Reproductive Health, Gender and Human Rights: A Dialogue

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2. Reproductive Health, Gender and Human Rights: The Sexuality Connection

The intersection of Reproductive Health, Gender and Human Rights reflects key issues articulated five years ago in Cairo at the International Conference on Population and Development—ICPD. As everyone is now aware, ICPD represented a major turning point in the population field because of its unprecedented emphasis on gender and rights, as well as its call for a broad array of reproductive health services—not just family planning to meet fertility-reduction goals. In the “Cairo” Programme of Action, all of Chapter VII was devoted to explaining the concepts of reproductive health and reproductive rights:

- Cairo defines reproductive health as: 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 reproductive system and to its functions and processes.
- Reproductive health therefore implies that people are able to have a satisfying and safe sex life as well as the capability to have children—and the freedom to decide if, when and how often to do so.
- This means that women and men have the right to be informed and to have access to effective, affordable contraceptive methods of their choice, as well as to safe abortion, where it is legal.
- It also means that women have the right to appropriate health-care services to enable them to go safely through pregnancy and childbirth and with the best chance of having a healthy infant.
- Cairo also states that reproductive rights embrace certain human rights that are already recognized in national laws, international human rights agreements and other consensus documents.
- To respond to the above rights, reproductive health services must be in the business of both preventing and solving reproductive health problems, as well as promoting sexual health.

In the six years since Cairo, governments, donors and health agencies have faced the challenge of defining and implementing “reproductive health services.” This has not been easy. However, the recent five-year assessment exercises on the Cairo agenda (ICPD+5) have documented that progress is being made in integrating family planning with services to meet clients’ other reproductive health needs, such as antenatal care, HIV prevention, and diagnosis and treatment of reproductive tract infections and sexually transmitted infections (STIs).

Far more difficult to define and to implement are the ICPD provisions that list rights to “sexual health” and “a satisfying sex life.” The fact that five years after Cairo, delegates to the ICPD+5 Preparatory Committee Meeting could not reach consensus on sex education in the schools and on sexual/reproductive health information and services for adolescents is indicative of this difficulty. While
human beings are clearly sexual beings, the area of human sexuality is often misunderstood and reduced to being synonymous with sexual intercourse. Human sexuality is, therefore, seldom discussed among reproductive health professionals, let alone incorporated into reproductive health programs. And yet, the majority of threats to reproductive health are not attributable to pathogens, lack of medicines and poor health services alone. They are equally rooted in sexual relationships that are negatively influenced by gender-biased societal norms.

**Six Dimensions of Sexuality**

Consider briefly these dimensions of sexuality—and how they can either enhance life or be a source of human misery, including reproductive health problems:

♦ **Sensuality**—physical feelings about our own and other people's bodies, especially the body of a sexual partner. It includes sexual attraction, sexual desire and sexual pleasure. The feelings are strong and can be the impetus for both healthy and unhealthy sexual experiences.

♦ **Intimacy**—the ability and need to be emotionally close to another human being, to give and receive love or affection, to experience mutual trust—to be connected to another in an ongoing relationship. This basic human need can be as strong as physical desire. It can lead to forming a mutually satisfying relationship or to entering into or staying in an abusive relationship. When intimacy is threatened, it can be the basis for murderous jealousy.

♦ **Sexual health and reproduction**—the reproductive system and all of its functions related to sex, conception, pregnancy and delivery, as well as all actions aimed at keeping it functioning optimally and free from diseases and harmful traditional practices. After ICPD, many family planning programs that earlier focused on preventing pregnancy have become “reproductive health programs” by adding other related services. However, information and counseling still focus on “the facts” and seldom include sexuality and gender issues.

♦ **Sexual identity** includes three interlocking pieces that affect how a person sees himself or herself—the individual’s sex, gender roles and sexual orientation. The sex of an individual is determined biologically as male or female, while his or her gender role is culturally derived. Society assigns certain roles, rules of behavior, entitlements and relative value to males and others to females—and there are sanctions if people deviate from these assignments. Almost everywhere, gender norms favor males and discriminate against females. As a
result, too few women have control over when to have sex and whether to use protection against pregnancy or STIs. Very few women even know that they are entitled to certain basic rights such as bodily integrity. Similarly, gender bias adversely affects those whose sexual orientation deviates from the norm. Homophobic societies see homosexuals and transgendered people as males and females who reject their gender “assignment.” Their human rights are routinely violated.

♦ **Sexual socialization**—consider the mixed messages young people receive about sexuality. Where and how do they learn about the reproductive system, sexual behavior, sensuality, intimacy and what it means to be a man or a woman? The messages are seldom consistent since they come from different sources with differing values: parents, religious leaders, teachers on one hand; on the other—radio, TV, magazines, observation of adult behavior, and perhaps the most common source, information and norms transmitted by one’s peer group. Girls become sexual beings at puberty and they are both admired and punished for it. They are warned against emotional and physical closeness to boys and men. Boys learn that it is okay to experiment with their sexuality—the more sexual conquests, the more manly they are—but that they must avoid appearing weak or showing emotions. Is it then surprising that globally one-third of women have experienced violence in an intimate relationship?

♦ Finally, there is **sexualization,** the use of sex to achieve other objectives—such as to control another person, to express anger, or to manifest domination over an ethnic group, as is the case of rape in wartime. Advertising also uses sex to sell products. Its message is “Say yes to this product and you will be sexy.” Sugar daddies—older men who offer money, food and gifts to little girls in exchange for sex—exploit young girls’ poverty status to gain sexual satisfaction or because they think they can avoid AIDS by sleeping with a virgin. Sexualization is only possible due to gender inequity.

### Managing Sexuality—Yesterday and Today

In order to address the various dimensions of sexuality and prevent negative outcomes, it is important to also remember how sexuality was managed traditionally and how it is being managed today. Traditionally societies managed sexuality, especially that of their adolescents and particularly girls, as in the following examples:

♦ Using shame and guilt to curb sex before marriage (Europe during the Victorian area)
♦ Secluding and veiling of girls during adolescence (in the Middle East)
♦ Marrying off girls at or just before onset of puberty (most parts of the world)
♦ Rites of passage ceremonies or programs that provide adolescents with fundamental life skills including how to manage one’s sexuality (parts of Africa)
These mechanisms of managing sexuality have either already disappeared in some places or are rapidly changing due to education, urbanization, media influences and the development of a global culture. Unfortunately, the family is in a noticeable decline, the extended multi-generational family of traditional societies giving way to nuclear families, single-parent households and the no-parent groups of street children\(^1\). In response to these dramatic changes, many sex education programs are designed to instill fear of disease and pregnancy; many offer “abstinence only” approaches to sexuality.

As mentioned, most reproductive health programs concentrate on “the plumbing,” teaching clients a little about the reproductive system, contraception, pregnancy and STIs—and the services and products to deal with them. Seldom do the topics of sexuality, gender and human rights or the skills to negotiate sex and gender norms arise for adolescents or even adults. Comprehensive sexuality education programs are often mired in controversy as adults try to censor content and eliminate the most critical components. This is often due to a variety of factors:

- Disagreements about whether sexuality education programs should focus on prevention of unwanted consequences of sex (as in Western Europe) or focus on the prevention of sex itself (as in many other countries).
- Lack of knowledge about the goals and outcomes of comprehensive sexuality education programs (even though a growing body of research shows that sex education does not promote promiscuity but leads to delayed initiation of first sex, reduction in number of partners and use of contraception among the already sexually active).
- Many adults are uncomfortable discussing sexuality issues with adolescents or with their spouses, even though lack of discussion may endanger their lives.

### Successful Interventions

And it must be asked: where are the programs that address gender issues and reproductive rights directly? There are very few. The good news is that things are slowly beginning to change. Let us discuss a few examples from PATH’s work in

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Kenya and Ghana and the work of colleagues in Senegal:

♦ In Kenya, participatory community education on cultural empowerment and reproductive health and rights, including the right to bodily integrity, led to the community’s mobilizing its members for change. The community replaced traditional coming-of-age ceremonies, which included female genital mutilation, with what we call Alternative Rites of Passage. In the alternative rite, modern sexuality education is added but all the relevant aspects of traditional sexuality education and the celebration, honor and feasting are retained. Only the cutting is eliminated.

♦ In Ghana, our baseline assessment revealed that rape and coercive sex occur quite commonly among adolescents. However, in training health workers and leaders of youth-serving organizations, we found that they themselves often placed blame on girls in cases of rape and coerced sex. Most of them agreed that if a young woman who was dressed provocatively or was in a place she was not supposed to be was raped, she deserved to be raped: “She was asking for it.” After the group had analyzed the provisions of several human rights instruments including the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) as well as relevant Ghanaian laws, there was a complete reversal in attitude. The participants said that the young woman might have been showing off her body, looking for admiring glances and comments to boost her self-esteem, possibly looking for a new boyfriend—but she was not looking for rape and did not deserve to be raped. They all acknowledged her rights to choose, to free association and to sexual and reproductive health, among other rights.

♦ In Senegal, a colleague organization called TOSTAN provided basic literacy, problem-solving and health and human rights education to village women. After receiving training on women’s health and human rights education, the women were able to connect several problems that they were earlier oblivious to: “When we circumcise our daughters, we violate their rights; when we send them to Dakar as domestic help, we violate their rights.” The women also realized that use of family planning for birthspacing is good for their own and children’s health and well-being. The women resolved to stop circumcising their daughters and sending them to Dakar to become domestic servants. Their declaration affected many other villagers who adopted their stance. Ultimately, it encouraged the Senegalese Government to pass a law against the practice of female circumcision or FGM.
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Recommendations

In the many African communities where PATH has worked, education on universal human rights and on national legal rights has been found to be empowering on its own. People are forever changed by exposure to such concepts. The question we need to ask ourselves is: “Are reproductive health information and services enough”? In fact, they are only part of an essential package for improved reproductive health. Donors and implementing agencies must think “outside the box”—outside the clinic walls—and increase support for the following complementary approaches at the policy, program and community levels:

♦ Address sexuality education comprehensively in school programs, reproductive health services and in communities.
♦ Incorporate gender socialization issues (for both boys and girls) and human rights and legal literacy into in-school programs, services and community education programs.
♦ Improve the understanding of program implementers about their own culture and that of others, in order to promote positive aspects of culture within programs.
♦ Re-orient the top-down IEC strategies used by many programs to become supportive behavior-change interventions involving individual and community stakeholders.
♦ Link national-level advocacy—monitoring and implementation of human rights conventions (CEDAW, CRC and others)—as well as positive policies and laws, to coalition-building and community-empowerment programs.
♦ Scale up successful pilot programs that address linkages among gender, human rights and reproductive health—and do not forget the sexuality connection.

If we invest in strengthening these community-based and rights-focused elements in our existing programs, we will see a rise in healthy behaviors protective of reproductive health and a simultaneous demand for improved services.