C2 | GENDERED APPROACH TO REPRODUCTIVE AND SEXUAL HEALTH AND RIGHTS

Historically, women's ability to make choices and exercise autonomy in matters of sexuality and reproduction have been conditioned and constrained by social (caste, class, gender, race religion, ethnicity, sexuality), economic and political structures, responding to a model that prescribes normative behavior, and disallowing behavior which deviates from this. Women's health is, for example, persistently relegated to 'maternal health' and 'family planning', especially for married women. Women's identities as 'reproductive beings' has been the basis for their domestication, relegating them to the private sphere of family. Reproduction, however, is in itself a site of coercion and social inequality, regulated by 'hetero-normativity' and social hierarchies. Further, non-normative gender and sexual expressions (e.g., same-sex sexual expressions) are largely marginalized and continue to remain invisible despite recognized violations of health and human rights.

Any conversation, therefore, on reproductive and sexual health and rights (SRHR), must employ the lens of intersectionality, whereby multiple tropes of identity and social locations are factored into analyses and policy perspectives. An intersectional approach to SRHR is necessary to understand and address inequities that impact autonomy, personhood, dignity, health and human rights. These are indelibly linked with the political economy of health and its intersections with the deep-rooted, multiple and structural discriminations. The abdication of its role in the provision of services by the State with the simultaneous promotion of privatization and corporatization has adversely impacted access, for a large number of people, to healthcare as well as other determinants necessary for their health. Inequalities within and across countries continue to grow, stoked by global policies that deny social, economic and political justice. This is further challenged by the rise in religious and political fundamentalisms that, in many parts of the globe, consolidate patriarchy, challenging democratic aspirations and institutions world-over. Following long struggles, the hard won rights to bodily integrity and autonomy, freedom from violence, access to safe abortion and to other reproductive and sexual health information and care stand threatened.

The Sustainable Development Goals (SDGs)[1], like their predecessor the Millennium Development Goals (MDGs), aim to transform global realities and inequalities. Specifically, goals [5] and [3] target the achievement of gender equality and empowerment of all women and girls and ensure healthy lives and

promote well-being for all at all ages, respectively. Cross-cutting both SDG 3 and 5 is the issue of SRHR (arrow, 2016). While the SDGs' call to 'leave no one behind' is significant, neither are the targets and indicators exhaustive, nor do they present a transformative potential (Hickel, 2015). (See Chapter A1.)

The following sections of the chapter illustrate a few pertinent debates, issues that are marginal in the public health discourse as well as in policies that build upon the preceding arguments vis-à-vis identities, intersectionality and inequity, in the context of SRHR.

Queering the right to health and healthcare

Discrimination on the basis of non-normative sexuality and gender identities is deeply entrenched and an area of grave concern. The public healthcare system has historically been at the centre of fostering such discrimination and violations of the health and human rights of those with marginalized sexualities and gender identities. With laws that criminalize homosexuality in many countries across the world, access to healthcare remains a particularly important challenge. The International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) in its 12th edition of 'State Sponsored Homophobia – A World Survey of Sexual Orientation Laws: Criminalisation, Protection and Recognition' has identified 72 countries where there is some form of criminalization, including 13 where homosexual acts can be punished with the death penalty (Carrol and Mendos, 2017). Among these 72 countries, most are located in the Global South. Thus the vulnerabilities of queer people regarding their right to health and healthcare are compounded due to their location as well as their identity.

Image C2.1 House rules in a guest house in Malindi, Kenya (By Nicor - Own work; License: CC BY-SA 3.0, https://commons.wikimedia.org/w/index.php?curid=8077400)

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According to a Report of the United Nations High Commissioner for Human Rights titled 'Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity' (United Nations, 2011) "The criminalization of homosexuality may deter individuals from seeking health services for fear of revealing criminal conduct, and results in services, national health plans and policies not reflecting the specific needs of LGBT persons…In countries where no criminal sanctions exist, homophobic, sexist and transphobic practices and attitudes on the part of health-care institutions and personnel may nonetheless deter LGBT persons from seeking services" (paragraphs 55 and 56).

The recognition of gender identities beyond the male and female binary, has however, witnessed some progress. During 2012–15 many countries accorded legal recognition to the identity of transgender people. For example, in Argentina in 2012 and in Denmark in 2014, self-identification became the sole criteria for legal recognition and change of name in identity documents for transgender people. In both countries, sex reassignment surgery or certification of any other medical or psychological intervention is not mandatory to obtain such recognition. Argentina includes the provision of surgical intervention and hormonal therapy as a right for those who desire to have them, in public, private as well as trade-union run services in the country as part of the

Box C2.1: Right to health of queer communities in India

In the context of India, for example, the Section 377 of the Indian Penal Code (IPC) that criminalizes 'sex against the order of the nature' is used to target and violate the rights of the queer community, including to healthcare. In 2009, a two-judge bench of the Delhi High Court recognized that section 377 obstructs people's right to health by hindering the outreach of public health measures for HIV/AIDS prevention. However, the Supreme Court of India's ruling in 2013 reaffirming the provisions of Section 377, while hearing an appeal against the Delhi High Court judgement of 2009 dealt a blow to human rights and health rights especially for the queer community in India[2]. The reference by the Supreme Court in its 2013 judgement to the queer community as a "miniscule minority" was a stark reflection of the prevalent attitudes as well as obfuscation of the right to sexual autonomy and non-discriminatory access to healthcare. While the struggle continues with curative petitions against the judgement being admitted by the Supreme Court towards determining the constitutional validity of the Section 377 (Rajagopal, 2016), 'queering' of the public health discourse, policy and programmes must remain central to the health movement and other campaigns.

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'Compulsory Medical Plan' for citizens[3]. Denmark, represents an exception in the Europe, where in 34 countries legal recognition by way of change of name and change of sex assigned at birth is linked with certification of some form of medical intervention (Ansari 2017). In India, in 2014, the Supreme Court of India accorded recognition to transgender and intersex people as the 'other' gender, upholding their right to self-identification and recognizing their fundamental rights guaranteed under the constitution as full citizens[4]. However, the implementation of this judgment through the Transgender Persons (Protection of Rights) Bill, 2016, and multiple state-level policies have met with criticism as they have placed disproportionate emphasis on medical diagnosis, proof of sex-reassignment surgeries and a plethora of 'evidences' that go against the very essence of self-identification as a trans-person. Iran too promotes the 'medicalization' of gender identity for transgender people. This has made it easier to access sex reassignment and transition related healthcare since 1987. However, an emphasis on medical intervention designates transgender identities as pathologies – as though it is a disorder in need of rectification (ibid.). Further, these measures stop short of facilitating access to social security measures including access to comprehensive healthcare by people who have been historically marginalized and been largely invisible in society.

Moreover, fundamentalisms – religious or otherwise – pose a great danger to the life and liberty of homosexual and transgender persons. In April 2016, two prominent gay rights activists of Bangladesh Xulhaz Mannan and Mahbub Tonoy were brutally murdered in Dhaka by religious fundamentalists. According to a compilation by the 'Trans Murder Monitoring Project', there were 2,343 reported killings of trans and gender-diverse people in 69 countries worldwide between 2008–2016. The report reveals: "Throughout all six world regions, the highest absolute numbers have been found in countries with strong trans movements and civil society organisations that carry out forms of professional monitoring: Brazil (938), Mexico (290), Colombia (115), Venezuela (111), and Honduras (89) in Central and South America; the United States (160) in North America; Turkey (44) and Italy (32) in Europe; and India (62), the Philippines (43) and Pakistan (39) in Asia (Transgender Europe (TGEU) 2017)."

Sex workers' health: an agenda for public health

For women in sex work, their identity as a 'sex worker' prevails over all else; ignoring their experiences as women affected by gender, norms related to sexuality, and their social locations. These, as well as stigmatization, as a consequence of criminalization and social control impact varied aspects of their lives, including their access to healthcare, housing, etc. (Pai et al., 2014). Stigma also reduces sex workers' access to institutions of law and order, justice in situations of violence. For sex workers, violence is rampant in intimate relationships, in their work as well as through interface with representatives of

institutions of health, law, justice (ibid.). Stigma and consequent self-imposed invisibility increases the risk of violence, and creates obstacles for public health interventions to reach them.

Moreover, sex workers have been historically targeted in a very instrumentalist manner – as 'vectors' of HIV, as high risk groups who need access to drugs or treatment so as to curb the spread of the disease among the 'general population' (Crago, 2015). Reports of sex workers being tested for HIV without their consent and the public disclosure of the results have repeatedly violated accepted standards of confidentiality and consent, while severely hindering their access to quality health services (SAMA, 2017). Such response to the HIV/AIDS pandemic also acted as one of the major catalyst for sex workers to organize themselves to advocate for rights against such targeting and to be seen as rights bearing individuals who are entitled to health as a human right. According to a *Lancet* paper, "sex workers' health programmes, including interventions focusing on safer sex, should be for the promotion of health of sex workers and not just a way to slow down the dissemination of HIV" (Wolffers and Beelen, 2003).

However, quality healthcare to address sex workers own health needs – access to safe abortion, access to pre- and post-natal care, healthcare in cases of sexual or domestic violence, counselling to deal with violence and stigma and other mental health issues – is virtually absent[5]. Sex workers are highly vulnerable to physical and mental health issues but have minimal access to medical and psychosocial care. Sex workers who access healthcare in public hospitals, are frequently denied treatment or find themselves at the receiving end of abuse and discrimination, and receive treatment of poor quality.

Sex work is frequently conflated with trafficking and is responsible for the rights of sex workers being severely compromised. While a proportion of sex workers are 'trafficked', a higher number enter sex work of their own volition. Poverty, caste and gender inequality are often underlying motivations for their entering sex work, but their decision is not without agency. In some countries, this leads to criminalization of sex workers and enforces invisibility. While trafficking – understood as illegal confinement, coercion, bonded labour and deception – are definitely a problem, most countries have laws to address these generally, as well as particularly in the realm of labour laws. Therefore, if sex workers enjoy the rights of workers, issues linked to their conditions at the workplace can also be addressed by existing laws against violation of labour rights. Sex workers have often argued for their recognition as workers and effective implementation of existing laws, instead of anti-trafficking laws that violate their rights. "Repressive policies toward prostitution and prostitutes and/or repressive, restrictive policies towards migration per se under the denominator of anti-trafficking policy, actually *preclude* an effective, adequate policy against those abuses that anti-trafficking policies should be designed to address (i.e. the abuse and violence in relation to the process of recruitment

and in relation to working conditions in prostitution). Anti-trafficking policies mostly address the wrong phenomena" (Vanwesenbeeck, 2011).

Laws and policies must distinguish between sex work and trafficking, measures to address trafficking in persons must not interfere with the human rights of sex workers, and the model of raids, 'rescue' and rehabilitation for sex workers must be abolished. Decriminalization of sex work and measures to safeguard health and occupational safety must be instituted. In order to establish a rights-based approach to sex work, participation of sex workers must be ensured in the design, implementation and monitoring of policies and laws (Sama, 2017). The Government must take steps to provide a full range of non-stigmatizing and confidential health services that is relevant to their needs.

Whither the *right* to safe abortion?

Women's rights over their own bodies and their reproductive autonomy are often rendered secondary, pitted against the conceptualization of the foetus as a 'person' which bears the 'right to life'. Access to safe abortion is a hugely contested issue globally with complete bans in some states. Abortion, under any circumstance, is banned in 11 African countries[6], 7 Latin American and Caribbean countries[7] and 3 Asian countries[8]. One of the major incidents that rekindled global debates on abortion was the death of Savita Halappanavar, a woman of Indian origin in Ireland in 2012. She died of septicemia that resulted from denial of medical care following a miscarriage.

Image C2.2 March for Choice in Dublin (William Murphy; License: CC BY-SA 2.0, https://creativecommons.org/licenses/by-sa/2.0/)

Though updated statistics are not available, according to 2008 data of the World Health Organization (WHO), “In developed regions, it is estimated that 30 women die for every 100 000 unsafe abortions. That number rises to 220 deaths per 100 000 unsafe abortions in developing regions and 520 deaths per 100 000 unsafe abortions in sub-Saharan Africa. Mortality from unsafe abortion disproportionately affects women in Africa. While the continent accounts for 29% of all unsafe abortions, it sees 62% of unsafe abortion-related deaths[9]”.

The recent reinstating of the ‘Global Gag’ Rule in 2017 by the current US President, Donald Trump, has only sparked further debate on the issue of abortion (see Box C2.2). The most recent version of the gag rule has been imposed on all US federal funding on global health, including family planning and also funding that comes as ‘foreign aid’. It affects sexual and reproductive rights globally and also threatens access to safe abortion services and pushes women to pursue unsafe abortions that put their health and lives at risk (Redden, 2017). Moreover, the ‘Global Gag’ Rule affects not just access to safe abortion, but also sexual and reproductive health and rights, including programmes against HIV/AIDS, Zika, etc. (ibid.).

In Brazil, the spread of the Zika virus and rising cases of children born with microcephaly has given impetus to women’s rights campaigns that are demanding an expansion of very restrictive abortion laws. Brazil criminalizes abortion and permits them only in case of a pregnancy resulting from rape, necessity to save a mother’s life and anencephaly in the foetus (Carless, 2016).

In 2016, thousands of women in Poland took to the streets to protest against a proposal to ban abortions in the country by the conservative government in the country. In response, the government dropped the proposal, yet refused to liberalize existing laws to facilitate greater access – which was a demand of the protesters (Borys, 2016). The law in Poland permits abortion only for pregnancy following rape and in case of danger to the mother’s life. More recently in June 2017, women in Poland have hit the streets yet again,

Image C2.3 International Sex Workers Day, 2012, Sex Workers Pride March (National Network of Sex Workers, India)

Box C2.2: What is the 'Global Gag' Rule?

The controversial 'Global Gag' Rule (also known as the Mexico City Policy) prohibits international family planning organizations receiving US aid from providing information, counselling, or referrals related to abortion – even if using their own non-US funding and even if the practices are legal in their own countries.

When reinstated as a matter of law, the GGR has terrible consequences for women and their families. While it was in effect between 2001 and 2009, the policy forced clinics to cut back on a range of critical health services that have nothing to do with abortion, such as family planning, obstetric care, HIV testing and malaria treatment.

A Stanford University study also suggested that the policy may be linked to a dramatic rise in induced abortions in Africa, including in Ghana, Guinea and Mozambique. These countries, which experienced the greatest cuts in US support for health organizations under the policy, saw the number of induced abortions double between 2001 and 2008, along with a decline in contraceptive use. Reduced access to contraceptives resulting from funding cuts may have led women to substitute abortion for contraception, according to the study, which is the first quantitative effort to examine the policy's impacts.

The GGR was first adopted in 1984 by President Ronald Reagan but has since been removed and reinstated several times. President Obama rescinded the policy when he took office in January 2009. President Donald J. Trump reinstated the 'Global Gag' Rule in 2017.

Source: Reproduced from Engender Health n.d. 'Raise Your Voice: Raise Your Voice: End the Global Gag Rule!' http://www.engenderhealth.org/media/info/globalgagrule-video.php?gclid=CjwKEAjwqIfLBRCk6vH_rJq7yDoSJACG18frScL5ER78knJ9AzYXa_yvq95mkFvfTw3wXRzux-VTQMRoCBw3w_wcB

to protest against the government's directive to ban over the counter sale of emergency contraceptives. Such a move curtails women's SRHR and allows greater control for medical practitioners (Lampen, 2017).

Towards a conclusion

The chapter suggests approaches to analysing and building the public health discourse and policies related to sexual and reproductive health and rights, which currently fall outside the normative framework. Illustrating three areas – right to health of queer people, sex workers' access to healthcare and access to safe abortion – the chapter focuses on key issues and concerns that

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Box C2.3: Abortion laws in India

In India, the law on abortion – the Medical Termination of Pregnancy Act 1971 (amendments in 2002) does not recognize women's absolute right to abortion but allows access to abortion under certain circumstances like pregnancy following rape, contraceptive failure, in case of foetal abnormalities and if a woman is experiencing physical or mental trauma. The Act recognizes termination of pregnancy till 20 weeks, beyond which, courts have the jurisdiction to decide based on the opinion of a duly constituted medical board that weighs the merits of each case. However, even when such boards rule in favour of the woman's plea to be allowed to abort, no legal precedent is set for medical boards to be constituted without the courts' intervention in subsequent cases. Such a stipulation restricts an adult woman's desire for terminating a pregnancy till a medical board determines that there is a danger to her physical and/or mental health in each case (Nadimpally and Banerjee, 2016). Amendments to the MTP Act are under consideration to increase the gestation limit from the present 20 weeks to 24 weeks for special categories of women. In addition, the amendment proposes to do away with the gestational limit for seeking abortions on grounds of foetal abnormality that is incompatible with life (PTI, 2017). An extremely progressive judgment in September 2016 by the Bombay High Court held that, "Pregnancy has profound effects on a woman's health and life. Thus, how she wants to deal with this pregnancy must be a decision she alone can make. Let us not lose sight of the basic right of women: the right to decide what to do with their bodies, including whether or not to get pregnant and stay pregnant" (Arvind, 2016).

Two issues that pose substantive barriers to access to abortion is criminalization of consensual sexual activity below 18 years and its conflation with gender biased selection. Mandatory reporting by healthcare providers under The Protection of Children from Sexual Offences (POCSO) Act 2012 severely curtails access to safe abortion for young girls. The positioning of sex selection versus access to abortion is not only misplaced, it immensely harms women's physical and emotional health whereby they are either forced to continue unintended pregnancies or have little choice but to access abortion in unsafe conditions. Further, the range of technologies, including pre-conception technologies for gender biased selection, continues to thrive and expand.

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are largely marginal in the SRHR discourse. There is a need to chart the future trajectory of activism around SRHR afresh. For too long, even major sections of health civil society movements, have been complicit in reducing the discourse on SRHR to one about maternal health and reproduction.

Rather than fragmented voices across the spectrum, there is a need to forge alliances and solidarities to resist retrograde steps that threaten human and sexual and reproductive health and rights. Mobilizations for development of 'shadow' reports by civil society under international instruments like the Universal Periodic Reviews (UPR) and reporting to the Committee under the 'Convention for Elimination of All Forms of Discrimination Against Women' (CEDAW) can be harnessed. Countries that have not signed/ratified some of the international treaties that accord protections and entitlements regarding SRHR must become sites of strategic mobilizations. The Women's March in the USA in January 2017 is an illustration of one such mobilization. People's collective resistances against inequalities and oppressions located at the intersections of hetero-patriarchal structures, neoliberal globalized markets, and other fundamentalisms, must be transformed to ensure that 'leaving no one behind' does not remain an empty slogan.

Notes

1 Under the 2030 Agenda for Development, in 2015 all member states of the United Nations agreed upon working towards achieving Sustainable Development Goals (SDGs). The 17 sustainable development goals (SDGs) are broken down into 169 specific targets that each country has committed to try and achieve voluntary basis over the next 15 years.

2 See: Supreme Court appeals case: Suresh Kumar Koushal and another ... versus NAZ Foundation and others CIVIL APPEAL NO.10972 OF 2013 http://judis.nic.in/supremecourt/imgs1.aspx?filename=41070

3 See: http://tgeu.org/argentina-gender-identity-law/

4 See: NALSA (National Legal Services Authority) Versus Union of India and others, WRIT PETITION (CIVIL) NO.400 OF 2012 http://supremecourtofindia.nic.in/outtoday/wc40012.pdf

5 See: Right to Health and Health Care 21. UPR report SANGRAM http://www.sexualrightsinitiative.com/wp-content/uploads/India-UPR-13-CREA.pdf

6 See: Abortion in Africa, Incidence and Trends https://www.guttmacher.org/fact-sheet/facts-abortion-africa

7 See: Abortion in Latin America And the Caribbean https://www.guttmacher.org/sites/default/files/factsheet/ib_aww-latin-america.pdf

8 See: Abortion in Asia https://www.guttmacher.org/sites/default/files/factsheet/ib_aww-asia.pdf

9 See: Factsheet by WHO, June 2017 http://www.who.int/mediacentre/factsheets/fs388/en/

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