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Symposium

Sexual and Reproductive Health & Rights: Advances and Setbacks

Aziza Ahmed[1], Alicia Ely Yamin[2] and Sofia Gruskin[3]

[1]Boston University, Boston, Massachusetts, United States; [2]Harvard University, Cambridge, Massachusetts, United States and [3]IIGH, USC, Los Angeles, United States

Abstract

This article first describes shifts in human rights law that have led to improvements in the realization of sexual and reproductive health and rights (SRHR) over the last decade. The article does so, however, with careful attention to the structural factors beyond formal legal mechanisms that may undermine the ability of governments, even with the best of intentions, to fully develop the necessary robust health and justice systems. Second, this article considers two additional factors: the political economy factors that enable or limit the ability of States to realize SRHR, as well as the growing evidence base that supports positive legal transformation.

Keywords: sexual and reproductive health and rights; reproduction; human rights; global health; political economy

Introduction

With a focus on the last decade, this article addresses both advances and challenges in the field of sexual and reproductive health and rights (SRHR). While SRHR has important overlaps with global health law, which is the principal subject of this Special Issue, SRHR must be taken on its own terms given the specificity of the political, economic, and legal issues that shape this domain of human rights law and its implementation.

In turn, the article focuses in on SRHR as a field, first describing shifts in human rights law that have led to improvements and setbacks in the realization of SRHR. Second, this article considers two additional dynamics: the political and economic context that enables or limits the ability of States to realize SRHR, as well the politicization of evidence on sexual and reproductive health and rights. The article concludes that realizing SRHR requires devoting greater attention to how political, social, and economic factors structure possibilities for legal reform and implementation for the enjoyment of SRHR in practice

SRHR in International Human Rights Law

Sexual and Reproductive Health and Rights have seen both enormous progress and major setbacks in the past ten years. Given space constraints, this section gestures to some of the transformations within sexual and reproductive health rights.

Progress

Since the upsurge of legal and political support at the global level for SRHR in the early 1990s, with the International Conference on Population and Development (ICPD) and Fourth World Congress on Women (FWCW) serving as lynchpins in offering definitions of both reproductive rights and sexual rights, sexual and reproductive rights advocates have been engaged in a continuous game — one step forward, two steps back.[1] This back and forth belies a linear evolution of sexual and reproductive health and rights in the context of international human rights law.

However, over the last decade, SRHR has made enormous progress through formal legal channels. There has been an overlapping consensus that criminalization of abortion can constitute gender-based violence,[2] a violation of the right to life with dignity,[3] and a violation of the right to sexual and reproductive health.[4] Violence against women has been declared an issue of *jus cogens* by the CEDAW Committee.[5] Affirmative entitlements to maternal health care have been enforced at international and national levels, including in low- and middle-income countries such as Uganda[6] and India.[7] SRHR of LGBTIQ+ persons have been recognized by constitutional jurisprudence.[8] Likewise, "obstetric violence" has been enshrined in national legislation and typified as a human rights violation by multiple supranational forums.[9]

Setbacks

Despite this progress, this decade has also seen setbacks:

- A number of States, working hand in hand with right-wing US-based organizations, attempted to stop the Center for Reproductive Rights from being in "official relations" with the World Health Organization (WHO) because of its work on abortion and reproductive rights;
- Right-wing governments have sought to remove global consensus on SRHR in myriad ways including to refer only to reproductive health and rights (RHR), even as the contours of what would and would not be included under this term remain unclear; and

Corresponding author: Aziza Ahmed; Email: azahmed@bu.edu

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- The Special Rapporteur on Violence Against Women produced a report on sex work, which she named "prostitution and violence against women and girls," where she seeks to undermine existing evidence that supports the health and rights of people engaged in sex work, by manipulating and inaccurately using bits and pieces of information to support her view that sex work is, in and of itself, violence.

Politicians from Trump to Bolsonaro to Orbàn have played key roles in this regression over the years; they overwhelmingly challenge ideas of human rights and democratic inclusion that have been so hard fought, including SRHR and gender equality.[10] Many seek to reestablish "traditional" family and traditional gender roles in opposition to what they denominated "gender ideology." In this context, gender ideology has come to

> signify the failure of democratic representation, and opposition to this ideology has become a means of rejecting different facets of the current socioeconomic order, from the prioritization of identity politics over material issues, and the weakening of people's social, cultural, and political security, to the detachment of social and political elites and the influence of transnational institutions and the global economy on nation states.[11]

Attacks on "gender ideology" normalize undermining basic health services and retrogressive legislation on issues impacting sexual and reproductive health and rights from abortion to gender affirming care.

Political Economy and Evidence

While a description of formal rights — both setbacks and progress — can help describe the landscape of SRHR, it is necessary to understand how the dynamics constitutive of legal reform contribute to the relevant legal environments.

Political Economy of SRHR in Global Health

Global health outcomes are heavily determined by political, economic, and commercial power structures. Approximately a third of women do not have even half of the recommended antenatal checks or receive essential postnatal care, while some 164 million women lack access to modern family planning methods.[12] Incantations to "leave no one behind" in the SDGs have come to seem like a cruel joke considering that there is simply not enough resource mobilization capacity in low-income countries to finance universal, resilient health systems. For 20 low-income countries alone, the annual external financing gap in health is estimated to be $22 billion between 2026 and 2030.[13] Despite the devastation of the COVID-19 pandemic, 59 governments will spend even less on health in 2027 than they did in 2019, before the pandemic.[14] This underfunding leads to the disrespect and abuse of gestating persons seeking healthcare, as well as to more persons opting out of care and more deaths from reproductive illnesses, abortion complications, and other maternal causes.

There are numerous barriers that prevent states from fully realizing SRHR, with austerity and fiscal consolidation disproportionately impacting SRHR among poor and marginalized populations. Sweeping neoliberal policies put in place in countries around the world since the 1980s and the financialization of health care that was fully unleashed after the turn of the millennium have had devastating consequences on SRH and its enjoyment.[15] Privatization of health care in low- and middle-income countries, and the introduction of public-private partnerships, has excluded remote communities and increased out-of-pocket costs for reproductive, sexual, and maternal health care. Simultaneously, austerity has exacerbated health care worker shortages and disparities in health care worker density between low- and high-income countries.[16]

Moreover, loan conditionalities often mean that heavily indebted countries cede control of their spending policies to meet international demands for fiscal consolidation. Since the pandemic, new waves of austerity measures are being imposed across low- and middle-income countries. Austerity affects SRH in multiple ways, including:

- In the health system, e.g., through wage cuts/layoffs of health personnel; increases in co-pays and out-of-pocket expenses even for critical services such as antenatal, post-abortion, and delivery care; reduced benefit packages or changes to eligibility criteria; disrupted access to insurance; and cuts to sexual and reproductive health services;
- Indirectly, through cuts in the education sector; reductions to food assistance and security programs; and reduced funding of temporary housing/shelters and housing subsidies that poor people depend upon; and
- Generally, through reduced unemployment support and tightening of targeted social programs disproportionately needed by women and children.[17]

Evidence

Evidence has long shown that in order to have a healthy population, it is necessary for people to have access to a full range of sexual and reproductive health services. While perhaps not as progressive as many in the SRHR field would hope, the SRHR legal standards put out at the UN level have come to be grounded in both public health and human rights evidence and serve as rationales for ensuring SRHR for all. As simply a few examples of evidence-based and rights-based SRHR policy in the last few years can illustrate, the:

- inclusion of transgender health in a new chapter on sexual health in the most recent International Classification of Diseases, removing it from the chapter on mental and behavioral disorders where it had been previously, recognizing that health diagnostic classifications are inextricably linked to global and national legal, regulatory, and policy environments;[18]
- recognition from WHO, in its most recent guidance on safe abortion, of the need for an enabling environment for abortion care that includes respect for human rights, a supportive framework of law and policy including full decriminalization of abortion, and a supportive, universally accessible, affordable, and well-functioning health system;[19] and
- global call and full body of work from UNAIDS, noting the need for states to decriminalize, for example, same-sex sexual relations, transgender people, HIV exposure, non-disclosure and transmission, and sex work.[20]

In all of these cases, UN policy changes have largely been because of the growing evidence-base in myriad SRHR areas, which show time and again that, despite growing political conservatism, strong laws that protect human rights are correlated with positive public health outcomes.[21]

However, there are efforts underway to undermine these rights-based and evidence-based legal and public health standards. The examples are widespread, but most vivid in the United States where conservative groups have actively manufactured false claims about abortion, including assertions about negative mental health consequences for abortion and that in vitro fertilization produces

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human life at the embryonic stage, for the purposes of decreasing access to abortion and other sexual and reproductive health services. Conservatives have also attacked gender affirming care in the register of medical practice on the grounds that it is harmful. In these instances they have produced studies which very often contain deep flaws in methodologies and analysis to arrive at misleading conclusions.

Conclusion

Leading Argentine feminist Rita Segato seeks to move from "the personal is political" to "domesticating the political."[22] This movement, which calls for structural shifts in our political economies, is inextricably entangled with structures of both reproductive and sexual governance, initially defined as "the mechanisms through which different historical configurations of actors […] use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviours and practices."[23] In considering the evolution of SRHR over this past decade and with recognition of increasing challenges, we must heed Segato's words and guarantee the formal recognition of rights, while ensuring the capacity of states to create adequate health infrastructure and support funding for research and evidence on SRHR and address the larger political and economic context which shapes SRHR.

Aziza Ahmed, J.D., is Professor of Law and N. Neal Pike Health Law Scholar at Boston University School of Law, Boston, MA, USA. She is the co-founder and co-director of the BU Program on Reproductive Justice.

Alicia Ely Yamin, J.D., M.P.H., Ph.D., is a Lecturer on Law and Director Global Health and Rights Project at Harvard Law School, Cambridge, MA, USA, Adjunct Senior Lecturer, at Harvard TH Chan School of Public Health and a Visiting Professor of Law at Universidad Torcuato Di Tella (Buenos Aires, Argentina).

Sofia Gruskin, J.D., M.I.A., is the Director of the Institute on Inequalities in Global Health and Distinguished Professor of Population, Public Health Sciences & Law at the University of Southern California, Los Angeles, CA, USA.

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