CROSS CUTTING ISSUES IN RESPECT OF THE RIGHT TO SEXUAL AND REPRODUCTIVE HEALTH

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Chairperson and members of the Committee:

At the outset, let me congratulate the Committee for its decision to formulate a General Comment on Sexual and Reproductive Health (SRH), and express anticipation for attainment of greater clarity and coherence on the rights embraced within its scope. The significance of International Conference on Population and Development (ICPD) held in Cairo in 1994 is that for the first time "States recognized that sexual and reproductive health is fundamental to individuals, couples and families" and that these concerns are integral to population and economic development.[1] This shift brought concerns sectoralised as biology and women specific, into the public domain of population and development, recognizing as well their linkages to human rights, and State obligations towards their promotion and protection. This recognition in itself signifies the breadth of cross cutting issues pertaining to SRH, their intersections and their respective rights dimensions.

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[1] E/CN.4/2004/49 at para 7

The term sexual and reproductive health in itself combines two distinct areas of concern - reproductive health and sexual health, both of which are interconnected despite their distinction. Each in turn is subsumed under larger umbrellas of sexual rights and reproductive rights respectively. Noting this distinction between the two, the ICPD Programme of Action clarified – reproductive health to be "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproduction system and to its functions and processes….," and sexual health to be "the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases."[2] This recognition imposes upon the States the obligation to provide universal access to health care services, equally to men and women, "including those related to reproductive health care, which includes family planning and sexual health."[3] Subsequently, the Beijing Platform for Action clarified the linkages of SRH to human rights of women, as "their rights to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."[4] Consequently, sexual and reproductive health evolved in connection with each other, and as distinct components that are integral and contingent upon the State obligation to respect, protect and fulfill human rights – relating to non discrimination, gender equality, sexuality, right to health and development. While some rights within this web of cross cutting concerns have gained independent recognition and endorsement, many other rights subsumed within its scope have remained contentious and sensitive. As a consequence, the decision to elaborate the right to SRH with all its cross cutting dimensions is a pressing human rights concern, that carries with it the

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[2] A/CONF.171/13, Chapter VII, para 7.2

[3] A/CONF.171/13, chap I, section I, principle 8

[4] A/CONF.177/20/Rev.1, chap.1, section 1, at para 96

onerous responsibility of capturing the complexity of the cross cutting concerns and constellation of rights embraced within the sweep of SRH.

This paper categorises cross cutting issues into two parts, to maintain some distinction although there are linkages between the two.

- The first section pertains to discrimination – covering grounds of discrimination, specific groups that are rendered additionally vulnerable to rights violations on account of intersectional discrimination, and discourses through which discrimination gets constituted across groups.
- The second part will look at the underlying determinants and structural frameworks necessary for realization of sexual and reproductive health, including national and transnational policies – to draw attention to coherence and integration of SRH concerns across sectors for the realization of rights.

I: FREEDOM FROM DISCRIMINATION AND VIOLENCE

Even as the principle of non-discrimination is reiterated in all treaty law, its realization continues to be a struggle. While sex and gender are major sites of discrimination in relation to sexual and reproductive health, impacting women in particular - specific attention towards discrimination on account of other status, operating singly or in combination with others is also required. To address the systemic protection gaps operating against groups rendered additionally vulnerable on account of intersecting discrimination, it is important to explicitly recognize such population groups, the violations specific to their contexts, and importantly, the discourses and social constructions that legitimize discrimination. This section will cover these – focusing as well on social constructions of gender and sexuality to draw attention to the root causes of discrimination across different population groups, so as to develop prevention obligations of the State in respect of the right to SRH.

Gender Equality: Women's inequality is a fundamental obstacle to the realization of the right to SRH. Gender roles for women and men are socially constructed to sustain patriarchal male privileges over female labour, body and reproduction. Such subordination and control over women is achieved through value systems and allocation of stereotypical roles and relationships that institutionalize inequality in the family, community and the market. This social construction often influences law and policy, thereby inter-locking discrimination in private and public spheres in a continuum. Inadequate laws on domestic violence (or poor implementation), legalization of martial rape, non availability of safe contraceptives, uninformed, non consensual implantation of contraception devices into women, lack of availability or access to quality obstetric facilities, unsafe abortion facilities and post abortion care, coercive family planning policies reflect the continuum of SRH violations from private to public – from the family to the state. Women's ability to determine if, when, the number and spacing of children requires decision making and negotiation capacity that is ultimately predicated upon gender equality and empowerment. Just as women's subordination has adverse implications for exercise of rights to SRH – the health sector can become a site of discrimination and violence for women, through culturally incompatible approaches, abuse by health providers, and lack of SRH services for women with disability, lesbians, transgender persons, single and young persons.[5]

The right to SRH can be exercised only when there is freedom from violence and coercion, the provisioning of reproductive and family planning services and sexuality education/ information.[6] The realization of the right is fundamentally contingent on women's equality – that can be achieved through empowerment, that includes temporary special measures necessary to achieve substantive equality or an equality of outcomes as set out under Articles 1-5 of CEDAW. In relation to women's reproductive rights, the UNSRVAW has called attention to

[5] Policies and practices that impact women's reproductive rights and contribute to, cause or constitute VAW, E/CN.4/1999/68 Add 4

[6] For a comprehensive elaboration of human rights standards in respect of sexual education, see the report of the UNSRE, A/65/162

culturally sanctioned practices and different forms of violence against women in the family, the community, during conflict, migration and displacement – that puts women at grave risk and requires State to recognize the violations, put in place measures for prevention, protection and redress. Gender inequality aggravates and compounds discrimination existing on account of other status – for instance HIV, migrant, disability and race.

Intersectional Discrimination: The grounds of discrimination may vary, and very often intersect with each other to exacerbate the degree of exclusion, stigma and vulnerability. The violations in respect of the right to SRH do not occur in isolation but are part of a continuum of violations that arise from other pre-existing discrimination, as for instance for discrimination on account of gender identity, sexual orientation, HIV status, disability, age, race, caste, indigenous, rural and immigrant status as well as occupation (sex work), in addition to sex and gender. The extent of violations that follow may vary – for some in may be with regard to recognition of the right altogether, while for others it may impede access to services and protection. Specific groups that are subjected to compounded discrimination are those who identify as LGBTI, HIV positive, sex workers, persons with disability, adolescents, and those marginalized on account of indigenous, migrant/ immigrant status, race or rural location,[7] require explicit mention so as to develop protection gaps in their regard. For instance, the protection gaps in respect of SRH for trans persons may be vastly different from those relating to women or other marginalized groups, as health services are premised on a male female binary, that is unable to recognize or respond to the gender and sexual diversity in society – and in fact may even reinforce exclusion and stigma. In fact, the social constructions of gender as well as sexuality are mutually reinforcing as they both serve to de-legitimise non conforming sexualities and gender identities, to sustain patriarchy. In this context a mere endorsement of non discrimination for all vulnerable groups, including LGBTI is not enough – there is a need for structural, content based and terminology

[7] For a discussion on intersectional discrimination and compounded vulnerability and stigma in respect of specific groups, see E/CN.4/2004/49, paras 32-40

corrections in SRH programmes, education/ information and policies, to reflect recognition of plurality in respect of gender and sexuality.

Sexuality and discrimination: Elaboration of the right to sexual health encompasses in part sexual rights, and requires a focus on human sexuality, in terms of the "complex societal factors within which such behaviour occurs or its social, cultural, political or economic determinants."[8] Sexuality, like gender is constituted by historical processes of norm setting that privilege some aspects of sexuality by labeling these as normal and natural, and stigmatise others as perverse or deviant irrespective of consent or adulthood of persons. So for instance in most jurisdictions marital rape is not deemed as criminal assault, the restitution of conjugal relations with a spouse is a legitimate matrimonial remedy, and similarly, the willingness of a rapist to marry the rape survivor may dissolve a criminal offence. This, despite the recognition that forced and non-consensual sex is a grave criminal offence. Like gender again, the social construction of sexuality seeks to perpetuate patriarchy – reflected by the privileging and social value attached to procreative sex within marriage, even where force exists. In contrast, same and opposite sex sexual conduct that are non procreative and outside of marriage, including sex work are tainted as deviant and often criminalized – on account of transgression of patriarchal gender roles.[9] The norms establish a hierarchy amongst sexualities – upholding martial heterosexual conduct as normal and natural, whilst simultaneously delegitimizing others. Accordingly, persons with disability are viewed as asexual, sex workers as immoral and as disease carriers, and lesbian, gay, trans, bisexual and intersex persons as perverse or unnatural, and HIV positive persons as being diseased. The social norms are at the heart of public health approaches lend labels such as unnatural and diseased to reinforce stigma and criminalization. National laws, health policies and SRH services need to be subject to scrutiny to assess the extent to which these reinforce social norms relating to sexuality that

[8] Rao Gupta, Geeta, Strengthening Alliances for Sexual Health and Rights, Health and Human Rights Vol. 2, No. 3, Second International Conference on Health and Human Rights (1997) p. 55-63

[9] For an elaboration of the linkage between criminalization of consensual sexual behaviour in three contexts and the right to health, see A/HRC/14/20

reproduce discrimination as a consequence. The extent to which SRH policies and programmes operate on the male and female binary shapes the extent to which it caters to the needs relating to procreative sex alone. Such assumptions and approaches, intentional or otherwise – directly and indirectly exclude, marginalize and reproduce discrimination differentially for those whose choices, preferences, occupations, and disability render them outside the purview of healthy heterosexual procreative sexuality, impacting LGBTI and the disabled (amongst others) adversely.

The mandate of the UNSRVAW has consistently drawn a connection between unequal gender relations and norms relating to women's sexuality and masculinity that establish dual moral standards for men and women, in the community and in the law.[10] The mandate holders have viewed dual sexual norms as root causes of control of female sexuality and violence against women in the family, the community, during armed conflict and by state policies - recommending the need for empowerment and public education as part of prevention obligation of the State. The elaboration of right to SRH presents a valuable opportunity to develop coherence between the distinct yet interconnected rights – of SRH and its links with sexuality and sexual rights.[11]

II: UNDERLYING DETERMINANTS AND STRUCTURAL CONIDITIONS

The inter-connected and indivisible nature of human rights makes the exercise and enjoyment of any specific human right contingent on the realization of other human rights. The realization of SRH is as a consequence predicated upon not just the fulfillment of social, economic and cultural conditions that enable the exercise of the rights, but also upon compliance of national and transnational policies with human rights standards.

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[10] E/CN.4/1995/42, paras 58-62; E/CN.4/1997/47, para 8; E/CN.4/2002/83; E/CN.4/2003/75; and E/CN.4/2004/66

[11] E/CN.4/2004/49, paras 50-55

Right to food, adequate housing, education, water and work/ livelihood and the right to available, accessible quality health care: As a component of the right to health, the realization of SRH and rights related thereto are contingent on the fulfillment economic, social and cultural rights without any discrimination on the basis of sex and gender, or any other single or multiple grounds.[12] As elaborated in CESCR General Comment 14, health it is not limited to the absence of disease but to the underlying social, economic and environmental determinants that enable a healthy life. It includes the right to food, adequate housing conditions, right to water, education, employment and livelihood. [13] These conditions enable the right to the highest attainable standard of health – for they enable life with dignity, decision-making, informed choice.

The effective realization of right to SRH is predicated upon another fundamental aspect of the right to health, being the availability of quality health care facilitates, programmes, services and goods that are accessible, affordable and acceptable across gender, culture and life cycle. Specifically, such health care must be public and affordable for access to the poor, available in rural locations and across regions, be inclusive of the needs of LGBTI/ gender and sexual diversity, young persons and the disabled, and minorities, and culturally compatible with the needs of population groups.

National policies: The recognition of the right to SRH has emerged in the context of population and development, and needs to be assessed against such policies. To what extent do population policies, and related measures that impact population and demographic change, are compliant with the right to SRH and other human rights. For instance, imposition of two child norm through economic disincentives or though disqualification for contesting local government elections, or indeed through forced sterilization, or sterilization without informed consent violate elements of the right to reproductive health. Such measures are to be examined not just through the prism of SRH violations but also through their intersections with discrimination on other grounds, to see

[12] See for instance CESCR General Comment 20, E/C.12/GC/20

[13] CESCR General Comments 11, 12, 14, 15

whether they target a particular demographic group. The sterilization of ethnic minorities, poor, those with disability are some examples. Another area of concern is policy making derived from religion or culture, market or other political considerations, rather than evidence based research of social realities and the advancement of human rights in all contexts. Policies directly related to SRH services such as denial, or indeed restrictions to availability of safe and accessible contraceptives, abortion services or post abortion care, are symbolic of patriarchal control by the state of women's sexuality and reproduction, and impact the poor most.

Economic, social, political, policies of the state reflect its national priorities and directly impact resource allocation towards fulfillment of its obligations to respect and fulfill socio economic rights across gender, class, age, and cultural disparities.[14] While this puts under scrutiny policies that relate to housing, food, water, education and so on, as they are key indicators of the extent to which the state takes its socio economic rights obligations seriously, state obligations are not reflected by these alone. Broader policy areas on economic development, growth, industry, mining, displacement, rehabilitation, agriculture, defense, conflict management, trade, science and technology amongst others, reflect the extent to which the larger structures accommodate respect for socio cultural and economic rights – or if they are inconsistent or indeed undermine human rights. The state policies of any one area, provides a fragmented or an atomized view that does not reflect is commitments and priorities holistically. A scrutiny of state policies broadly, beyond the key areas of the underlying determinants – reveals coherence and complementarily in all sectors of planning and governance. Policies that allocate disproportionately large resources towards militarization, or favour growth oriented development plans, or indeed, fuel identity politics and conflict – intentionally neglect their obligations to fulfill socio economic rights for all, across disparities, differences and diversity.[15] An

[14] SRVAW's report on 'Policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women', E/CN.4/1999/68 Add 4

[15] Rhonda Copelon and Rosalind Petchesky, 'Towards an Interdependent approach to Reproductive and Sexual Rights as Human Rights: Reflections on the ICPD and Beyond',

assessment of state policies in all these areas is necessary to evaluate its obligations to health, components of health, and the fulfillment of underlying determinants necessary for realisation of the right to health.

Transnational agreements, cooperation, trade and aid policies: The right to SRH needs to focus on the interconnections with transnational policies of all entities, including those of corporations, the global market, multi laterals,[16] and philanthropic aid. For instance, the biogenetic futures market generates capital and profit from 'human hope' derived from patriarchal values attached to fertility and biological progeny, rather than evidence based research. Similarly, the transnational trends in assisted reproductive technologies (ART), that includes cross border reproductive labour markets (surrogate industry), sale and donation of human embryonic matter, eggs and tissue, extend patriarchal control and use of female reproductive labour and embryonic material from poorer women in the North and the South. These pro-business agreements fostered by GATT, TRIPPS, and the WTA, ensure that those who donate body parts for research neither retain property rights over materials nor derive a share in ensuing profit.[17] Policy frameworks that regulate patents and trade, technological exchange, and research, and indeed donor aid reflect ways in which reproduction and sexuality is being controlled to serve profit, religious, patriarchal objectives – diverting attention away from gender equality, causes of infertility, eugenics and sex selection, poverty, and prevention of ill health. These policies often reconfigure patriarchy and population control through modern technology, research and trade – resulting in discrimination on several grounds, especially in respect of sex, class, ethnicity. Nonetheless, these developments seem to promise new reproductive options that might be useful in limited contexts. Blanket policy approaches may not as a consequence be useful,

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Basic Needs to Basic Rights: Women's Claim to Human Rights, ed: Margaret A Schuler, Institute for Women, Law and Development (Washington DC, 1995)

[16] Unravelling the Fertility Industry: Challenges and Strategies for Movement Building: Report of the International Consultation on Commercial, Economic and Ethical Aspects of Assisted Reproductive Technologies (2010, New Delhi), Sama – Resource Group for Women and Health

[17] Unravelling the Fertility Industry, as above, at page 51

and instead, greater deliberation and interaction with human rights discourse is fundamental to finding a way forward.

The areas covered above are indicative of the complexity of rights concerns embraced within SRH serve to underscore the need for a comprehensive General Comment. It is equally important that the title of such a General Comment reflects the constellations of rights covered within its scope, through adoption of the term 'rights' to indicate this plurality.

Thank you for the opportunity to present to the Committee.

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