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Global health, sexual and reproductive health and rights, and gender: square pegs, round holes

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In 1948, the WHO posited health to be, '…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', to be enjoyed by 'every human being without distinction of race, religion, political belief, economic or social condition.' The WHO Constitution[1] defines the responsibilities of states to be 'the promotion and protection of health […] by the provision of adequate health and social measures.' Subsequent frameworks, including the Millennium Development Goals, the Sustainable Development Goals and WHO's own results frameworks (most recently the 13th General Programme of Work) have progressively attempted to define these by setting objective measurable targets for biomedical health outcomes, as well as for the political and programmatic means of attaining these outcomes, namely the state's provision of health and health-related services.

The Commission on the Social Determinants of Health (2005–2008) attempted to broaden this instrumentalist 'objective' vision of public health to acknowledge the conditions in which people are born, grow, live, work and age. However, it falls short of extending the analysis beyond the individual and composite determinants, to incorporate the complex, interconnected power structures and processes that produce and sustain unequal health outcomes, and foster inequities over time. Furthermore, the instrumentalist approach fails to adequately consider intersectionality and sits awkwardly with a feminist decolonial approach[2] to health, gender equality and rights. The latter draws on conceptual, political and epistemological influences far beyond public health and biomedicine to account for the ways in which gendered and other power asymmetries (such as, among others, those that have their roots in histories of colonialism and historic and present day racial/ethnic discrimination) at the structural level intersect and shape people's thinking about, and experiences of, health.

Sen asserts a more subjective vision of well-being and of the 'agency' required to achieve it: 'what a person is free to do and achieve in pursuit of whatever goals or values he or she regards as important',[3] 'judged in terms of her own values and objectives, whether or not we assess them in terms of some external criteria as well'.[4] Within this framework, the State's role is not simply to 'promote' and 'protect' health outcomes by providing the rather vaguely defined 'adequate health and social measures'. Rather, it is to ensure that such measures are ones that equip all its citizens with the opportunities, capabilities and resources to achieve a state of well-being that they themselves define and desire. In sexual and reproductive health and rights (SRHR), perhaps more than any other area, the state's—and indeed the health sector's—role as an enabler of this freedom is essential (states have committed to this role through various normative mechanisms, including, among others, through articles 10, 12 and 16 of the Convention on the Elimination of Discrimination against Women (1979) and the Beijing Platform for Action (1995)). Lack of reproductive and sexual agency underpins gender inequality, as societal controls over sexuality and reproduction are a means of maintaining power asymmetries, governed by gender norms regarding the relationship between sexuality, reproduction and biological sex. For SRHR, this is the crux of where public health and the feminist project of gender equality intersect. In SRHR, the overall health and well-being objective cannot only be tangible health outcomes, but, more significantly, also reproductive and sexual agency and bodily autonomy.

Gender transformative approaches to SRHR are those that seek to dismantle

the relationship between sexuality, reproduction and gender norms, and hence transform the power asymmetries constructed on their basis. Their purpose is to ensure that any individual has the necessary agency to determine their reproductive decisions and sexuality, regardless of gendered norms and gender-based discrimination. Following this same logic, SRH policies, services and products constitute resources, rather than ends in themselves. Agency over resources[5] can be understood as informed decision making by women, girls and gender diverse individuals to determine, design and access these policies, services and products, and, ultimately, to achieve bodily autonomy.

A focus on the process of unmasking and shifting power is therefore essential. To transform power, SRH policies, services and programmes need to be designed in such a way that they significantly contribute to the agency of all women, girls and gender-diverse individuals to access not just adequate, but appropriate and empowering, SRH resources. Interventions should explicitly posit bodily autonomy as their objective (rather than solely the delivery of services and specific health outcomes). To achieve this objective, they should seek to disrupt the socially and culturally imposed and constructed relationship between sexuality and reproduction on the one hand, and, on the other, restrictive gender norms and relations.

This relationship plays out differently but is equally consequential for diverse groups. Both cisgender women and girls' self-determined sexuality and reproductive autonomy, as well as LGBTQI+ 'transgression' of normative gender identity and heterosexuality, disrupt the binary relationship between gender norms and sexuality/reproduction that underpins current structural power asymmetries. In both cases, SRH interventions that support and contribute to that disruption are means of achieving bodily autonomy and gender equality.

SRH has a long history of grappling with this relationship with respect to bodily autonomy for reproductive decision making and health, especially with respect to access to contraceptives and abortion care. Arguably, the relationship between gender norms and bodily autonomy with respect to sexuality and sexual well-being has been less well contemplated. However, consideration of women, girls and gender-diverse individuals as persons with sexual desires, needs and rights beyond their reproductive functions is an important means of dismantling controls over sexuality. These same controls feed into limits on bodily autonomy by encouraging us to construct cisgender women and girls as merely reproductive vehicles and those whose gender identity and/or sexual orientation do not fit societal norms as 'unnatural' because they undermine this construction.

Therefore, at the same time as continuing to advance reproductive autonomy, SRHR research and programmes need to give much fuller attention to gender norms and identities, sexuality and sexual health. Certain key aspects of such work could be particularly gender transformative, including, for example, interventions that affirm and support women's sexual health, well-being and pleasure (during and beyond their reproductive years); gender transformative and gender inclusive comprehensive sexuality education; shifting masculinities in relation to sexuality (as well as reproduction); attention to the underlying gender norms governing sexuality and/or gender identity that underpin gender-based violence and harmful practices (female genital mutilation (FGM); intersex interventions, etc); gender transformative and gender inclusive sexual health preventative care and treatment; and, gender-affirming care for trans and gender diverse people.

It is also essential that SRH interventions operationalise a feminist decolonial approach to grapple with the intersection of harmful gender norms and relations with other forms of discrimination, given that intersectional inequalities also underpin the maintenance of power asymmetries. Feminist decolonial approaches recognise that the expression and meaning of bodily autonomy, and the means of attaining it, are contextually and culturally defined. Any imposition of meanings, knowledge and strategies potentially contributes to the (neo)colonial project and existing power asymmetries. Sexual and reproductive rights, including bodily autonomy, are non-negotiables but are expressed in diverse ways according to different cultural and social contexts. They require differentiated approaches across all SRH programmes, driven by women, girls and gender diverse individuals themselves.

This decolonial approach to intersectionality does not negate the need to invest in targeted interventions to ensure the sexual and reproductive rights of specific groups facing vulnerability and discrimination such as, among others, migrants; women, girls and gender diverse individuals experiencing gender-based violence; those living with disabilities; and groups facing racial or ethnic discrimination. The precise configuration of these priority groups, however, will differ by context and by type and focus of intervention. Therefore, analytical participatory approaches that allow for the contextual identification of such groups and of the structural drivers of the inequalities and discrimination that affect them, as well as for the appropriate formulation of approaches to address these, are more important than any a priori listing of 'vulnerable groups'. This is especially true when that listing is constructed by those in power at global level with potentially paternalistic, rather than transformative, connotations.

Despite this rethink of the objective, states' accountability is no less important. Currently, our means of measurement of outcomes, process and causal relationships are limited. We need much better and contextually relevant measurement and monitoring of bodily autonomy as an impact level outcome as well as of the relationship between: (A) gender norms, relations and discrimination; (B) delivery of, and access to, SRH services and (C) bodily autonomy. This requires

innovation in qualitative and quantitative measures and tools, and an openness to look beyond accepted forms of knowledge and evidence. We also need much stronger accountability mechanisms to ensure feminist decolonial approaches to SRHR, considering meaningful participation and inclusive governance for agenda setting, design and monitoring of strategies.

This is a tall order. WHO, however, has had the mandate to set standards since 1948. The UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) has successfully taken up the challenge of promoting and operationalising progressive approaches to SRHR for the last 50 years. We are well placed to advance gender equality by taking on the feminist decolonial hammer to the square peg of sexual and reproductive bodily autonomy.

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