THE RIGHT TO HEALTH

PROMOTION AND PROTECTION OF WOMEN'S RIGHT TO SEXUAL AND REPRODUCTIVE HEALTH UNDER INTERNATIONAL LAW: THE ECONOMIC COVENANT AND THE WOMEN'S CONVENTION

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INTRODUCTION

A woman's right to sexual and reproductive health is an essential element of international human rights law. According to this body of law, States[1] are required to take all appropriate measures to respect, protect, and fulfill that right. In addition, the Convention on the Elimination of All Forms of Discrimination Against Women[2] (Women's Convention), obligates States to pursue this right within the context of a broader policy aimed at the elimination of discrimination against women and the removal of all female stereotypes.

Now that we are on the threshold of the Fourth World Conference on Women, it is important to examine the potential of international human rights law to promote and protect women's right to sexual and reproductive health. Health issues have been high on the women's human rights agenda ever since the First World Conference on

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1. By "State" I mean all components and all levels of public authority.

2. Women's Convention, *infra doc. biblio.* The Women's Convention entered into force on September 3, 1981. As of June 1, 1994, 133 States had ratified this document. *See State of Ratifications of Major Human Rights Conventions*, 12 NETH. Q. HUM. RTS. 341, 341-51 (1994) [hereinafter *Ratification of Major Human Rights Conventions*].

Women in Mexico in 1975.[3] Health and human rights, however, were commonly perceived as separate and *unrelated* issues.

The original draft of the Women's Convention, for example, failed to refer to health as an independent right. It was only when the draft Convention was being scrutinized by the General Assembly's Third Committee, which deals with social, humanitarian, and cultural matters, that Denmark and the Netherlands proposed to insert a separate article on women's right to health.[4] This occurred after the text already had been adopted by the Commission on the Status of Women (CSW) and approved by the Economic and Social Council (EcoSoc).

As a result of this last-minute amendment, the final version of the draft Women's Convention, eventually adopted by the U.N. General Assembly in December 1979,[5] explicitly obligated States Parties "to take all appropriate measures" to promote and protect the health of women.[6] Thus, at first glance, the health provision in the Women's Convention seems to complement the gender-neutral health provision in the International Covenant on Economic, Social and Cultural Rights (Economic Covenant).[7]

In the early 1980s, women's health and women's human rights activists slowly started to collaborate. The coalition between both disciplines was strengthened at the 1980 World Conference on Women in Copenhagen and the 1985 Conference in Nairobi.[8] It was only after 1985, however—and notably under the influence of the HIV pandemic—that policymakers, public health workers, scientists, and women's-rights activists alike started to acknowledge the intrinsic interrelationship between health and human rights.[9] The language

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3. *See* Noreen Burrows, *The 1979 Convention on the Elimination of All Forms of Discrimination Against Women*, 32 NETH. INT'L L. REV. 419, 419-21 (1985).

4. *See* LARS A. REHOF, GUIDE TO THE TRAVAUX PRÉPARATOIRES OF THE UNITED NATIONS CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN 145 (1993).

5. *See* Women's Convention, *infra doc. biblio.*

6. Marjolein van den Brink & Aart Hendriks, *Artikel 12: Vrouwen en de gezondheidszorg* [*Women and health care*], *in* AALT WILLEM HERINGA ET AL., HET VROUWENVERDRAG: EEN BEELD VAN EEN VERDRAG [THE WOMEN'S CONVENTION: A PICTURE OF A TREATY] 166 (1994).

7. *See* Economic Covenant, *infra doc. biblio.* The Economic Covenant was adopted by the U.N. General Assembly on December 16, 1966. *Id.* The Covenant entered into force on March 23, 1976. *Id.* As of June 1, 1994, 129 States had ratified this document. *See Ratification of Major Human Rights Conventions*, *supra* note 2, at 341-51.

8. *See World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, The Nairobi Forward-Looking Strategies for the Advancement of Women*, U.N. Doc. A/CONF.116/28 (1985) [hereinafter *The Nairobi Forward-Looking Strategies for the Advancement of Women*]. The Nairobi Forward-Looking Strategies were partially inspired by a more comprehensive view of women's health as a human rights issue.

9. JONATHAN M. MANN, TOWARDS A NEW HEALTH STRATEGY FOR AIDS (1993).

of the Programme of Action of the U.N. International Conference on Population and Development is very much inspired by a rights-based approach to health issues. The increasing influence of law on health issues is also reflected in the work of the Committee on the Elimination of Discrimination Against Women (CEDAW). In several of its General Recommendations, CEDAW refers to practices that are particularly harmful to women's health, and defines these in terms of human rights violations.[10]

Worldwide there is a growing recognition of the health damage inflicted on women and men as a direct or indirect result of human rights violations.[11] Unlike men, however, women not only have to fear human rights violations because they are human beings, but also because of their gender. The vulnerability of women to human rights violations as well as to health damage is often perpetuated by repressive laws. In this respect it should be noted that sexuality and reproductive health issues—including ages of consent, homosexuality and bisexuality, abortion, and other matters—are often exclusively defined within the realm of the penal law system, even though they are presented as threats to individual or public health.

The health and human rights impacts of both sexuality and reproductive health are now widely known. This has not, however, always resulted in legal reform and the abolition of outdated laws.[12] In spite of slow progress, however, there is an undeniable, worldwide reappraisal of health as a human rights issue.[13] This is reflected in present-day terminology. We now speak, for example, of a woman's right to sexual and reproductive *health*, instead of a woman's right to sexuality and reproductive autonomy. The significance of health as a human rights issue—and thus the inherent meaning of health as a human right—consequently deserves further exploration before defining the responsibilities and duties of the State in regard to women's sexual and reproductive health.

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10. *See General Recommendations Nos. 12, 14, 15, 18, and 19, discussed infra* notes 83-86 and accompanying text.

11. *Cf.* Jonathan M. Mann et al., *Health and Human Rights*, 1 HEALTH & HUM. RTS. 6-23 (1994).

12. Sheila Martin, *A Woman Centered Approach to Laws on Human Reproduction*, *in* HUMAN RIGHTS IN THE TWENTY-FIRST CENTURY: A GLOBAL CHALLENGE 905-18 (Kathleen E. Mahoney & Paul Mahoney eds., 1993).

13. In September 1994, the first international conference on health and human rights was organized by the François-Xavier Bagnaud Center for Health and Human Rights in Cambridge, Massachusetts.

Gender Discrimination

Before starting to examine the nature, essence, and legal implications of a woman's right to sexual and reproductive health, it is necessary to mention the health ramifications of a phenomenon called "gender discrimination," a term largely coined to refer to discrimination against women. It is widely believed that human rights violations against women, and thus women's vulnerability to disease, disability, and premature death, are often perpetuated by deep-rooted patterns of gender discrimination.[14] Gender discrimination often results from underestimating or overestimating the importance of women's childbearing capacities. Other causes of discrimination are ignorance, prejudice, and misinformation about women's sexuality.

To the extent that researchers have tried to analyze women's sexual health, they have commonly confined themselves to studying the repercussions of reproductive sex on women's health. The importance of other issues, including recreational sex, sexual violence inside and outside marriage,[15] sex not involving a male partner, and female genital mutilation remain largely unexplored. Throughout history, women's sexuality and reproductive capacities have been portrayed and experienced as a "disability"—a "restriction or lack of . . . ability to perform an activity in the manner within the range considered *normal* for a human being."[16] As is the case with other socially construed—or perhaps more accurately, man-made—"disabilities," women's sexuality and reproductive capacities consequently became perceived as disadvantages that were believed to limit their functional performance.[17] We should be aware, however, that what we consider "normal" and whom we perceive as "normal" or "abnormal" first depend on our focus of comparison.[18]

It goes without saying that in a male-dominated society, white, able-bodied, heterosexual, fertile men are the self-proclaimed norm. The overwhelming majority of people who deviate from this "norm" are

14. *See* PATRICIA SMYKE, WOMEN & HEALTH (1991).

15. *See, e.g.*, Lori L. Heise et al., *Violence Against Women* (World Bank Discussion Papers No. 255, 1994).

16. WORLD HEALTH ORGANIZATION, INTERNATIONAL CLASSIFICATION OF IMPAIRMENTS, DISABILITIES, AND HANDICAPS 28 (1980) (emphasis added).

17. *Cf.* DAVID LOCKER, DISABILITY AND DISADVANTAGE: THE CONSEQUENCES OF CHRONIC ILLNESS (1983).

18. MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW (1990).

consequently labeled as "different," and have to carry the burden of their difference, without being granted a right to be different.[19]

This process, which typically underlies most patterns of gender discrimination, today is believed to be particularly harmful to women's health. With respect to almost all health indicators, women score considerably lower than men,[20] but health discrepancies between the genders are probably most noticeable with respect to sexual and reproductive health.[21]

A woman's right to sexual and reproductive health is not only threatened by current expressions of deep-rooted, harmful practices—including sexual violence against women and girls, forced marriage, and female genital mutilation—but is also challenged by progress in reproductive medicine.[22] It is well known that the uncontrolled application of new reproductive techniques not only brings along benefits for potential mothers and parents, but also jeopardizes some of the fundamental rights of the very same people,[23] as well as of their offspring.[24] As Professor Sheila McLean noted, "[s]cientific advances and technological development may enhance liberty, but they also have the capacity to restrict it."[25]

Given these new insights and the ongoing rapid developments in medical science, it is understandable that women, and those who sympathize with their cause, increasingly turn towards human rights

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19. Aart Hendriks & Theresia Degener, *The Evolution of a European Perspective on Disability Discrimination*, 1 EUR. J. HEALTH L. 343, 343-60 (1994).

20. *See* 40 WORLD HEALTH STATISTICS 194-290 (1987); *see also* LORRAINE DENNERSTEIN ET AL., PSYCHOSOCIAL AND MENTAL HEALTH ASPECTS OF WOMEN'S HEALTH (1993); SMYKE, *supra* note 14, at 25-58; WORLD BANK, SOCIAL INDICATORS OF DEVELOPMENT 1991-92 (1992); WORLD BANK, WORLD DEVELOPMENT REPORT 1993: INVESTING IN HEALTH (1993).

21. Maria Ladi Londoño E., *Reproductive and Sexual Rights as Human Rights*, 8 BEYOND LAW 26 (1993).

22. Aart Hendriks & Manfred Nowak, *The Impact of Advanced Methods of Medical Treatment on Human Rights*, *in* THE IMPACT OF TECHNOLOGY ON HUMAN RIGHTS 243 (Christopher G. Weeramantry ed., 1993); Michael Kirby, *Medical Technology and New Frontiers of Family Law*, *in* LEGAL ISSUES IN HUMAN REPRODUCTION 3 (Shelia McLean ed., 1989); Renate Klein, *The Impact of Reproductive and Genetic Engineering on Women's Bodily Integrity and Human Dignity*, *in* HUMAN RIGHTS IN THE TWENTY-FIRST CENTURY: A GLOBAL CHALLENGE, *supra* note 12, at 889-904; Kimberly Nobles, *Birthright or Life Sentence: Controlling the Threat of Genetic Testing*, 65 S. CAL. L. REV. 2081 (1992).

23. *Cf.* Committee of Ministers, Council of Europe, Prenatal Genetic Screening, Prenatal Genetic Diagnosis and Associated Genetic Counselling, Recommendation No. R (90) 13, Principle 9 (June 19, 1990) ("In order to protect the woman's freedom of choice she should not be compelled by the requirements of national law or administrative practice to accept or refuse screening or diagnosis. In particular, any entitlement to medical insurance or social allowance should not be dependant to undergoing these tests.").

24. *Cf. id.* pmbl. (emphasizing "the fear that prenatal screening and diagnosis could adversely affect social attitudes to the handicapped").

25. Sheila McLean, *Women, Rights and Reproduction*, *in* LEGAL ISSUES IN HUMAN REPRODUCTION, *supra* note 22, at 223.

law in an effort to tackle all forms of gender discrimination and to ensure that health becomes equally accessible to both women and men. But does human rights law, a body of law that has also been accused of reflecting male standards and norms,[26] have anything to offer?

This Essay will analyze the role States can and should play in ensuring the realization of women's sexual and reproductive health as part of their overall responsibility toward the promotion and protection of women's health. Although a woman's right to health—or, as some prefer to say, right to health care[27]—is explicitly covered by international human rights law, only a few efforts have been made as yet to articulate the meaning of this right for women in a more systematic way.[28] In my view, the potential of the Economic Covenant and the Women's Convention in seeking to eliminate the root causes of gender-related health inequalities has, unfortunately, long been underestimated and, consequently, has usually been neglected. I will therefore also try to indicate how we can make better use of the health provisions in both documents to further the cause of women's sexual and reproductive health.

I. WOMEN'S RIGHT TO SEXUAL AND REPRODUCTIVE HEALTH AS A SOCIAL HUMAN RIGHT

A woman's right to sexual and reproductive health is an essential element of a woman's general right to health.[29] If we endeavor to analyze women's right to sexual and reproductive health within the broader legal context in which this right has been proclaimed, it becomes rapidly evident that we should start with an analysis of the

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26. Andrew Byrnes, *Women, Feminism and International Human Rights Law—Methodological Myopia, Fundamental Flaws or Meaningful Marginalisation?*, 12 AUSTL. Y.B. INT'L L. 205, 225-26 (1992).

27. *See, e.g.*, HENRIETTE D.C. ROSCAM ABBING, INTERNATIONAL ORGANIZATIONS IN EUROPE AND THE RIGHT TO HEALTH CARE (1979); Ruth Roemer, *The Right to Health Care, in* THE RIGHT TO HEALTH IN THE AMERICAS: A COMPARATIVE CONSTITUTIONAL STUDY 17-23 (Hernan L. Fuenzalida-Puelma & Susan Scholle Connor eds., 1989); Edward V. Sparer, *The Legal Right to Health Care: Public Policy and Equal Access*, HASTINGS CTR. REP., Oct. 1976, at 39, 39-47 (1976).

Professor Virginia Leary has argued—in my view convincingly—that the term "the right to health" is more appropriate as a short-hand expression to indicate "the right to the highest attainable standard of health" than terms such as the "right to health care" and "the right to health promotion." *See* Virginia Leary, *Implications of a Right to Health, in* HUMAN RIGHTS IN THE TWENTY-FIRST CENTURY: A GLOBAL CHALLENGE, *supra* note 12, 481-93; *see also* Margaret A. Somerville, *The Right to Health: A Human Rights Perspective, in* SIDA, SANTÉ ET DROITS DE L'HOMME [AIDS AND HUMAN RIGHTS] 75-90 (Jonathan M. Mann & C. DuPuy eds., 1993).

28. *But see* REBECCA J. COOK, HUMAN RIGHTS IN RELATION TO WOMEN'S HEALTH (1993); KATRINA TOMAŠEVSKI, HUMAN RIGHTS IN POPULATION POLICIES (1994).

29. *Cf.* Aart Hendriks, *The Political and Legislative Framework in Which Sexual Health Promotion Takes Place, in* PROMOTING SEXUAL HEALTH 155-66 (Hilary Curtis ed., 1992).

meaning of the "right to health." Women's sexual and reproductive health cannot be separated from their overall well-being. At the same time, however, as the World Health Assembly noted in 1992, "women's health means their health throughout their life-span, and not only their reproductive health."[30]

One of the merits of human rights law is that it bestows women with equal rights independent of motherhood.[31] Human rights law also intends to protect women against unnecessary medicalization of their sexuality and reproductive capacities. It is in this spirit that this essay seeks to explore and articulate the responsibility of the State for women's health.

Of course, the extent to which women can benefit from sexual and reproductive health does not depend exclusively on the efforts a State makes to realize the right to health. The enhancement of women's sexual and reproductive health also requires that other rights—mostly civil and political rights—are maximally observed. These include the right to private life; the right to life; the right to be free from inhuman and degrading treatment; the right to have, and to avoid, information; the right to marry or not to marry; and the right to found or not to found a family. This reflects the indivisibility and interdependence of all human rights.

Examining the meaning of a woman's right to health—and, as a component thereof, the woman's right to sexual and reproductive health—presupposes conceptual clarity about the term "health." According to the World Health Organization (WHO), health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[32] The bulk of current denotations of sexual and reproductive health are manifestly influenced by this WHO definition. In 1991, an international conference defined sexual health in the following way:

> [It is] an integral part of overall health, not restricted to the avoidance of STDs and HIV/AIDS. Sexual health contributes to the fulfillment of individual sexuality, enabling a person to share this with consenting others, without jeopardizing the health and well-being of other persons. Sexual health requires the enjoyment of free choice, expression and responsibility, with particular regard to the prevention of transmission of STDs/HIV. The sexual health

30. World Health Assembly, Women, Health and Development, Res. WHA45.25 (June 17, 1992).

31. *Cf.* KATRINA TOMAŠEVSKI, WOMEN AND HUMAN RIGHTS 17 (1993).

32. *Constitution of the World Health Organization*, *in* WORLD HEALTH ORGANIZATION, BASIC DOCUMENTS 7 (1994).

> of an individual contributes to the well-being and health of the individual involved, his/her sexual partner(s), and the ultimate community as a whole.[33]

In the literature, meanwhile, reproductive health is often defined as:

> A condition in which the reproductive process is accomplished in a state of complete physical, mental and social well-being and is not merely the absence of disease and disorders of the reproductive process. Reproductive health, therefore, implies that people have the ability to reproduce, to regulate their fertility and to practice and to enjoy sexual relationships. It further implies that reproduction is carried to a successful outcome through infant and child survival, growth and healthy development. It finally implies that women can go safely through pregnancy and childhood, that fertility regulation can be achieved without health hazards and that people are safe in having sex.[34]

The right to health is a human right that typically relates to the overall category of "social rights," which include economic, social, and cultural rights. While the right to health is solidly rooted in the Economic Covenant as well as a number of other human rights instruments,[35] the legal basis of social rights has always been a controversial subject.

Numerous human rights scholars have persistently denied that social rights have the same importance as civil and political rights.[36] Although there is, of course, a certain dichotomy between both sets of rights, certain legal commentators have consistently tried to reinforce these differences, thus undermining the complementary nature of both categories of human rights law.

Social rights have been under attack from various sides and for various reasons. Often their arguments have been convincing. As I

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33. Hendriks, *supra* note 29, at 156 (discussing definition of sexual health as established at the Second International Conference on Prevention of Sexual Transmission of HIV and Other Sexually Transmitted Diseases, entitled "Promoting Sexual Health").

34. Mahmoud F. Fathalla, *Reproductive Health: A Global Overview*, 626 ANNALS N.Y. ACAD. SCI. 1, 1-10 (1991), *cited in* COOK, *supra* note 28, at 13.

35. *Cf.* Universal Declaration of Human Rights, *infra doc. biblio.*, art. 25, ¶ 1; Convention on Racial Discrimination, *infra doc. biblio.*, art. 5; Convention on the Rights of the Child, *infra doc. biblio.*, art. 24; European Social Charter, *infra doc. biblio.*, art. 11; African Charter, *infra doc. biblio.*, art. 16; Additional Protocol to the American Convention on Human Rights in Area of Economic, Social and Cultural Rights ("Protocol of San Salvador"), art. 10, *reprinted in* 10 NETH. Q. HUM. RTS. 232, 236 (1992).

36. *See, e.g.*, E.W. Vierdag, *The Legal Nature of the Rights Granted by the International Covenant on Economic, Social and Cultural Rights*, 9 NETH. Y.B. INT'L L. 69, 102-05 (1978). For a more differentiated analysis, see HECTOR GROS ESPIELL, LOS DERECHOS ECONÓMICOS, SOCIALES Y CULTURALES EN EL SISTEMA INTERAMERICANA [THE ECONOMIC, SOCIAL AND CULTURAL RIGHTS IN THE INTER-AMERICAN SYSTEM] (Ediciones del Instituto Interamericano de los Derechos Humanos, 1986).

will show, however, over time they have all been vitiated in various ways.[37]

A. Response to Attacks on Social Rights

1. Connection of social rights to communism

For a long time, social rights were associated with communism, seen as the justification given by socialist governments to suppress the civil and political rights of their political opponents. The degree of government interference that these rights seemed to necessitate were, in addition, often perceived to be "inherently incompatible" with the rules of a free market economy.[38]

The recognition of the indivisible, interdependent, and interrelated nature of human rights,[39] however, implies that States should respect both categories of rights. The fact that some governments allegedly violate civil and political rights is an insufficient reason to deprive individuals of their social rights. In addition, the argument that social rights are incompatible with the rules of a free market economy and can only flourish under communist dictatorships was rebutted by the Inter-American Commission on Human Rights in its 1979-1980 Annual Report, which concluded that "there is no political or economic system, or individual development model that has demonstrated a clearly superior capability to promote economic and social rights."[40]

2. Encouraging government action over individual rights

Some have argued that social rights create targets for governmental action instead of embodying individual rights.[41] Unlike civil and political rights, which were thought to require mere recognition of individual rights and a corresponding noninterference by the State, social rights were perceived to require at most "gradual" or "progres-

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37. *See, e.g.*, DE TOENEMENDE BETEKENIS VAN ECONOMISCHE, SOCIALE EN CULTURELE MENSENRECHTEN [THE ELEVATED IMPORTANCE OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS] (A.P.M. Coomans et al. eds., 1994); AALT WILLEM HERINGA, SOCIALE GRONDRECHTEN: HUN PLAATS IN DE GEREEDSCHAPSKIST VAN DE RECHTER [SOCIAL RIGHTS: THEIR PLACE IN THE 'TOOLS' BOX' OF THE JUDGE] (1989); Asbjørn Eide, *Realization of Social, Economic and Cultural Rights and the Minimum Threshold Approach*, 10 HUM. RTS. L.J. 35, 35-51 (1989). *See generally* THE RIGHT TO FOOD (International Studies in Human Rights) (Philip Alston & Katarina Tomaševski eds., 1984).

38. Philip Alston & Gerald Quinn, *The Nature and Scope of States Parties' Obligations Under the International Covenant on Economic, Social and Cultural Rights*, 9 HUM. RTS. Q. 156, 160 (1987).

39. *Cf.* Vienna Declaration and Programme of Action, *infra doc. biblio.*, ¶ 3.

40. *Annual Report of the Inter-American Commission on Human Rights 1979-1980*, OAS Doc. OEA/Ser.G/CP/doc.110/80, at 152 (1980), *quoted in* Alston & Quinn, *supra* note 38, at 181.

41. *See, e.g.*, Vierdag, *supra* note 36, at 103.

sive achievement." The U.S. government—particularly in times of a Republican President—is historically one of the strongest advocates of this view. The U.S. government has repeatedly stated that social rights belong to a "qualitatively different category" of rights, and that they should in fact not be seen as rights at all, but rather as goals for economic and social policy.[42] In this respect, the Vienna World Conference on Human Rights, where the U.S. administration for the first time "recognized" social rights as human rights, was a landmark in the U.S. human rights tradition.

While it is definitely true that the realization of social rights ultimately depends on the State as guarantor and provider of these rights, this alone does not imply that States are totally free to determine how they think that they can best comply with their obligation to "gradually" or "progressively" achieve these rights.[43] The so-called "Limburg Principles" provide clear guidelines as to how States should comply with their duties under the Economic Covenant.[44]

Another important nuance concerns the distinction between an "obligation of conduct" and an "obligation of result."[45] An "obligation of conduct" refers to the behavior a State should follow or abstain from, thus restricting the State's margin of appreciation. An "obligation of result," on the other hand, is primarily concerned with the outcome of State behavior.[46] On the basis of this distinction, commentators have been able to stipulate how the Economic Covenant should be applied in the domestic context.[47]

3. Difficulties defining social rights

Legal commentators and human rights scholars seem unable to define precisely either the content of these rights or the specific

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42. *Alternative Approaches and Ways and Means Within the United Nations System for Improving the Effective Enjoyment of Human Rights and Fundamental Freedoms: Reports of the Secretary-General*, U.N. GAOR 3d Comm., 40th Sess., Agenda Item 107, ¶ 17, U.N. Doc. A/40/C.3/SR.36 (1985) (statement of Mrs. Rogers), *quoted in* Alston & Quinn, *supra* note 38, at 158.

43. *Cf.* Damilo Türk, *The Realization of Economic, Social and Cultural Rights*, U.N. ESCOR, 44th Sess. ¶¶ 31-33, U.N. Doc. E/CN.4/Sub.2/16 (1992).

44. *The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, U.N. ESCOR, 43d Sess., U.N. Doc. E/CN.4/17 (1987) [hereinafter *Limburg Principles*].

45. *Summary Records of the Twenty-Ninth Session*, [1977] 1 Y.B. INT'L L. COMM'N 214-33, U.N. Doc. A/CN.4/SER.A/1977; *see also* Guy S. Goodwin-Gill, *Obligations of Conduct and Result*, *in* THE RIGHT TO FOOD, *supra* note 37, at 111-18.

46. Asbjørn Eide, *The New International Economic Order and the Promotion of Human Rights*, U.N. ESCOR, 39th Sess., U.N. Doc. E/CN.4/Sub.2/23, ¶ 71, at 15 (1987) (Report by the Special Rapporteur on the Right to Food).

47. Matthew C.R. Craven, *The Domestic Application of the International Covenant on Economic, Social and Cultural Rights*, 40 NETH. INT'L L. REV. 367, 367-404 (1993).

obligations these rights would imply for States.[48] The U.N. Committee on Economic, Social and Cultural Rights has, however, committed itself to interpret the relevant provisions and to provide guidance to the States Parties to the Covenant, as well as to any other, as to the precise requirements that flow from the provision of the Economic Convenant through the adoption of "General Comments."[49] A General Comment is an authoritative statement by the Committee of its understanding of a right in the Economic Covenant.[50] On the basis of the General Comments, States Parties to the Economic Covenant are aware of the type of action, or inaction, the Committee expects them to undertake to realize a social right.[51]

4. Negative versus positive rights

Governments have often thought that it is easier to comply with "negative" rights—rights that oblige the State to refrain from interfering with individual freedoms—than with the obligations enshrined in "positive" rights—rights that require actual State action. But in the human rights literature, the polarization between "positive" and "negative" rights has been successfully invalidated on the grounds that all human rights require States to undertake appropriate action to ensure that individuals can effectively enjoy and exercise the rights granted to them.[52]

The full exercise and enjoyment of the right to privacy, for example, presupposes that there are adequate guarantees against abuses of an individual's privacy. This may require the introduction of administrative, legislative, or other measures, which would imply

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48. Eide, *supra* note 46, at 10, ¶ 40.

49. Philip Alston, *Disability and the International Covenant on Economic, Social and Cultural Rights, in* HUMAN RIGHTS AND DISABLED PERSONS 94 (Theresia Degner et al. eds., 1995).

50. *Report on the Eighth and Ninth Sessions*, U.N. ESCOR, Committee on Economic, Social and Cultural Rights, U.N. Doc. E/1994/23 (1993); *see also* Aart Hendriks, *The Right to Health*, 1 EUR. J. HEALTH L. 187, 187 (1994).

51. So far the following General Comments have been adopted: *General Comment No. 1: Reporting by States Parties, in Report on the Third Session*, U.N. ESCOR, Committee on Economic, Social and Cultural Rights, 3d Sess., Annex III, at 87-89, U.N. Doc. W/22 (1989); *General Comment No. 2: International Technical Assistance Measures, in Report on the Fourth Session*, U.N. ESCOR, Committee on Economic, Social and Cultural Rights, 4th Sess., Annex III, at 86-89, U.N. Doc. E/23 (1990); *General Comment No. 3: The Nature of States Parties Obligations, in Report on the Fifth Session*, U.N. ESCOR, Committee on Economic, Social and Cultural Rights, 5th Sess., Annex III, at 83-87, U.N. Doc. E/23 (1991); *General Comment No. 4: The Right to Adequate Housing, in Report on the Sixth Session*, U.N. ESCOR, Committee on Economic, Social and Cultural Rights, 6th Sess., Annex III, at 114-20, U.N. Doc. E/23 (1992); *General Comment No. 5: Persons with Disabilities, in Report on the Seventh Session*, U.N. ESCOR, Committee on Economic, Social and Cultural Rights, 7th Sess., U.N. Doc. E/C.12/WP.13 (1994).

52. Caroline Forder, *Positieve verplichtingen in het kader van het Europese Verdrag tot bescherming van de rechten van de mens [Positive Obligations in the Context of the European Convention on the Protection of Human Rights]*, 17 NJCM BULL. 611 (1992).

that the State has to undertake "positive" action to uphold a "negative" right. The differences between both sets of rights should, therefore, not be overestimated, but instead be seen in perspective. As Professors Philip Alston and Gerald Quinn have stated, the two sets of rights differ more in terms of degree than in kind.[53]

5. Economic burdens of social rights

Finally, it was widely believed that compliance with civil and political rights was cost-free, whereas the realization of social rights posed an economic burden on the State. This argument also turned out to be unfounded.[54] The organization of presidential or parliamentary elections, for example, may in fact be extremely expensive, while there are many preventive health measures that can be implemented at low or no cost.[55]

These newly emerging views on social rights have far-reaching repercussions for the State's responsibility for the promotion and protection of women's health. It can no longer be maintained that this right entails a vague, ideologically inspired socio-political target that States can only pursue at great cost and at the expense of the fundamentals of a free-market economy. The argument that these rights are alien to the legal tradition of countries in the Western Hemisphere has also turned out to be unfounded. The adoption of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights[56] dates back to 1988[57]—that is to say, prior to the collapse of the Soviet Union.

A survey conducted by the Pan American Health Organization (PAHO) demonstrated that most of its Member States recognize the right to health within the realm of constitutional or national law.[58] Professor Patrick Molinari recently noted that the number of countries affirming the right to health is still growing.[59] The need to articulate the meaning of this right thus becomes increasingly evident.

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53. Alston & Quinn, *supra* note 38, at 184.

54. G.J.H. Van Hoof, *The Legal Nature of Economic, Social and Cultural Rights: A Rebuttal of Some Traditional Views*, *in* THE RIGHT TO FOOD, *supra* note 37, at 97.

55. Virginia Leary, *The Right to Health in International Human Rights Law*, 1 HEALTH & HUM. RTS. 24 (1994).

56. *Reprinted in* 10 NETH. Q. HUM. RTS. 232 (1992).

57. *See* Larry LeBlanc, *The Economic, Social and Cultural Rights Protocol to the American Convention and Its Background*, 10 NETH. Q. HUM. RTS. 130 (1992).

58. *See* THE RIGHT TO HEALTH IN THE AMERICAS, *supra* note 27, at 27.

59. Patrick A. Molinari, Trends in Health Legislation and Human Rights, *presented at* 10th World Congress on Medical Law, Jerusalem (1994) (unpublished).

As with all social rights, the right to health primarily obligates States to "take steps." These "steps" should be aimed at the attainment of the highest possible level of health for all. In order to achieve this goal, States should undertake action, or refrain from undertaking action, to enhance individual and collective health. These duties correspond with rights of individuals, some of which can also be invoked against third parties, which is known as third-party applicability or *Drittwirkung.* The nature of the State's duties and, correspondingly, the nature of the rights of individuals depend, however, on various factors that all need to be carefully considered before we can assess State compliance with its international obligations.

To determine the responsibility of the State for the health of women, it may be helpful to use the typology suggested by Professor Asbjørn Eide in 1987.[60] According to Eide, we should distinguish three types of state obligations. First, there is the *obligation to respect,* requiring that States abstain from doing anything that violates the integrity of the individual or violates their freedom. Second, there is the *obligation to protect,* which obligates States to take all necessary measures to prevent other individuals or groups from violating individuals' integrity, dignity, well-being, or other human rights. According to Alston and Quinn, obligations to protect or "ensure" must be implemented immediately, whereas the obligation to respect reflects merely a minimalist undertaking.[61] Third, there is the *obligation to fulfill,* requiring the State to take all necessary measures to ensure for each person within its jurisdiction opportunities to obtain satisfaction of their needs, particularly those needs recognized in human rights law.

Obligations can be subdivided into *obligations of conduct* and *obligations of result.* Furthermore, reference should be made to the "Limburg Principles"[62] and General Comment No. 3 of the U.N. Committee on Economic, Social and Cultural Rights on "The Nature of States Parties Obligations."[63] Both the Principles and the General Comment provide additional insight regarding the way States Parties to the Economic Covenant are required to interpret their obligations to fulfill.

On the basis of this typology, a number of more or less concrete State obligations toward the promotion and protection of women's health can be derived from Article 12 of the Economic Covenant.

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60. Eide, *supra* note 46, ¶¶ 66-69, at 14-15.
61. Alston & Quinn, *supra* note 38, at 185-86.
62. *See supra* note 44.
63. *General Comment No. 3, supra* note 51.

B. The Realization of Social Rights

1. The obligation of the State to do everything possible to optimally respect the health of all individuals

A State should carefully assess the potential for health damages of any measure it considers to take. The underlying condition seems to be that a State has the duty to respect the equality of all persons, and should do everything reasonably possible to enhance the equal rights of all persons. In conjunction with this, a State should pay particular attention to the needs of the most vulnerable, especially in times of economic recession. As the U.N. Committee on Economic, Social and Cultural Rights stated:

> The Committee underlines the fact that even in times of severe resources constraints whether caused by a process of adjustment, of economic recession, or by other factors the vulnerable members of society can and indeed must be protected by the adoption of relatively low-cost targeted programmes.[64]

2. The obligation to optimally protect the health of all individuals

Appropriate administrative, legislative, and other measures should be taken to ensure that individuals can optimally develop themselves without undue or otherwise unacceptable interference. Following this obligation, a State is obligated to prevent others from violating the health rights of an individual. Examples of the ways States might do this include prohibiting female genital mutilation, rape within or outside marriage, and other forms of sexual violence targeted at spouses and third parties. Equally, a State is required to design policies conducive to health promotion and disease prevention, including the implementation of safety standards, providing clean drinking water, and the implementation of health education programs.

3. The obligation to fulfill

The obligation to fulfill implies an obligation to achieve, among others, the following goals: the right of everyone to the enjoyment of the highest attainable standard of health;[65] making provisions for the reduction of the stillbirth rate and infant mortality, and for the

64. *General Comment No. 3, supra* note 51, ¶ 12.
65. *See* Economic Covenant, *infra doc. biblio.*, art. 12(1).

healthy development of the child;[66] the improvement of all aspects of environmental and industrial hygiene;[67] the prevention, treatment and control of epidemic, endemic, occupational, and other diseases;[68] and the creation of conditions that would assure all individuals medical service and medical attention in times of sickness.[69]

From the text of Article 12 it is clear that this list of measures is exemplary instead of exhaustive; the language used is "the steps to be taken . . . include." Consequently, a State Party to the Economic Covenant is required to undertake any other measure either deemed necessary or that may otherwise lead to the fulfillment of the aspirations enshrined in this right.

a. Core content

In the human rights literature it has been suggested that all social rights have a so-called minimum *core content.*[70] As soon as the "essence" of a social right can be defined, individuals can be bestowed with an enforceable right, which, according to some authors, remains an absolute requirement to qualify as a human right.[71] Most often, however, social rights are only indirectly justiciable, often by calling upon the nondiscrimination principle.[72] According to this principle, States are not allowed to arbitrarily deprive individuals or groups of individuals of their rights and entitlements.

b. Nondiscrimination

In 1987, the Human Rights Committee stated that Article 26 of the International Covenant on Civil and Political Rights (Civil and Political Covenant) not only prohibits discrimination in respect to the rights set forth in the Covenant itself, but also applies to human rights defined outside the realm of the Covenant.[73] In other words, social rights should also comply with the nondiscrimination principle. In its General Comment on Non-Discrimination, the U.N. Human Rights Committee reaffirmed the special nature of Article 26 of the Civil and Political Covenant:

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66. *See* Economic Covenant, *infra doc. biblio.*, art. 12(2a).
67. *See* Economic Covenant, *infra doc. biblio.*, art. 12(2b).
68. *See* Economic Covenant, *infra doc. biblio.*, art. 12(2b).
69. *See* Economic Covenant, *infra doc. biblio.*, art. 12(2d).
70. *E.g., cf.* Türk, *supra* note 43, ¶ 30.
71. Vierdag, *supra* note 36, at 92-93.
72. HERINGA, *supra* note 37, at 105-09; *see also Limburg Principles, supra* note 44, ¶¶ 35-41.
73. *See* Broeks v. The Netherlands, *Report of the Human Rights Committee*, U.N. GAOR, 42d Sess., Supp. No. 40, at 148-49, U.N. Doc. A/42/40 (1987).

> [Article 26] prohibits discrimination in law or in fact in any field regulated and protected by public authorities. . . . In other words, the application of the principle of non-discrimination contained in article 26 is not limited to those rights which are provided for in the Covenant [on Civil and Political Rights].[74]

c. Indicators

A last method to assess State compliance with those obligations imposed by the right to health is through the formulation of health *indicators* or, more broadly, socio-economic indicators.[75] The importance of indicators is rapidly gaining momentum.[76] Indicators are not only a yardstick with which to measure State compliance, but through the formulation of socio-economic indicators, it seems possible to attune the core content of a social right to a country's level of development.

Without any differentiation between countries, it is not unthinkable that the core content of social rights will eventually correspond with the lowest common denominator of achievement of both rich and poor countries. Such unaspirational standards will serve as a pretext to justify social cutbacks, instead of encouraging States to undertake all necessary measures to realize a social right. It therefore seems utterly desirable to gear a right's core content to the level of socio-economic development of a country.

II. WOMEN'S RIGHT TO SEXUAL AND REPRODUCTIVE HEALTH AS A HUMAN RIGHT

When exploring the right to health, it is important to be aware of the gender aspects of health, and the extent to which policymakers, care providers, health educators, health researchers, and others are sensitive to women's health needs. For a long time, gender issues have been notoriously absent in human rights documents. To the extent that pre-1970 human rights documents refer to women's

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74. *General Comment No. 18: Non-Discrimination, in Report of the Human Rights Committee*, U.N. GAOR, 45th Sess., Supp. No. 40, Annex VI, at 173-75, U.N. Doc. A/45/40 (1990).

75. WORLD HEALTH ORGANIZATION, DEVELOPMENTS OF INDICATORS FOR MONITORING PROGRESS TOWARDS HEALTH FOR ALL BY THE YEAR 2000 (1981); *see also* World Health Organization, *Indicators to Measure the Realization of the Right to Health, Background Paper for the Seminar on Appropriate Indicators to Measure Achievements in the Progressive Realization of Economic, Social and Cultural Rights* (U.N. Centre for Human Rights 1993); World Conference on Human Rights, *Report of the Seminar on Appropriate Indicators to Measure Achievements in the Progressive Realization of Economic, Social and Cultural Rights*, U.N. Doc. A/CONF.157/PC/73 (1993).

76. Türk, *supra* note 43, ¶¶ 182-186.

health, the relevant provisions seem merely to be concerned about the health of women in their role or potential role as mothers.[77]

Another issue commonly neglected by international human rights law concerns the impact of gender discrimination on the enjoyment and exercise of social rights. The WHO definition of the right to health even seems to suggest that gender discrimination is a non-issue in the field of health care:

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination of race, religion, political belief, economic and social conditions.[78]

Since the 1970s, however, it has become increasingly clear that women encounter different—and generally more—problems in getting access to adequate and affordable health care than men. Studies have demonstrated that health promotion and disease prevention campaigns were often primarily focused on the health needs of men, and that women were almost systematically excluded from biomedical research.[79] As a consequence, little was known about the side effects of new drugs and therapies on women's health. There were other facts, including the widespread requirement by the health care system of spousal authorization, the training of health care workers primarily to work with male patients, and the socio-economic status of women.[80] In short, it turned out that medicine and health care were primarily men's issues and that women's health was pervasively neglected.

The call for special attention to women's health should be understood against this background. Women's organizations around the world started to challenge the omnipresent male bias in medicine and health delivery systems. In a growing number of countries, policymakers eventually turned out to be susceptible to the criticism echoed by women's groups.[81] There are, therefore, countries today, such as Australia, that have comprehensive women's health pro-

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77. *Cf.* European Social Charter, *infra doc. biblio.*, art. 8 ("With a view to ensuring the effective exercise of the right of employed women to protection, the Contracting Parties undertake . . . to prohibit the employment of women workers in underground mining, and, as appropriate, on all other work which is unsuitable for them by reason of its dangerous, unhealthy, or arduous nature.").

78. *Constitution of the World Health Organization*, *supra* note 32, at 1.

79. *See* Vanessa Merton, *The Exclusion of Pregnant, Pregnable, and Once-Pregnable People (a.k.a. Women) from Biomedical Research*, 19 AM. J.L. & MED. 369, 370-71 (1993).

80. *Cf.* SMYKE, *supra* note 14.

81. GENDER, WOMEN, AND HEALTH IN THE AMERICAS (Gómez Gómez Elenn ed., 1993).

grams—policies that do not confine themselves to sexual and reproductive health issues.[82]

Concern about women's health is also reflected in numerous human rights standards that have been set since the 1970s. Inspired by Article 12 of the Women's Convention, CEDAW issued a number of General Recommendations recognizing the gender-specific impact of current public-health problems, including recommendations on such issues as violence against women,[83] female circumcision,[84] HIV-related discrimination,[85] and disabilities.[86]

The importance of women's right to health care was also explicitly acknowledged at the World Conference on Human Rights in Vienna in 1993:

> The World Conference on Human Rights recognizes the importance of the enjoyment by women of the highest standard of physical and mental health throughout their life span. In the context of the World Conference on Women, and the Convention on the Elimination of Discrimination against Women, as well as the Proclamation of Teheran of 1968, the World Conference on Human Rights reaffirms, on the basis of equality between women and men, a woman's right to accessible and adequate health care and the widest range of family planning services, as well as equal access to education at all levels.[87]

When seeking to define the State's obligations with respect to women's right to health, it is important to take a closer look at the standards prescribed by the Women's Convention, couched first in terms of the main objectives of this document.

The principle goal of the Women's Convention is to eliminate all forms of discrimination against women. According to Article 1, women are entitled to protection against discrimination in both the public and private domains. It is of crucial importance that the scope of this anti-discrimination provision explicitly cover the private

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82. *Cf.* WOMEN'S HEALTH UNIT, NATIONAL WOMEN'S HEALTH POLICY: ADVANCING WOMEN'S HEALTH IN AUSTRALIA 78-106 (1989).

83. *General Recommendation No. 12: Violence Against Women, in Report of the Committee on the Elimination of Discrimination Against Women,* 8th Sess., U.N. Doc. A/44/38 (1989); *General Recommendation No. 19, in Report of the Committee on the Elimination of Discrimination Against Women,* 11th Sess., U.N. Doc. A/47/38 (1992).

84. *General Recommendation No. 14: Female Circumcision, in Report of the Committee on the Elimination of Discrimination Against Women,* 9th Sess., U.N. Doc. A/45/38 (1990).

85. *General Recommendation No. 15: Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS), in Report of the Committee on the Elimination of Discrimination Against Women,* 9th Sess., U.N. Doc. A/45/38 (1990).

86. *General Recommendation No. 18: Disabled Women, in Report of the Committee on the Elimination of Discrimination Against Women,* 10th Sess., U.N. Doc. A/46/38 (1991).

87. Vienna Declaration and Programme of Action, *infra doc. biblio.*, ¶ 41.

domain,[88] because women are particularly vulnerable to such harmful practices as sexual violence and female genital mutilation by spouses, family members, and others acting within the "private" sphere.

The duty to eliminate gender discrimination is phrased in terms of an "obligation to fulfill." According to Article 2, States should take "appropriate means" to achieve this aim. Because the elimination of discrimination is a very concrete goal, it can be maintained that it concerns here an obligation of result. This implies that the State has a margin of appreciation to determine the type of measures deemed suitable, as long as these are adequate to reduce discrimination against women and to enhance their equality.

Moreover, it is important to note that Article 2 obligates States to pursue an anti-discrimination policy "without delay." This is a concrete criterion against which State action can be measured.

The Women's Convention further stipulates that States should *ensure* that "social and cultural patterns of men and women [be modified], with a view to achieving the elimination of prejudices . . . and all other practices which are based on the idea of inferiority or superiority of either of the sexes or on stereotyped roles for men and women."[89] It is hard to underestimate the importance of this provision for the emancipation of women.[90] Deep-rooted, stereotyped roles for women are probably among the main obstacles for the enhancement of health equality between women and men. The reduction of womanhood to motherhood and the denial of recreational sex as integral—and often the main—component of women's sexuality are typical for a society that fails to acknowledge that women are equal human beings. It is important that such stereotyped views around sexuality and procreation be rebutted.

The strength of Article 5 lies in the word "ensure." As noted above, the duty to ensure corresponds with an obligation to protect. The application of this right can thus be made justiciable immediately.

Given the importance the Women's Convention attaches to nondiscrimination and the elimination of female stereotyped roles, it is easier to understand the inherent meaning of Article 12. According to this Article:

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88. Titia Loenen, *Het discriminatiebegrip* [*The Concept of Discrimination*], *in* HERINGA, *supra* note 6, at 1-13.

89. Women's Convention, *infra doc. biblio.*, art. 5.

90. Liesbeth Lijnzaad, *Over rollenpatronen and the rol van het verdrag* [*About Role Patterns and the Role of the Treaty*], *in* HERINGA, *supra* note 6, at 43-57.

> States Parties shall *take all appropriate measures* to eliminate discrimination against women in the field of health care in order to *ensure*, on a basis of equality of men and women, access to health care services, including those related to family planning.[91]

Moreover, paragraph 2 states that:

> States Parties shall *ensure* to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.[92]

On the basis of Article 12, States are thus obligated to take a number of concrete measures to promote and protect women's right to health. States are required to provide and guarantee access to various types of services, including: services for sex education; counseling and means to prevent unintended pregnancy; treatment for unwanted pregnancy; and prevention of sexually transmitted diseases and other manifestations of sexual and reproductive dysfunctions, including infertility.[93] More generally, these services should be directed at: the reduction of maternal morbidity and mortality;[94] the full respect for the autonomy and privacy of women, notably by ensuring that women's sexual and reproductive choices are always based on women's freely given informed consent; respect for women's sexuality and women's right to establish sexual relations with consenting others; respect for women's right to life; and ensuring that women can enjoy the benefits of scientific progress.[95] These services should, moreover, contribute to the elimination of gender discrimination and the removal of female stereotypes both inside and outside the health care sector.

In order to assess State compliance with these obligations it is important to design health and health-related indicators that are geared to the needs of women. Social-scientific surveys and epidemiological studies should regularly be carried out to determine if sexual and reproductive health have improved or declined. On the basis of a periodic evaluation of policies and their effects, health measures become—if necessary—adjusted.

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91. Women's Convention, *infra doc. biblio.*, art. 12 (emphasis added).
92. Women's Convention, *infra doc. biblio.*, art. 12 (emphasis added).
93. *Cf.* COOK, *supra* note 28.
94. *Cf.* Rebecca J. Cook, *Reducing Maternal Mortality: A Priority for Human Rights Law, in* LEGAL ISSUES IN HUMAN REPRODUCTION 185-212 (Sheila McLean ed., 1989); *see also* Rebecca J. Cook, *International Protection of Women's Reproductive Rights*, 24 N.Y.U. J. INT'L L. & POL. 645 (1992).
95. Merton, *supra* note 79, at 369-451.

Moreover, to the extent that women's right to health corresponds with obligations to protect, efforts should be made to grant women enforceable rights. According to Article 12, women are entitled to access to an independent court in case they are denied the right to equal access to health care facilities, as well as in case of a failure of the State to provide a minimum amount of services.

The justiciability of obligations to respect and fulfill remain more problematic, but may correspond with enforceable rights over time.[96] Legal commentators have, however, suggested how the rights of individuals can also be strengthened with respect to these obligations. According to Professor Rebecca Cook, for example, a State does not comply with its obligation to fulfill in a case where the protection of women's "well-being is obstructed by governmentally, legislatively or judicially constructed barriers."[97] The definition of other "negative" and "positive" obligations can be construed according to socio-economic and health indicators geared to the level of socio-economic development of a country.

CONCLUSION

The participants at a 1978 international conference on the right to health adopted the following health definition:

> Health is a state in which one does not feel the body . . . . When you offer men and women health, you let them have the freedom of their body, the freedom of their movements. However modest it may be, the freedom of one's body is always the beginning of one's freedom.[98]

Up until the present day, women's bodily freedom has often been defined within the narrow context of sexual and reproductive decisionmaking. In this essay I have argued that it is important to conceptualize and articulate women's sexual and reproductive health within the broader context of the right to health, a social right that figures in both the Economic Covenant and the Women's Convention.

On the basis of Eide's typology I have pointed out that the right to health consists of three types of obligations. Some of these obligations correspond with enforceable rights of individuals. This typology, together with the definition of a core content, the formulation of indicators, the adoption of General Comments and the "Limburg

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96. *Limburg Principles*, *supra* note 44, ¶ 44.

97. COOK, *supra* note 28, at 44.

98. RENE-JEAN DUPUY, LE DROIT À LA SANTÉ EN TANT QUE DROIT DE L'HOMME [THE RIGHT TO HEALTH AS A HUMAN RIGHT] 482 (1979).

Principles," provides useful tools to define the State's general responsibility with respect to women's right to health.

The Women's Convention places the implementation of the right to health in a gender context. For the further promotion and protection of women's right to health, as well as women's right to sexual and reproductive health, it is important to read both treaties in conjunction. On the basis of both treaties it can be maintained that States should pursue a comprehensive policy aimed at the economic, social, cultural, political, and civil equality of women and men,[99] and the removal of female stereotypes. Elimination of gender discrimination and female stereotypes, deeply rooted in the field of women's reproductive and sexual health services, should become a number-one priority for States worldwide.

99. *Cf. The Nairobi Forward-Looking Strategies for the Advancement of Women, supra* note 8.