Commentary

Spousal Veto over Family Planning Services

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Abstract: In many countries a spouse, usually the husband, can veto a partner's use of family planning services. Where spousal veto acts as a barrier to family planning services it represents a serious threat to the lives and health of women and children. Removal of spousal authorization requirements has been shown to increase the use of family planning services. The Family Guidance Association of Ethiopia, for example, removed their requirement in 1982 and clinic utilization increased by 26 per cent within a few months.

Courts of several countries have held that spousal veto practices violate principles of personal privacy and autonomy and the right to health care. The effect of such judgments has been to reinforce rights to sexual nondiscrimination found, for example, in national constitutions and the Convention on the Elimination of All Forms of Discrimination against Women. This article discusses the nature and application of spousal veto practices, explains how such requirements can violate certain human rights, and explores possible remedies to this problem, including ministerial, legislative, and judicial initiatives. (*Am J Public Health* 1987; 77:339–344.)

Introduction

In many countries a spouse, usually the husband, can veto a partner's use of family planning services. Where spousal veto acts as a barrier to family planning services it represents a serious threat to women's lives and health. In Sub-Saharan Africa, for example, if all women who want no more children were using effective contraceptives, it is estimated that 5 to 18 per cent of maternal deaths could be averted.[1]

Removal of spousal authorization requirements has been shown to increase the use of family planning services. Until 1982, the Family Guidance Association of Ethiopia, for example, required the husband's signed consent in order to provide contraceptives to his wife. As a result, 16 per cent of the women who requested contraceptives were turned away for lack of spousal authorization. When the spousal authorization requirement was removed, clinic utilization increased by 26 per cent within a few months.[2] This suggests that, in addition to the women who were turned away, there were many women who never came to the clinic because they were aware of the spousal authorization requirement.

Courts of several countries have held that spousal veto practices violate principles of personal privacy and autonomy and the right to health care. The effect of such judgments has been to reinforce rights to sexual nondiscrimination. The Convention on the Elimination of All Forms of Discrimination against Women (The Convention)[3,4] prohibits distinctions made on the basis of sex that impair women's exercise of rights on a basis of equality with men. As of May 1986, 87 countries had ratified or acceded to this Convention, thereby becoming States Parties to it and accepting obligations to eliminate *all forms* of discrimination against women (Table 1).

In this paper, we discuss the nature and application of spousal veto practices, explain how such requirements can

TABLE 1—States Which Have Ratified or Acceded to the Convention as of May 1986

Argentina	Jamaica
Australia	Japan
Austria	Kenya
Bangladesh	Lao People's Democratic Republic
Barbados	Liberia
Belgium	Mali
Bhutan	Mauritius
Brazil	Mexico
Bulgaria	Mongolia
Byelorussian Soviet Socialist Republic	New Zealand
Canada	Nicaragua
Cape Verde	Nigeria
China	Norway
Colombia	Panama
Congo	Peru
Costa Rica	Philippines
Cuba	Poland
Cyprus	Portugal
Czechoslovakia	Republic of Korea
Democratic Yemen	Romania
Denmark	Rwanda
Dominica	Saint Christopher and Nevis
Dominican Republic	Saint Lucia
Ecuador	Saint Vincent and Grenadines
Egypt	Senegal
El Salvador	Spain
Equatorial Guinea	Sri Lanka
Ethiopia	Sweden
Federal Republic of Germany	Tanzania
France	Thailand
Gabon	Togo
German Democratic Republic	Tunisia
Ghana	Turkey
Greece	Uganda
Guatemala	Ukranian Soviet Socialist Republic
Guinea	Union of Soviet Socialist Republics
Guinea-Bissau	United Kingdom of Great Britain and Northern Ireland
Guyana	Uruguay
Haiti	Venezuela
Honduras	Viet Nam
Hungary	Yugoslavia
Iceland	Zambia
Indonesia	
Ireland	
Italy	

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violate certain human rights, and explore possible remedies to this problem.

Spousal Veto Practices

Spousal authorization requirements for the sale and distribution of contraceptives, and the provision of voluntary sterilization and abortion services, are found in laws, regulations, and clinic guidelines. Often these requirements violate principles of sexual nondiscrimination found in national constitutions or international human rights conventions. They persist, in part, because of misperceptions about what the law allows and what cultures can require. Many cultures subscribe formally or informally to beliefs that men have rights to their wives' fertility, and that whoever impairs or exploits that fertility commits wrongs against them.

A Papua New Guinea law, for example, bars the sale of contraceptives to a married woman without her husband's authorization, but not vice versa.[5] A Turkish law requires spousal consent for either partner to obtain a voluntary sterilization and the consent of the husband for a woman to obtain an abortion.[6] The Japanese Eugenic Protection law, the South Korean Maternal and Child Health Law, and the Taiwan Eugenic Protection Law all require the husband's authorization for a married woman seeking abortion services.[7] The East Asian laws provide for an exemption if, for example, a woman's husband is unavailable or when the abortion is necessary to save her life, whereas the Turkish law does not do so.

Spousal authorization requirements also exist in national ministry of health regulations, clinic guidelines, or customary practice. In Niger, for example, it is commonly accepted that contraceptives can be provided only with spousal authorization.[8] These requirements persist in countries where married women are said to lack legal capacity. In some countries today, as was the case in England before the Married Women's Property Act of 1882, married women do not have the legal autonomy to contract for health services. Where this is so, consent to contract may be given, in theory, by their husbands on their behalf. In the customary law of Swaziland, a woman was not allowed to "spend" a beast or a goat without the approval of the family.[9] As women increasingly earn their own income, they can use it as they like, e.g., to pay for their own health services without the need to obtain authorization from their husbands or families.

Even though some countries have changed their laws to give married women the legal power to contract for services, own their own property, and have equal access to family planning services, many clinics, nonetheless, have maintained their spousal authorization requirements. The maintenance of such requirements is not only contrary to the law, but also contrary to the professional ethics of the health service providers who are trained to provide care according to the health and welfare needs of their clients, not of their spouses.

Some clinics retain authorization requirements because their staff think, often incorrectly, that their laws recognize spousal rights to a partner's procreative ability. Clinic directors providing voluntary sterilization without spousal authorization fear that the law would find liability and assess damages against their clinics for loss of an individual's procreative ability. Due in part to this fear—however ill-founded—some health service providers still maintain spousal authorization requirements.

A review of the informed consent forms used in voluntary sterilization projects funded by the Association for Voluntary Surgical Contraception (AVSC) shows that spousal authorization is required in 26 of 127 projects.[10] From the wording of these consent forms, spousal authorization is a precondition for either the husband's or the wife's sterilization. As the consent forms do not give the source of such requirements, further research is necessary to determine whether these requirements are based on legal, ministerial, or clinic mandates. For example, the Colombian Ministry of Health regulations[11] do not require spousal authorization even though the consent forms of the AVSC-funded projects do.

In many countries, more women than men obtain contraceptive sterilizations[12] despite the fact that male sterilization is safer and less expensive than female sterilization.[13] In Colombia, for example, 50,600 women, compared to 700 men, underwent voluntary sterilization in 1983.[14] In such situations, spousal authorization requirements disproportionately affect women's access to such services. Spousal authorization requirements can also affect men's access to voluntary sterilization. For example, 79 per cent of private physicians in the US performing vasectomies require spousal consent, while only 50 per cent of those performing female sterilization require spousal consent.[15]

How the public perceives laws, regulations, and guidelines is as important as what the law actually requires. The perception on the part of health officials that spousal authorization is required, even if it has no basis in law, can determine how family planning services are provided. In order to assess the perception of such requirements, a survey of health officials from 10 African countries and Haiti was undertaken at the 1985 training course at Columbia University's Center for Population and Family Health.* Eight of these officials said that in their country the husband's authorization is required for the wife to obtain contraceptives or undergo a voluntary sterilization, but not vice versa. They cited government law, ministry of health regulations, or clinic guidelines as authority. None of these officials thought that a wife's authorization was necessary for the husband to obtain contraceptives or undergo a voluntary sterilization.

How Spousal Veto Practices Violate Human Rights

Many national constitutions[16] and international treaty law[17] prohibit discrimination on grounds of gender. A definition of discrimination against women is perhaps best articulated in Article 1 of the Convention:

> . . . the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

In determining whether spousal veto of family planning services is "discrimination against women", two questions must be asked:

1) Do spousal veto practices make "any distinction, exclusion, or restriction" on the basis of sex?
2) If they do make a distinction, does it have "the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their

*A. Steinberg, a 1986 MPH graduate, School of Public Health, Columbia University, undertook this survey.

marital status, on a basis of equality of men and women, of human rights and fundamental freedoms . . .''?

The answer to the first question is yes. Where a spousal veto can be exercised by the husband, but not the wife, there is a ''distinction'' on the basis of sex on the face of the law, policy, or guideline in question. Where the law provides for a veto power for both husband and wife but a clinic applies it in such a way as to recognize only the husband's power of veto, a restriction on women is made in the way the law is applied.

The answer to the second question is also affirmative. Spousal veto practices have ''the effect or purpose of impairing or nullifying'' women's recognition or exercise of their human rights or freedoms. Furthermore, women ''irrespective of their marital status'' are entitled to exercise their rights.

Not all practices that place women at a disadvantage constitute ''discrimination against women'' within the meaning of Article 1. Many family planning programs are designed to serve primarily women. Often these programs exist in countries where laws and practices require spousal authorization. Under such regulations and programs only the husbands' vetoes but not the wives' can be exercised. This would not violate Article 1 because there is no express distinction made on the basis of sex in the language of the regulation or in its application. However, Article 3 of the Convention would require the removal of spousal authorization requirements in such female-centered programs

> . . . to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.

Article 3 would also require countries to redesign their female-centered national family planning programs to ensure men's access such that men can share in the duties and costs of contracepting.[18]

According to Article 5(a) of the Convention, spousal veto practices that constitute ''discrimination against women'' or inhibit their ''full development and advancement'' violate obligations to

> . . . modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority and the superiority of either of the sexes or on stereotyped roles for men and women.

Spousal veto practices are often ''. . . based on the idea of the inferiority [of women] and the superiority [of men] . . . and on stereotyped roles'' thus contravening this Article. For example, many Latin men, consistent with their machismo image, believe that they are superior by virtue of the fact that their authorization is required.[14]

Some of women's human rights that are impaired or nullified by spousal veto practices are their rights to life,[19] health care,[20] rights to privacy and autonomy,[21] and the right to found a family according to one's wishes.[22] The Convention requires (Article 12, 1) that all appropriate measures be taken

> . . . to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality of men and women, access to health care services, including those related to family planning.

Moreover, Article 16, 1(e) of the Convention requires that all appropriate measures be taken to ensure, on a basis of equality of men and women,

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

The Convention's articles 1, 3, 5, 12, and 16 require the elimination of *all forms* of discrimination against women in the delivery of family planning services. Discrimination needs to be eliminated from the language of the law or policy in question and in how it is applied. Moreover, where chronic situations exist that are adverse to ''the full development and advancement of women'' they need to be remedied to guarantee women the ''exercise . . . of human rights on the basis of equality with men'' (Article 3).

Court Decisions

The belief that a person has a right to beget a child with a particular spouse is not supported in the law of most countries. Even where a commitment does exist through marriage or a contract, the law will not force a woman to become pregnant or a husband to impregnate a woman. The law may recognize refusal to have children as a ground for divorce and dissolve the marriage, enabling that man or woman to have children with another consenting spouse. The English Court of Appeals recognized a man's vasectomy without his wife's authorization as a reason for divorce in *Bravery vs Bravery*.[23] Similarly, in the case of W vs H applied in Swaziland,[24] a wife was granted a divorce on grounds of malicious desertion when her husband refused to have sexual intercourse without using contraceptives.

In the US, there is no legal precedent for requiring spousal authorization for an individual to obtain a voluntary sterilization even though in actual practice spousal authorization is often necessary. US courts have consistently rejected such claims, recognizing that a woman has a fundamental right to choose whether to bear children.[25] This right follows from a woman's ''right to privacy'' or 'liberty'' in matters related to marriage, family, and sex and has been consistently acknowledged in at least three US cases. In *Ponter vs Ponter*,[26] the New Jersey Superior Court recognized the desirability of consultation between husband and wife regarding decisions on voluntary sterilization but held that a married woman has a constitutional right to obtain a sterilization without her husband's authorization. A similar issue arose in the *Sims* case[27] where the Eastern District Court of Arkansas held that spousal consent was not a prerequisite to the performance of surgical sterilization procedures and ordered the University of Arkansas Medical Center to discontinue its policy of requiring married women seeking sterilizations to obtain their husbands' authorization.

In *Murray vs Vandervander*,[28] the Court of Appeals of Oklahoma rejected a husband's claim for damages resulting from a hysterectomy performed on his wife without his consent. The court, in dismissing the husband's claim, emphasized that there was no authority for the proposition that a husband has a right to a childbearing wife as a feature of their marriage.

Although courts generally uphold the right of women to choose voluntary sterilization without spousal authorization, in practice women are continually denied access to the procedure because of lack of their husbands' authorization. Some of these women will become pregnant and resort to abortion, often risking their health and life. In Colombia, for example, illicit abortion is one of the three leading causes of maternal death.[29] Limited access to abortion because of lack of spousal authorization can carry similar health risks.

As with the law governing sterilization, husbands are allowed neither to veto nor to compel lawful abortions. Courts in general agree that one partner may not compel the other to reproduce, although they have recognized that unreasonable refusal may be grounds for divorce. For example, in the Indian case of *Satya v Siri Ram,*[30] the Punjab High Court held that where a woman undergoes an abortion without her husband's consent at a time when he and his relatives are anxious for a child, her conduct amounted to "cruelty" and as a result granted the husband a divorce.

In the *Danforth* case,[31] the US Supreme Court ruled that a Missouri law was unconstitutional which made the provision of a first trimester abortion generally conditional on the prior written authorization of the husband. The Court took the view that the state cannot delegate to the husband a veto power over a woman's privacy right which it does not itself possess during that stage of pregnancy.

In the English *Paton* case,[32] a married man sought an injunction against his wife's contemplated abortion without his authorization. The court held that the 1967 British Abortion Act does not give the man a legal right to be consulted. The European Commission of Human Rights, in upholding the English decision, found the 1967 British Act compatible with the European Convention on Human Rights[33] and, as a result, the husband has no power of veto.[34]

The Conseil D'Etat, France's highest court, also decided that a man could not veto his wife's decision to have an abortion.[35] The husband brought his case under the French abortion law which encourages spousal consultation when possible.[36] The Court, in rejecting the plea, said the spousal consultation provision is purely to facilitate the decision and can not have the effect of denying the woman in question her right to decide for herself whether the situation justifies an abortion.

An Ontario High Court confirmed in the *Medhurst* case[37] that a husband does not have a veto power over his wife's decision to have an abortion where it was medically certified according to Canadian law. The Israeli Supreme Court also refused to recognize a husband's veto power in the case of *A vs B.*[38] The judges agreed that Israeli law does not vest the husband with a veto power over an approved abortion. It is clear from these decisions that high courts of the US, England, France, Ontario, and Israel as well as the European Commission of Human Rights do not recognize a legal power of veto of the husband over his wife's decision to have an abortion.

Remedies

Where governments have established rights to sexual nondiscrimination in their national constitutions or by ratification of international human rights conventions, they have legal duties to implement those rights. Where duties to treat men and women equally have not been observed, those whose rights have been so denied are entitled to remedies. Thus individuals who have been denied family planning services on account of their sex and who have suffered harm as a result of such denial are entitled, in principle, to remedies.

Where rights exist in public law such as through constitutional or international human rights conventions, remedies may be collective rather than individual. This means that instead of an individual being awarded payment of damages for a violation, a country may be required to give assurance of future compliance. Countries may have to remove offensive legislation, such as those laws containing spousal authorization requirements, where courts do not themselves exercise authority to declare such laws void.

Those seeking remedies are usually individuals whose rights have been violated, but others (such as family planning clinics) may act on their behalf. In order for complainants to seek recourse in the courts, they usually have to show that they have exhausted means of administrative redress available to them. A first line of approach is to attempt to change offensive clinic guidelines or ministerial regulations through administrative mechanisms. Once administrative relief has been tried unsuccessfully, individuals or agencies acting on their behalf may seek redress in the courts. The majority of individuals, however, do not have recourse to courts, so they might have to find other means of complaint, such as using the media to publicize the injustice.

Removal of Spousal Authorization Requirements

Family planning associations should recognize that maintaining their requirements for husband's authorizations violates women's rights to sexual non-discrimination and are contrary to the professional ethic of health care providers. In fact, many clinics with such requirements know they are a sham since women obtain forged authorizations. Family planning service providers should be one of the prime agents that foster gender equality and personal privacy by removing such requirements.

Education of Service Providers

Where spousal authorization is not legally mandated but persists in practice, service providers should be informed that they are not, in general, legally required to obtain authorization before providing services. They need to understand that seeking spousal authorization would be a breach of duty and that liability might result from that breach.

Where spousal authorization requirements exist in laws which have not yet been brought into compliance with principles of sexual non-discrimination, service providers need to know how the requirement is limited in law. The authorization power does not include the power of arbitrary veto of necessary prudent services. Thus, there may be no liability when a woman whose health is endangered by future pregnancy is given protection against pregnancy without her husband's authorization, or even over his veto, since he has no legal right to insist that her health remain in jeopardy.

Where spousal authorization requirements exist, service providers face little or no liability in providing a woman with contraceptive protection when they are reasonably satisfied that its absence would leave her at risk, or would prejudice her or her existing children's health. Service providers can presume that husbands intend to observe rather than to violate their legal responsibilities to protect the lives and health of their partners. Laws expressly requiring that a husband authorize his wife to receive family planning services may not necessarily require that his approval be given in a particular form, for instance, in writing. In such cases, service providers may place legal reliance upon a wife's statement of a husband's authorization. The husband need not be notified of provision of a service unless the law so mandates by unambiguous express language. Indeed, in the absence of such legal mandate, disclosure to a husband may constitute legal breach of both contract and the commitment of confidentiality—a case in point being the 1984 resolution of the Honduran Ministry of Public Health[39]—while refusal to continue services to a client may constitute legally actionable negligence or abandonment.

Programs to Involve Men in Family Planning

It is said that in some countries service providers fear that removal of spousal authorization will offend cultural values, such as Islamic law which recognizes spousal consultation,[40] and might result in actions or public criticism against them. One way to prevent such results may be to develop programs that involve men[18] in sharing contraceptive responsibility, educating them as to the increased risk of pregnancy-related deaths particularly to older women of high parity and, for example, explaining that spacing births at intervals of less than two years can endanger the lives of existing and future children.[41]

Until such time as spousal veto practices are removed, men need to understand that they cannot arbitrarily veto their wive's access to family planning services particularly where it puts their wive's health in jeopardy, which denial of family planning services would often do. Most laws provide that one spouse is bound to provide the other with medical care necessary for the preservation of life and health, and cannot lawfully prevent the other's access to such care.

Consultation

Spousal authorization requirements might usefully be replaced by a consultation service for those individuals who object to their spouse's use of family planning services. Individuals can feel wronged or uncomfortable by their spouse's desire to not have any or additional children. By consulting with others, particularly their peers who have experienced and overcome some of the same inhibitions, such individuals might be more accommodating of their spouse's desires. In providing such services, caution must be taken not to breach the confidentiality of the care of clients, whatever their spouse's desires.

In the same way that courts are deciding that refusal of medical care must be no less informed than acceptance,[42] family planning clinics may propose that a husband's refusal of family planning services for his wife must be as informed as acceptance. He may be required to show that exercise of refusal has been informed through proper consultation regarding its consequences to the health of his wife and children. Accordingly, opportunities may be created for individual education in reproductive and family health.

Ministerial Regulations

Where spousal veto practices persist contrary to a country's laws, the ministry of health could issue corrective regulations.** Such regulations could stipulate that spousal authorization is not required by law, and is contrary to:

- The constitutional right of sexual non-discrimination;
- international treaty obligations to bring national laws and policies into compliance with the right of sexual nondiscrimination;
- the professional ethic of health providers who have duties to respect their clients' privacy and autonomy, health, and welfare.

The ministerial regulations could state that no legal liability will result from the failure of the health provider or clinic to obtain spousal authorization, and, by way of explanation, might point out that:

- failure of married persons to obtain spousal authorization might be an offense against the spouse and, as a result, could be a grounds for divorce;
- health providers cannot let the spousal authorization requirement stand between them and their professional duty of care for the health, privacy, and autonomy of their patients; and
- if in fact health providers breach this professional duty of care by seeking spousal authorization and it results in harm to their patients, the health providers might well be liable to their clients for the harm so done to them.

Legal Reform

Where spousal authorization requirements exist in the law—such as in Japan, Papua New Guinea, South Korea, Taiwan, or Turkey—or where a woman lacks legal power of autonomous consent, legal reform should be sought either through the courts or the legislatures. Complainants can argue that spousal veto practices violate the right of sexual nondiscrimination found in national statutory or constitutional law or in the Convention.[3,4] Complainants can also show that spousal veto practices can deny individuals access to family planning services on account of their sex and that denial can limit their rights to life and health care.

Where spousal veto practices limit only men's access to family planning services, it is important to argue for repeal of such laws because any form of sex discrimination, whether against men or women, can be used as a rationale for additional forms of sex discrimination. Once it is established that sex discrimination, whether against men or women, violates a person's human rights, that decision can be used to argue against other sex discriminatory practices.

CEDAW Reports

The 87 countries that have ratified the Convention are obligated to report to the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW). CEDAW meets annually to consider reports "on the legislative, judicial, administrative and other measures they have adopted to give effect to the Convention and the progress made . . ." (Article 18). States Parties may also report on "factors and difficulties affecting the degree of fulfillment of obligations under the present Convention." States Parties are obligated to report within a year of becoming a State Party, and thereafter every four years, or whenever else CEDAW requests.

Where spousal veto practices exist in countries that are States Parties to this Convention, such practices might usefully be highlighted in the reports to CEDAW. Where governments are hesitant to include discussion of such practices, family planning associations and other groups might encourage them to do so or file an alternative report.

Conclusion

The case against legal accommodation and toleration of spousal veto over access to family planning services appears irresistible both in principle and in practice. The professional ethic of health providers requires them to respond to the health and welfare needs of their patients and to respect the individual privacy and autonomy of the patients, not that of the spouses. In many legal systems, individuals do not have a *legally* protected right or interest in ensuring their partner's use or nonuse of family planning services. In most legal systems, courts will not interfere with such a personal matter.

**Such a ministerial initiative was taken in Swaziland where clinics still require spousal authorization. The initiative states: "(t)he objective of family planning is to improve the health of the mother and child and to protect the unwed mother from accidental pregnancy. During the health worker-client interviews, the health worker is professionally trained to assess the needs of each client in accordance with the above named objectives. To then ask the client to produce a signed consent form from either the parent or his/her relative is contrary to the professionalism of the health worker."

Even in the matter of voluntary sterilization, which amounts to a denial of the other partner's ability to procreate with a particular individual, courts are hesitant to interfere. Marriage contracts, generally, accord husbands and wives equal rights and duties in marriage. A marriage contract, however, does not entitle one spouse, upon marriage, to exercise rights over the other person's body and health. Under most legal systems, individuals do not have an enforceable right to procreate with another person. Rather, it is a freedom of personal reproductive autonomy which the courts will protect. The exercise of the right to not procreate is an individual choice over which no one but that individual has legal control.

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20. See, e.g., Article 12.1, International Covenant on Economic, Social and Cultural Rights', adopted December 19, 1966, entered into force January 3, 1976, G.A. Res. 2200 (XXI), 31 U.N. GAOR, Supp. (No. 16) 49, U.N. Doc. A/6316 (1966); Article 16, African Charter on Human and People's Rights, adopted June 27, 1981, O.A.U.Doc. CAB/LEG/67/3/Rev. 5, reprinted in 21 I.L.M. 58 (1982); see also The Preamble to the Constitution of the World Health Organization, 2 Official Records of the World Health Organization 100, June 1948, which defines health as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
21. See, e.g., Article 8, European Convention on Human Rights, adopted November 4, 1950, entered into force September 3, 1953, 213 U.N.T.S. 222.
22. See, e.g., Article 17, American Convention on Human Rights, adopted November 22, 1969, entered into force July 18, 1978, O.A.S. Treaty Series No. 36 at 1.
23. *Bravery v. Bravery* [1954] 3 All ER 59.
24. *W v. H,* 1965 (3) S.A. 740 (O).
25. See, e.g., *People v Belous,* 71 Cal. 2d 954, 458 P.2d 194, 80 Cal. Rptr. 354, (1969) cert. denied 397 U.S. 915 (1969).
26. *Ponter v. Ponter,* 342 A.2d 574 (1975).
27. *Sims v. University of Arkansas Medical Center,* No. LR-C 76-67 (E.D. Ark. 1976), unreported but available from the Library Association of Voluntary Surgical Contraception, 122 East 42 Street, New York, NY 10168.
28. *Murray v. Vandervander,* 522 P.2d 302 (1974).
29. World Health Organization: Prevention of Maternal Mortality. Report of a WHO Interregional Meeting. Geneva: WHO, November 11–15, 1985.
30. *Satya v. Siri Ram,* A.I.R., 1983 Punjab and Haryana 252 (India).
31. *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52 (1976).
32. *Paton v Trustees of British Pregnancy Advisory Service* [1978] 2 ALL ER 987. For further discussion of this case see Kennedy IM: Husband Denied A Say in Abortion Decision. The Modern Law Rev 1979; 42:324–331.
33. *Paton v UK,* 3 EHRR 408 (1980).
34. McKNorrie K: Family Planning & the Law: Other People's Rights. Br J Fam Plann 1985; 10:102–107.
35. Conseil d'Etat (C.E.), October 31, 1980, S.J. 1982, 19732 (Note Semaine Juridique, Francoise Dekeuwer Defossez) (France). For further discussion of this and other similar cases, see Knoppers B: Modern Birth Technology and Human Rights. Am J Compar Law 1985; 33:1–19.
36. Article L. 16204 of the French Law on Voluntary Interruption of Pregnancy, Law 79-1204 of 31 December 1979. For English translation, see IDHL 1980; 31:505.
37. Re Medhurst and Medhurst (1984), 45 O.R. 2d 575 (Ont. S.C.); *Medhurst v. Medhurst* (1984), 46 O.R. (2d) 263. For further discussion of this and other similar cases, see Cook RJ, Dickens BM: Issues in Reproductive Health Law in the Commonwealth. London: Commonwealth Secretariat, 1986.
38. *A v. B* (1981) 35(iii) P.D. 57. For further discussion of this and other similar cases, see Shalev C: A Man's Right to be Equal: The Abortion Issue. Israel Law Rev 1983; 18:381–430.
39. See, e.g., the Honduran Ministry of Public Health Resolution No. 141-84 of June 18, 1984, prescribing provisions governing the practice of voluntary and therapeutic sterilization. These provisions require that the spouse be informed of the procedure, its irreversibility, and possible consequences prior to the procedure. Section 6(a), La Gaceta, Diario Oficial de la Republica de Honduras, July 18, 1984, No. 24369, p. 7. Translated into English and published in IDHL 1984; 35:767.
40. Islamic Law recognizes spousal consultation. Under Islamic law, a husband is not allowed to ejaculate outside the vagina without his wife's consent. A wife is not allowed to block the mouth of the uterus without her husband's consent. In "bad times" (i.e., war and corruption) there is no need of spousal consent. See Musallam BF: Sex and Society in Islam: Birth Control Before the Nineteenth Century. Cambridge: Cambridge University Press, 1983.
41. Maine D, McNamara R: Birth Spacing and Child Survival. New York: Center for Population and Family Health, Columbia University, 1985.
42. See, e.g., *Truman v. Thomas* 27 Cal 3d 285; 611 P. 2d 902 (1980).