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THE UTILITY OF INTERNATIONAL LAW FOR PROTECTING WOMEN'S HEALTH RIGHTS

Professor Vanessa Merton†

In all candidness, I know little about international law, but I do have some sense of how to use the domestic law on women's health issues. I know how to prosecute men who beat and murder their wives. I know how to sue companies that profit from pharmaceuticals that have not been properly tested and, therefore, harm women. I know how to use administrative advocacy to help poor women get prenatal care, to challenge psychiatric misdiagnoses of women patients and to oppose occupational safety regulations that neglect women workers. But when I try to imagine using the body of documents and the group of institutions that make up this elusive and, to me, exotic animal called international law, it is, to quote Rogers and Hammerstein, a puzzlement.¹

One level of my puzzlement is the body of law itself: what do these documents mean? For example, Article 3 of the Universal Declaration of Human Rights of 1948 guarantees the "right to life, liberty and the security of the person."² Who interprets and declares the meaning of this language and in light of whose experience and values? The effectiveness of international legal institutions is another level of puzzlement. Does anything really change when a nation becomes a "state party" to a Convention? If it *is* decided, by whomever, that the State has violated its obligations, what are the real consequences?

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¹ Richard Rogers and Oscar Hammerstein, *The King and I*.

² UNIVERSAL DECLARATION OF HUMAN RIGHTS [hereinafter DECLARATION], *adopted*, Dec. 10, 1948, G.A. Res. 217A(111), 3 U.N. GAOR (Resolutions part 1) at 71, U.N. Doc. A/810 (1948).

Does a Declaration or a Protocol actually modify human behavior?

Certainly, women face an array of threats to our health that transcend national boundaries, but may not be very amenable to international legal intervention. First, in every country, women are poorer than men and access to both health care and healthful living conditions is tied to economic status. Thus, women are far more likely than men to lack the basics that promote and preserve health: clean water, adequate food, healthful shelter and, of course, medical care.³ But it's unclear to me whether international law can address that disparity. Second, female *reproductive* activity, inherently and because of social conditions, is more dangerous than male reproductive activity. International law can hardly alter that. Third, around the world, biomedical research systematically fails to investigate women's health needs with a resultant "knowledge gap" of science that would benefit women.⁴ Can international law help? Not very directly.

There is one area, however, where international law seems to hold promise; certain cultural practices that pose special, direct threats to the lives and health of women (although male infants and children often share women's vulnerability in this regard). I have in mind sexual slavery, coercive prostitution and pornographic exploitation, rape, compulsory marriage, coerced impregnation and its converse, coerced abortion and sterilization; spousal abuse, dowry deaths and coerced suicide, female infanticide and sex-specific abortion. All of these practices are the product not of microbes, poor hygiene, or a lack of health care, but of deliberate human behavior. All these practices have a double identity; you can call them health problems, epidemics, pandemics, and you can also see them as forms of

³ "Women make up more than half the world's population, yet perform two thirds of its work, receive one tenth of its income, and own less than one hundredth of its property." United Nations, Office of Public Information, United Nations Decade for Women 1976-1985, *Really Only a 'Beginning,'* 22 UN CHRON., July-Aug. 1985, at ii.

⁴ VANESSA MERTON, *The Exclusion of Pregnant, Pregnable, and Once-Pregnable People (a.k.a. Women) from Biomedical Research*, 19 AMER. J.L. & MED. 369 (1993); VANESSA MERTON, *Ethical Obstacles to the Participation of Women in Biomedical Research*, FEMINISM AND BIOETHICS: BEYOND REPRODUCTION 216 (Susan Wolf, ed. 1996).

violence against women — techniques of social control. This dual identity may converge under the rubric of human rights to the extent that the right to health is a component of basic human rights. But whether these practices are considered symptomatic of pathology or the product of power structures, or both, the question remains; does international law have a role to play in response to such phenomena and, if so, what is it?

Now, to make this exercise a bit less abstract, I'd like to put on the table one such phenomenon: the practice now commonly referred to as "female genital mutilation."⁵ Without going off on too much of a tangent about FGM, I'd like to use it as an illustrative problem of women's health and examine the potential implications of international law for its continuation. FGM is a good vehicle for this purpose, I think, because it is a pervasive, worldwide practice that everyone agrees has significant consequences for the physical and psychological health of women (whether those consequences are perceived to be deleterious, as they are by many Europeans and European-Americans and African and African-American feminists, or perceived to be positive and life-enhancing, as they are by its practitioners in the thirty or so countries where FGM is prevalent).

I should probably pause to define what I mean by FGM. According to the basic World Health Organization definition,⁶ FGM is the partial or total removal of a woman's external genitalia, or other injury to the female genitalia, whether for cultural or other non-therapeutic reasons. It ranges from slitting or snipping the clitoris, to complete excision of the clitoris and labia minor, to amputation of the entire labia and suturing the

⁵ A whole panel could be devoted just to the issue of terminology for this phenomenon. Some consider it less loaded to use a phrase such as "traditional female genital surgeries" or "female circumcision" or "female genital cutting;" some suggest indigenous terms such as "irua" (Kenya) or "tahur" (Sudan). See L. Amede Obiora, *Bridges and Barricades: Rethinking Polemics and Intransigence in the Campaign Against Female Circumcision*, 47 CASE W. RES. L. REV. 275, 289-90, 297 (1997); Hope Lewis, *Between Irua and "Female Genital Mutilation": Feminist Human Rights Discourse and the Cultural Divide*, 8 HARV. HUM. RTS. J. 1 (1995). I prefer the acronym "FGM," which can be heard/read either as "female genital mutilation" or "female genital modification."

⁶ World Health Organization, *FEMALE GENITAL MUTILATION: A JOINT WHO/UNICEF/UNFPA STATEMENT 3 (1997)* [hereinafter WHO STATEMENT].

resulting wound so that scar tissue obstructs most of the vaginal opening, leaving only a tiny passage for bodily excretions.⁷

FGM is traditionally performed by a lay practitioner using a razor, knife, scissors, broken glass, or perhaps a sharpened stone, with no anaesthesia or antibiotics in a nonsterile environment, often out-of-doors.⁸ It is performed on newborns and mature women, including women in advanced stages of pregnancy, but occurs most commonly among children 4-12 years of age "at a time when they can be made aware of the social role expected of them as women."⁹ In many societies it is associated with the transition to adulthood and becoming marriageable.¹⁰

I suppose this would be as good a place as any to read a brief description of a typical FGM:

[W]hen I was a girl of ten, I was told to be brave and not to cry, that I'd be a big girl after the ordeal. But when I saw the half-blind old woman, with her razor, I bolted. My mother and aunts held me down and spread open my legs. Suddenly, I felt excruciating pain. She sliced off my clitoris and now it lay in her gnarled hands. She then sliced my inner lips until there was nothing left. There was blood everywhere, but by now I felt no more pain, not even when she stuck a thorn from the acacia tree into me to keep the wound closed.¹¹

The health effects of FGM are massive. Common sequelae include hemorrhage, shock and toxic shock, tetanus and/or sepsis, blood clots, inability to urinate or incontinence, kidney and bladder damage, genital ulcers, and excruciating pain during intercourse and vaginal birth as well as indescribable psychic trauma and distress, infertility, and neonatal and perinatal death.¹² However, it is argued that much of this could be mini-

⁷ WHO STATEMENT, *supra* note 6 at 3; *see also* Sandra D. Lane and Robert A. Rubinstein, *Judging the Other: Responding to Traditional Female Genital Surgeries*, 26 HASTINGS CENTER REP. 31, 32 (1996).

⁸ WHO STATEMENT, *supra* note 6 at 3-4; *see also* Catherine L. Annas, *Irreversible Error: The Power and Prejudice of Female Genital Mutilation*, 12 J. CONTEMP. HEALTH L. & POL'Y 325, 329 (1996).

⁹ NAHID TOUBIA, FEMALE GENITAL MUTILATION: A CALL FOR GLOBAL ACTION 9 (1993); *see also* WHO STATEMENT, *supra* note 6 at 4.

¹⁰ ASMA EL DAREER, WOMEN, WHY DO YOU WEEP? CIRCUMCISION AND ITS CONSEQUENCES 71 (1982).

¹¹ Joleen C. Lenihan, *A Physician's Dilemma: Legal Ramifications of An Unorthodox Surgery*, 35 SANTA CLARA L. REV. 953 at 953 (1995).

¹² TOUBIA, *supra* note 9 at 13-19.

mized if FGM were performed instead in the context of modern Western medicine, as it has been for decades in Egypt¹³ and as is beginning to happen here.¹⁴

It is estimated that over 130 million women now alive have been subjected to FGM, with an annual increment of about 2 million — roughly 6,000 girls per day.¹⁵ (I can't resist the calculation: FGM will have been performed about 60 times during the time I'm standing here.) Indigenous primarily to Central Africa, it is also practiced in Yemen, Indonesia and Malaysia, the Indian subcontinent, and because of immigration, it is now found in much of Europe, the United States, Canada, Brazil, Australia, and Israel.¹⁶

While the epidemiological data is not very reliable, it's accepted that FGM has been performed on 90%-98% of the female population of Ethiopia, Sierra Leone, Somalia, and the Sudan; 70%-80% of women in Egypt, Mali, Burkina Faso, and the Gambia; and about 50-60% of women in Togo, Nigeria, Kenya, and Chad. Elsewhere the incidence is in the range of 10-30%.¹⁷ Although associated with Islam, FGM is practiced in Christian, Jewish, and traditional African cultures, and predates all of these; it has been traced back at least 4000 years.¹⁸

Domestic legislation to prohibit FGM of minors has been enacted in a number of European and African countries — Switzerland,¹⁹ Belgium,²⁰ Sweden,²¹ the Netherlands,²² Ghana,²³

¹³ Kay Boulware-Miller, *Female Circumcision: Challenges to the Practice as a Human Rights Violation*, 8 HARV. WOMEN'S L.J. 155, 156 (1985).

¹⁴ For example, in September 1996, Harborview Hospital in Seattle announced a tentative decision to permit pediatricians to perform a "mild" form of FGM. See L. Amede Obiora, *Bridges & Barricades: Rethinking Polemics and Intransigence in the Campaign Against Female Circumcision*, 147 CASE W. RES. L. REV. 275, 365 (1997). Intense reaction from the anti-FGM movement quickly led to the shelving of the idea. Tom Paulson, *Doctors Weigh Female Circumcision*, PITTSBURGH POST-GAZETTE, Sept. 15, 1996, at A13; Carol M. Ostrom, *Harborview Debates Issue of Circumcision of Muslim Girls*, THE SEATTLE TIMES, Sept. 13, 1996, at A1; Tom Brune, *Compromise Plan on Circumcision of Girls Gets Little Support*, CHICAGO TRIBUNE, Oct. 28, 1996, at A1.

¹⁵ WHO STATEMENT, *supra* note 6 at 5.

¹⁶ TOUBIA, *supra* note 9 at 26.

¹⁷ Nahid Toubia, *Female Genital Mutilation and the Responsibility of Reproductive Health Professionals*, 46 INT. J. GYNECOL. OBSTET. 127, 129 (1994).

¹⁸ FRAN P. HOSKEN, THE HOSKEN REPORT: GENITAL AND SEXUAL MUTILATION OF FEMALES 71-84 (4th rev. ed. 1993).

¹⁹ Lenihan, *supra* note 11 at 959.

²⁰ TOUBIA, *supra* note 9 at 44.

England,²⁴ Australia²⁵ — including, as of this month, the United States.²⁶ In France the general child abuse statute has been interpreted to outlaw FGM on women under 15.²⁷ However, the practice persists in the face of legislation. In the Sudan, one form of FGM has been criminalized since World War II but is still rampant.²⁸ Officially, Egypt has medicalized the practice, but it continues in nonmedical settings.²⁹

In terms of international law, as early as 1964, a United Nations Conference denounced FGM as both a health problem and a violation of human rights.³⁰ In 1979, the World Health Organization recommended an educational campaign to “eradicate” FGM.³¹ It seems to me that several different embodiments of international law could, in theory, be deemed to cover FGM. I have already mentioned the “right to life, liberty and the security of the person” of the Universal Declaration of Human Rights of 1948.³² Most of the states where FGM is prevalent are signatories of the African Charter on Human and People’s Rights which guarantees the “right to respect for life and integrity of the person” under Article 4.³³ The United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment (opened for signature 1984) prohibits; “any act by which severe pain or suffering . . . is intentionally inflicted . . . for such purposes as . . . intimidating or coercing . . . or . . . based on discrimination of any kind . . . by . . . or with

²¹ Lenihan, *supra* note 11 at 959.

²² *Id.* at 960.

²³ TOUBIA, *supra* note 9 at 44.

²⁴ Prohibition of Female Circumcision Act, 1985, ch. 38, 1 (Eng.).

²⁵ TOUBIA, *supra* note 9 at 44.

²⁶ 18 U.S.C. 116 (1996).

²⁷ Bronwyn Winter, *Women, the Law and Cultural Relativism in France: The Case of Excision*, 19 SIGNS 943 (1994).

²⁸ Karen Hughes, *The Criminalization of Female Genital Mutilation in the United States*, 4 J.L. & POL’Y 321, 336 (1995).

²⁹ Judy Mann, *A Welcome Reversal*, WASHINGTON POST, Dec. 27, 1995, at F13.

³⁰ Boulware-Miller, *supra* note 13 at 164 n.56.

³¹ EL DAREER, *supra* note 10 at 96.

³² DECLARATION, *supra* note 2 at 71, adopted Dec. 10, 1948, G.A. Res. 217A(111), 3 U.N. GAOR (Resolutions part 1) at 71, U.N. Doc. A/810 (1948). A fairly recent American Bar Association Report seems to assume that FGM is covered under this provision. See AMERICAN BAR ASSOCIATION REPORT ON WOMEN’S HUMAN RIGHTS, 30 INT’L LAW. 209, 212 (1996).

³³ AFRICAN CHARTER ON HUMAN AND PEOPLE’S RIGHTS, adopted June 27, 1981, O.A.U. Doc. CAB/LEG/67/3/Rev. 5, (1981), (entered into force Oct. 21, 1986).

the consent or acquiescence of a public official or other person acting in an official capacity.”³⁴ Could this apply to state-licensed medical personnel who perform FGM?

The United Nations Convention on the Rights of the Child requires under Article 19 that signatories take “all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse” and under Article 24, “all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.”³⁵ The Convention was predated by the Declaration of the Rights of the Child (1959) which declares that “children must be given special protection, and the opportunity to develop physically, mentally, morally, spiritually, and socially, in a healthy and normal manner and in condition of freedom and dignity.”³⁶

Most commentators focus on the Convention on the Elimination of All Forms of Discrimination Against Women, known as CEDAW, which has been in force for 15 years. Under Articles 2 and 5, parties must “take all appropriate measures . . . to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women” and “all appropriate measures . . . [t]o modify . . . social and cultural patterns of conduct . . . with a view to achieving the elimination of prejudices and customary . . . practices which are based on the idea of the inferiority or the superiority of either of the sexes [or on stereotyped roles for men and women].”³⁷ That certainly *sounds like* FGM, but again, FGM is prevalent in many states which are CEDAW signatories, although often with substantial reservations. Moreover, unlike other human rights treaties such as the International Covenant on Civil and Political

³⁴ Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *adopted* Dec. 10, 1984, G.A. Res. 39/46, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1985) (entered into force June 26, 1987).

³⁵ Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, 44 U.N. GAOR Supp. (No. 49) at 165, U.N. Doc. A/44/736 (1989).

³⁶ UNITED NATIONS DECLARATION ON THE RIGHTS OF THE CHILD, G.A. Res. 1386, U.N. GAOR, 14th Sess., Supp. No. 16, at 19, U.N. Doc A/4354 (1959).

³⁷ Convention on the Elimination of All Forms of Discrimination Against Women, *adopted* Dec. 18, 1979, G.A. Res 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/36 (1980)(entered into force Sept. 3, 1981).

Rights,³⁸ CEDAW requires only reports from State Parties and has no provision for complaints either by states or by individuals claiming violation of their rights.

So, do all these conventions and declarations, none of which specifically refers to FGM as such, cover FGM or not? If that depends on whether there already exists an unambiguous universal international norm, the answer would seem to be no. Two million cases a year doesn't sound like consensus. And I'm not sure whether this is clarified or further obscured by what I believe is the first international law document to explicitly address FGM; the 1994 Declaration on the Elimination of Violence Against Women. Article 2 of this Declaration provides that "[v]iolence against women shall be understood to encompass . . . physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children . . . , dowry-related violence, marital rape, [and] female genital mutilation . . ." and then instructs states to "exercise due diligence to prevent, investigate, and in accordance with national legislation, punish acts of violence against women, whether these acts are perpetrated by the State or by private persons."³⁹ Signatory states should also "condemn violence against women and . . . not invoke any custom, tradition, or religious consideration to avoid their obligations with respect to its elimination."⁴⁰ So, because FGM is explicitly addressed in this Declaration for the first time, is it definitely *not* covered by prior international law, as might be argued about a similar national statute? Or does the Declaration merely detail a general principle set forth in CEDAW, which after all does call on states to modify traditional practices that demean women?

Finally, I'm left with a parallel set of questions about the impact of international law on other practices that might be compared with FGM. If in fact international law can successfully suppress FGM, could it also suppress the American practice of cosmetic breast implants? The American Society of Plastic and Reconstructive Surgeons estimates that almost

³⁸ *Adopted* Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976).

³⁹ United Nations: General Assembly Resolution 48/104 Containing the DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN, *adopted without vote* Feb. 23, 1994, *reprinted in* 33 I.L.M. 1049 (1994).

⁴⁰ *See id.*

100,000 women a year undergo this procedure,⁴¹ which to be even-handed, I might refer to as "breast implant mutilation" or "BIM." Even as highly medicalized as it is, BIM can produce serious harm, including separation of scar tissue from breast tissue, severe pain and hardening, infection and skin necrosis, blood clots, interference with lactation and cancer detection, and of course there is the ongoing controversy about autoimmune disease.⁴²

If international human rights law can be used to suppress FGM, could it also be used to suppress the practice of routine male infant circumcision (RMIC, referred to by its critics as "MGM" or male genital mutilation)?⁴³ Much of the claimed therapeutic and hygienic effect of RMIC has been exposed as fallacious or at least highly subject to question.⁴⁴ The American Academy of Pediatrics no longer recommends it as a standard

⁴¹ Eugenie Anne Gifford, *"The Courage to Blaspheme: Confronting Barriers to Resisting Female Genital Mutilation"*, 4 UCLA WOMEN'S L.J. 329, 362 (1994).

⁴² See *id.*

⁴³ Routine neonatal circumcision of male infants is the most common operation performed on males in the United States. S. Daniel Niku et al., *Neonatal Circumcision*, 22 UROLOGIC CLINICS OF NORTH AMERICA 57, 57 (1995). Over 60% of the male infants born in the United States in 1987 were circumcised (a substantial reduction from the 90% rate circumcised through the 1960's). See *id.* Only about a quarter of male newborns are circumcised in the United Kingdom, however, and the procedure is rare in northern European countries, Central and South America, and Asia, except among aborigines, Muslims, and Jews. See *id.* Eighty-five percent of the world's male population is not circumcised. HUMAN SEXUALITY: AN ENCYCLOPEDIA (Vern L. Bullough & Bonnie Bullough eds., 1994) 119 at 119. See also CANADIAN PEDIATRIC SOCIETY, *Neonatal Circumcision Revisited*, 154 CANADIAN MED. ASS'N J. 769 at 769 (1996).

⁴⁴ CANADIAN PEDIATRIC SOC'Y, *supra* note 43 (literature review to assess whether neonatal circumcision offers health benefits led to recommendation that circumcision of newborns should not routinely be performed); BRITISH MEDICAL ASSOCIATION, *Circumcision of Male Infants* (1996) ("rarely necessary to circumcise an infant for medical reasons"); AUSTRALASIAN ASSOCIATION OF PAEDIATRIC SURGEONS, *Guidelines for Circumcision* (1996) ("inappropriate and unnecessary as a routine to remove the prepuce, based on the current evidence available"). See also Edward O. Laumann et al., *Circumcision in the United States: Prevalence, Prophylactic Effects, and Sexual Practice*, 277 JAMA 1052, 1056 (1997) (no benefit from neonatal circumcision in avoiding sexually transmitted diseases); Ronald L. Poland, *The Question of Routine Neonatal Circumcision*, 322 NEW ENG. J. MED. 1312-1315 (1990) (because benefits of neonatal circumcision are so uncertain procedure should be considered discretionary, not a part of routine medical care); HUMAN SEXUALITY: AN ENCYCLOPEDIA, *supra* note 43 at 119-122 (description of role of prepuce in normal male sexual function and "lifelong" impact of removal of "normal sexually functional tissue").

procedure.⁴⁵ Its opponents describe RMIC as “barbaric” and as destructive of future sexual function, bodily integrity, and psychic well-being as FGM is considered by many Americans.⁴⁶

These deeply ingrained practices seem to present an even more basic question: is there a valid role for any kind of law, domestic or international, in confronting such a custom? Is FGM more like cigarette smoking, which is widely perceived as unhealthful, but virtually nowhere illegal, or is it more like the abuse of other drugs, which, although their harm may be confined to their users, is criminal in almost all countries?⁴⁷

Perhaps the more telling analogue is nontherapeutic abortion. It is argued by some that government should stay away from abortion, either because it is utterly futile to try to use the law to stop it,⁴⁸ or because it ought to be a private decision of the pregnant woman and her health care provider.⁴⁹ Is a similar hands-off stance appropriate in regard to practices like FGM?

International human rights law has been effective, I know, in the struggles against apartheid, slavery, colonialism, and genocide. I look forward to hearing the thoughts of the panelists

⁴⁵ COMMITTEE ON THE FETUS AND THE NEWBORN, *Report of the Ad Hoc Task Force on Circumcision*, 56 PEDIATRICS 610, 611 (1975) (“no valid medical indications for [male] circumcision in the neonatal period”); TASK FORCE ON CIRCUMCISION, *Report of the Task Force on Circumcision*, 84 PEDIATRICS 388, 391 (1989) (“newborn [male] circumcision has potential medical benefits and advantages as well as disadvantages and risks; both should be explained to parents”). See also Eleanor LeBourdais, *Circumcision No Longer A “Routine” Surgical Procedure*, 152 CANADIAN MEDICAL ASSOCIATION JOURNAL 1873 (1995) (comparing medical attitudes about FGM and routine male infant circumcision).

⁴⁶ See generally JIM BIGELOW, *THE JOY OF UNCIRCUMCISING!* (2d ed. 1995); THOMAS J. RITTER, M.D. & GEORGE C. DENNISTON, M.D., *SAY NO TO CIRCUMCISION!* (2d ed. 1996); J.P. Warren & James Bigelow, *The Case Against Circumcision*, 21 BRITISH JOURNAL OF SEXUAL MEDICINE 6 (1994); Thomas Szasz, *Routine Neonatal Circumcision: Symbol of the Birth of the Therapeutic State*, 21 JOURNAL OF MEDICINE AND PHILOSOPHY 137 (1996).

⁴⁷ Doug Bandow, *War on Drugs or War on America?*, 3 STAN. L. & POL'Y REV. 242, 245 (1991).

⁴⁸ See, e.g., RONALD DWORKIN, *LIFE'S DOMINION* 13-15, 31 (1993); cf. Ronald J. Krotoszynski, Jr., *Building Bridges and Overcoming Barricades: Exploring the Limits of Law As An Agent of Transformational Social Change*, 47 CASE W. RES. L. REV. 423, 424-26, 432-33 (1997).

⁴⁹ See *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 762 (1986); but see *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). See also LAURENCE H. TRIBE, *ABORTION: THE CLASH OF ABSOLUTES* 102-04 (1990).

on whether, in present form or with further development, it has real potential as a tool for the protection of women's health. Thank you.