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UN Special Rapporteur on the Right to Health

A discussion paper on

Sexual health and rights: intersections with reproductive justice, gender, and gender-based violence

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Today, the sexual and reproductive health and rights of millions of people around the world remain unmet. There are continued high maternal mortality rates, high incidence of unsafe abortion, persistent prevalence of HIV, harmful cultural practices such as female genital mutilation and child marriage, sexual and domestic violence, and pervasive discrimination based on sexual orientation, gender, age, disability, and other intersectionalities.

International human rights law, national constitutions, and domestic legislation have all codified the right to non-discrimination. Substantive equality, rather than formal equality, underscores the duty of states to eliminate discrimination in the design and implementation of sexual and reproductive health and rights laws. The Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health is therefore mandated to apply a gender perspective and to consider the situation of vulnerable and marginalized groups, including when considering sexual and reproductive health rights.

In this fourth Handover Dialogue, the focus is on the linkages between the right to health, sexuality, and gender. Sexual health and sexual rights are the two interrelated concepts central to the discussion. Sexual health is defined as a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. It requires equitable access to family planning services, skilled attendants at all births, emergency obstetric care, postpartum care, safe abortion services, and post-abortion care. Sexual rights are rights recognized in international and regional human rights instruments, including freedom from coercion, discrimination, and violence around sexuality, irrespective of one's sexual orientation or gender identity.[1]

Former Special Rapporteur mandate holders have contributed to a better understanding of sexual health and rights. The first Special Rapporteur (2002-2008), Paul Hunt, took the view that sexual and reproductive health should be considered through the prism of the right to health.[2] This perspective is particularly useful given the substantive focus on sexual and reproductive health and rights in the UN Sustainable Development Goals (SDGs) on health (goal 3), education (goal 4), and gender equality (goal 5). Anand Grover, the second Special

Rapporteur (2008-2014), focused on decriminalization of sexual orientation and gender identities and certain behaviors such as sex work. His work showed how criminalization serves as a barrier to accessing health services, which further exacerbates the transmission of HIV and fuels discrimination and social stigma.[3] The third Special Rapporteur (2014-2020), Danius Pūras, paid special attention to the sexual health of children and adolescents highlighting the discrimination and barriers they continue to face in accessing health information, services, and contraception.[4] He promoted a holistic approach to address violence, especially for groups in vulnerable situations, and urged consideration of the intersecting vulnerabilities when trying to achieve all SDG targets, including that on violence.[5] In 2018, in his report on deprivation of liberty and the right to health, Danius Pūras also considered the ways in which power imbalances, including through loss of liberty, or between patients and health workers, discriminated against individuals based on their identities and behaviors and other status including sexual orientation and gender identity, sex work, HIV status, or needs for abortion.[6]

Tlaleng Mofokeng, the current Special Rapporteur, the first woman to take up this role, is from the global south. She has committed to being an "advocate for the application of the right to health framework to deepen understanding of the negative impact of coloniality, racism and the oppressive structures embedded in the global health architecture, which disproportionately affects Black people, Indigenous communities and other groups who are racially discriminated against in the global South."[7] As such, she will address the interrelated and entrenched obstacles that prevent individuals from enjoying their sexual and reproductive health rights. Building on the work done by her predecessors, sexual and reproductive health will be a key priority theme of the Special Rapporteur during her tenure.

This dialogue discusses the importance of intersectoral collaboration among stakeholders to bring about change and fulfillment of sexual health and health rights. It will explore the relationship between state laws and policies, the global health architecture, women and gender minorities' sexual and reproductive rights, multiple intersections such as racial and gendered oppression, stigmatization related to disabilities, and paternalism immersed in structures that influence policies on sexual and reproductive health rights. The role of identity politics in overcoming barriers to the enjoyment of sexual and reproductive health and rights will be explored. An intersectional approach to removing the sexual and health rights obstacles experienced by women, adolescents, migrants and asylum seekers, people living with HIV, people living with disabilities, lesbian, gay, bi-sexual, transgender, and gender-diverse persons, older persons, Indigenous people, and people living in poverty will be considered. Such an approach pays attention to how social locations or vectors such as ethnicity, age, geographic location, level of education, class, and disability, interact to inform and determine access to health care.

The magnitude of the challenge

Despite significant progress at the global level to reduce maternal morbidity and mortality, there are still far too many preventable deaths and injuries. Paul Hunt acknowledged that the burden of maternal mortality is borne disproportionately by developing countries.[8] In recognition of the high prevalence of maternal mortality and morbidity, the Revised Maputo Plan of Action 2016-2030 was adopted by the African Union.[9] Women and girls continue to face inadequate pre- and post-natal care and obstetric violence, and the majority still live in countries where abortion is restricted or criminalized. Their access to essential health services such as voluntary testing, counseling and treatment for sexually transmitted infections, including HIV, and breast and reproductive system cancers, as well as infertility treatment remains a challenge.

Women and girls with disabilities suffer sexual and reproductive harms including coerced contraception, sterilization, and forced pregnancy and abortions.[10] A double standard is at play when it comes to recognizing the sexual and reproductive rights of persons with disabilities.[11] Even in jurisdictions that aspire to be progressive and protective of human rights, there is a marked reluctance to positively affirm the sexual and reproductive autonomy of persons with disabilities. Many jurisdictions have laws, policies, and practices that deny their sexual and reproductive rights or condone their violation based on a perception of persons with

disabilities as asexual or even hypersexual, incapable of deciding about sexual relationships, and unfit for reproduction and parenthood. Discrimination against the sexual and reproductive rights of persons with disabilities is more pronounced in respect of persons with intellectual disabilities. Persons with disabilities in institutionalized settings, including mental health institutions, are particularly vulnerable to abuse and violence such as physical restraints, beatings, and coerced treatment. Importantly, this systemic segregation and exclusion, alongside the side effects of forced treatment and forced contraception means individuals are robbed of their bodily autonomy including their sexual and reproductive decision-making.

It is necessary to protect persons with disabilities from all harm, including sexual health and rights violations. It is therefore important to ensure that social institutions, including the family, care institutions, health facilities, laws, policies, and the courts provide protection in ways that do not violate the rights of individuals to their sexual and reproductive desires and aspirations. More importantly, legal regulations that do not recognize the sexual autonomy of persons with disabilities are not acceptable under the rights-based framework ushered in by the Convention on the Rights of Persons with Disabilities (CRPD). The CRPD contains several provisions that can be used to respect, protect and, ultimately, fulfil sexual and reproductive rights of persons with disabilities, including article 12 on equal recognition before the law, article 23 on respect for home and the family and article 25 on the right to health including sexual and reproductive health.

Abortion as a sexual and reproductive health right

Unsafe abortion is one of the main causes of maternal mortality and morbidity. There is clear evidence linking criminalized abortion and abortion-related morbidity and mortality. Anand Grover reported on the effect of the criminalization of abortion including a higher number of maternal deaths, poor physical outcomes, and negative mental health outcomes. [12]

Barriers that may not be explicitly addressed in abortion laws, policies, and practices can prevent women from accessing safe abortion goods and services. Countries that have legalized or decriminalised abortion have the lowest abortion-related morbidity and mortality providing there is equitable access to abortion services. Evidence also shows that criminalizing abortion does not prevent abortions. Rather, criminalization has the effect of fueling access to unsafe, 'backstreet' abortions and contributes to mortality and morbidity rates.[13]

Globally, including in the African region, there has been a trend towards liberalizing abortion laws mainly through broadening the grounds for eligibility. Significantly, close to 50 percent of African states now recognize health as a ground for abortion. Only a minority of states in Africa have retained colonially-spawned laws which, historically, have been highly restrictive of abortion. Domestic abortion laws have their roots in laws that were developed in Europe in the 18th century and later transplanted to colonial states.[14]

Over the past three decades, there has been an increasing recognition of abortion as a human right by United Nations (UN) treaty-monitoring bodies in concluding observations and in general comments, general recommendations, and decisions on communications brought under UN treaties' optional protocols. Furthermore, in Africa, women's rights to safe abortion have been accorded the highest human rights recognition through the adoption of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol).

But notwithstanding a discernible trend toward liberalization, domestic law reforms have, on the whole, not translated into tangible access to safe abortion services. Even in countries where abortion is legal, women continue to experience barriers to safe services. There is a general lack of implementation of abortion laws as well as institutional opposition towards abortion, including in the healthcare sector. The legal landscape, containing hundreds of abortion laws globally, which allow abortion on certain grounds, limits sexual and reproductive autonomy. Thus, abortion should be completely decriminalized so it is simply regulated as is any other medical treatment or procedure.[15]

In addition, ensuring universal access to safe abortion requires the removal of restrictions on medical abortion or abortion with pills and telehealth service support outside the hospital setting. Medical abortion continues to be highly regulated from the extremes of complete prohibition, to self-use in the absence of information on how to use, to criminalization of self-use, and restricted access via health services. Access to medical abortion, including with telehealth and self-managed abortion should be expanded. Self-managed abortion challenges conventional approaches and opinions on abortion; it requires different service deliveries, quality of care, discourse on abortion, and shifts the procedure away from formal healthcare systems to informal community-based care. All of these changes highlight the need to reconceptualize regulatory frameworks and health care systems, including pharmaceutical care, to integrate self-use of medical abortion pills. COVID-19 has illustrated the importance of having equitable access to the internet for all to gain access to medical abortion.

Influence of international aid on sexual and reproductive health

There is recognition in General Comment No 14 that states have a duty to provide aid when requested to enable low-income countries to fulfill their core obligations related to the right to health.[16] The donor community provides important funding for sexual and reproductive health care in many low-income countries. However, the influence of neocolonial foreign assistance that systematically targets global sexual and reproductive health and rights programs must be acknowledged. Frequently the aid does not promote access to the range of services needed for the enjoyment of the right to sexual and reproductive health, including abortion services. For example, the 'global gag rule' is a US Republican Party policy that curtails access to essential reproductive health services, including safe abortion services.[17] The United States has being applying the global gag rule intermittently since 1984 to prohibit foreign non-governmental organizations (NGOs) from receiving US health aid if they support any aspect of abortion care or advocacy.

There is growing evidence of the impact of foreign aid tied to anti-abortion agendas and curtailment of sexual and reproductive rights. Organizations based in the global north, mainly from North America and Europe, presenting themselves as 'pro-family' premised on the "traditional family values" narratives have been providing funding to local organizations (or local branches) based in the global south. This has supported the growth of conservative movements against sexual and reproductive rights. For example, there has been a proliferation of crisis pregnancy centers in countries with liberal abortion regimes such as South Africa. These centers are known for providing directive counseling, spreading misinformation on abortion procedures, and disseminating religious propaganda. Such neocolonial violations of reproductive rights must be replaced by a reproductive justice approach that supports the rights and needs of all women. Reproductive justice reflects an understanding of women's decisions and reproductive needs based on social circumstances and histories of oppression. The COVID-19 pandemic, which has deepened inequality, has also amplified the need to address these issues. Part of this, and of paramount importance is strengthening the movement for abortion rights.

While it is recognized that international funders have right to health obligations to assist, there is need for aid recipient states to fulfill their own self-determined goals and national plans. In this context, allowing safe early abortions should be prioritised, rather than only addressing unsafe abortion complications.

Gender-based violence

The right to control one's health and body is further constrained by gender-based violence, including rape, and other forms of sexual abuse, female genital mutilation (FGM), and forced marriage. These are serious breaches of sexual and reproductive freedoms and are inconsistent with the right to health. Addressing gender-based violence is critical to protecting sexual and reproductive health and rights. The Commission on the Status of Women has noted that the fulfillment of reproductive rights is "a necessary condition to achieving gender equality" and "to prevent and mitigate violence against women."[18] Gender-based violence

continues to be one of the biggest challenges that women and girls face, exacerbated by inadequate legal protections and lack of social support. Harmful practices such as FGM and forced marriage are human rights violations and forms of gender-based violence that put women's and adolescents' sexual and reproductive health and rights at risk.[19] Adolescents and adults with intellectual disabilities are especially vulnerable. Evidence shows that the risk of sexual violence and abuse towards persons with disabilities is much greater than that of persons without disabilities. In General Comment No 3, the Committee on the Rights of Persons with Disabilities took into cognizance that, compared to the broader population, women and girls with disabilities have a heightened risk of exposure to sexual violence, abuse, and exploitation that is perpetrated within the family, household, or community.[20]

Moreover, specific groups of women such as minority women, lesbian, bisexual, transgender, and intersex persons, women with disabilities, rural women, older women, refugees and internally displaced women, migrant women, and Indigenous women, or any combination of these, continue to suffer various forms of violence and discrimination. Comprehensive responses to gender-based violence including legal and policy responses, services, and care must take into account women's varying and intersecting experiences.[21] Violence against transgender persons has tended to fall below the radar of GBV. They face many forms of violence including assault, murder, torture, rape, and other types of sexual assault. Transsexual or transgender-related violence and sexual health are a neglected intersection, including in respect of coerced treatments, without their free and informed choice and consent.[22]

In 2019, the World Health Organization (WHO) renamed transsexualism as "gender incongruence" and moved the classification from the Mental and Behavioural Disorders chapter of the International Classification of Diseases (ICD) to the sexual health chapter, indicating that the condition is no longer considered negatively as a pathology but as a health concern that might warrant health professional attention and treatment where it is desired, as opposed to being imposed.[23] This is a major milestone standard setting for global transgender health and rights that now requires states to ensure their health systems and laws are compliant.

Discrimination and stigma continue to pose a serious threat to sexual and reproductive health for many groups, including people living with HIV. Health status, in addition to other grounds, is an unacceptable characteristic to impair the equal enjoyment of the right to health. There is ample evidence of the implications of the HIV epidemic on women's health and well-being.[24] Certain population groups, including women, internally displaced persons, people with disabilities, people who use drugs, prisoners, and sex workers face higher risks of contracting HIV because of discrimination and exclusion. The underlying social, economic, and political determinants, such as poverty, access to treatment and preventive measures, lack of political will, and stigmatizing cultural practices exacerbate women's vulnerability to HIV infection. Gender-based violence, including intimate partner violence, rape, and child marriage also prevent women and adolescent girls from being able to adequately protect themselves from HIV.

Time for bold action

The myriad intersecting factors raised in this paper have brought about an understanding of discrimination and inequality and the pressing challenges related to sexual health and sexual rights. This dialogue will provide an opportunity to discuss how the many different aspects of sexual and reproductive health and rights intersect and to explore more equitable, sustainable, and robust approaches to fulfilling these rights. The liberation, empowerment, and autonomy of women and gender minorities are not only vital for their health and wellbeing, but also as key contributors to sustainable development.

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