

A b s t r a c t

This article illustrates how underlying social conditions that compromise women's health are exposed through recognition of gender stereotyping. The applicability of international human rights law, requiring states to remove stereotyping that negatively affects women's status and health, justifies individual and nongovernmental organization initiatives to assist states in conforming to the law, as well as to hold them accountable for their failures. The article explains the contribution that health professionals can make through recognition of the links between women's health status and the socially structured environments in which women live. Awareness of gender-based personal vulnerabilities to domestic violence and unwanted pregnancy, for instance, and of gender-based constraints on equality and liberties enables understanding of the many factors beyond clinical health services which contribute to women's health. The article concludes by exploring how principles of human rights law can inspire individual and collective initiatives to remove barriers to the achievement of optimal health status for women.

Este artículo ilustra como las condiciones sociales subyacentes que comprenden la salud de la mujer son expuestas a través del reconocimiento de estereotipos de género. La aplicación de la ley de los derechos humanos internacionales requiere de los estados el remover los estereotipos que afectan negativamente la condición y la salud de la mujer, justifica iniciativas individuales y de organizaciones no gubernamentales para ayudar a los estados a ejercer esta ley, así como responsabilizarlos por sus fallas. Este artículo explica la contribución que los profesionales de la salud pueden hacer a través del reconocimiento de los lazos entre la condición de la salud de la mujer y los ambientes socialmente estructurados en los que la mujer vive. La conciencia de las vulnerabilidades personales basadas en el género, tales como la violencia doméstica y los embarazos no deseados, y de las restricciones en igualdad y libertad basadas en el género facilitan el entendimiento de que tanto contribuyen a la salud de la mujer más que los mismos servicios clínicos a la salud. El artículo concluye explorando como los principios de la ley de los derechos humanos puede inspirar a individuos e iniciativas colectivas para remover barreras y alcanzar el estado de salud óptimo de la mujer.

Cet article illustre comment les conditions sociales sous-jacentes incluant la santé des femmes sont révélées à travers la reconnaissance de la discrimination sexuelle. L'applicabilité des lois des droits de l'homme internationaux exigeant des états l'élimination des stéréotypes qui affectent négativement le statut des femmes et leur santé, justifie les initiatives des individus et des organisations non-gouvernementales pour aider les états à se conformer aux lois et aussi pour les tenir responsable de leurs infractions. L'article nous montre la contribution que les professionnels de la santé peuvent apporter à travers la reconnaissance de l'existence de liens entre la situation sanitaire des femmes et les structures sociales dans lesquelles elles vivent. La prise de conscience de la vulnérabilité individuelle selon son sexe, par exemple, à la violence domestique et la grossesse non désirée, ainsi que les contraintes sur l'égalité et sur les libertés liés aux sexes, permettent de comprendre que bien d'autres facteurs contribuent à la santé des femmes en dehors des services de soins. Finalement, l'article explore comment les principes des lois des droits de l'homme peuvent inciter à des initiatives individuelles et collectives pour éliminer les obstacles à une santé optimale de la femme.

GENDER, HEALTH AND HUMAN RIGHTS

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Motherhood can take a woman to the heights of ecstasy and the depths of despair; it can offer her protection and reverence. But it can also deny a woman consideration as anything more than a vehicle for human reproduction. Women's reproductive function fits within a social framework of gender that affects women's capacities and health. While traditional cultures established laws to protect women's reproductive functions, these laws have confined women to the extent that they have been denied almost all additional and alternative opportunities to flourish as individuals and to achieve complete health in their communities and wider societies. Emphasizing that health is more than a matter of an individual's medical condition, the World Health Organization (WHO) asserts that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."¹

It has been only recently recognized that states must address the protection and advancement of women's health interests through gender planning, to achieve not simply the abstract value of justice, but to conform to legally binding international human rights obligations as well. Gender planning concerns both practical and strategic needs of women in developing and industrialized countries.² Their practical needs are addressed through programs like the Safe Motherhood Initiative, co-sponsored by several UN agencies and in-

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ternational nongovernmental organizations.³ This program focuses on reducing the rates of maternal mortality, unwanted pregnancy, and sexually transmitted diseases, including HIV infection. Comparable programs address women's health and nutritional needs throughout the life cycle.⁴

Women's strategic needs transcend such practical needs however, because they address the value of women to society—a value extending beyond motherhood and service in the home. Focusing on strategic needs promotes women's roles in such areas as the economic, political, spiritual, professional and cultural life of communities. Most importantly, it opens the way to women's achievement of complete health as defined by WHO.

There is a paradox in addressing women's practical and strategic needs: those concerned with practical needs may develop concepts whose effects, and perhaps whose purpose, confine women to maternal, domestic and subordinate social roles. This denies women's legitimate strategic needs and prevents them from flourishing to their full capacity within the family, community and society.

This article addresses how the gender role in society occupied primarily by women has constrained women's growth to the detriment of their complete health. It also outlines how international human rights law obliges states to liberate women from this constraint to permit women's pursuit of health and achievement in areas of their own choice.

Sex and Gender

Medicine has historically used male physiology as the model for medical care, based on research studies involving exclusively men.⁵ Accordingly, women have been considered only to the extent that they are different from men, focusing medical attention on reproductive characteristics.

Further, medicine progressed from being an art of human interaction to a science dominated by biological revelations achieved in laboratories. More and more, it is driven by the institutional demands of hospital-based medicine, where results of laboratory science and, more recently, medical engineering and technology, can be applied. In moving the locus of their functions from the community to the laboratory and hospital, doctors have become isolated from those

social realities that condition the lives and health status of their patients.

In many regions of the world, health agencies are increasingly recognizing how functions performed by community members can protect and enhance people's health, and how important it is to reassess how an individual woman's self-esteem and health status are affected by the value placed on women by her community.⁶ Health professionals themselves are becoming more sensitive to the health impact of patients' social experiences. For example, the 1994 World Report on Women's Health, issued by the International Federation of Gynecology and Obstetrics, concluded that future improvements in women's health require not only improved science and health care, but also social justice for women and removal of socially and culturally conditioned barriers to women's equal opportunity.⁷

The experiences of women in their families and communities are different from those of men. The difference transcends reproductive functions, although the reproductive role of women in the creation and maintenance of families has commonly been used to justify women's subordination and denial of equal opportunity. The dominant view that women are distinguishable from men only as regards their biological constitution and reproductive role hides the profound psychological and social differences based on gender that societies have created, and that compromise women's complete health.⁸

The terms *sex* and *gender* are frequently used interchangeably. The latter is often preferred over the crude and salacious connotations of the former; but strictly speaking, the terms are different. *Sex* is a matter of biological differentiation, whereas *gender* is a social construct by which various activities and characteristics are associated with one or the other sex. For instance, leadership through success in battle is male gendered, whereas caring for the dependent young, sick, and elderly is female gendered. Popular imagery of leadership in, for example, politics, commerce, industry, the military, and religion is male gendered, whereas nursing and domestic service are female gendered. It is obvious that women can be political and industrial leaders, and that men can be care-givers, but it has been considered exceptional for

people to assume a gender role at variance with their sex. Activities and characteristics are preconceived via gender stereotypes, which determine the parameters of the normal. "Masculine" behavior in women, and "feminine" behavior in men have long been considered deviant. That which is normal or self-evident escapes special attention, because it is taken as the norm from which only departures are of interest. Behavior that is in accordance with conventional expectations and presuppositions of gender roles is generally unremarkable.

Women's Subordination and Exclusion

In societies around the world, female-gendered status is inferior and subordinate to male-gendered status. The male protects the female through the attributes of gallantry and chivalry, he is bold in courtship, aggressive in initiative, and forthcoming among peers. The female is passive, renders service in modest fulfillment of duty, and offers comfort in responsive obedience. Societies have modelled their role expectations on these assumptions of the natural order of humankind. Historic social structures, including the organization and conduct of warfare, the hierarchical ordering of influential religious institutions, the attribution of political power, the authority of the judiciary, and the influences that shape the content of the law, reflect this gender difference of male dominance and female subordination.

Because women naturally tend to behave in female-gendered ways, they have been vulnerable to confinement to female status by social, political, religious and other institutions, populated exclusively by men, that act in male-gendered ways. Women have accordingly been subordinated to assume only inferior, servile social roles, and have traditionally been excluded from centers of male-gendered power by legal and other instruments. These include legislatures, military institutions, religious orders, universities, and the learned professions, including medicine. This is still the age of "first women," such as the first woman medical school dean, the first woman Supreme Court justice, and the first woman head of a medical association.

The historic subordination, silencing, and imposed inferiority of women (beginning at birth as an expendable and

often unwanted girl child) has been invisible because it has been considered not simply a natural feature of society, but the very condition by which society can exist. Traditional forces emphasizing that women's "natural place" is in the home and that their natural functions in the rearing of children must always be protected, cannot envisage that women can aspire to and achieve the same advances in areas of male-gendered activities as men; nor do they acknowledge that it is oppressive of women's human rights to confine them to servile functions traditionally considered natural to their sex.

It is becoming increasingly recognized that an individual's health status is determined not only by chance genetic inheritance and the geographical availability of nutritional resources, but also by socio-economic factors.⁹ Relatively affluent people, and those content with their lives, enjoy better health status than impoverished, frustrated, and oppressed people who suffer disrespect in their communities and poor self-image. The determinants of earned income, including education, literacy, employment opportunities, and, for instance, financial credit for launching income initiatives, all show how women have been disadvantaged by their inferior gender role. Even within affluent families, women have often suffered frustrations—through male preference in inheritance, education preceding marriage, and training to occupy positions of influence and power within their communities. Women have been denied a commitment of family resources for these opportunities, in the belief that upon marriage, they will attenuate association with their own families (reflected, for example, in their shedding family names) and will assume a role of service within their husbands' families.

Complex social dynamics have produced a modern reality, common to communities across the full spectrum of economic and industrial development, of women being primary or sole economic supports of their families, and also being unmarried, widowed, or abandoned mothers of their children. Women's unequal opportunities to participate in the resources and well-being of their communities, and to contribute to political, economic, spiritual, and related leadership has a serious impact. It deprives those families that financially depend on women of equal opportunities for well-being; and

it robs women themselves of the economic, psychological, and social determinants of health. Women's vulnerability to sexual subordination through the greater physical, military, and social force of men produces harmful health consequences in women extending beyond pain, indignity, unwanted pregnancy, and venereal infection.

How Health Professions Have Constructed Women

Members of the health professions have done much to mitigate the health consequences of women's gendered disadvantage. They have cared for the distressed and violated, relieved physical pain, and eased women through unwanted and, at times, violently imposed pregnancy. As participants in traditional communities, however, undertaking the male-gendered functions of decision-making and leadership, doctors have tended to share prevailing perceptions of women's natural role, and exhibit blindness toward women's gender-specific health risks. Indeed, in the past, doctors have considered women constitutionally unsuited to political, commercial, and professional life, prone to swoon under stress and to require nine months of bed rest while pregnant.

When society blamed women for resorting to prostitution as a means of economic maintenance, while denying them alternative opportunities to support themselves and their families, doctors, among others, promoted the image of women as vectors of disease. Accordingly, when, for instance, victorious soldiers returned to the United States from 1918 to 1920, 18,000 women—alleged to be prostitutes—were detained in a medically supported governmental initiative, for fear that they would spread venereal infection.¹⁰ Women's image as vectors of disease to sexual partners and to children they conceive has been recycled in the modern pandemic of AIDS.¹¹

In many parts of the world, medicine retains marks of its gendered practice, for instance in placing women under the patriarchal control of men and others who exercise male-gendered authority. For example, in some countries, a woman's request for health care is accepted only with the express authorization of her husband.¹² Women's requests for control over their reproduction have so threatened male dominance of women's fertility that birth control and voluntary

sterilization were condemned until recently, as Crimes Against Morality.¹³ Voluntary abortion remains a major point of contention almost universally within institutions of traditional power, which are male-gendered. Whether it is discriminatory and socially unconscionable to criminalize a medical procedure that only women need is a question that usually goes not simply unanswered, but unasked.

Medicine Serving the Status Quo

By focusing its attention on the distress of individual women in clinical settings, medicine in general and psychiatry in particular have inadvertently served as agents of the continued subordination and oppression of women.¹⁴ Women have suffered feelings of ill health and emotional dissonance with family and community, as a reaction to denial of equal opportunities to seek their own achievements and their confinement to seeking satisfaction in the care of children, the sick and the dependent. Health professionals have conscientiously looked for physiological and psychiatric causes of maladjustment in patients' lives, and for other medical reasons for unhappiness and discontent.¹⁵ Illness alone was used to explain women's unhappiness in the midst of affluence and caring family members, a situation that by conventional standards should produce contentedness.

One effect of modern feminist sensitivity has been to expose feelings of frustration and anger as not being unnatural reactions to natural conditions, but as natural healthy reactions to social injustice. By diagnosing women's discontent and "disorders" as medical problems, physicians have reinforced and perpetuated the injustice of the prevailing social order, which prejudices women's health, rather than acting as instruments of remedy.

Medicine has a history of paternalism. Patients have been infantilized and denied social status, for example, by being called by their first names and presumed incapable of exercising informed choice among treatment options. A legal recognition of only recent evolution is that treatment choices are not to be medically dictated, but are to be medically-informed personal choices made by patients as an act of self-determination. Physicians are increasingly required by law to afford patients respect as equals—capable of and respon-

sible for making critical life decisions—by providing them the medical information they need to fully exercise choice.

However, while meeting this objective standard of medical disclosure, doctors must recognize how women's experiences in female-gendered roles have affected their medical histories and health prospects. The critical transition is from doctors treating women as inferior to men, physiologically different only in reproductive functions, to recognizing women as equal to men, only different because of the gendered experiences that affect their health.

As the health care system moves from a biomedical model of practice to a health promotion model, health professionals must meet the challenge and opportunity of reshaping their understanding of how women's experiences affect health. Restoration of health in reaction to illness and dysfunction can no longer concentrate only on the sciences, including physiology, biology, chemistry, and pharmacology. At the clinical level, these disciplines are essentially impersonal and neutral to the social, political, and environmental conditions that influence health. When health professionals concentrate on promoting health rather than just treating disease and dysfunction, they are compelled to consider the social, economic, and, for instance, environmental determinants of health. They must confront among other influences, gender-based discrimination which denies women opportunities for achieving physical and mental health.¹⁶

Clinically trained health professionals enhance their diagnostic and therapeutic capacities via recognition of the links between women's health status and the social environments they inhabit. Their knowledge about gender-based vulnerabilities to, for example, domestic violence and unwanted pregnancy, and their awareness of gender-based social constraints on career ambitions, will educate health professionals about the many factors beyond clinical services which contribute to women's health. As health professionals come to realize the extent to which health is compromised as a result of gender discrimination, they may turn to human rights principles and instruments in order to find ways in which discrimination maybe remedied or even prevented.

The Development of Human Rights

The function of modern human rights is to redress the imbalance between society's privileged and unempowered members.¹⁷ Countries may now be held to international account for internal policies, practices, and failures of public intervention, by which an individual's human dignity is violated. It usually falls to the weak and vulnerable of a society, and to those who advocate on their behalf, to invoke inherent human rights for the protection and promotion of their interests. Similarly, those who enjoy the privilege of power and protection resist challenges to their conventional authority. While at times sympathetic to rights rhetoric that may advance their own claims to entitlement, the privileged often resist service to rights that requires them to yield or share their privilege, observe duties related to rights, or support action that would reduce their privilege to no more than the rights that are shared by all others.

The United Nations was founded in 1945 on principles of respect for individual human rights, and paid tribute to its inspiration in its 1948 Universal Declaration of Human Rights. Post-war reconstruction and the Cold War preoccupied much of the early UN work to advance human rights. Rights of sexual equality were submerged in efforts against colonialism, of relieving the plight of refugees, and of resisting Apartheid. General international human rights conventions that gave legal substance to the Universal Declaration, namely the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, condemned sexual discrimination in only nominal terms. The several related regional human rights conventions were no more vigorously applied in this area.

It was not until 1966 that the UN adopted the International Convention on the Elimination of Racial Discrimination. The move to advance women's equality was more prolonged, because violations of women's rights were not as visible to male authorities as those suffered on racial grounds. However, one of the most dynamic perceptions of the late 20th century has been growing recognition of the unjust exclusion, oppression, and subordination of women through gender stereotyping practiced by such reputable institutions as, for instance, democratic governments, organized religions,

and higher education, as well as such professions as medicine and law.

In 1979, the UN adopted the Convention on the Elimination of All Forms of Discrimination against Women (the Women's Convention), and ratifications brought the Convention into legal effect with unusual speed. The Convention is currently ratified by at least 140 countries, although it remains subject to such extensive exceptions of applicability by some ratifying states that it is legitimate to ask whether, by tests of international treaty law, these states are truly parties.¹⁸ Nevertheless, the Women's Convention reinforces previous general and regional human rights conventions, and provides language to express those specific and binding entitlements to respect for individual dignity that constitute the human rights of women.

The points at which women's social inequality and negative stereotyping can be demonstrated are recognized more and more. Modern analysis has shown systemic denial and suppression of information concerning women's victimization by violence and rape in their homes.¹⁹ In fact, rape has been re-characterized by feminist scholarship not as a sexual act perpetrated by force, but as a violent act perpetrated through sex.²⁰ Certain countries, including Canada, now grant refugee status to women fleeing their countries due to a well-founded fear that they or their daughters would be circumcised.²¹ Sexual abuse in military conflict has been exposed as an act of dominance against women that amounts to torture. Additionally, it is often intended as a means of aggression towards men, who consider the chastity and sexual availability of women in their communities to be their exclusive possession. Recently, the Inter-American Commission on Human Rights, in a report on the situation of human rights under the administration of Raoul Cedras, determined that the rape and abuse of Haitian women constituted violations of their rights to be free from torture and inhuman and degrading treatment, and their right to liberty and security of the person.²²

Human Rights Relating to Women's Health

The International Covenant on Economic, Social and Cultural Rights explicitly names the right to the highest at-

tainable standard of health, and to enjoyment of the benefits of scientific progress. But because the determinants of health, including socio-economic status and the capacity to realize reasonable life ambitions, are multifaceted, most, if not all, named human rights contribute in differing degrees to the protection and promotion of health.²³ In its Preamble, the Women's Convention observes that the need for this separate legal instrument to reinforce the sexual nondiscrimination provisions of previous international conventions arises from the concern that "despite these various instruments, extensive discrimination against women continues to exist." It goes on to state that, "in situations of poverty, women have the least access to food, health, education, training and opportunities for employment and other needs." By Article 12(1) of the Women's Convention, States parties agree that they will "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."

Promotion of women's health depends upon the interaction of most, if not all, human rights. Rights relevant to health include those to protect women's employment and grant equal pay for work of equal value; to education; to information; and to political participation, influence, and democratic power within legislatures. These last rights permit women's rights to be respected in the general conduct of states.

In international and regional human rights conventions, the common prohibition of discrimination on grounds of sex has not been applied to condemn discrimination on grounds of gender. Elimination of sexual discrimination alone would bring women's status closer to that of men, and afford women the means that men enjoy to protect and advance their health. However, the wider health disadvantage that women suffer on grounds of gender must be tackled. Further, it must be based not only on the biological difference between the sexes, but on socially-structured gender differences that compromise women's achievement of "the highest attainable standard of health." By Article 5(1) of the Women's Convention, States parties agree to deconstruct gender discrimination by

taking appropriate measures to modify the social and cultural patterns of conduct of men and women. This is agreed upon with a view toward eliminating prejudices, and customary and all other practices based on the inferiority or superiority of either sex, or on stereotyped roles for men and women.

Women's poor physical and psychological health may represent a metaphor for the poor health of women's rights in the body politic and in influential community institutions, whether political, economic, religious, or health care. Application of human rights law may provide a remedy that results in improvements in women's health status. While this legal application faces formidable challenges, these challenges are increasingly being addressed by developments in legal doctrine.

Legal Approaches to Apply Human Rights to Health

Human rights law makes an important distinction between *negative* and *positive* rights. Of the two, negative rights are more easily applied, as they require states to do nothing but permit individuals to pursue their own preferences. In fact, states have not trusted women to make decisions affecting their own lives—rather, they have encumbered those women pursuing reproductive and other health interests with burdens, conditions, and at times, ferocious penalties.

Male-gendered institutions of government, religion, and the health professions have justified intervention in women's reproductive self-determination by invoking their own principles of public order, morality, and public health. Laws have been developed in many countries that punish women, and those who assist them, for resorting to contraception or abortion, and women's access to health examinations and services have been made dependent upon authorization by husbands and fathers. Women's negative human rights require that states remove all such barriers to women's pursuit of their health interests, except for those governing safety and efficacy of health services in general.

Positive rights require more of states—even amounting in some cases to social reconstruction. For example, the Colombian Ministry of Health's interpretation of the Women's

Convention led it to introduce a gender perspective into national health policies. These policies consider "the social discrimination of women as an element which contributes to the ill-health of women."²⁴ One Ministerial resolution orders health institutions to respect women's decisions on all issues that affect their health, lives, and sexuality, and rights "to information and orientation to allow the exercise of free, gratifying, responsible sexuality which cannot be tied to maternity."²⁵

Human rights regarding health require that the state provide health care that individuals are not able to obtain or provide on their own. This includes clinic and hospital-based services dependent on specialized skills of health care professionals, surgical interventions, and medical technologies. It also includes less sophisticated means, such as the supply of routine antibiotics and contraceptives that require little more than minimum counselling, nursing, and pharmaceutical services.

Positive rights may be difficult to observe in states with strained resources. However, it is a notorious fact that states invoking poverty to justify nonobservance of duties to defend women's health often provide disproportionately large military budgets. This is consistent with male-gendered perceptions of a population's needs.

Epidemiological data can be used to show how human rights can be made relevant to women's health. For example, international law has not yet developed the right to life beyond the duty to apply due process of law in cases of capital punishment. The right to life has not been invoked on behalf of the estimated 500,000 women annually who die of pregnancy-related causes because of lack of appropriate care.²⁶ Supplying appropriate care for women may be characterized as a duty of positive human rights to which states must allocate resources. An estimated 200,000 of these deaths are due to unsafe abortion alone.²⁷ Health indications for abortion include pregnancies that come too early, too late, too frequently, and too closely spaced. Permitting women access to qualified health personnel willing to perform the procedure is a negative human right that states are increasingly recognizing. The challenge remains of requiring states to satisfy

the positive duty of providing qualified services when women have no access to them on their own.

Feminist legal analysis exposes further areas of human rights observance to which states can be held. A distinction is commonly drawn between public and private law. Typically, the state engages its machinery for public law concerns such as governmental administration and maintenance of public order, but excludes itself from such private law matters as family relationships and functioning. Feminists identify domestic violence, discrimination against female children, women's exclusion from family inheritance, and demands for husbands' authorization of wives' medical care, as oppression and subordination. They point out that these impair women's health, but are not observed and remedied by the state.²⁸ In many countries, laws excluded husbands from liability for rape of their wives until recently, while these laws are still maintained in others. Feminist theories show how such male-gendered laws are structured and enforced at a cost to women's health. Similarly, laws permitting younger marriage of girls than boys promote the stereotyping of women in childbearing and service roles, and exclude them from the education and training that boys receive to fulfill their masculine destiny as family and social leaders.

Conclusion

Recognition of gender stereotyping exposes the underlying social conditions that compromise women's health. International human rights law requires state action to remove stereotyping that negatively affects women's status and health. Further, it justifies individual and nongovernmental organization initiatives to both assist states in conforming to the law, and to hold states accountable for their failures.

Achieving respect for each person's right to the highest attainable standard of health is in itself an important goal of international law, but that right is interdependent with many other human rights. Good health is the precondition to individuals' exercise of rights to equal participation in communal and social life. At the same time, an individual's capacity for participation in activities of their choice enhances their health status.

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