

Chapter 4

MY BODY MY RIGHTS

International treaties and declarations provide foundations for the right to bodily autonomy and integrity

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WHOLENESS СОПРОТИВЛЕНИЕ
LAS NUEVAS FORMAS DE VER LA MASCULINIDAD
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CHOICE
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MY BODY MY RIGHTS

International treaties and declarations provide foundations for the right to bodily autonomy and integrity

Do people have rights to make decisions about their own health care, including reproductive health care? Do these rights include making choices about contraception? Does a woman have a right to say no—or yes—to sex, when she wants and with whom she wants?

According to international human rights law, the answer to these questions is an emphatic “yes”.

Even though bodily autonomy is a foundation upon which human rights are built, it is rarely articulated as a right in and of itself (UN General Assembly, 2007). Rather, bodily autonomy underpins or is subsumed in a number of rights that are spelled out in treaties and international agreements.

Bodily autonomy in the context of sexual and reproductive matters encompasses rights that enable individuals to make informed choices and decisions regarding their sexual and reproductive health needs, and to do so free from discrimination, coercion and violence. These rights were first articulated in the Programme of Action of the 1994 International Conference on Population and Development (ICPD), and the Platform for Action of the 1995 Fourth World Conference on Women (United Nations, 1995; UNFPA, 1994).

Depending on the treaty or agreement, “autonomy” in matters related to sexuality and reproductive health and decision-making may encompass access to comprehensive sexuality

education, contraceptive information and services, maternal health care, infertility treatment, gender-affirming interventions, such as hormonal and surgical treatment, and comprehensive abortion care. Autonomy also touches on matters of civil status, ranging from marriage and divorce to the legal capacity to make decisions about one's own body and the power to express one's gender identity.

Rights to bodily *autonomy* are aligned with rights to bodily *integrity*, which are tied physically to liberty and security of the person, and to freedom from torture and cruel, inhuman or degrading treatment, as well as the inviolability of one's self: body and mind. In the context of reproduction and sexuality, violations of bodily integrity include practices such as female genital mutilation, virginity testing and punitive anal examinations, as well as rape, including rape by a spouse or partner, and other forms of gender-based violence.

Rights related to bodily autonomy and integrity enable individuals to make their own decisions in the realms of reproduction and sexuality. States affirm and regulate these rights through policies and laws that define "legal capacity" or determine the age of consent for sex, marriage or accessing services such as contraception.

Autonomy rights are interdependent and mutually supporting, regardless of how they are expressed, whether as a "right to respect for... physical and mental integrity" (European Union, 2012, Article 3(1)), as "rights to life, physical and mental integrity, liberty and security of the person" (UN General Assembly, 2007a, Article 7(1)), as freedom from torture,

cruel, inhuman and degrading treatment, or as a right to dignity and privacy, or in the right to health as expressed in many national constitutions (Viens, 2020).

Bodily autonomy and reproductive decision-making

Human rights law robustly affirms the right to information and means to make decisions about childbearing. Article 16.1(e) of the Convention on the Elimination of All Forms of Discrimination against Women, commonly known as the Women's Convention, requires States Parties to uphold women's rights "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights" (UN General Assembly, 1979).

The Convention on the Rights of Persons with Disabilities, known as the Disabilities Convention, specifies that the right to make decisions about the number and spacing of children applies to persons with disabilities (UN General Assembly, 2007). The right to decide on the number and spacing of children is mirrored in the African Charter on Human and Peoples' Rights, in its Protocol on the Rights of Women in Africa, the "Maputo Protocol" (African Union, 2003). Similar language is also found in the ICPD Programme of Action and the Beijing Declaration and Platform for Action of the Fourth World Conference on Women.

Human rights and the United Nations treaty system

Human rights are basic guarantees, which the international community recognizes and promises to uphold. These rights cover civil, political, social, economic and cultural matters and establish what governments can and cannot do, as well as what they should do for all of us without discrimination. Everyone, regardless of sex, gender, race, ethnic origin, religion, nationality, language, disability, place of residence or any other status, has these rights.

Human rights are often expressed and guaranteed by law, in the forms of treaties, customary international law, general principles and other sources of international law (OHCHR, n.d.).

Human rights treaties are overseen by the United Nations through treaty-monitoring committees, known as treaty bodies, which ensure that States Parties honour their commitments under each treaty. For example, the United Nations Committee on the Elimination of Discrimination against Women monitors progress for women made in countries that are States Parties to the 1979 Convention on the Elimination of All Forms of Discrimination against Women. The Committee also makes recommendations on issues to which it believes the States Parties should devote more attention.

Similar bodies have been established to monitor progress in meeting obligations to other treaties, such as the Convention on the Rights of the Child.

Treaty bodies may issue non-binding recommendations, or Concluding

Observations, which suggest certain actions countries should take to better meet their human rights obligations. They may also issue General Comments or Recommendations to help governments understand their treaty obligations and provide authoritative interpretation as to the meaning of treaties. In certain cases, treaty bodies can act like courts and issue opinions that are meant to settle disputes and points of law.

Another important source of human rights norms comes from political consensus agreements, such as the ICPD Programme of Action and the Platform for Action of the 1995 Fourth World Conference on Women. These agreements, together with the United Nations Sustainable Development Goals, establish global policies and targets for the realization of rights, including sexual and reproductive rights.



Artwork by Kaisei Nanke

First, do **no harm**

Virginity testing violates individuals' human rights and dignity, the United Nations has resoundingly asserted. When performed without consent, it constitutes torture and a form of sexual violence. It is also scientifically useless, and a violation of medical ethics (WHO and others, 2018). Yet it persists in every region of the world; its continued practice has recently made headlines in the United Kingdom, for instance, where a bill is under review to ban the practice. Virginity tests are used to enforce or encourage abstinence among unmarried women and girls, with justifications ranging from the preservation of their "purity" and family "honour" to the prevention of HIV transmission and adolescent pregnancy (Olson

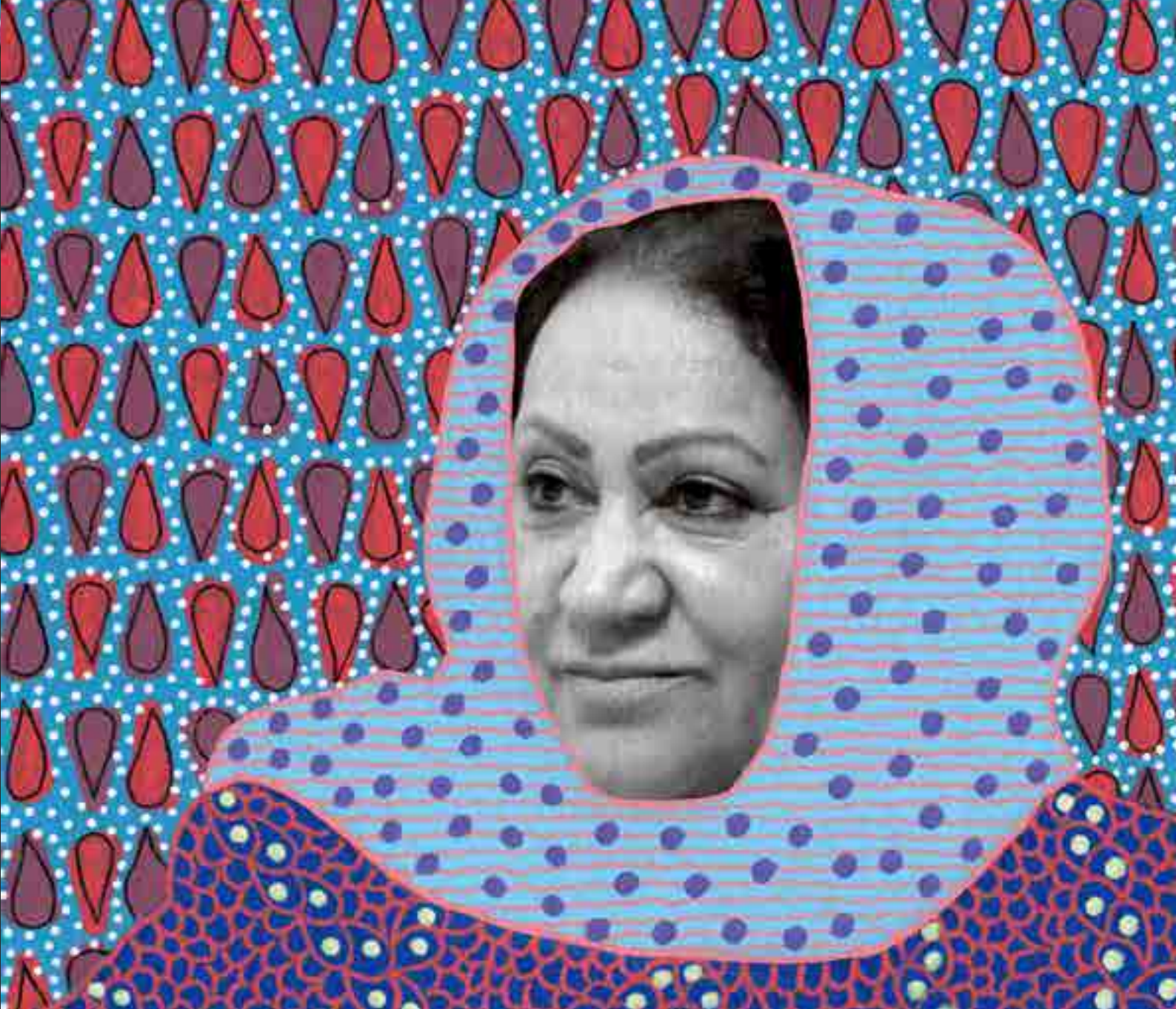
and García-Moreno, 2017). And yet many of its defenders invoke feminist language to argue for its continuation.

A virginity test, also known as a hymen exam or "two-finger" test, typically involves an examination of the hymen, a thin tissue often, but not always, present in the vagina. The test relies on the assumption that physical characteristics of the hymen or vagina can demonstrate whether a woman or girl has engaged in vaginal intercourse—a belief overwhelmingly discredited by medical studies. Unscientific examinations to "prove" or "disprove" intercourse only reinforce harmful social norms and must be banned, medical and human rights experts assert. These include not only

virginity tests but also forced anal exams, which involve the insertion of fingers or objects into the anus of a man or transgender woman with the purported objective of finding "proof" of homosexual conduct. Forced anal tests have been reported throughout the Arab States and East and Southern Africa regions, yet they are "medically worthless" and "amount to torture or ill-treatment", said the 2018 report of an independent expert to the United Nations Human Rights Council (UN HRC, 2018).

Virginity tests, as well as forced anal exams, are physically invasive, painful and stigmatizing. Suraya Sobhrang, a medical doctor and former human rights commissioner in Afghanistan, says the tests used to be

"This is a violation of human rights and it's against human dignity"




Suraya Sobhrang describes how medical and legal personnel perpetuated nonconsensual virginity testing in Afghanistan. Original artwork by Naomi Vona; photo © UNFPA/A. Mohaqqueq.

ordered punitively after any perceived transgression, such as sitting next to a member of the opposite sex. “All this was a ‘moral crime,’” Dr. Sobhrang described.

Examination conditions were often neither sanitary nor private, and women could be forced to undergo the test repeatedly, she said. “This was traumatizing these

women... One woman told me, ‘I feel that the second time, somebody raped me.’”

Women could be imprisoned for failing a virginity test.



“Some women did self-immolation after this testing,” Dr. Sobhrang recalled. Others were killed by their families.

Dr. Sobhrang and her colleagues helped to ban nonconsensual virginity tests in Afghanistan in 2018. Today, virginity tests can only be performed in Afghanistan when there is a court order and consent of the patient—though enforcement of this rule remains a concern, especially in rural areas. And both doctors and patients can still face consequences if they decline the test. Mozghan Azami, a forensic medicine specialist in Kabul, recalled one girl who refused twice, despite a court order: “The third time, the court sent her back to us saying that if the doctors do not perform the test this time, they will be placed under investigation. Therefore, after two hours of talking to the girl, we convinced her to do the test.”

Dr. Azami agrees that virginity tests, particularly when performed under duress, can “hurt them psychologically”. Yet she defends the test in some instances, if performed confidentially, with dignity and full informed consent. Those views are shaped by real fears

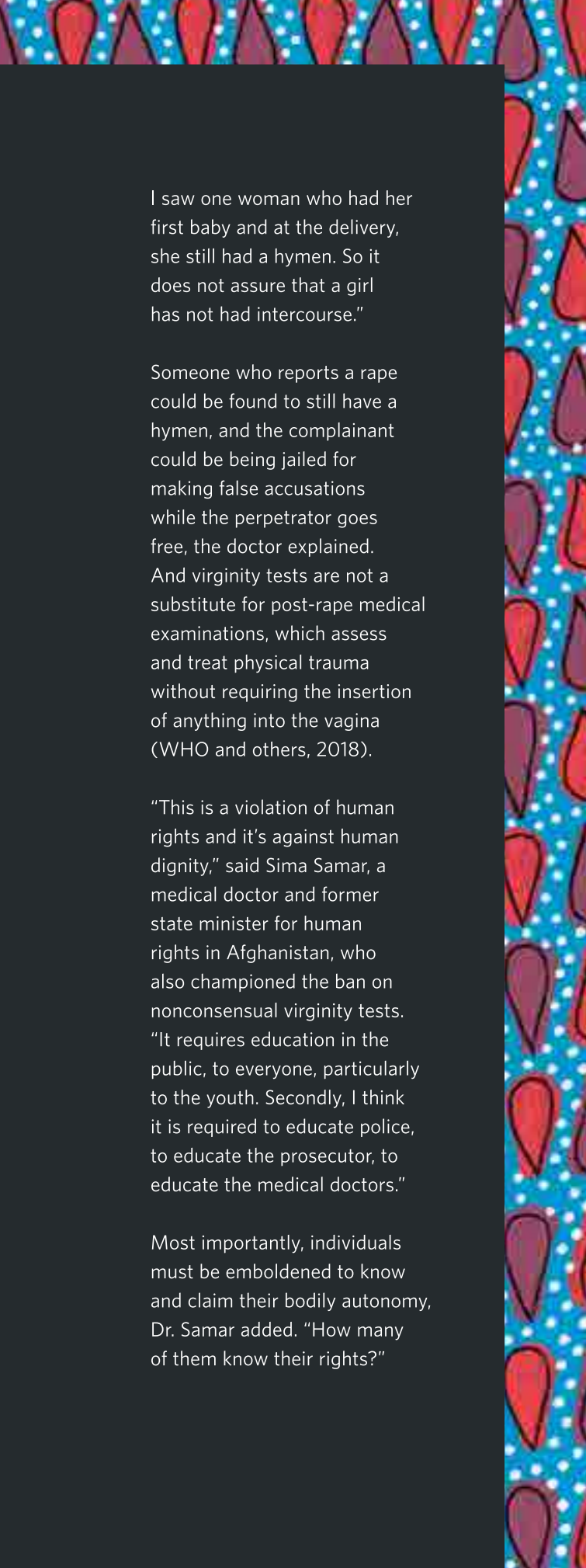
and realities: in places without scientifically sound medical procedures, such as DNA testing, virginity testing offers one of the few ways survivors can submit evidence to support an allegation of rape. “For the victim, the hymen test is a tool through which to seek justice and fight back against social and traditional blame,” Dr. Azami said.

The test, if its results are favourable, can also help women avoid violence in places where a perceived loss of virginity can be a death sentence. “On a marriage night, a white cloth or paper is given to the couple that should be coloured red by the blood of the hymen after the marriage is consummated,” Dr. Azami added. If “the man doesn’t see the signs of virginity, the virginity test will be performed... based on the request of the girl,” typically in the hope that her hymen will show an indication of tearing.

In some communities, such as in South Africa’s KwaZulu-Natal Province, virginity testing is also seen by some as protection from adolescent pregnancy, HIV and other harms (UN HRC, 2016). “It is believed that virginity testing will prevent girls being coerced

into having sexual relations and abuse by ‘iintsizwa’ [older men], especially girls in grades 10, 11 and 12,” said Chief Msingaphansi of Umzimkhulu in KwaZulu-Natal. He suggests the tests, largely performed by women elders, emphasize the cultural value on abstinence, thereby encouraging girls to reject peer pressure and delay sexual activity. Chief Msingaphansi couches the ritual in the language of empowerment: “Following the tests, the girls are made aware of their rights,” he said, adding that they learn to identify exploitative relationships. Yet these tests are often nonconsensual, making them illegal. “The parents decide,” acknowledged a “virginity inspector” from uMgungundlovu and uThukela districts.

Despite these justifications, the test contributes to the erroneous belief that a woman’s virtue is dependent on her sexual history, and it perpetuates a flawed understanding of human anatomy. Lending credibility to the test will inevitably lead to harm, Dr. Sobhrang stressed. “The hymen, some women don’t have one. And sometimes the structure is very elastic.



I saw one woman who had her first baby and at the delivery, she still had a hymen. So it does not assure that a girl has not had intercourse.”

Someone who reports a rape could be found to still have a hymen, and the complainant could be being jailed for making false accusations while the perpetrator goes free, the doctor explained. And virginity tests are not a substitute for post-rape medical examinations, which assess and treat physical trauma without requiring the insertion of anything into the vagina (WHO and others, 2018).

“This is a violation of human rights and it’s against human dignity,” said Sima Samar, a medical doctor and former state minister for human rights in Afghanistan, who also championed the ban on nonconsensual virginity tests. “It requires education in the public, to everyone, particularly to the youth. Secondly, I think it is required to educate police, to educate the prosecutor, to educate the medical doctors.”

Most importantly, individuals must be emboldened to know and claim their bodily autonomy, Dr. Samar added. “How many of them know their rights?”

Bodily autonomy and health

Deciding for oneself, seeking and receiving information, and accessing services for reproductive and sexual matters are understood and included in the right to health, according to the United Nations Committee on Economic, Social and Cultural Rights (UN CESCR, 2016). At the same time, enjoying sexual and reproductive health is “indispensable to [women’s] autonomy” and “intimately linked to civil and political rights underpinning the physical and mental integrity of individuals and their autonomy” (UN CESCR, 2016, para. 34).

The rights “to make free and responsible decisions and choices, free of violence, coercion and discrimination regarding matters concerning one’s body and sexual and reproductive health”, and to have “unhindered access to a whole range of health facilities, goods, services and information” are therefore two sides of the same coin (UN CESCR, 2016, para. 5).

According to the United Nations Committee on the Elimination of Discrimination against Women, health services must create an enabling environment where people can exercise their autonomous choices and States should “[r]equire all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice” (UN CEDAW, 1999).

Rights and infertility treatment

Access to infertility treatment is part of reproductive health care and includes techniques such as in vitro fertilization (Zegers-Hochschild and others, 2009). International human rights require all reproductive and sexual health-care services to be available and accessible on the basis of non-discrimination and equality. Various treaty bodies have concluded that where in vitro fertilization is available within a State, it must not be unduly restricted, or offered in such a way as to violate other human rights (UN CESCR 2019; UN CCPR, 2016; UN CEDAW, 2015).



Artwork by Kaisei Nanke

Bodily autonomy and privacy

Being able to make decisions about private and family life are additional aspects of rights to bodily autonomy. For example, the Political Rights Covenant provides that “No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation” (UN General Assembly, 1966, Article 17(1)).

Similar formulations of the right to privacy are also included in other international and regional human rights treaties, notably the Children’s Convention (UN General Assembly, 1989, Article 16), the American Convention on Human Rights (OAS, 1969, Article 11), the European Convention on Human Rights (Council of Europe, 1950, Article 8), the African Charter on the Rights and Welfare of the Child (African Union, 1990, Article 10) and the ASEAN Human Rights Declaration (ASEAN, 2012, Article 21).

The European Court of Human Rights and Inter-American Court of Human Rights have interpreted their treaties in a similar way, emphasizing that “the notion of personal autonomy is an important principle underlying the interpretation of its [Article 8 privacy] guarantees” (ECtHR, 2002).

In the United States more than a century ago, Samuel Warren and Louis Brandeis articulated a right to privacy as the “right to be left alone” (Warren and Brandeis, 1890). Since then, privacy has gained a much broader definition in the United States and elsewhere and applies

Abortion and bodily integrity and autonomy

United Nations treaty bodies, the committees that monitor governments' application of their human rights obligations, have called on States to reform abortion laws to protect women's bodily integrity and autonomy. According to the United Nations Committee on Civil and Political Rights, for example, laws must permit women the choice to end pregnancies that endanger their lives (UN CCPR, 2019).

Laws that compel women against their wishes to continue non-viable pregnancies, or impel them to travel outside their countries to terminate such pregnancies, or those which endanger their lives, violate a range of recognized human rights (UN CCPR, 2017). States must also ensure that where their laws permit women to elect an abortion, no barriers are erected to impede them in exercising their choice (UN CCPR, 2011, 2005).

The ICPD Programme of Action is a foundational document that has guided the work of UNFPA since 1994. It stresses that measures or changes related to abortion within the health system are matters left to national legislative process. The Programme of Action also affirms that where abortion is legal, it should always be safe; and, in all cases, women should be provided quality care for the consequences of abortion.

Meanwhile, international, regional and national human rights bodies and courts increasingly recommend ensuring that even where access is restrictive, women's health and lives should be promoted and protected. Moreover, they direct States to decriminalize abortion—both for the women who seek services and the health-care practitioners who provide services—thereby reducing the stigma and discrimination that they might face.



Artwork by Kaisei Nanke

to decisions about sexual and reproductive health, including contraceptive information and services, access to abortion, infertility treatments, sexual relations, sexual orientation and gender identity. International, regional and national courts have found that rights to privacy

prohibit governmental interference with private, consensual sexual and reproductive behaviour between adults (UN CCPR, 1994). The United States Supreme Court based its decision in *Roe v. Wade* on such a right to privacy.

Legalized same-sex relationships mean greater autonomy for previously excluded groups

Mirroring laws that discriminate against people, particularly women, within marriage or coerce them into unwanted marriage, there are widespread legal restrictions on sexual relations between consenting adults of the same sex, as well as restrictions on same-sex partners contracting a legal marriage.

In recent years, the Office of the High Commissioner for Human Rights of the United Nations and other international organizations concerned with human rights have recognized that LGBTI persons' autonomy rights are violated through discriminatory laws and actions. The 2015 report of the High Commissioner for Human Rights stated forthrightly: "States that criminalize consensual homosexual acts are in breach of international human rights law since these laws, by their mere existence, violate the rights to privacy and non-discrimination" (OHCHR, 2015).

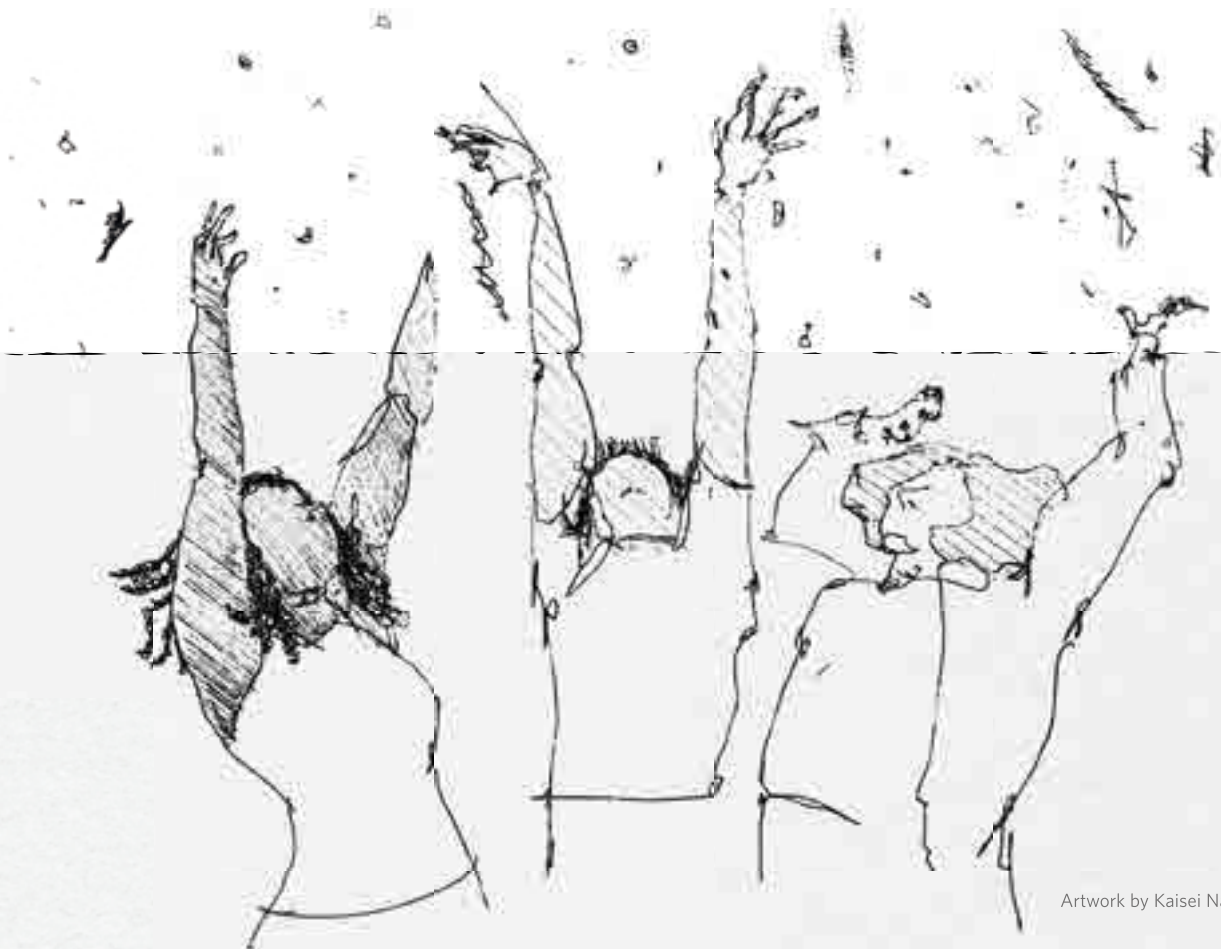
In a groundbreaking address at a ministerial meeting of the United Nations General Assembly in 2017, the High Commissioner for Human Rights said: "But the premise for dialogue must be clear: not whether to end these abuses, but how. LGBTI people are full members of the human family. They are not lesser than the rest of us; they are equal—and, as such, they are entitled to enjoy the same rights as everyone else." The High Commissioner called on all governments to

allow individuals to love whom they choose and to enjoy the same rights as others (OHCHR, 2017).

In this statement the High Commissioner was acknowledging that such a change in laws and attitudes concerning our understanding of bodily autonomy would have a liberating effect on the estimated 300 million people worldwide who identify as LGBTI (Patterson and D'Augelli, 2012).

However, the High Commissioner acknowledged that not only was progress slow, it was regressing due to political agendas that cater to prejudice and bigotry. In fact, there are 69 countries in the world today where consensual same-sex sexual relations are illegal (ILGA World, 2020).

Along with the human rights implications of such laws, discrimination against LGBTI people has important implications in many other spheres, such as health. The Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity of the United Nations Office of the High Commissioner for Human Rights has found that such laws "hinder the ability of relevant government departments and other actors involved in health responses", in, for example, the response to HIV and AIDS. A recent report pointed out that punitive legal environments,



Artwork by Kaisei Nanke

combined with stigma, discrimination and high levels of violence, placed gay men and other men who have sex with men at high risk of HIV infection because they are driven underground out of fear of prosecution or other negative consequences. As a result, they do not receive appropriate health education, and are reluctant to seek health-care services, testing and treatment (UN HRC, 2018).

An important part of achieving full equality under the law is the ability of LGBTI individuals to form unions with the same legal standing as that of opposite sex unions: “The United Nations and regional human rights bodies... have urged States to provide legal recognition of same-sex couples and their children and ensure that same-sex couples are not discriminated against compared to different-sex couples... It is up to the State to

determine the form of recognition, but whatever form is chosen, there should be no difference in treatment between same-sex and different-sex couples” (United Nations, 2016). This recognition is far from being achieved throughout the world.

But things are changing. In 1989, same-sex registered partnerships became a reality in Denmark. Two years later, the Netherlands legalized same-sex marriage. Since then, the legal right of same-sex partners to marry and establish families has also been recognized in Argentina, Austria, Belgium, Brazil, Canada, Colombia, Ecuador, Finland, France, Germany, Greenland, Iceland, Ireland, Luxembourg, Malta, New Zealand, Norway, Portugal, South Africa, Spain, Sweden, Taiwan Province of China, the United Kingdom, the United States of America and Uruguay (World Population Review, 2020).

Going to labour: the job of a surrogate

Josefina remembers making the choice to become a surrogate. "Part of it was for the money, but what really moved me was having the power to make real the dream of many women of having a baby," she said. What she did not anticipate was how poorly run—and abusive—the surrogacy agency would turn out to be.

"I thought there would be other women like me: confident in their decision, with a minimum of one child, just like the requirements established. But the place where I arrived wasn't like that. There were a lot of young women who had

not had any children before. I remember thinking 'where am I?'" A few months into her pregnancy, she, along with two or three other surrogates and some of their children, were taken to a dilapidated house with no water, electricity or food—and then locked inside.

The situation was only temporary. But Josefina (not her real name), who lives in Mexico, said she suddenly started worrying that the pregnancy wasn't actually for the purpose of being a surrogate. "A lot of ideas came to my mind such as child trafficking or organ trafficking."

She still had her mobile phone and was able to surreptitiously contact the intended parents of the baby, something she had been expressly forbidden to do. "I found the parents through Facebook," she said. "They were very nice to me and supportive." They moved to another surrogacy agency, bringing Josefina with them. "I continued the process in a safer place, where I felt more confident."

Yet even after that perilous experience, Josefina says she never doubted her decision. "I was sure that I wanted to have the baby. I don't regret it."

"I saw this opportunity of helping others get something they really desired: a baby."



Policymakers seldom consider the perspectives of surrogates when crafting surrogacy laws, experts say. Original artwork by Naomi Vona; photo by Alexander Krivitskiy on Unsplash.

It was an adventure," she said. "Once I met the parents, I was pleased with the process."

She would even consider doing it again.

The issue of surrogacy has long been considered ethically and legally fraught. Highly publicized lawsuits and custody battles in the United States, India and elsewhere have raised

questions about the rights and responsibilities of surrogates and intended parents, as well as the rights of the baby produced by the surrogacy arrangement (Nadimpally

and others, 2016). Laws vary widely across and within countries. Some ban surrogacy; some ban commercial, also called compensated, surrogacy but allow so-called altruistic surrogacy; some permit both; and others have no specific surrogacy laws at all (UCLS, 2019).

Where compensated surrogacy is permitted, a lucrative industry often emerges, comprising assisted reproductive technology clinics, medical tour operators, law firms, recruiters and others. Countries with lower costs can become sought-after destinations for commissioning parents. Yet, in such places, surrogacy is often one of the few well-paying opportunities available to economically marginalized women, creating the potential for exploitation. Brokers and agencies may control the exchange of money and information as well as the provision of health care. Surrogates may be left underpaid, underinformed and medically underserved (Nadimpally and others, 2016).

The highly gendered nature of surrogacy and motherhood also creates vulnerabilities on both sides of the agreement. Infertile women may face

intense cultural pressure to become mothers while same-sex couples or single parents are often barred from commissioning surrogates because they fail to meet accepted norms of parenthood. And surrogates may be criticized for betraying the perceived sacred bond between a woman and the fetus she carries. Josefina kept her surrogacy arrangement quiet for just this reason. "It's a taboo. A lot of people get scared when they hear about it, so I decided not to tell that many people. Actually, a lot of people from my own family don't know," she said.

"Stigma has grown a lot in the last 10 years," said Isabel Fulda, Deputy Director of Grupo de Información en Reproducción Elegida, a reproductive justice organization in Mexico, which has advocated on behalf of both surrogates and commissioning parents. Surrogacy laws vary across Mexico, but have generally grown more restrictive in recent years. "Even if the initial intentions of reform are good, and intended for better protection of every party, it has unfortunate consequences, especially for surrogate women," she said. In places that have implemented strict

prohibitions, "the practice still goes on, but now in an underground and unsafe way."

Josefina bore many of these consequences. "When I was with the first agency, we didn't even have a contract. A contract would have given me safety that everything would be okay." She believes the restrictions are only pushing surrogacy further into the shadows, where unethical agencies can thrive without regulation and surrogates themselves are penalized. "If it was legal, people would feel safer," she said.

Rather than bans, there must be more nuanced policies that account for the input and perspectives of those affected, said Sarojini Nadimpally, a founding member of the Sama Resource Group for Women and Health in India and expert on the social and legal issues surrounding surrogacy. "Have the surrogates and infertile couples been involved in the policy formulations? Were they asked what they want in the policy or in the legislation? How accessible will these legal provisions be for surrogates?"

Not only are surrogates' experiences neglected in the crafting of legislation, but

stigmas and punitive rules have made it harder for them to raise their voices. “The more political the issue becomes, the more they are silenced,” Fulda said. In place of surrogates’ real stories, a caricature has emerged, in which compensated surrogates are depicted as victims while altruistic surrogates “are often portrayed as angels who are willing to breed for nine months, and expose themselves to possible risks just for the love their hearts carry. It becomes unbelievable to think they would want money for it,” Fulda said.

The distinction between compensated and altruistic surrogacy doesn’t make sense to Josefina. For her, being a surrogate was both a job and a gift. She did not resort to it because of poverty: “My economic situation at that time was not really that bad. My choice was made because I wanted to do something different with my life and to do something positive for someone else... I am a mother as well, and I know the happiness a child can bring.”

Even in cases of alleged harmful sexual behaviour, the European Court of Human Rights directs governments to carefully balance the State’s interests against an individual’s autonomy interests and right to engage in private, consensual sexual activity (ECtHR, 1997).

Privacy, especially as it relates to family life, is capacious enough to encompass all manners of decision-making related to sexuality and reproduction, embracing “the right to respect for both the decisions to become and not to become a parent” (ECtHR, 2010, 2007). The privacy jurisprudence of the European Court of Human Rights is most developed; abortion as well as medically assisted reproduction for heterosexual and same-sex couples and individuals (including surrogacy, both compensated and altruistic) have been interpreted under the private and family life protections of Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (Roseman, 2020).

Non-discrimination and gender equality

Enjoying autonomy and having the capacity to make decisions free from discrimination are central to human rights.

Being free from discrimination and enjoying equal treatment means that States may not make any distinction in law or policy on the basis of characteristics such as sex, age, race, ethnicity, gender expression, religion, nationality, marital status, health or disabilities (UN CESCR, 2009). Discrimination based on sex, for example, would include distinctions made “not only on physiological characteristics

but also the social construction of gender stereotypes, prejudices and expected roles” (UN CESCR, 2009, para. 20). Unequal access by adolescents to sexual and reproductive health information and services is an example of age-based discrimination (UN CESCR, 2009).

States must respect individuals’ bodily autonomy and integrity irrespective of social context. According to a human rights working group on the issue of discrimination against women in law and in practice, “The right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy”

(UN Working Group on Discrimination Against Women in Law and Practice, 2017).

Women and girls have often been denied rights to make their own decisions because of social and cultural stereotyped beliefs or attitudes that assign more value to the opinion of men and parents. International human rights law views these beliefs and attitudes as gender-based stereotypes associated with harmful practices, including female genital mutilation, marital and “curative” rape (against individuals based on their sexual orientation or gender identity), child marriage, forced marriage and forced childbearing.

These beliefs and attitudes have also resulted in exclusion from comprehensive sexuality education, denial of contraceptive information and services, and forced abortion, as well as violence against people of diverse sexual orientation and gender identities (UN CEDAW and UN CRC, 2014). These coercive and violent



**UNEQUAL ACCESS
BY ADOLESCENTS
... IS AN EXAMPLE
OF AGE-BASED
DISCRIMINATION**

practices are all predicated on social beliefs that privilege heteronormativity and seek to control and subordinate women's sexual and reproductive capacities.

States have a duty "to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and

all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women" (OAS, 1994, Article 8(b); UN General Assembly, 1979, Article 5(a)).

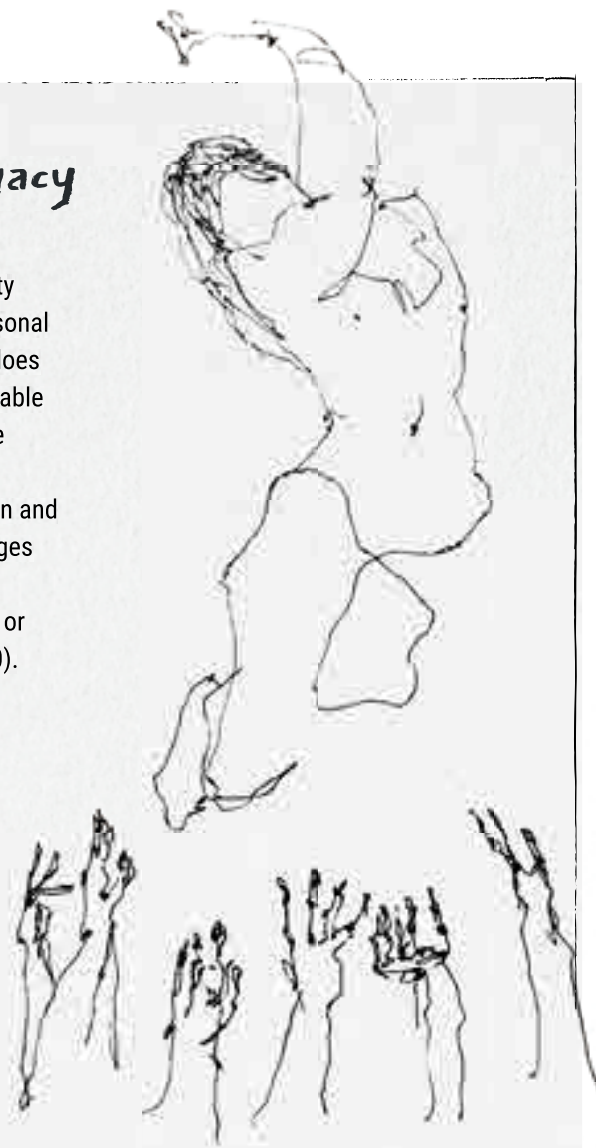
Governments can, and sometimes must, treat people differently; however, there must be a legitimate justification for the disparate

Transactional sex and surrogacy

What are the limits for exercising bodily autonomy in sexuality and reproduction? According to human rights principles, personal choices that do no harm to others should be permitted. But does the exchange of money do no harm? Should an individual be able to be financially compensated for sexual acts or reproductive services? There is great variability in national laws and regulations regarding sex work, prostitution, gamete provision and gestational surrogacy. Some governments see these exchanges as inherently exploitative and criminalize them. Others view sex work and gestational surrogacy as legitimate livelihoods or forms of labour (UN HRC, 2018a; UN General Assembly, 2010).

Human rights law does not provide definitive answers, although rights-based arguments have been invoked to support both prohibition and legalization.

For example, the UNAIDS Global Commission on HIV/AIDS and the Law has recommended decriminalizing sex work, while the Human Rights Council has recommended that in cases of compensated surrogacy the human rights of all parties involved must be considered and respected appropriately in law (UN HRC, 2019a; UNDP, 2012).



Artwork by Kaisei Nanke

Legal capacity and age of consent

The Office of the High Commissioner for Human Rights defines legal capacity as “the capacity and power to exercise rights and undertake obligations by way of one’s own conduct, i.e., without assistance or representation by a third party” (OHCHR, 2005). Recognition in law of having “capacity” means a person can give or withhold consent to sexual activity, health services, marriage and more.

A legacy of deeming women, children and persons living with disabilities “incompetent” to make decisions for themselves or in need of protection from exploitation is what international human rights redress. For example, the Women’s Convention directs that “States Parties shall accord to women, in civil matters, a legal capacity identical to that of men” and they shall have “the same opportunities to exercise that capacity” (UN General Assembly, 1979, Article 15(2)).

Given the history of discrimination faced by women with disabilities, the Convention on the Rights of Persons with Disabilities emphasized the importance of legal capacity for autonomous decision-making by women with disabilities: “All women with disabilities must be able to exercise their legal capacity by taking their own decisions, with support when desired, with regard to medical and/or therapeutic treatment, including by taking their own decisions on retaining their fertility and reproductive autonomy... Restricting or removing legal capacity can facilitate forced interventions, such as sterilization, abortion, contraception, female genital mutilation, surgery or treatment performed on intersex children without their informed consent and forced detention in institutions” (UN CRPD, 2016).

Another way of understanding legal capacity is “age of consent”. Minimum ages of consent vary among and sometimes within nations by activity and sometimes by sex (although this is considered incompatible with human rights standards). The Children’s Convention directs States to recognize the evolving capacities of children, specifically adolescents, with regard to consent to sexual activity as well as access to sexual and reproductive health services and



Artwork by Kaisei Nanke

information. The Committee on the Rights of the Child urges governments to put supportive laws and policies in place so that “children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality” (UN CRC, 2013). These policies include providing confidential counselling to children, without the need for parental or guardian consent, as well as conferring presumptive legal competency for adolescents to seek and obtain sexual and reproductive health services, commodities and information (UN CRC, 2016). According to the Committee on the Rights of the Child, governments should avoid criminalizing consensual, non-exploitative sexual activity among adolescents of similar ages (UN CRC, 2016).

The right to marry and found a family is recognized in both the Universal Declaration of Human Rights, Article 16 (UN General Assembly, 1948), and the Political Covenant, Article 23, specifying that “no marriage shall be entered into without the free and full consent of the intending spouses” (UN General Assembly, 1966). Any marriage entered into without such consent is forced and is always a human rights violation. The Women’s Convention clearly states that child betrothal and marriage is legally null and void and directs States to establish minimum ages for consent to marriage (UN General Assembly, 1979, Article 16(2)). In keeping with the principle of evolving capacities, most nations, following the Children’s Convention, establish a minimum age of consent to marriage at 18, although in some settings the minimum age varies, depending on the sex of the individual (Pew Research Center, 2016). In over half of the world’s nations, parental consent can override any age-related minimum (Arthur and others, 2018).

treatment, balancing all the respective rights (Clapham, 2015). The general principle of “best interests” in the Children’s Convention is an illustration of this approach. While parents and guardians make decisions on behalf of their children, children have a right to participate meaningfully in decisions that affect them, with no clear line delimiting an appropriate age (Coyne and Harder, 2011). As children’s capacities evolve, the Children’s Convention expects parents to include them and eventually cede final control over such decisions to them when they are mature. One example of respecting children’s evolving capacities is in the shift in thinking about intersex infants. In the past, it was widely accepted that surgery should be performed immediately to assign the genitalia to one sex or the other. That attitude has largely been replaced by one of waiting for the children to make their own choice about surgery (Reis, 2019; Zillén and others, 2017). Without intersex children’s meaningful consent, such surgeries have been labelled violations of bodily integrity, tantamount to torture (UN HRC, 2016a).

Similarly, the categorical denial of the sexual and reproductive desires and choices of persons living with physical or developmental disabilities evidenced by giving authority to parents, guardians and institutions, or “substituted decision-making”, has been transformed into the standard of “supported decision-making”, where every effort is made to educate and ascertain the person’s will and enable them to execute it (UN CRPD, 2018, 2014).

Bodily integrity

As a general principle, rights related to bodily integrity prevent the State or third parties from intruding on someone's physical body without obtaining free and informed consent.

The foundation for the notion of informed consent in relation to bodily integrity flows from Article 7 of the Political Convention: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation" (UN General Assembly, 1966). This idea has been echoed in international and regional human rights treaties, including the Disability Rights Convention, Article 15 (UN General Assembly, 2007); the Children's

Convention, Article 37(a) (UN General Assembly, 1989); and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN General Assembly, 1984).

Bodily integrity has been interpreted by the Human Rights Committee as protected by the right to liberty and security of the person in the Political Convention (UN HRC, 2014) and by Article 7 of the Political Convention, which protects all individuals from cruel, inhuman or degrading treatment.

Rights to bodily integrity are formally recognized in human rights instruments. The Disabilities Rights Convention, for example, notes that "Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others" (UN General Assembly, 2007, Article 17). A number of regional human rights treaties recognize bodily integrity outright or as part of the right to humane treatment, for example, the African Union Banjul Charter (African Union, 1981, Article 4); the African Union Maputo Protocol (African Union, 2003, Article 4(1)); and the American Convention on Human Rights (OAS, 1969, Article 5(1)).

An array of sexual and reproductive health and rights matters have been adjudicated by regional human rights courts. For example, the Inter-American Court of Human Rights has found violations of the right to bodily integrity in cases of forced nudity and vaginal inspections (IACtHR, 2006), threats of rape and sexually transmissible infection (IACtHR, 2014) and a wide range of other forms of sexual violence (IACtHR, 2013, 2010).

RIGHTS TO BODILY AUTONOMY AND INTEGRITY ARE FORMALLY RECOGNIZED UNDER INTERNATIONAL HUMAN RIGHTS LAW

Obligations of States Parties

Rights to bodily autonomy and integrity are formally recognized under international human rights laws and address a range of reproductive and sexual health and rights matters. But how do these rights translate into what governments can, cannot or must do for the people and populations they serve?

Governments primarily observe their human rights duties through legislation, policy and budgetary appropriation; some actions can be taken immediately and others may be taken progressively over time so that rights are respected, protected and fulfilled (UN CESCR, 2016; Gruskin and Tarantola, 2002).

Remove barriers to individual decision-making

Respecting the rights to bodily autonomy and integrity requires governments to ensure that their laws, policies and programmes do not infringe on individuals' ability to make decisions about their reproductive and sexual lives. This means removing barriers that interfere with access to comprehensive sexual and reproductive health services, goods, education and information (UN CESCR, 2016).

Laws, policies and programming must take into account the differing needs and vulnerabilities of women, children, LGBTI communities, migrants, racial and ethnic minorities and people in rural areas, and ensure that measures to protect one group do not infringe on others along the way (UN CESCR, 2000).

According to the United Nations Committee on Civil and Political Rights, criminal laws related to contraception, comprehensive sexuality education, abortion and accessing information about sexual and reproductive health violate rights to bodily autonomy and integrity (UN CCPR, 2019; UN CESCR, 2016). Laws that require third-party authorization or consent (taking account of the evolving capacities of children) also violate rights (UN CEDAW, 1999).

Human rights treaty bodies have criticized States that have permitted third parties, whether parents, spouses or others, to obstruct individuals from making decisions about their own bodies and reproductive and sexual lives (UN CCPR, 2005).

Human rights treaties and agreements direct governments not to interfere with “adult consensual sexual activity in private” or to enact criminal laws against same-sex sexual activity among adults in “private” (UN CCPR, 1994, para. 8.2). Furthermore, laws that “criminalize” abortion, non-disclosure of HIV status and transgender identity or expression run afoul of bodily autonomy and integrity rights (UN CESCR, 2016, para. 40).

The United Nations Committee on Economic, Social and Cultural Rights states that laws and policies can fulfil a government's human rights obligations provided they are enabling and guarantee all individuals access to affordable, safe and effective contraceptives and comprehensive sexuality education, liberalize restrictive abortion laws, guarantee women and girls access to safe abortion services and quality post-abortion care, and

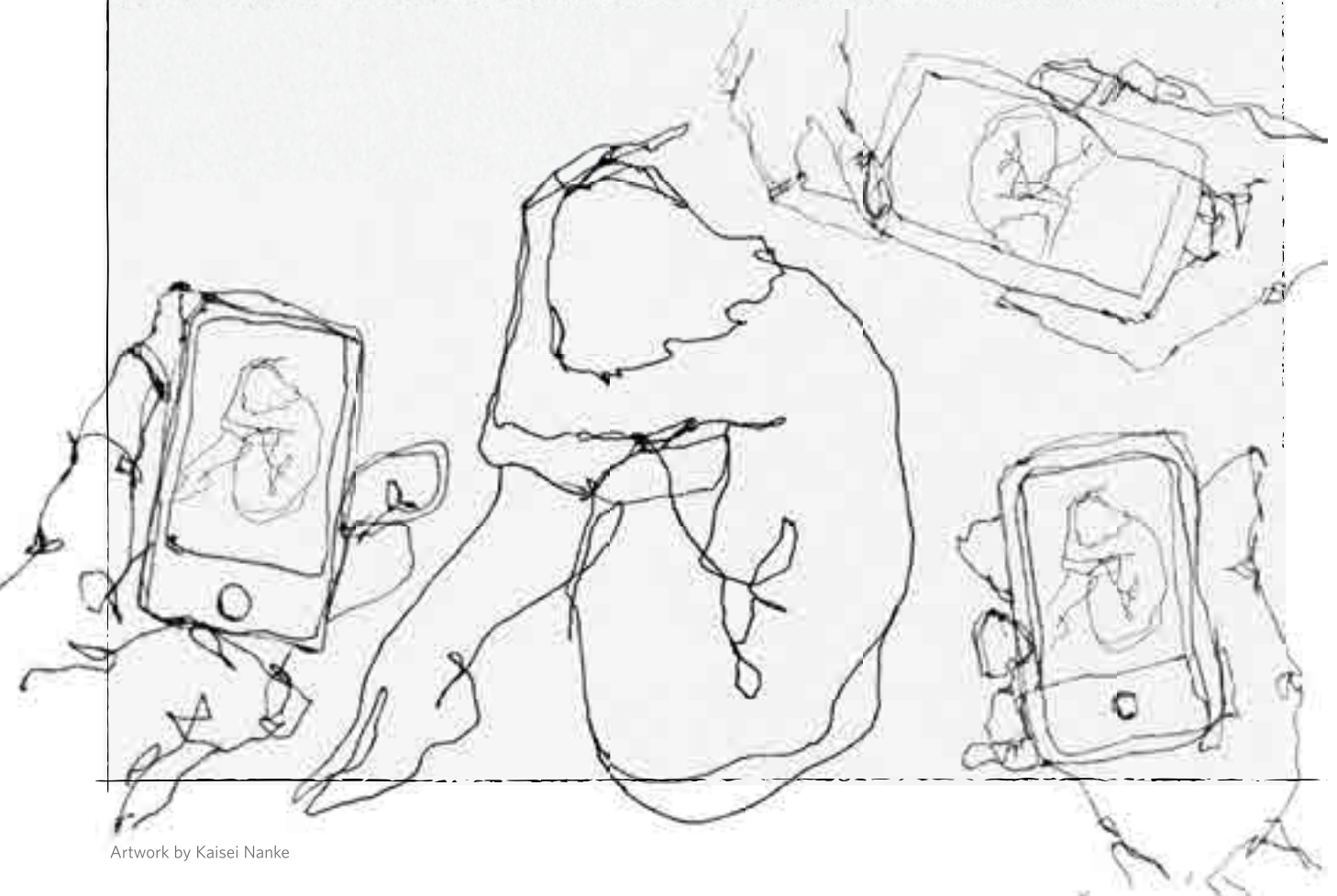
“Conversion therapy”

“Conversion therapy” aims to change sexual orientation and gender identities that do not conform to heteronormative social and cultural expectations. It employs methods such as “corrective rape”, aversion therapy, chemical castration and hormonal treatments, and even exorcism.

In 2020, the Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity published a report on practices of so-called conversion therapy. In it, he observed that all such practices share “the specific aim of interfering in [an individual’s] personal integrity and autonomy” (UN HRC, 2020,

para. 59). He detailed the psychological and physical pain and suffering conversion therapy causes and noted that treaty bodies have found these practices to violate the rights to equality and non-discrimination, health and freedom from torture and ill-treatment.

The Independent Expert recommended that States ban the practice of conversion therapy and take affirmative measures to protect bodily autonomy and integrity through interventions including eliminating prejudice and discrimination against LGBTI communities (UN HRC, 2020).



Artwork by Kaisei Nanke

respect women's right to make autonomous decisions about their sexual and reproductive health (UN CESCR, 2016).

Uphold adolescents' rights

Having accurate information about one's own body and health and understanding what it means is indispensable to exercising bodily autonomy (UN CESCR, 2016). This means ensuring that adolescents have such access "regardless of their marital status and whether their parents or guardians consent, with respect for their privacy and confidentiality" (UN CESCR, 2016, para. 44).

Some States have criminalized child marriage and sex under the age of 18, in the interest of protecting vulnerable populations from exploitation or harm (Khosla and others, 2017). But human rights advocates are generally sceptical about criminal prohibitions, despite their symbolic importance, because they disproportionately affect communities that are already marginalized and comparatively disempowered, and have few alternatives. Advocates instead recommend redressing the conditions that render such individuals and communities vulnerable to exploitation in the first place, such as providing economic opportunities for young women (Miller and Roseman, 2019).

Establish systems to redress rights violations

Protecting rights to bodily autonomy and integrity requires a functioning system to redress rights violations. The United Nations Committee on Economic, Social and Cultural Rights in 2016 called on governments to put into place laws, policies and programmes that

ACCURATE INFORMATION ABOUT ONE'S OWN BODY AND HEALTH... IS INDISPENSABLE TO EXERCISING BODILY AUTONOMY

"prevent, address and remediate violations of the right of all individuals to autonomous decision-making on matters regarding their sexual and reproductive health, free from violence, coercion and discrimination" (UN CESCR, 2016).

In addition to removing requirements for third-party authorization to access services and information, the Committee called for ending health-care professionals' "conscientious objection" to the provision of services and for requiring referrals to providers "capable of and willing to provide the services being sought" (UN CESCR, 2016, para. 43).

Laws that are aligned with human rights guarantee equal protection for all individuals aiming to exercise their rights to bodily autonomy and integrity. But all around the

The language of violation

In her years as a survivors' advocate in the United States, Leidy Londono has grown accustomed to the language of shock, fear and shame that people use when grappling with the aftermath of sexual assault. And she has listened to people struggle to put into words one particular form of sexual violation, a phenomenon that is pervasive yet poorly understood, even by those who experience or perpetrate it: reproductive coercion.

"It involves behaviours that a partner or someone uses to maintain power and control in a relationship that are connected to reproductive health," explained Londono, who has accompanied

survivors to hospitals and provided hotline counselling. She now works as an educator and programme manager at Planned Parenthood in Washington, DC. "It can take a lot of different forms. There are explicit attempts to impregnate a partner against their own wishes. It could be about controlling the outcomes of a pregnancy, coercing a partner to have unprotected sex, interfering either explicitly or implicitly with birth control methods, or lying or deceit around birth control methods."

Survivors lack a common language to describe the specific violation felt when they are denied ownership of their fertility or sexual

health, whether or not they consented to a sexual encounter. Without the words to identify this experience, they often express confusion and self-recrimination. Londono recalled one young person who discovered that their partner had secretly removed a condom during consensual sex—a practice known as stealthing. "At first they were like, 'Am I just exaggerating this?'"

The concept of reproductive coercion is relatively new, with most studies on the topic taking place in the last 20 years, often in the United States, where the prevalence of reproductive coercion is estimated at 15 to 25 per

"There's a universal involved here, and it is male entitlement to control female partners."



Leidy Londono has worked in person, over the phone and via online chat to provide support and information to survivors of sexual assault. Original artwork by Naomi Vona; photo © UNFPA/R. Zerzan.

cent (Park and others, 2016). But recent inquiries show that it is widespread globally, perpetrated not only by partners but even by families and community members (Grace and Fleming, 2016). It may even be abetted by health systems, via policies that

require husbands' permission before a woman can use family planning, for example.

Dipika Paul has worked for decades as a researcher in sexual and reproductive health in Bangladesh, yet even she says she was not familiar

with the term reproductive coercion. Rather, she and health workers and advocates spoke more generally about "barriers in family planning".

Today, Paul is an expert in the topic. As an adviser at Ipas in Dhaka, she sees many forms of

reproductive coercion. "With husbands... it can start with telling them, 'do not use any contraception', then women will follow their husband's opinion. And it also ranges to severe violence. Sometimes husbands withhold food or money if she wants to continue using contraception," Paul said. Often this pressure is related to "husbands' or other family members' desire for more children or desire for sons". Forced use of contraception and forced abortion are also seen, she added.

These coercive acts are not widely regarded as forms of violence because reproduction may be seen as a family decision. "In-laws, they play a big role," Paul said. This is particularly true for younger and underage wives; the median age of marriage is 16, according to a Demographic and Health Survey from 2018. "It is difficult for young women to take decisions alone."

And yet there is a clear link between reproductive coercion and violence. Paul estimates that, in a study she is currently conducting, about three in five women who said they had experienced reproductive coercion also experienced sexual or physical violence from their husbands.

Jay Silverman, a professor at the University of California, San Diego School of Medicine, began his career working with men and boys who had perpetrated intimate partner violence. He has since studied reproductive coercion in Bangladesh, India, Kenya, Niger and the United States. Even though reproductive coercion may sometimes be carried out by female family members, the violation is rooted in gender inequality, Silverman said.

"There's a universal involved here," he explained, "and it is male entitlement to control female partners... On some level, that sense that men do have, that entitlement to that control, is something that's ubiquitous in, I think, most of our societies."

Silverman and his colleagues, including Ipas in Bangladesh, are piloting tools to help health workers identify reproductive coercion, such as questions about partner attitudes and behaviour. Once coercion is acknowledged, women can reassert bodily autonomy by, for example, selecting family planning methods that are undetectable by a partner.

Even as women lack the language to describe reproductive coercion,

Silverman explained, "I also believe human beings innately resist against being controlled... There are many different coping strategies that women in communities around the world have developed to cope with reproductive coercion, including women supporting women. That is something that is just happening organically, everywhere. It always has, whether it be a neighbour or female family member hiding your pills for you or helping you get to a clinic." Where clinics give out pamphlets about reproductive coercion, partner violence and how to seek help, women often "take handfuls" so they can share the information with other women.

Much of the burden of addressing reproductive coercion falls to service providers, who often face a double bind: they must strike a balance between engaging men in reproductive health matters without ceding full decision-making power to them. "The ideal of male engagement in sexual and reproductive health and maternal and child health internationally has become a priority," Silverman said. Male involvement has been associated with increased family planning and contraceptive use and improved maternal and child

health outcomes (Kriel and others, 2019; Assaf and Davis, 2018). But when men wish to control the reproductive choices of their partner, “involving men is obviously detrimental”.

And men—indeed, people of all genders and sexual orientations—can also be victims of reproductive coercion. “Anyone can experience reproductive coercion,” said Londono. “Women in marginalized communities experience levels of violence at disproportionate rates, and that includes reproductive coercion... but that doesn’t negate the fact that I have talked to young boys and young men—men in general—who are trying to identify their own experiences and put it into words and contextualize it.”

Fluency in the language of reproductive coercion is needed, particularly among policymakers. “When our laws and our policies are vague and our language is ambiguous, it doesn’t provide for survivors,” Londono said.

And learning about bodily autonomy is also crucial. In one recent project, Paul said, “we talked to women, and they chose this terminology: ‘my body, my rights.’... They all agreed that we need to disseminate this among the population—that my body is mine.”

world, there are examples where protections are anything but equal. Violence and discrimination against people of diverse sexual orientation or gender identities, for example, is well-documented and has been perpetrated by State and non-State actors (UN HRC, 2016b).

Similarly, women and girls, especially those facing intersectional discrimination, such as those with disabilities or those who are members of ethnic or religious minorities, face higher rates of gender-based violence and disparities in access to justice and fair policing (UN CEDAW, 2015a). Impunity for sexual and gender-based violence, marital rape and “curative rape” targeted at gender-non-conforming individuals are other egregious examples of unequal protection under the law (UN CESCR, 2016).

Enabling everyone to exercise the rights to bodily autonomy and integrity

Fulfilling rights to bodily autonomy and integrity requires that governments make quality sexual and reproductive health information, services and methods available and accessible (UN CESCR, 2016, 2000). According to United Nations treaty bodies, this would entail services and information that support decisions about family formation (contraception, infertility treatment, maternal health care, safe abortion) and about sexual health (prevention of sexually transmitted infections, including HIV, comprehensive sexuality education, treatment for sexual dysfunction, prevention of sexual violence and care for survivors), and gender-affirmative

The right to reproductive health and rights in the Programme of Action

“Reproductive health is 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 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 rights 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. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.... Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on



the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents” (UNFPA, 1994). —Excerpts from the Programme of Action of the International Conference on Population and Development

Artwork by Kaisei Nanke

health care (World Professional Association for Transgender Health, 2011).

Services and information, as detailed by the United Nations Committee on Economic, Social and Cultural Rights, must be:

- *Available*—in sufficient quantities;
- *Accessible*—reachable and affordable by all;
- *Acceptable*—sensitive to gender, culture, age and medically ethical;
- *Quality*—meeting scientific and medical standards of care and delivered with respect for rights.

Having the means to exercise the rights related to bodily autonomy and integrity through reproductive and sexual health services is inseparable from the recognition of those rights in the first place. According to the United Nations Human Rights Council, “Health settings must empower users as rights holders to exercise autonomy and participate meaningfully

and actively in all matters concerning them, to make their own choices about their health, including sexual and reproductive health, and their treatment, with appropriate support where needed” (UN HRC, 2017, para. 43).

International human rights to bodily autonomy and integrity ensure that every person can make decisions that affect their sexual and reproductive lives and have the means to do so. This requires States to provide comprehensive, age- and culturally appropriate information about sexuality and reproduction, as well as the quality goods and services to effectuate those decisions, free from discrimination, coercion and violence.

Human rights provide the common ground upon which States build their national legal and policy standards to promote and protect bodily autonomy and integrity in the context of sexual and reproductive health. But many States still have a long way to go to ensure all people have the power to make their own decisions about health care, contraception and sex—and about many other dimensions of bodily autonomy.



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