies goes well beyond reducing the economic dependency of the elderly upon transfers from the young. It also goes beyond the importance of reducing the rate at which society must save for the later stages of life, though this is an important issue.

Society must further face the educational implications of the fact that a life has a new shape. People must be educated to think prospectively about what an additional 15 or 20 years beyond age 65 should include. It will be necessary to undertake extensive adult education so that people can actively prepare for the projects and plans an extended life makes possible. The new shape of a life makes it more important to provide people with the means and opportunity to revise their plans of life relatively late in life. It is also necessary to explore new housing and community living arrangements that would harness the co-operative energy of the expanded numbers of elderly. Many attitudes towards education, work, family and living arrangments are tied quite directly to the old shape of a life. It would be imprudent not to revise those attitudes and the institutions that arise from them. Not revising them will lead to unjust, that is, imprudent distributions of resources between the old and the young. Not revising them will threaten the welfare rights articulated in the Universal Declaration on Human Rights.

Conclusion

This paper has offered a rather abstract and general description of two problems of distributive justice highlighted by the aging of society. Solving them provides a way to clarify the content of welfare rights and to resolve disputes about intergenerational equity. It would be easy in this paper to lose sight of the most important aspect of this approach: it offers a unifying vision. Everyone passes through institutions that distribute goods over their life span. If those institutions are prudently designed each will benefit throughout life. It is only prudent for people to treat themselves differently at different stages of life, as needs change. What is prudent with respect to different stages of a life determines what is fair between age groups. Prudence here guides justice. If, as policy makers, planners and the general public, people can keep an eye on this unifying vision and ignore the divisive talk about competition between age groups and birth cohorts, then the target will be policies that benefit everyone throughout their life. Establishing such policies would mean doing justice to the old and the young. It would mean giving clear content to people's welfare rights.

Notes

1/ For a detailed study of the effects of the "baby boom" generation as this demographic bulge passed through schools, entered the work-force and faces retirement, see Russell (1982).

2/ These problems are not really new. As every society has some system of transfers of wealth, power and other goods between age groups and birth cohorts, its practices embody, at least implicitly, a solution to the age group and birth cohort problems. Stable, traditional institutions camouflage the existence of these long-standing solutions to such problems. One does not see the problems because nothing unusual seems to be happening. But changing economic, social and demographic conditions force one to face those problems anew.

3/ Of course, traditional agricultural societies varied considerably in the degree to which, and the arrangments by which, they met the needs of the elderly; this author is not advocating a myth of the pre-modern golden age of the family (see Daniels, 1988, chap.2; and Laslett, 1972 and 1976).

4/ This is not to imply that family support no longer is an important way of meeting the personal-care needs of the frail elderly in industrialized societies. Families provide about 80 per cent of such support in the United States (Frankfather, Smith and Caro, 1981).

5/ Throughout this discussion, the present author avoids, as much as possible, philosophical questions about whether those welfare rights are themselves basic or are derived from other, more basic moral notions; the point about their content arises in any case. See Daniels (1985) for an argument that health-care rights derive from more basic notions in a theory of distributive justice, namely, from a principle protecting equality of opportunity.

6/ This is not to say that in general, e.g., in the social sciences, one can talk about the old and the young in abstraction from the different experiences those groups have which derive from differences between cohorts. The experience of old age, for example, will vary from birth cohort to birth cohort, depending upon facts about each cohort's education and prior history (see Featherman, 1983).

7/ In Daniels (1988), it is argued that considerations of prudence require even further restrictions on the knowledge of the deliberators, making them even less like the standard fully informed consumer of economic theory. For example, they should judge their well-being by reference to all-purpose goods, like income and opportunity, rather than through the very specific lens of the plan of life they happen to have at a given stage of life; otherwise, the design of the lifetime allocation may be biased by a conception of what is good which just happens to be held at a given point in life (see also Rawls, 1971, 1982 and 1988).

8/ This proposal requires modifications of the equal opportunity principle discussed by Rawls, however (see Daniels, 1985, chap. 3).

9/ At the level of resources it is a zero sum game, though the resource can be allocated in ways that can be estimated to make their lives go better or worse over all.

References

Aaron, Henry J. (1966). The social insurance paradox. Canadian Journal of Economics and Political Science, No. 32 (August), pp. 371-377.

__________ (1982). Economic Effects of Social Security. Washington, D.C.: Brookings Institutions.

__________, and W. Schwartz (1984). The Painful Prescription: Rationing Hospital Care. Washington, D.C.: Brookings Institution.

American Association for International Aging (1985). Aging Populations in Developing Nations. Washington D.C.: United States Agency for International Development.

Andrews, G. R., and others, (1986). Aging in the Western Pacific. Manila: World Health Organization.

Binstock, Robert H., Chow Wing-sun, and James H. Schulz, eds. (1982). International Perspectives on Aging: Population and Policy Challenges. Policy Development Studies, No. 7. New York: United Nations Fund for Population Activities.

Boskin, Michael J., ed. (1978). The Crisis in Social Security: Problems and Prospects, 2nd ed. San Francisco: Institute for Contemporary Studies.

__________, and John B. Shoven (1987). Concepts and measures of earnings replacement during retirement. In Issues in Pension Economics, Zvi Bodie, John B. Shoven and David A. Wise, eds. Chicago: University of Chicago Press for National Bureau of Economic Research, pp. 113-141.

__________ (1988). Poverty among the elderly: where are the holes in the safety net? In Pensions in the U.S. Economy, Zvi Bodie, John B. Shoven and David A. Wise, eds. Chicago: University of Chicago Press for National Bureau of Economic Research, pp. 115-138.

__________, and others (1986). Social security: a financial appraisal across and within generations. Unpublished paper.

Callahan, Daniel (1987). Setting Limits: Medical Goals in an Aging Society. New York: Simon and Schuster.

Callahan, J. J., and S. S. Wallack, eds. (1981). Reforming the Long-Term-Care System. Lexington, Massachusetts: D.C. Heath.

Daniels, Norman (1985). Just Health Care. Cambridge, England and New York: Cambridge University Press.

__________ (1988). Am I My Parents' Keeper?: An Essay on Justice Between the Young and the Old?. New York: Oxford, University Press.

Epstein, R. A. (1988). Justice across the generations. Paper prepared for the Conference on Intergenerational Justice, University of Texas, Austin.

Featherman, D. L. (1983). The life-span perspective in social science research". In Life-Span Development and Behavior, P. B. Blates and O.G. Brim, Jr. eds., vol. 5. New York: Academic Press, pp. 1-59.

Frankfather, D. L., M. J. Smith, and F. G. Caro (1981). Family Care of the Elderly. Lexington, Massachusetts: Lexington Books.

Gibson, Robert M., and Charles R. Fisher (1979). Age differences in health care spending, fiscal year 1977. Social Security Bulletin (Washington, D. C.), vol. 42, No. 1, pp. 3-16.

Heisel, Marsel A. (1985). Aging in the context of population policies in developing countries. Population Bulletin of the United Nations, No. 17 - 1984. Sales No. E.84.XIII.13, pp. 49-63.

Kreps, Juanita Morris (1971). Lifetime Allocation of Work and Income: Essays in the Economics of Aging. Durham, North Carolina: Duke University Press.

Laslett, Peter, ed. (1972). Household and Family in Past Time. Cambridge, England: Cambridge University Press.

__________ (1976). Societal development and aging. In Handbook of Aging and the Social Sciences, Robert H. Binstock and Ethel Shanas, eds. New York: Van Nostrand Reinhold, pp. 87-160.

Lawton, M. Powell (1982). Environments and living arrangments. In International Perspectives on Aging: Population and Policy Challenges, Robert H. Binstock, Chow Wing-sun and James H. Schulz, eds. Population Development Studies, No. 7. New York: United Nations Fund for Population Activities, pp. 159-192.

Leimer, D. R., and P. A. Petri (1981). Cohort specific effects of social security policy. National Tax Journal, vol 34 (March), pp. 9-28.

Longman, Philip (1987). Born to Pay: The New Politics of Aging in America. Boston: Houghton Mifflin.

Moffitt, R. (1982). Trends in social security wealth by cohort. Paper prepared for the National Bureau of Economic Research Conference on Income and Wealth, Madison, Wisconsin, 14-15 May 1982.

Neugarten, B. (1974). Age groups in American society and the rise of the young-old. Annals of the American Academy of Political and Social Science, 415, pp. 189-198.

Parsons, Donald O., and D. R. Munro (1978). Intergenerational transfers in social security. In The Crisis in Social Security: Problems and Prospects, Michael J. Boskin, ed. San Francisco: Institute for Contemporary Studies, pp. 65-86.

Preston, Samuel H. (1984). Children and the elderly: divergent paths for America's dependents. Demography (Alexandria, Virginia), vol. 21, No. 4 (November), pp. 435-457.

Rawls, John (1971). A Theory of Justice. Cambridge, Massachusetts: Harvard University Press.

__________ (1982). Social unity and the primary goods. In Utilitarianism and Beyond, Amarteja K. Sen and Bernard Williams, eds. Cambridge, England; and New York: Cambridge University Press, pp. 159-185.

__________ (1988). The priority of right and ideas of the good. Philosophy and Public Affairs, vol. 17, No. 4, pp. 251-276.

Russell, Louise B. (1982). The Baby Boom Generation and the Economy. Washington: Brookings Institution.

Soldo, G. J., and K. G. Manton (1985). Changes in the health status and service needs of the oldest old: current patterns and future trends. Milbank Memorial Fund Quarterly, vol. 63, No. 2, pp. 286-323.

Spengler, J. and J. Kreps (1963). Equity and social credit for the retired. In Employment, Income, and Retirement Problems of the Aged, J. Kreps, ed. Durham, North Carolina: Duke University Press, pp. 198-229.

Thomson, David (1989). The welfare state and intergenerational conflict: winners and losers. In Workers versus Pensioners: Intergeneration Justice in an Ageing World, C. Conrad, P. Johnson and D. Thomson, eds. New York: Academic Press.

United States Department of Commerce, Bureau of the Census (1988). Aging in the Third World. International Population Reports Series P-95, No. 79. Washington D.C.: Government Printing Office.

United Nations (1988). Human Rights: A Compilation of International Instruments. Sales No. E.88.XIV.1.

Veatch, Robert C. (1988). Justice and the economics of terminal illness. Hastings Centre Report (Hastings-on-Hudson, New York), vol. 18, No. 4 (November), pp. 34-40.

Vogel, Ronald J., and Hans C. Palmer, eds. (1982). Long-term Care: Perspectives from Research and Demonstrations. Washington, D.C.: United States Department of Health and Human Services, Health Care Financing Administration.