Abstract

Women's right to health in international law comprises an array of interrelated rights. The nature and scope of state obligations concerning those rights, as an aggregate and individually, have important consequences not only for determining when remedies may be available for violations, but also for the utility of rights-based claims in political discourse aimed at influencing health policies. This article identifies components of women's rights to health and outlines a theoretical framework for conceptualizing the correlative human rights obligations, including questions concerning minimum core obligations, the normative effect of the prohibition of gender discrimination on obligations, and justiciability. The precise character of obligations regarding women's rights to health must be elaborated in jurisprudence examining specific factual circumstances.

El derecho de la mujer a la salud en el derecho internacional abarca un arreglo de derechos interrelacionados. La naturaleza y el alcance de las obligaciones del estado respecto a estos derechos, tanto como un agregado e individualmente, tienen consecuencias importantes no solamente en determinar cuando los remedios pueden estar disponibles en el caso de las violaciones a estos derechos, pero también en la utilidad en los discursos políticos dirigidos a influenciar las políticas de la salud. Este artículo identifica los componentes del derecho de la mujer a la salud e esboza un marco teórico para la conceptualización de las obligaciones correlativas de los derechos humanos, incluyendo preguntas concernientes a las obligaciones mínimas esenciales, el efecto normativo de la prohibición de la discriminación sexual en las obligaciones y su caracter justiciable. El caracter preciso de las obligaciones respecto al derecho de la mujer a la salud debe de ser desarrollado en la juridprudencia examinando circunstancias específicas objetivas.

Le droit de la femme à la santé dans le cadre des lois internationales comprend un ensemble de droits étroitement liés entre eux. La nature et l'étendue des responsabilités de l'état face à ces droits, aussi bien du point de vue général qu'individuel, ont des retombées importantes non seulement sur la détermination du moment où des solutions sont disponibles en cas de violation de ces droits, mais aussi sur l'utilité de revendications légales inclues dans les discours politiques qui visent à influencer les politiques sanitaires. Cet article identifie les composantes du droit de la femme à la santé et présente un modèle théorique pour la mise en place de concepts liés aux obligations des droits de l'homme. Il comprend des questions relatives aux obligations élémentaires, l'effet normatif de l'interdiction de la discrimination des sexes sur les responsabilités ainsi que l'application de ces droits. La caractérisation précise des obligations concernant le droit de la femme à la santé, doit être développée par la jurisprudence traitant de situations concretes spécifiques.

The Nature And Scope of Human Rights Obligations Concerning Women's Right to Health

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The nature and scope of human rights obligations regarding women's health have important implications for efforts to establish accountability at the international level for the realization of women's right to health. Accountability implies both a normative framework for assessing the *de jure* and *de facto* status of women's right to health, and effective procedures for monitoring compliance with relevant norms. This article examines the first aspect of accountability, focusing on the nature and scope of relevant obligations. The character of those obligations is significant. It both shapes the utility of rights discourse in public and private sector decision-making processes, and conditions the extent to which the rights concerned may be the subject of legal remedies for individuals and groups.

As with a number of other economic and social rights, there is scant international jurisprudence concerning women's right to health, or the right to health itself. Consequently, important questions regarding the state's obligations related to women's right to health have yet to be clarified. These include: when do those obligations constitute duties of im-

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mediate effect; when do they create justiciable rights; what types of measures should be taken to give effect to those obligations; and which obligations may be considered core duties of the state.

These questions assume particular importance because, it is suggested, the substantive content of women's right to health encompasses an array of rights. Like the general right to health in international law, women's right to health should be understood in the context of the broad concept of health framed by the World Health Organization (WHO).[1] Health is defined in the WHO Constitution as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[2] This comprehensive concept of health implicates a range of civil, political, economic, social, and cultural rights well beyond those related to the provision of health care.[3]

Because *de jure* and *de facto* gender discrimination impairs women's ability to realize a "state of complete physical, mental and social well-being," the realization of their right to health also implicates the general prohibition of discrimination and non-discrimination guarantees specific to women. The significance of the prohibition of gender discrimination for obligations regarding women's right to health should be understood principally with reference to the broad objectives of the Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention). The Women's Convention aims, first, to ensure that gender does not impair women's ability to exercise their human rights, and, second, to dismantle the structures that perpetuate women's subordination in public and private life.[4]

Women's right to health comprises an aggregate of rights, each of which has distinct normative content and may entail a range of duties. The content of the relevant norms has not been elaborated to uniform degrees in international or national jurisprudence. Certain rights within this aggregate may be constituent elements of women's right to health, while others are enabling rights that create the pre-conditions necessary for realization of this right.

Part I of this article outlines women's health-related needs and correlate rights, to demarcate the normative pa-

rameters within which state obligations regarding women's right to health may arise. Part II proposes a framework for conceptualizing those obligations; discusses the nature and scope of specific duties regarding women's right to health under the Women's Convention and the Covenant on Economic, Social and Cultural Rights (Economic Covenant); and analyzes the effect of the prohibition of gender discrimination on the character of state obligations. In the Conclusion, a typology is suggested for characterizing obligations of immediate effect, minimum core obligations, obligations regarding justiciable rights, and obligations regarding violations by non-state actors.

This article focuses on the obligations established in human rights treaties that bind states as a consequence of their having ratified these instruments. Accountability of non-state actors for the realization of women's right to health is of critical importance, but lies largely beyond the scope of this article.

I. Women's Health-Related Needs And Correlate Rights

The comprehensive concept of health defined by WHO, and the broad concept of gender equality embodied in the Women's Convention point to the wide range of needs that must be addressed to realize fully women's right to health. Important aspects of the general right to health relating to health status and health coverage have been elaborated in the goals and indicators developed to monitor the WHO programs on Health for All by the Year 2000 and Primary Health Care. [5] In addition, a number of commentators have identified various health-related needs and correlate rights specific to women.[6] The latter analyses have stressed the interrelationship between subordination of women in public and private life and denials of their right to health. They have therefore emphasized women's empowerment as the key to realizing their right to health.

Among women's health-related needs are: primary health care, preventive care; treatment of disease and rehabilitative care; reproductive and sexual health care; access to health-related information and education; freedom from violence and services for survivors of violence; healthy and safe working

conditions; safe medical and pharmaceutical technologies; the benefits of scientific progress; primary and secondary education; a healthy environment; freedom to advocate for their health needs and the means to do so; the ability to secure other components of an adequate standard of living, including food, housing, clothing and clean water; legal capacity and equality before the law in order to exercise and vindicate rights; access to judicial or other effective remedies for violations of the right to health or discrimination that interferes with the exercise of the right to health; protection against *de facto* gender discrimination in public and private life, including effective guarantees of equality in marriage and family relations; freedom from *de jure* and *de facto* gender discrimination in access to resources necessary to sustain an adequate standard of living, including discrimination in inheritance and property rights; an enabling economic environment, including the macroeconomic environment; the ability to participate in and influence decision-making on health matters at the national and international levels, including decision-making in the context of development assistance; and protection against *de jure* and *de facto* discrimination on grounds other than gender, including, among others, race, ethnicity, age, property, birth or other status, and sexual orientation.

States parties to human rights treaties have accepted binding obligations regarding rights instrumental for securing many of these needs. The aggregate of rights comprising women's right to health contains norms found in a range of human rights instruments. A partial listing includes the International Covenant on Civil and Political Rights (Political Covenant),[7] the International Covenant on Economic, Social and Cultural Rights (Economic Covenant),[8] the Women's Convention, the Convention on the Elimination of All Forms of Racial Discrimination,[9] the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment,[10] and the Convention on the Rights of the Child.[11] Relevant guarantees are also established in regional human rights instruments and conventions adopted by the International Labor Office.

Of particular importance are the rights established in the Women's Convention and the Economic Covenant. The Women's Convention addresses rights regarding access to

health care, and the rights to control fertility, to family planning information and services, and to healthy and safe working conditions. Also of relevance are the general and specific protections against discrimination enunciated in the areas of participation in public life, education, employment, legal capacity and equality before the law, and marriage and family life. Article 5 of the Convention, which requires the state to take measures to eliminate gender stereotyping, imposes an obligation central to modifying gender relations of power.

The general right to health is recognized in Article 12 of the Economic Covenant, which refers to the right to "enjoyment of the highest attainable standard of mental and physical health" and lists specific steps to be taken toward realization of that right. The Covenant also addresses the rights to education, a healthy environment, consent to marriage, and maternity leave. Among other components of women's right to health are: the right not to be arbitrarily deprived of life; the rights related to security and integrity of the person; the right to freedom of information; the right to equality before the law and equal protection of the law; the right to equal rights in marriage; and the rights associated with the prohibition of various forms of violence against women.[12]

In addition, there are norms and standards relevant to women's right to health in situations of particular risk, including those applicable to women subjected to forced prostitution and trafficking, and to refugee and displaced women. The Convention on the Rights of the Child[13] and the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families[14] contain guarantees directly addressing the right to health, as well as rights linked to the conditions necessary to achieve and maintain a state of health.

As suggested by this partial listing, women's right to health well illustrates the interrelationship and interdependence of civil, political, economic, social, and cultural rights. Violations of a particular aspect of women's right to health may involve violations of both civil and political rights, and economic and social rights. For example, involuntary sterilization implicates the rights to integrity of the person,[15] to freedom of information,[16] to health,[17] and to decide freely on

the number and spacing of children.[18] The civil and political rights components of economic and social rights have served as primary vehicles for judicial protection of the latter.[19] Analyses of the civil and political rights components of women's right to health can be further developed to facilitate an integrated approach to the justiciability of the right to health. For example, if health care benefits are provided or health rights are protected as statutory rights at the domestic level, due process protections may apply to withdrawal or refusal of those benefits or denial of those rights.

Within this normative aggregate, constituent rights may be distinguished from enabling rights. The latter comprise those rights that create the pre-conditions necessary to maintain and achieve a state of health as comprehensively defined, including rights instrumental in dismantling systemic gender discrimination. The content of the category of constituent rights will vary in particular factual contexts, but the following form a core set of constituent rights: the right to health care, including reproductive health care; the right to life and rights associated with the security and integrity of the person; the right to equality before the law and equal protection of the law in matters directly related to health status or health care; the right to *de facto* gender equality in practices directly affecting health status, such as nutrition, or access to health care; the right to education and information regarding matters associated with health status or health care; and the right to the benefits of scientific progress in areas affecting health status or health care.

The distinction between constituent and enabling rights is significant for purposes of judicial or quasi-judicial review to determine whether a state has breached its obligations regarding women's right to health as such. Although legal as well as policy assessments of women's right to health must take account of the interrelationship among rights, a correlation between the denial of a right associated with health and a decline in health status does not necessarily establish a causal relationship between the two. For example, while many studies indicate that higher levels of education correlate to lower levels of maternal mortality, high levels of education can not be causally linked to declines in maternal mortality,

which some studies show to be attributable to factors other than education.[20]

The distinction between constituent and enabling rights is also important for identifying the types of information that states parties submitting reports under human rights treaties should present concerning the provisions of those instruments directly addressed to health.[21] It is not, however, relevant for defining the appropriate scope of policy measures to protect women's right to health, as national policy to ensure women's right to health must address various practices of discrimination against women and the underlying political, economic, social, and cultural conditions that shape health status (i.e., enabling rights).

II. The Character Of Obligations Regarding Women's Right To Health

Because a broad range of rights is encompassed within the aggregate comprising women's right to health, it is difficult to identify rules of general applicability regarding obligations. The following analysis attempts to outline a theoretical framework within which obligations may be conceptualized. Their precise character must be determined in specific factual contexts, with reference to the particular rights concerned. Interpretations of the relevant provisions in existing jurisprudence, and not merely the texts of those provisions, must be taken into account in elaborating the gender-specific dimensions of the rights concerned and their application to women's right to health. The development of jurisprudence clarifying interpretation of relevant norms in particular factual circumstances should lead to the formation over time of more general principles regarding the nature and scope of obligations.

A. Progressive Implementation and Justiciability of Rights

Women's right to health involves duties regarding economic and social rights as well as civil and political rights. Although several rules of general applicability have been suggested regarding distinctions between duties to implement economic, social, and cultural rights and duties to implement civil and political rights, these have been subject to persuasive critiques. First, the view that civil and political rights

entail merely negative duties, while economic and social rights require positive action by the state to achieve their realization is contradicted by examples of civil and political rights that can be fully realized only by intervention that may include substantial resource allocation,[22] and by examples of negative duties entailed by economic, social, and cultural rights.[23] Therefore, the distinction between negative and positive duties is of little assistance in analyzing either the civil and political rights or the economic and social rights components of women's right to health.

Duties regarding civil and political rights have also been contrasted with duties regarding economic and social rights, on the ground that the former are capable of immediate implementation, while the latter are to be progressively implemented by the state to the "maximum of its available resources."[24] Although the Economic Covenant makes realization of rights subject to the availability of resources, all states parties have obligations to "take steps"[25] toward the "widest possible enjoyment of the relevant rights under the prevailing circumstances," regardless of their level of economic development.[26] Certain duties of immediate effect regarding rights under the Covenant can be identified, as discussed in greater detail below.[27]

Finally, economic and social rights have been contrasted with civil and political rights on the ground that the former are not justiciable (i.e., not capable of being applied by courts) because the relevant provisions are drafted in broad terms as duties to achieve a general result (obligations of result) over time, rather than duties to take specific steps toward that end (obligations of conduct or means).[28] However, the international expert body that monitors implementation of the Economic Covenant, the Committee on Economic, Social and Rights, and a number of commentators, have demonstrated that uncertainty regarding justiciability of economic and social rights may be attributed largely to the lack of institutionalized practice regarding interpretation of those rights. Elements of economic and social rights, particularly those concerning labor rights, have been subject to judicial review, and others are capable of being applied by courts.[29] The economic and social rights components of women's right to health thus must be examined in specific contexts to deter-

mine when they are justiciable.

B. Duties to Respect, to Protect, and to Assist and Fulfill

Obligations flowing from the normative aggregate comprising women's right to health, taken as a whole, and from particular rights within the aggregate, can be characterized broadly as obligations to respect, to protect, and to assist and fulfill those rights.[30] The duty to respect obligates the state to refrain from carrying out violations of the right to health. The duty to protect demands action by the state to prevent violations by non-state actors, including individuals, groups, and organizations. The duty to assist requires the state to take measures that will improve the capacity of individuals and groups to achieve and maintain a state of health (such as educational measures), and the duty to fulfill requires states to take those measures necessary to ensure full realization of their right to health. These include direct provision of services or resources necessary to ensure a minimum core content of the right to health, when individuals or groups are unable to secure those services or resources.[31]

This tripartite framework, formulated by Professor Eide with regard to economic and social rights, can also be applied to the civil and political rights components of women's right to health. The Political Covenant establishes a general obligation to "respect and ensure" the rights guaranteed. The duty to ensure requires the state to protect against certain private interferences with those rights.[32] Because the subordination of women in the family and within communal structures circumscribes their ability to realize health-related rights, the duty to protect is a particularly critical aspect of state obligations regarding those rights. In addition, as Professor Eide has observed, certain civil rights require the state to provide direct assistance to fulfill them, and therefore entail obligations at all three levels.[33]

C. Rights Under the Women's Convention Associated With Health Care

The core obligations regarding women's right to health are those established by the Women's Convention and recognized in the Economic Covenant. References to health in the Women's Convention are centered on the right to health care;

other aspects of the right to health are addressed in the provisions establishing substantive guarantees in such areas as political participation, education, employment, and equality in marriage and family relations. The duties imposed by the Women's Convention are to be interpreted with reference to the broad scope of the definition of discrimination established in Article 1, which applies to intentional and unintentional discrimination, state and non-state action, and discrimination in public and private life.

Article 12(1) of the Women's Convention imposes an obligation of result "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." It thus requires States parties to ensure women access to health care on a basis of equality with men, but does not clearly create an underlying duty to ensure health care itself.

Similarly, duties imposed by Articles 10(h), 11(1)(f), and 16(1)(d) are formulated as obligations to ensure the "equal rights of men and women" to: education and information on family health, including family planning; protection of health and safety in working conditions, including reproductive health; and access to the information, education, and means to enable them to determine freely and responsibly the number and spacing of their children. Of course, the duties established by these provisions are not limited to the guarantee of formal equality. States parties cannot evade their obligations by arguing that failure to address particular health conditions or risks experienced solely or predominantly by women, does not constitute discrimination against women, because men do not experience the same disease or health risk.

The exceptions to this focus on non-discrimination rather than duties to realize the underlying rights are Article 12(2), 11 and 14 of the Convention. Paragraph 2 of Article 12 goes beyond prohibition of discrimination, to require states to ensure "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." Article 11((2)(d) calls for "appropriate measures ... to provide special protection to women during

pregnancy in types of work proved to be harmful to them." These obligations to realize aspects of the underlying right to health are linked to women's reproductive role. The corresponding rights are derivative of women's childbearing and childrearing roles. The Convention thereby both responds to the real health needs of women, and reinforces existing material and ideological constructions that focus on women's reproductive role at the expense of their full humanity.

For the category of rural women, the Convention establishes obligations to ensure aspects of the underlying rights to health and health care *beyond* those associated with reproductive health. Article 14(2)(b) guarantees rural women a right of "access to *adequate health care facilities*, including information, counselling and services in family planning" (emphasis added), and subparagraph (h) guarantees their right to "enjoy adequate living conditions, particularly, in relation to housing, sanitation, electricity and water supply...."

Obligations under the Convention are framed in several different ways. Some provisions are formulated as obligations of means that are capable of being immediately implemented and are clearly justiciable. Others are framed as obligations of result, without identifying specific means to be adopted, and still others, as obligations of result that also detail specific steps to be taken. A meeting of international legal experts convened in 1994 to prepare a draft optional complaints procedure under the Convention concluded that it should be possible to identify minimum core obligations for all articles of the Convention. Even those provisions formulated only as duties "take all appropriate measures" to achieve a general goal could therefore be subject to judicial or quasi-judicial interpretation.[34]

Article 12 states such a general obligation of result. Means to achieve that end may be detailed by reference to: the definition of discrimination in Article 1 of the Convention; duties regarding the general right to health (see below); goals identified in the political commitments undertaken by governments at United Nations conferences on the advancement of women, the environment and development, human rights, population and development, and social development;[35] the practice of regional and international human

rights bodies; the practice of the expert body charged with monitoring implementation of the Convention, the Committee on the Elimination of Discrimination Against Women;[36] and the practice of states with regard to legislative, administrative, and judicial protection of women's right to health.

Articles 10 and 11(1) require States parties to "take all appropriate measures" to eliminate discrimination in the fields of education and employment, but further require that they "ensure" the specific rights listed. Article 16 calls on States parties to "take all appropriate measures to eliminate discrimination against women in matters relating to marriage and family relations, and in particular [to] ensure" the specific rights listed. These include the right to the information, education, and means to enable women to decide freely on the number and spacing of their children. Thus, although Articles 12(1), 10(h), 11(1)(f), and 16(1) focus on non-discrimination rather than substantive guarantees of the underlying rights, they include identifiable obligations of conduct that are justiciable.

Articles 11(2)(d), 12(2) and 14(2)(b) and (h) of the Convention, which clearly impose duties regarding the underlying rights, express obligations of both result and means. Article 12(2) refers to "appropriate" services in connection with pregnancy, confinement, and the post-natal period, but also stipulates that free services are to be granted when necessary, and that adequate nutrition is to be ensured during pregnancy and lactation. Article 11(2)(d) is framed as an obligation of result to provide special protection to pregnant women in work proved to be harmful. Obligations of means, including justiciable obligations, under Article 11(2)(d) can be elaborated by reference to the extensive inquiry and standard setting that has occurred in the legal, labor, and medical fields on measures to protect pregnant women against occupational health hazards. Finally, Article 14(2)(b) and (h) create general obligations of result regarding access to "health care facilities" and enjoyment of "an adequate standard of living," but identifies specific components of these rights. Obligations of means regarding these rights can be further detailed by reference to international practice concerning the general right to health.

States parties have several general duties of immediate

effect applicable to all these provisions, in addition to those obligations that are, by the terms of specific provisions, immediately effective. These duties are derived from the broad definition of discrimination in Article 1 and the general undertakings set forth in Article 2.[37] They constitute minimum core obligations applicable even to rights that demand expenditure of resources for their fulfillment. Minimum core obligations include, but are not limited to: [38] adoption of a national policy for the protection of women's right to health that is consistent with the provisions and broad aims of the Women's Convention; creation of systems for monitoring the status of women's right to health—including monitoring to identify groups of women most at risk of denials of the right to health, specific health risks faced by women, and discriminatory practices that impair women's health; and repeal of discriminatory legislation that impairs women's health status or their access to health services.

D. The Right To Health Under the Economic Covenant

Because the Women's Convention has not been interpreted as creating a general obligation to fulfill the underlying right to health, the right to health under Article 12 of the Economic Covenant is an essential protection. States parties to the Covenant are required to "take steps ... to the maximum of [their] available resources with a view to achieving progressively the full realization"[39] of the "highest attainable standard of physical and mental health."[40] Paragraph 2 of Article 12 provides a non-exhaustive catalog of specific steps to be taken toward this result: provision for reduction of the stillbirth rate and infant mortality; improvement of environmental and industrial hygiene; prevention, treatment, and control of epidemic, endemic, occupational, and other diseases; and creation of conditions that would ensure medical service and attention to all in the event of sickness.[41]

Although the Covenant makes realization of the right to health subject to resource constraints, the Committee on Economic, Social and Cultural Rights has made clear that States parties must demonstrate that every effort has been made to use all resources at their disposition to satisfy, *as a matter of priority*, minimum obligations under the Covenant.[42] All States parties, therefore, have duties under Ar-

ticle 12 regardless of their level of economic development and must account for how they allocate available resources, including international assistance, in order to comply with their obligation to realize the right to health.[43]

Similarly, although full realization of the right to health under the Economic Covenant is to be progressively achieved, the Committee has identified several duties of immediate effect regarding all rights in the Covenant. In its general comment interpreting Article 2(1), the general obligations provision of the Covenant, the Committee stated that the undertakings to "take steps" and to guarantee that the recognized rights will be exercised without discrimination on the grounds of, *inter alia*, gender, constitute particularly important duties of immediate effect.[44]

States parties are required to "move as expeditiously and effectively as possible" by appropriate means toward the realization of the rights recognized.[45] The duty to "take steps" toward realization of the right to health is thus of immediate application and may be fulfilled by "all appropriate means." The Committee has suggested that in "fields such as health...the adoption of legislation may... be an indispensable element for many purposes."[46] It further stipulated that appropriate measures may also extend to provision of judicial remedies in cases of discrimination or where relevant articles of the Covenant are capable of immediate application by judicial bodies.[47] Other appropriate means may be, *inter alia*, measures of administrative, financial, educational, or social nature.[48]

A wide range of means to protect various aspects of women's right to health, with particular focus on their reproductive health and rights, has been outlined by Professor Cook and other commentators. A partial listing includes: safeguards against coercive practices impairing women's freedom of choice regarding health care; elimination of spousal authorization practices; procedures for ensuring informed consent to health care; development of research protocols reflecting women's health needs and circumstances; regulation of health care delivery systems in order to ensure quality of care; adoption and enforcement of safeguards against occupational health hazards; delivery of services, education, and counsel-

ling to women in groups at high risk of maternal mortality or morbidity; delivery of a full spectrum of health care services, including services in connection with reproductive and sexual health; measures to prevent and respond to violence against women in the family;[49] adoption and enforcement of laws stipulating a minimum age for marriage; education to eliminate gender stereotyping; and measures to ensure women's right to political participation and their capacity to influence decision-making processes concerning health policy.[50]

There is a need to define minimum core duties within this spectrum of means for realizing women's right to health under the Economic Covenant. The concept of minimum core duties to respect, protect, and assist and fulfill the rights expressed in the Covenant has been proposed as a means of determining when the state may be considered to have breached its obligations to achieve progressive realization of those rights. The Committee on Economic, Social and Cultural Rights has indicated that there are minimum core obligations to satisfy "minimum essential levels" of the rights in the Covenant.[51]

Among examples of the failure to satisfy minimum obligations cited by the Committee is deprivation of essential primary health care for "any significant number of individuals."[52] The minimum content of the duty to fulfill the right to health by providing "essential primary care" has not been defined by the Committee. Moreover, consensus has not yet emerged among states or advocates and scholars regarding the scope of the state's responsibility for direct provision of services or resources necessary to ensure a core content of the right to health.[53] As with other rights under the Covenant, the state's duty as direct provider of health care may range from minimum "safety net" care to comprehensive care,[54] but should be interpreted to include at least the direct provision of primary health care (or resources necessary to secure such care) when measures to respect, protect, and assist and fulfill are insufficient to permit individuals or groups to secure those services or resources through personal efforts.[55]

The core content of the right to health was among the subjects addressed by participants in a discussion on Article 12 held before the Committee in 1993. Participants suggested

several types of measures that, in addition to the obligations of means specified in Article 12, might be considered aspects of the state's minimum duties. They emphasized the necessity for measures to prevent discrimination and ensure the health needs of disadvantaged groups, giving priority to existing health inequalities. It was also proposed that elements of the basic standard of health to be realized could be elaborated by reference to indicators developed to monitor health status and health coverage.[56]

Other commentators have similarly suggested that the indicators developed to monitor the WHO programs on Primary Health Care and Health for All by the Year 2000 establish elements of the state's core responsibilities to protect health,[57] although indicators developed for the purpose of monitoring health status and health coverage suffer from several deficiencies in this regard. These include lack of gender-disaggregated data or data on inequalities in distribution of services by region or income group.[58] While existing indicators do provide important evidence regarding components of the state of health, they do not adequately address the full range of concerns implied by the comprehensive concept of health. Most importantly, they were designed to measure progress toward goals elaborated within the framework of public health policy, rather than human rights.

Data collection methodologies created to support public health policy will not necessarily yield information establishing a nexus between breach of a particular right and the health status revealed by the data (causation). Moreover, these methodologies are not designed to provide information establishing the State's international legal responsibility for failure to realize the right to health where non-state actors are involved. These include situations involving systems of mixed public and private sector health care delivery, or where the denial of the right to health involves a human rights violation by non-state actors (such as violence in the family).

Thus, existing data may be insufficient to sustain a legal determination that breach of a particular obligation associated with the right to health has occurred, and that the state must remedy the violation.[59] However, data demonstrating a gross failure to protect the right to health, or accompanied

by information indicating that the state failed to make every effort to dedicate available resources to protecting a core content of women's right to health, may support a finding that the state has breached its international obligations. Existing data also serve as important indicia in monitoring procedures designed to establish *political* accountability for the failure to make progress toward realization of the right to health.

There is a critical need to develop fact-finding methodologies that will better support legal analyses of the state's compliance with specific duties regarding women's right to health. Such fact-finding methodologies should take women's priority needs as their starting point and incorporate analysis of the relationship between gender and other factors such as ethnicity, race and class, as well as feminist analysis of the systemic effects of gender discrimination.

In the process of developing, implementing and modifying indicators, elements of the minimum duties regarding women's right to health can be clarified. Further guidance concerning those duties may be derived from, *inter alia*, the practice of regional and international human rights bodies; goals endorsed by governments at United Nations conferences;[60] and legislation and jurisprudence at the national level. Certain *types* of obligations may be suggested as threshold core duties, however, derived from the general obligations established in the Economic Covenant, the Women's Convention and the Political Covenant.

Threshold core duties include, but are not limited to: adoption of national health policies to ensure respect for, to protect, and to assist and fulfill women's right to health, giving priority to the needs of women in disadvantaged groups;[61] creation of systems for monitoring the status of women's right to health;[62] repeal or amendment of legislation that impairs the exercise of women's right to health; adoption of legislation when necessary to protect women's right to health against interferences by third parties, including regulatory regimes; establishment of adequate remedies for those violations of aspects of the right to health for which remedies are a necessary safeguard (such as violations of the right to informed consent to treatment), or for violations of the right to health that implicate civil and political rights (such as integrity of

the person), regarding which states have independent duties to provide remedies under other human rights instruments.

E. Non-Discrimination Norms

These threshold minimum duties can be further elaborated by reference to non-discrimination norms. The Economic Committee and a number of commentators have identified the prohibition of discrimination as an obligation of immediate effect under the Economic Covenant.[63] It has been further suggested that measures to ensure that discrimination does not impair the right to health should be considered part of the minimum obligations regarding that right. [64] This approach is consistent with the significance accorded to the general prohibition of discrimination in international law.

The normative effect of the prohibition of gender discrimination on the nature and scope of obligations regarding women's right to health should be considered in light of the standard applicable to discrimination in general international law, as well as the more comprehensive approach adopted in the Women's Convention. The general prohibition of discrimination in international law encompasses discrimination on a number of grounds in addition to gender, such as race, language, and religion. International and regional human rights bodies have interpreted the general prohibition of discrimination to permit distinctions on one of the proscribed grounds if those distinctions are based on "objective and reasonable" criteria and the difference in treatment is proportionate to the justification.[65]

As has been pointed out by feminist commentators, this standard may mask the effects of the social and political construction of gender itself. In practice, it measures women's human rights against criteria based on the paradigm of men's experience, to determine which distinctions are "objective and reasonable." It is therefore necessary to avoid narrow interpretations in applying this standard, to ascertain when there is gender discrimination that would require immediate action to secure women's right to health as a matter of priority. The concept of gender equality embodied in the Women's Convention is broader, as it encompasses the restructuring of gender relations of power.

However, neither the general prohibition of gender dis-

crimination nor the norms set forth in the Women's Convention can be understood as transforming all rights related to women's right to health into core content or duties of immediate effect. The principle that the guarantee of non-discrimination should be immediately implemented as a priority may be applied to some aspects of the duties to respect and protect women's right to health in a relatively straightforward manner. Pursuant to its duties to respect and protect, the state should, at a minimum: establish the basic prohibition of gender discrimination in national law; repeal discriminatory legislation that impairs the exercise of the right to health; adopt legislation prohibiting discrimination by state authorities or third parties (non-state actors, including individuals, organizations, and enterprises) that impairs exercise of right to health; and ensure effective remedies for discriminatory practices by state authorities or third parties that impair the exercise of the right to health.

Immediate implementation of non-discrimination guarantees may not be possible regarding other aspects of the duties to respect and to protect, however. For example, prevention of discriminatory interferences by state authorities with the right to health requires an institutional framework and procedures to ensure training and supervision of officials, in addition to legislative guarantees and remedies. Institutions and procedures effective for these purposes can rarely be created immediately.

The normative effect of the prohibition of gender discrimination on the content of core duties to fulfill women's right to health also requires closer analysis, as fulfillment of the right demands expenditure of resources. This duty cannot always be satisfied solely through allocation of resources to health rights rather than to military expenditures or other non-rights related matters. States may face competing claims for resources to meet the health or other rights-related needs of individuals or groups subject to other forms of discrimination, or otherwise disadvantaged. Or, they may confront widespread health crises demanding large-scale expenditures of resources.

To suggest that rights relating to women's health be given priority in all such circumstances would privilege gender discrimination above other forms of discrimination that are simi-

larly prohibited under international law, and which are also experienced by women. Whether the state has breached its minimum duties to fulfill women's right to health by failing to allocate resources can be determined in specific factual circumstances, taking into account the severity and scope of the deprivation of rights.

When the state demonstrates that resources were dedicated to the health needs of groups experiencing other forms of discrimination or otherwise disadvantaged, or to demands stemming from health crises, the principle of proportionality should be applied to assess whether the state has failed to comply with its obligations regarding women's right to health. Assessing the proportionality of the state's action in such circumstances is consistent with the general premise that the state should strive for the "widest possible enjoyment" of rights recognized in the Economic Covenant.[66] Of course, this approach is predicated on an institutional framework within which women's health rights and needs are adequately monitored, and women are empowered to influence decision-making processes. The availability of cost-effective means for fulfilling the right to health and the need to stress preventive approaches to health also should be considered in any such assessments.[67]

A second, related but distinct principle affects the character of obligations regarding women's right to health. Priority is to be given to efforts to realize the rights to health of the most disadvantaged groups in society and/or those most at risk of deprivation of their right to health. This principle is emphasized in the WHO program of Health for All[68] and has been explicitly recognized in the Protocol of San Salvador.[69] It is consistent both with the notion that states should address the most acute denials of rights as a matter of priority, while giving due consideration to preventive measures, and with core human rights values concerning dignity and equality.

Systemic gender discrimination may render women as a group generally disadvantaged with regard to their ability to exercise particular health rights (such as those associated with reproductive and sexual health), at risk of particular violations of the right to health (such as violence in the family),

and particularly at risk of denials of the right to health (such as denials of access to adequate nutrition). Obligations regarding women's right to health may thus become minimum duties in circumstances where women as a group are disadvantaged with regard to particular rights, or at risk as a group—or where sub-groupings of women are disadvantaged or at risk[70] based on such factors as income, social status, or ethnicity. The corresponding rights do not constitute group or collective rights as such, however, unless the group of women in question may otherwise be considered part of a group holding collective rights under international law (such as indigenous peoples).[71]

Conclusion

Women's right to health comprises an aggregate of rights which, individually and taken as a whole, create obligations to be satisfied by the state at multiple levels. Those levels of obligation may be categorized as duties to respect, to protect, and to assist and fulfill the rights concerned. The duty to respect requires the state to refrain from carrying out violations. The duty to protect demands action by the state to prevent violations committed by non-state actors, and the duty to assist/fulfill requires states to take steps necessary to ensure realization of the various components of women's right to health. Obligations both of result and means are included in the spectrum of duties flowing from rights within the aggregate.

This spectrum of obligations includes duties of immediate effects, and duties to be progressively realized, but the content of these categories is fluid. Certain rights are by their terms capable of immediate implementation, such as the right to equality before the law or the freedom to receive information regarding family planning. States parties to human rights treaties have additional duties of immediate effect, derived from their general obligations regarding implementation of those treaties as a whole.

Thus, States parties to the Economic Covenant have a duty of immediate effect to "take steps" toward realization of women's right to health. A wide variety of means may be employed to satisfy this obligation. The prohibition of dis-

crimination also creates duties of immediate effect, but does not in the abstract transform all duties regarding women's right to health into obligations of immediate effect.

The spectrum of obligations includes minimum duties that must be satisfied by the state. These include the obligations of means identified in a number of treaty provisions regarding rights associated with women's right to health. They include both obligations derived from rights capable of immediate implementation, and obligations concerning rights that must be implemented via action requiring expenditure of resources. These core duties thus offer means for determining when states may be considered to have breached duties with regard to progressive implementation of women's right to health.

While the core content of women's right to health (or of the general right to health) has yet to be defined, certain threshold core duties can be identified on the basis of the general obligations provisions of human rights treaties. Minimum duties will need to be further elaborated by reference to the priority needs of women, and to such sources of evidence as the practice of regional and international human rights bodies, state practice, and political commitments undertaken by governments in recent United Nations conferences.

Certain minimum duties can be derived from the principle of non-discrimination and the principle that priority is to be given to disadvantaged groups and/or groups most at risk of suffering denials of their right to health. Neither principle can be interpreted to mean that, because women as a group face systemic discrimination and are at risk of denials of their right to health, all obligations associated with their right to health constitute core duties. The content of the category of minimum duties should shift as the state succeeds in addressing priority health-related needs, and should expand with increases in available resources.

Finally, the spectrum of obligations includes a number of justiciable duties. These include obligations regarding rights that are by their terms justiciable, such as the right to minimum age of marriage, and others comprising minimum duties capable of judicial review, such as the duty to adopt a

national policy for realization of women's right to health.

Although this typology addresses obligations of the state, it encompasses certain duties regarding violations by non-state actors. For example, the prohibition of gender discrimination in the Women's Convention explicitly applies to private persons, organizations, or enterprises.[72] States parties must hold private individuals accountable under national law for interferences with women's health-related rights under the Convention. In addition, under other treaties or even customary law, the state may be accountable under international law for its failure to take steps to prohibit and remedy certain human rights violations by private individuals.[73] The state may therefore have duties to take action against private violations of aspects of women's right to health (such as rights related to security and integrity, freedom of assembly, and private life).

The *duty to protect* as a necessary aspect of realizing women's right to health includes a range of measures by the state to prevent third party violations, including regulation of delivery of services and of drug testing and marketing, and measures to eliminate violence against women in the family. Finally, there is emerging jurisprudence in the European context making human rights directly applicable against third parties where permitted under national law (as contrasted with indirect accountability of private actors based on failure of the state to act).[74] Through this approach, aspects of women's right to health might constitute enforceable rights against private actors in national courts, such as private health care providers.

In order to realize women's right to health, accountability must be established not only for states and private actors at the national level, but also for international financial institutions and multinational corporations. The policies and programs of international financial institutions have direct as well as indirect effects on women's right to health. Development projects routinely target women in the areas of reproductive health, nutrition, and a broad range of other health-related issues. Macroeconomic policies have similarly pervasive, and often devastating, effects on women's health. The policies and operating practices of multinational corporations also have a far-reaching impact on women's right to health.

Thus, there is a pressing need for standards and implementation procedures to hold international financial institutions directly accountable for the effects of their policies and programs on women's right to health. Those standards and procedures must be based on human rights norms, and entail independent monitoring.[75]

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References

1. For discussion of the definition of the "right to health," see V. Leary, The Right to Health in International Human Rights Law," *Health and Human Rights* 1 (1994):24-56; K. Tomasevski, "Health Rights," in *Economic, Social and Cultural Rights A Textbook*, eds. A. Eide, C. Krause, and A. Rosas (Dordrecht: Nijhoff, 1995):125-142; and H. Feunzalida-Puelma and S. Scholle Connor, "Summary and Analysis," in *The Right to Health in the Americas*, eds. H. Feunzalida-Puelma and S. Scholle Connor (Washington: Pan American Health Organization, 1989) pp. 596-605.
2. Constitution of the World Health Organization, in *Basic Documents*, 39th ed. (Geneva: World Health Organization, 1992).
3. See J. Mann, L. Gostin, S. Gruskin, T. Brennan, Z. Lazzarini, and H. Fineberg, "Health and Human Rights," *Health and Human Rights* 1 (1994): 7-23, 8-9, 19-21.
4. Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979).
5. The goal of Health for All by the Year 2000 was adopted by the World Health Assembly in May 1977 (WHA 30.43). The WHO primary health care program is based on the Declaration of Alma Ata, Primary Health Care, adopted at the International Conference on Primary Health Care, Sept. 12, 1978, World Health Organization, Geneva. Regarding indicators, see World Health Organization, *Development of Indicators for Monitoring Progress for Health for All by the Year 2000* (Health Series No. 4, 1981); World Health Organization, Implementation of the Global Strategy of Health for All by the Year 2000, Second Evaluation and the Eighth Report on the World Health Situation, WHO Doc. A45/3 (1992); World Health Organization, Third Monitoring of Progress, Common Framework, CFM3, Implementation of Strategies for Health for All by the Year 2000, WHO Doc. HST/GSP/93.2 (1993); World Health Organization, Indicators to Measure the Realization of the Right to Health, Paper for the Seminar on Appropriate Indicators to Measure Achievements in the Progressive Realization of Economic, Social and Cultural Rights, U.N. Doc. HR/Geneva/Sem./BP.19 (1993).
6. See generally R. Cook, *Women's Health and Human Rights* (Geneva: World Health Organization, 1994). Regarding women's reproductive health and rights, see The American University Law Review 44 (no. 4) (proceedings of the Conference on the International Protection of Reproductive Rights sponsored by the Women in the Law Project of the International Human Rights Law Group and the Washington College of Law of the American University, Washington, November 1994). For bibliography on

women's health and human rights, see R. Cook and V. Oosterveld, "A Select Bibliography of Women's Human Rights," ibid., pp. 1429-1475; (EDITOR'S NOTE: See also, S. Gruskin and D. Studdert, this volume).
7. International Covenant on Civil and Political Rights, G.A. Res. 2200 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966).
8. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 49, U.N. Doc. A/6316 (1966).
9. Convention on the Elimination of All Forms of Racial Discrimination, December 21, 1965, 660 U.N.T.S. 195.
10. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment, G.A. Res. 39/45, U.N. GAOR, 39th Sess., Supp. No. 51, at 197, U.N. Doc. A/39/51 (1985).
11. Convention on the Rights of the Child, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, U.N. Doc. A/44/49 (1990).
12. See R. Cook, "Human Rights and Reproductive Self Determination," *The American University Law Review* 44 (1995):975-1016 (identifying clusters of rights that comprise women's reproductive rights).
13. For discussion of international standard setting regarding the right to health of the child, see K. Tomasevski, note 1, p. 134.
14. Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, G.A. Res. 45/158, UN GAOR. 45th Sess., Supp. No. 49, at 261, UN Doc. A/45/49 (1990).
15. Political Covenant, see note 7, Articles 7, 9.
16. Ibid, Article 19.
17. Economic Covenant, see note 8, Article 12.
18. Women's Convention, see note 4, Article 16(1)(e).
19. M. Scheinin,"Economic and Social Rights as Legal Rights," in A. Eide *et al* (eds), see note 1, pp. 41-62, 44-52. See also Human Rights Committee, General Comment No. 6, Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1, pp. 5-6, para. 5 (1992) (stating that Article 6 of the Political Covenant, which guarantees the right to life, "requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics").
20. D. Maine, "Facing Facts: The Role of Epidemiology in Reproductive Rights Advocacy," *The American University Law Review* 44 (1995): 1089-1092, 1090.
21. The six core international human rights instruments each create expert committees charged with monitoring implementation by States parties. States parties are required to report to the treaty bodies on a periodic basis, and guidelines have been established concerning the basic information that should be included in those reports, including specific categories of information to be presented under each substantive provision of the treaty in question. For guidelines on reporting under Article 12 of the Economic Covenant, see P. Alston, "The International Covenant on Economic, Social and Cultural Rights," in *United Nations Manual on Human Rights Reporting*, pp. 39-77, 63-65, U.N. Doc. HR/PUB/91/1 (1991).
22. Examples include rights related to the administration of justice and voting rights.
23. Examples include the duties to respect the right to strike and to respect the liberty of parents to ensure the religious and moral education of their children in conformity with their convictions. Eide observes that

economic and social rights can often "best be safeguarded through non-interference by the State with the freedom and use of resources possessed by the individual." A. Eide, "Economic, Social and Cultural Rights as Human Rights," in A. Eide, et al. (eds.), see note 1, pp. 21-40, 38.
24. Political Covenant, see note 7, Article 2(1). The right to health, like the other rights set forth in the Economic Covenant, is subject to the general undertaking in Article 2(1) to "take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."
25. Ibid.
26. V. Leary, see note 1, p. 46; P. Alston and G. Quinn, "The Nature and Scope of States Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights," *Human Rights Quarterly* 9 (1987): 156-229, 177-81.
27. See text at pp. 380-381,384-385.
28. It is generally acknowledged that the rights related to labour and social security (Articles 6-9) are justiciable because they are formulated more precisely than other provisions of the Covenant and their normative content has been clarified in domestic jurisprudence, and, in the case of Articles 6-8, the practice of the International Labour Office. See P. Alston, "No Right to Complain About Being Poor: The Need for an Optional Protocol to the Economic Rights Covenant, " in *The Future of Human Rights Protection in a Changing World*, eds. A. Eide and J. Helgesen (Oslo: Norwegian University Press: 1991):79-100, 86-89. As Scheinin notes, economic and social rights can be formulated in precise language that clearly meets the requirements of justiciability, as illustrated by the example of the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, see note 19, p. 43.
29. For an overview of the justiciability of economic and social rights, see M. Scheinin, see note 19. Scheinin analyzes the application of civil and political rights to secure judicial protection of economic and social rights and reviews emerging practice and jurisprudence under the European Social Charter, the Treaty of Rome, the Treaty on European Union (Maastricht Treaty) and domestic law. See also P. Alston and G. Quinn, see note 26, pp. 169-71; The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, U.N. Doc. E/CN.4/1987/17, Annex, *reprinted in Human Rights Quarterly* 9 (1987):122-35, para. 19.

The Economic Committee has proposed the adoption of an Optional Protocol establishing a complaints procedure under the Covenant, and in that context concluded that a complaints procedure should apply to all rights in the Covenant rather than attempting to distinguish justiciable from non-justiciable rights in the abstract. See U.N. Doc. A/Conf.157/PC/62/Add.5, Annex II (1993) (analytical paper submitted by the Committee on Economic, Social and Cultural Rights to the World Conference on Human Rights). See also Committee on Economic, Social and Cultural Rights, Draft optional protocol providing for the consideration of communications, Report by Mr. Philip Alston, U.N. Doc. E/C.12/1994/12, at 5 (1994); Netherlands Institute of Human Rights (SIM), Draft Optional Protocol to the International Covenant on Economic, Social and Cultural Rights adopted by the Utrecht Expert Meeting, Utrecht, Jan. 1995, p. 2, Article II (1).
30. A. Eide, see note 23, pp. 37-38; A. Eide, *The Right to Adequate Food*

as a Human Right (Geneva: United Nations, 1989):34-37, U.N. Sales No. E.89.XIV.2 (1989). For more detailed application of this framework, see A. Eide, "The Right to an Adequate Standard of Living Including the Right to Food," in A. Eide et al. (eds.), see note 1, pp. 89-105, 99-105.
31. A. Eide, see note 23, p. 38; A. Eide, "The Right to an Adequate Standard of Living Including the Right to Food," see note 30, pp. 104-105.
32. See generally A. Clapham, *Human Rights in the Private Sphere* (Oxford: Clarendon, 1993):89-297, 343-56; D. Sullivan, The Public/Private Distinction in International Human Rights Law," in *Women's Rights, Human Rights: International Feminist Perspectives*, eds. J. Peters and A. Wolper (New York: Routledge, 1995):126-134.
33. A. Eide, see note 23, p. 38. Eide cites the example of government assistance necessary to counteract child malnutrition as an aspect of the duty to fulfill the right to life. See also Human Rights Committee, see note 19.
34. See Women in the Law Project of the International Human Rights Law Group and the Maastricht Centre for Human Rights, Background Paper for the Expert Group Meeting on the Adoption of an Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (Sept. 29 - Oct. 1, 1994), prepared by A. Byrnes and J. Connors: 6-14 (on file with the author).
35. See United Nations, Report of the World Conference of the United Nations Decade for Women: Equality, Development and Peace, Copenhagen, July 1980, U.N. Doc. A/Conf.94/35 (1980); United Nations, Report of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, Nairobi, July 1985, U.N. Doc. A/Conf.116/28/Rev.1 (1985); United Nations, Agenda 21, Report of the United Nations Conference on Environment and Development, Rio de Janeiro, June 1992, U.N. Doc. A/Conf.151/26 (1992); United Nations, World Conference on Human Rights, The Vienna Declaration and Programme of Action, Vienna, June 1993, U.N. Doc. A/Conf.157/24 (1993); United Nations, Report of the International Conference on Population and Development and Various Recommendations of the World Health Organization, Cairo, Sept. 1994, U.N. Doc. A/Conf.171/13 (1994); United Nations, Report of the World Summit for Social Development, Copenhagen, March 1995, U.N. Doc. A/Conf.166/9 (1995). (EDITOR'S NOTE: For an analysis using the Programme of Action of the International Conference on Population and Development and various recommendations of the World Health Organization to define the minimum content of reproductive health care, see A. Rahman and R. Pine, this volume).
36. The Committee periodically adopts general recommendations on specific articles of, or specific concerns arising under, the Convention. The Committee has adopted general recommendations on, *inter alia*, violence against women (no. 12), female circumcision (no. 14), prevention and control of HIV/AIDS (no. 15), disabled women (no. 18), and violence against women (no. 19). Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1, pp. 68-71, 73-80 (1992). While general recommendations no. 12, 14 and 18 are framed more as resolutions than as interpretative statements, with the adoption of general recommendation no. 19 on violence against women in 1992, the Committee initiated a practice of using general recommendations as a vehicle for elucidating the meaning of particular provisions of the Convention. Ibid, pp. 74-80. See also Z. Ilic, "The Convention on the Elimination of All Forms of Discrimination Against Women," in *Manual on Reporting*, see note 21, pp. 153-76 (Guidelines for

reporting by States parties, which identify issues to be addressed in connection with each article of the Convention).
37. For discussion of Article 2, see R. Cook, "State Accountability Under the Convention on the Elimination of All Forms of Discrimination Against Women," in *Human of Women: National and International Perspectives*, ed. R. Cook (Philadelphia: University of Pennsylvania, 1994):228-56, 230-31.
38. Minimum core obligations include duties of immediate effect and justiciable duties. The categories of obligations of immediate effect and justiciable obligations are broader than the category of minimum core duties, however.
39. Economic Covenant, see note 8, Article 2(1).
40. Ibid, Article 12. Alston and Quinn note that the character of obligations regarding provisions which "recognize" rights, a category which includes Article 12, is to be interpreted with reference to the general obligations established in Article 2(1), see note 26, p. 185.
41. See also Article 10(2), providing that "[s]pecial protection should be accorded to mothers during a reasonable period before and after childbirth. During such periods, working mothers should be accorded paid leave or leave with adequate social security benefits."
42. Committee on Economic, Social and Cultural Rights, General Comment 3, The nature of States parties obligations (art. 2, para. 1 of the Covenant), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1, pp. 48-52, para. 10.
43. Leary points out that there is no automatic link between resources and health status and has identified several cost-effective means of promoting health, see note 1, pp. 47-49.
44. Committee on Economic, Social and Cultural Rights, General Comment 3, The nature of States parties obligations (art. 2, para. 1 of the Covenant), see note 42, paras. 1-2. For further analysis of the duty to "take steps" as an obligation of immediate effect, see P. Alston and G. Quinn, see note 26, pp. 165-66.
45. Committee on Economic, Social and Cultural Rights, General Comment 3, The nature of States parties obligations (art. 2, para. 1 of the Covenant), see note 42.
46. Ibid., paragraph 3.
47. Ibid., paragraph 5.
48. Ibid., paragraph 7.
49. Committee on the Elimination of Discrimination Against Women, General Recommendation no. 19 on violence against women, see note 36.
50. R. Cook, see note 1, and note 12.
51. Committee on Economic, Social and Cultural Rights, General Comment 3, The nature of States parties obligations (art. 2, para. 1 of the Covenant), see note 42, para. 10.
52. Ibid.
53. An influential study by the Pan American Health Organization on The Right to Health in the Americas concluded that there was no consensus regarding the extent of state responsibility to provide health care, in contrast with the consensus existing on the state's duty to provide free primary education. H. Feunzalida-Puelma and S. Scholle Connor, see note 1, p. 602. Tomasevski notes a similar absence of consensus among European states, see note 1, p. 133.
54. A. Eide, see note 30, p. 104 (with regard to the right to an adequate standard of living, of which health care is one component).
55. Ibid, p. 100.

56. A. Hendriks, "The Right to Health," *European Journal of Health Law* 1 (1994):187-96.
57. V. Leary, see note 1, pp. 41-43; R. Cook, see note 6, pp. 14-15; H. Fuenzalida-Puelma and S. Scholle Connor, see note 1, pp. 603-604. Fuenzalida-Puelma and Scholle Connor note that the targets identified by the program of Health for All by the Year 2000 are not definitions of an individual right to health and are most reliable in measuring compliance with regard to the statistical average of the population as whole, but affirm their utility as indicators which "have achieved a certain level of legal validity." Ibid, p. 604.
58. R. Cook, see note 6, pp. 14-15. For general discussion of indicators, see K. Tomasevski, "Indicators," in A. Eide et al. (eds.), see note 1, pp. 389-401.
59. Public health data obviously yields necessary *evidence* supporting claims concerning patterns of violations.
60. See note 35.
61. The Committee has stated that the obligation to devise strategies and programs for the promotion of economic, social and cultural rights is a core obligation "not in any way eliminated as a result of resource constraints" (i.e., a duty of immediate effect). Committee on Economic, Social and Cultural Rights, General Comment 3, The nature of States parties obligations (art. 2, para. 1 of the Covenant), see note 42, para. 11.
62. Ibid. The Committee has emphasized that States parties have a minimum core obligation to monitor the extent of the realization of rights protected by the Covenant (which constitutes a duty of immediate effect). As explained above, monitoring systems should include monitoring for the purpose of identifying groups of women most at risk of being deprived of their right to health, specific health risks faced by women, and discriminatory practices that impair women's health.
63. Article 2(2) of the Covenant prohibits discrimination on grounds of, *inter alia*, sex, with regard to the rights in the Covenant and Article 3 calls on States parties to ensure the equal rights of women and men under the Covenant. Articles 2(1) and 3 of the Political Covenant establish parallel guarantees. In addition, Article 26 of the Political Covenant creates an autonomous right to the equal protection of the law.
64. Participants in the day of discussion on Article 12 before the Committee on Economic, Social and Cultural Rights emphasized the centrality of measures to ensure non-discrimination. A. Hendriks, see note 56, pp. 192-95.
65. See South West Africa Cases, (Ethiopia v. South Africa; Liberia v. South Africa), 1966 International Court of Justice 6, 313-16 (Tanaka, J., dissenting); Abdulaziz, Cabales and Balkandali v. United Kingdom, 94 European Court of Human Rights (ser. A) p. 38.
66. Committee on Economic, Social and Cultural Rights, General Comment 3, The nature of States parties obligations (art. 2, para. 1 of the Covenant), see note 42, para. 11.
67. V. Leary, see note 1, pp. 45, 47-49.
68. The WHO program of Health for All emphasizes "preferential allocations of health resources to the social periphery as an absolute priority." See Declaration of Alma Ata, see note 5, p. 2.
69. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), done at San Salvador, November 24, 1988, *International Legal Materials* 28 (1989):156. Article 10 establishes an obligation to ensure universal primary health care and stipulates that states should ensure "[s]atisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable."

70. The analysis of the normative effect of the prohibition of discrimination on the scope of duties to fulfill women's right to health when there are competing claims to resources or widespread health crises can also be applied to the principle that disadvantaged groups are to be given priority in efforts to fulfill the right to health.
71. Similarly, the existence of systemic discrimination does not *ipso facto* convert rights of non-discrimination to group rights.
72. Women's Convention, see note 4, Articles 1, 2(e), 5.
73. See A. Clapham, see note 32, p. 97-124.
74. Ibid., pp. 178-244.
75. The World Bank has established a three member Inspection Panel with the power to investigate complaints concerning the adverse effects of the Bank's failure to comply with its operational policies and procedures, and to make findings and recommendations thereon to the Executive Directors of the Bank. See D. Bradlow, "International Organizations and Private Complaints: The Case of the World Bank Inspection Panel," *Virginia Journal of International Law* 34 (1994): 553-613. However, the standards for review of complaints consist of the Bank's internal policies and procedures, not human rights norms, and the members of the Panel are appointed by the Executive Directors of the Bank.