Sexual and reproductive health and rights: A useful discourse for feminist analysis and activism?

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The fight for sexual and reproductive rights has been the cornerstone of feminist activism and struggle for many decades. The second wave of feminism saw women’s organisations and feminists mobilising around (amongst other important struggles for political and social equality) the right to abortion, access to safe contraceptives, better policies and laws to address rape, domestic violence and the eradication of female genital mutilation. As a movement, we have won battles and we have lost battles. Issues such as HIV and AIDS threaten to – and have – eroded some of our gains, and the sexual and reproductive rights of marginalised women are particularly contested sites of struggle. Indeed, many struggles still remain before women experience the full spectrum of sexual and reproductive health, rights and freedoms; and the reality is that feminist organisations and movements are unable to effect such changes alone. In order for women to realise sexual and reproductive rights, international and national state and non-state actors need to play a critical role.

The discourse on sexual and reproductive health first emerged in the mid-1980s as a result of feminist struggles against rape, domestic violence, access to safe and effective contraceptives and safe motherhood: as noted, the feminist movement has had a long history of activism around women’s sexuality (and all that it entails) although this was not articulated in a sexual and reproductive health framework per se, but rather focused on sexual and bodily autonomy. Thirty years on, and the issues have – for want of a better word – been mainstreamed into the agendas of different agencies and role-players. The problem with ‘mainstreaming’ as a process, as demonstrated clearly in the mainstreaming of ‘gender’, is that concepts that provide a political framework to understand women’s reality and oppression become watered down, more technical and lose their political meanings.

There has been a shift in the acknowledgement of, and access to, some aspects of sexual and reproductive rights – not necessarily from a women’s rights or feminist perspective, but which does impact on women’s daily realities in some contexts. It is testimony to feminist movements globally that sexual and reproductive health and rights discourses have been integrated to varying extents within many social justice movements and are increasingly integrated into global and national policy frameworks, especially those relating to gender equality and health. Examples of these include national health programmes, national AIDS plans and women’s health programmes. It is important to celebrate these victories as well as to interrogate the impact of the mainstreaming of sexual and reproductive rights, for example, to dissect how terms are defined in order to understand and identify what is missing from the agenda and, as such, is impacting on the realisation of rights.

What then is the influence on, and change in, women’s sexual and reproductive rights (and we are purposefully not including health which further waters down and depoliticises the concepts) once mainstream organisations take on the issues? Is it acceptable to lose the feminist analysis of sex, sexuality and reproduction, which frames the structural understanding of why women are oppressed and why
Sexual and reproductive health and rights can be understood (in theory) as the right for all, whether young or old, women, men or transgender, heterosexual, gay, lesbian or bisexual, HIV positive or negative, to make choices regarding their own sexuality and reproduction, providing these respect the rights of others to bodily integrity.

the struggle for bodily autonomy is central to women’s wellbeing, if rights are realised? This article seeks to define sexual and reproductive health and rights frameworks, unpack the terms most commonly used and ask whether the frameworks and principles further the feminist aims of body integrity, autonomy and challenging patriarchy.

Mainstream views of sexual and reproductive rights

Sexual and reproductive health and rights can be understood (in theory) as the right for all, whether young or old, women, men or transgender, heterosexual, gay, lesbian or bisexual, HIV positive or negative, to make choices regarding their own sexuality and reproduction, providing these respect the rights of others to bodily integrity. Mainstream interpretations of sexual and reproductive rights often have a heterosexist bias, may favour men, and do not necessarily focus on women and especially on marginalised women; matters of grave concern for feminists. The UN agencies, whilst having their own individual nuanced definitions, essentially agree that sexual health refers to a state of physical, emotional, mental and social well-being in relation to sexuality – and is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled (WHO 2000).

Sexual rights extend the notion of sexual health and point to specific rights. As such, sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all people to have the highest attainable standard of sexual health, including the right to access sexual health care services; seek, receive and impart information related to sexuality; positive and inclusive sexuality education; respect for bodily integrity; be able to choose their partner(s); decide to be sexually active or not; have consensual sexual relations; decide when, if and whom to marry; decide whether or not, and when, to have children; and, pursue a satisfying, safe and pleasurable sexual life.

Therefore, reproductive health implies that people are able to have a satisfying and safe sex life (linking to sexual rights) and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (Cairo Programme of Action paragraph 94).

How do feminist definitions of these terms and concepts differ?

The cornerstone of feminist theory is the notion of sexual politics: women’s bodies – both in and outside of intimate relationships are sites of patriarchal power – and are spaces where men are at their most oppressive, and women are most oppressed. The control over women’s bodies by intimate partner, family, community, society and the state manifests itself in sexual and reproductive rights: for many heterosexual women, an open expression of their sexuality is not possible and it is obviously much more difficult for lesbian, bisexual and transgendered women. Furthermore, state policy, lack of access to effective and appropriate services, and patriarchal views of women and their reproductive role control women’s decisions around contraception, pregnancy, abortion and determine if, when and how many children women should have.
Linked to the issue of bodies and control, within feminist understandings and definitions the notion of power is also central. Technocrats will talk about the right of women, for example, to have sexual pleasure – without an understanding of power relations. As noted, ‘patriarchal relationships involve, to varying degrees and within different sites, inequalities of power, and without power women are likely to experience little control over sexual relations with men. It is within the context of unequal power relations that women are required to take preventative and protective actions aimed at minimizing their risk of contracting HIV’ (Travers and Bennett, 1996, p.67). Clearly asserting the right is not enough to ensure the right: the context is all important, for example, asserting the right to choose who you have sex with in a country that criminalises same sex behaviour is obviously a contradiction.

In short, feminist activism around sexual and reproductive rights comes from a starting point of patriarchy – and an understanding of the function of sex, sexuality and reproduction in upholding an unequal and oppressive society. Mainstream work on sexual and reproductive rights is more often than not apolitical and does not factor in the oppression of women in general, although it may focus on issues of class and gender in the analysis of the problem. If women are to realise their sexual and reproductive rights, it is imperative that responses acknowledge and address that patriarchal sexual control is context specific and culturally defined.

What is on the mainstream agenda?

The interest in sexual and reproductive rights by mainstream international organisations has resulted in some positive efforts. Ironically, in a global social context where women are expected to reproduce as one of their primary roles, it has taken the pregnancy-related death of millions of women to eventually elicit a response. The latest research shows that maternal mortality rates are highest in Africa and in South Asia, with maternal mortality becoming one of the leading courses of death in southern Africa. Maternal mortality has reached such alarming rates that there is now a global effort to reduce the number of women who die during pregnancy, birth and post-natally.

Millennium Development Goal number 5 focuses substantially on reducing the maternal mortality rate; acknowledgement is made of the specific vulnerability of women giving birth in sub-Saharan Africa and South Asia where the majority of women deliver without skilled care. The second part of the goal is to achieve universal access to health care in general, including ensuring that more women access antenatal care, reducing inequalities in pregnancy care, and expanding access to, and use of, different contraceptives for women (noting that the use of contraception is lowest among the poorest women and those with no education). It is acknowledged that inadequate funding for family planning is a major factor behind the failure of some countries to fulfil their commitments to improve women’s reproductive health.

A lack of state intervention and commitment is another barrier – and the MDGs rely on political will and resources to make them a reality. Progress has been made in this regard with the milestone Declaration of Commitment adopted at the 3rd Pan African Speakers Conference October 2011 in Johannesburg. The delegates committed themselves to prioritising both policy and budget support for the implementation of African Union Summit Decisions – in particular the 2010 Kampala Summit Declaration on the theme of ‘Actions on Maternal, Newborn and Child Health Development in Africa’.

This public commitment is the first of its kind by African Speakers of Parliament, and marks significant progress in Africa towards the attainment of MDGs 4 and 5 on child and maternal health respectively. It also promises high-level parliamentary support to hasten the implementation of the Africa Parliamentary Policy and Budget Action Plan on Maternal, Newborn and Child Health, which was agreed by Chairs of Finance and Budget Committees of national parliaments in October 2010. However, these commitments need to be tracked by civil society to ensure implementation.

Meanwhile, MDG 2 refers to halting and then beginning to reverse the spread of HIV and AIDS by 2015. The spread of HIV does appear to have stabilised in most regions, and more people are surviving longer. However, there is no room for complacency, especially in the light of dwindling funds for the Global Fund to Fight AIDS, TB and Malaria. The specific HIV goal under MDG aims to focus on young people and women and also acknowledges the link between gender-based violence and HIV and the need to address this link as a priority.

The fight for sexual and reproductive rights is not a universal, catch all slogan. Whilst gains have been made as noted above, the feminist agenda has not been fully adopted and there are many issues that the technocrats will not fight for. In the mainstream approach to sexual
and reproductive rights, the focus is on certain issues; the United Nations agencies, for example, are tackling the issue of maternal mortality and HIV but do not have the same global profile in pushing for access to safe abortion for all women. Some issues are more controversial and are more likely to remain on the agenda of feminist organisations and not become ‘mainstreamed’, and these include strong advocacy on LGBTI rights, assisted pregnancies, microbicides for adolescent girls, sex workers and women living with HIV and AIDS.

What is not on the agenda?

While the MDG goals and efforts from various role-players are important and do shift the agenda and impact on specific women’s conditions, such efforts do not, from a feminist perspective, impact on the fundamental position of women. Without an understanding of power inequalities, especially in intimate relationships which essentially provide the framing for sexual and reproductive issues, mainstreaming sexual and reproductive health and rights can only improve the health of the women they reach and will do little to shift the status quo.

In the fight for women’s sexual and reproductive rights, women are not a homogeneous group. Within the category women, there are those who are marginalised and doubly oppressed due to their identity, subject position and geographic location. This means that the traditional understanding of sexual and reproductive rights does not necessarily speak to their lived realities and special needs. Unless the group themselves take up the issue, such issues may never surface or end up on the agenda. In this regard, it is worth highlighting the marginalised position of three groups of women to interrogate why their issues are not necessarily on the agenda – namely, sex workers, women living with HIV and AIDS, and lesbians.

If women generally face issues in accessing sexual and reproductive services, sex workers in particular experience huge challenges in accessing health services; this is mainly due to their identity as sex workers, although other structural and logistic issues also have an impact. Similarly, the coercive and forced sterilisation of women living with HIV has been documented in three southern African countries – Namibia, South Africa and Swaziland – with anecdotal evidence emerging from other countries. These cases involved women with HIV and AIDS being sterilised as they approached hospitals for reproductive health services. In some cases, the sterilisation happened as a trade-off for another sexual or reproductive service – for example, one woman who was raped and fell pregnant was only granted an abortion if she agreed to be sterilised. Another woman who was in labour and needed a caesarean section in order to guarantee both her own life and that of her unborn child had to agree to be sterilised before the caesarean would be performed. Some women have had to choose between ARV therapies and sterilisation or no access to life saving drugs, whilst some women have only discovered later on when asking for contraceptives that they have been sterilised. It is clear that the forced (although the legal term is coerced from a feminist perspective it is clear that such experiences are forced) sterilisation of women living with HIV is the ultimate denial of their rights and one which impacts significantly on their identity.

It is important to note though that the practice of forced sterilisation is not restricted to women living with HIV, as anecdotal evidence from other groups of marginalised women (for example, women with physical or mental disabilities, and women migrants in South Africa) indicates that they have also been sterilised against their will.

In a region with the highest prevalence of HIV, and with women disproportionately affected by HIV and AIDS, there is understandably a focus on women in prevention and treatment issues (although it is not sufficient). However, within the discourse around women, HIV and AIDS, certain women are left off the agenda, including women with disabilities and lesbians. A recent study in southern Africa highlights that lesbians are in fact vulnerable to HIV and engage in high risk behaviour (including but not limited to having sex with a man) and that there are a growing number of lesbians living with HIV.1 Access to information on HIV and AIDS for lesbians is non-existent and the attitudes of health care workers make it difficult for women to disclose their sexual orientation and thus get appropriate support and services.

Another aspect of sexuality that is not part of the traditional sexual and reproductive health and rights agenda, but is critical to feminist efforts to ensure that women realise their full sexual potential, is sexual pleasure and desire. The sexual double standard places great emphasis on male sexual pleasure and denies women’s needs and rights to pleasure and bodily integrity and autonomy. The control of women’s bodies is very much centred on control of their vaginas and genitals. For example, in many countries in southern Africa (and beyond) it is culturally determined that women carry out different so-called ‘interventions’ for a variety of reasons, including hygiene, health, acceptable and expected social norms and control of women’s pleasure and sexuality (Tallis 2012). A common vaginal practice is the use of drying agents to ensure a non-lubricated vagina, which has the sole purpose of enhancing sexual pleasure for men during intercourse. And while some of these practices might promote the enhancement of male sexual pleasure, they also increase women’s vulnerability.

Value of a rights framework?

Rights frameworks, including those addressing sexual and reproductive rights, cannot be replaced by other frameworks that attempt to define the obligations of society to individuals (Corea 2008). But rights frameworks cannot compensate by themselves for social struggles where oppressed people confront unequal
power relations. The rights framework in this sense is fluid and
dynamic and represents a discourse that is developing out of
the arena of these struggles rather than a static charter that has
already been defined at a global level. There are many difficulties
for women in challenging male power in the most intimate moment
when the negotiation of safer sex is most necessary and when she
often has the least access to power.

As can be seen, there are a range of diverging understandings of
sexual and reproductive rights. Some of these understandings focus
more on health, while others draw attention to the significance
of rights in women’s and men’s sexual and reproductive choices.

Feminist understandings and activism around sexuality go further
to analyse a lack of sexual and reproductive freedoms and locate
this firmly in patriarchal societies in which control over women’s
bodies remains a fundamental way in which men oppress women.
It is possible for mainstream organisations to take up an agenda of
sexual and reproductive rights and make tangible differences to
women’s enjoyment of, and access to, these rights. Indeed, progress
has been made and the impact is slowly being felt. However, unless
the root causes of oppression and lack of autonomy are confronted
and the whole gamut of oppression is tackled – including the more
controversial issues – the sexual and reproductive freedoms of most
women will continue to be compromised.

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Endnote

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