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Tensions and exclusions: the knotty policy encounter between sexual and reproductive health and rights and HIV

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Conflicting frames

The International Conference on Population and Development or ICPD (Cairo, 1994) provided a global policy framework centred on reproductive rights instead of population control. Global standards on sexual and reproductive health and rights (SRHR) and on HIV rapidly expanded throughout the 1990s.¹ Considerable activist mobilisation in both arenas advanced health issues as politically salient decision-making venues where human rights and health advocacy were urgently needed, rather than scientific and technical showcases.

The ICPD, quickly followed by the Fourth World Conference on Women (1995), stressed that reproductive rights are anchored in governments' human rights obligations and development commitments, including to gender equality, health, bodily autonomy and the full spectrum of rights. The ICPD foregrounded individual rights that had been denied to women, whether in decision-making on if, when and with whom to have children, or accessing quality reproductive health services without violence, coercion or discrimination.

While the ICPD advanced an expansive understanding of sexual health and sexuality, and of HIV within a broad SRHR agenda, intergovernmental negotiations rejected an understanding of sexual rights *per se*, despite vociferous advocacy by many civil society groups engaging the process. In the face of difficult negotiations at the ICPD, compromise language of "sexual and reproductive health and reproductive rights" was finally agreed. Some of this has been ameliorated in later intergovernmental negotiations, although strong mobilisation of conservative forces has stymied these efforts. Still, SRHR actors continue to struggle with resistance to encompassing the full expression

of gender and sexual diversity and integrating all key populations.

Policy and programming dialogues on HIV proceeded parallel to and sometimes intersecting with that of SRH. While the ICPD focused on SRHR, the Global Strategy Framework on HIV/AIDS² advanced a human rights approach with a commitment to greater participation of people with AIDS. It also insisted on attention to those most at risk of contracting HIV. However, it failed to articulate the understanding of HIV as part of a broader SRHR agenda. As a result, critical SRHR issues have been left out of the HIV response, well-documented with regard to several issues such as the neglect of gender-based violence, abortion, and cervical cancer in the HIV response.^{3,4}

Global HIV frameworks, in contrast to the broad scope articulated in the ICPD process, have tended to advance a vertical approach. However, critics have called for a horizontal approach that would attend to structural health inequity. These critics have further drawn attention to the need to strengthen health system, though this is emerging more recently as a global health priority.^{5,6}

Tension and exclusions in implementation

Following the ICPD, a wide variety of stakeholders – supported by a small but significant set of bilateral and private foundation donors – set out to integrate SRHR pledges into national policies and align legal frameworks with human rights principles.⁷ Significantly, the ICPD defined reproductive health to include sexual health and a satisfying and safe sex life, and with this, a core set of services (commonly comprising contraception, safe abortion, maternity care, and prevention

and treatment of sexually transmitted infections and HIV). The World Health Organization now acknowledges these as a guaranteed minimum.⁸

However, implementation has too often omitted marginalised groups. Thus the focus on access to the full range of sexual and reproductive rights largely occluded the particular needs and rights claims of lesbians and other women who have sex with women, gay and other men who have sex with men, bisexuals, transgender, gender-non-conforming and intersex individuals, sex workers, people who use drugs, people living with HIV, refugees, migrants, and members of ethnic and racial minorities – those encompassed by “most at-risk” or “key populations” in the HIV context. While the work to realise the promise of ICPD helped bring some people and issues to the foreground (for instance, the rights of women living with HIV or the issue of coercive sterilisation of most marginalised women), it historically obscured others, such as gay men and transgender persons.

Polarised policy debates around SRHR, in which sexuality was a flashpoint, resulted in the marginalisation of key populations in SRHR discussions. UNAIDS defines key populations to include

“gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services.”⁹

SRHR has often been specifically associated with women and girls to the exclusion of all others, and sidelining sexual and gender diversity and marginalised groups in SRHR programmes, policies, services and advocacy.

In contrast to the ICPD, HIV actors focused on “key populations,” emphasising gay and other men who have sex with men, sex workers, drug users and transgender women, with an agenda to promote rights and challenge discrimination. The framing of most-at-risk or key populations put a spotlight on those who were being left behind as a result of structural and legal barriers. However, a frequent focus on stigma and discrimination sometimes concealed other groups among whom HIV was rising, including adolescent girls and young women. Moreover, lagging support for prevention efforts and investments meant little attention was paid to addressing structural inequalities and person-centred approaches to address the

broad SRHR of people. For example, the focus on HIV harm reduction for sex workers (many of whom are women) often omitted access to SRH services.

As rights-based approaches gain support, HIV advocates challenged the existing HIV discourse’s deeply moralistic tenor. Alternatives to the early disapprobation of deviance emphasised risk over aberration, ultimately settling on the concept of “key populations.” This “othering” generated stigma and discrimination against those flattened as health risks. Edstrom notes that this led

“to individuals being categorized as threats and to subsequent attempts to reduce the supply of threats by removing them or limiting their mobility ... they were seen as ‘vectors of transmission’ (like mosquitoes or rats in other epidemics) ... embodied ‘precursors’ to potential disease in other people.”¹⁰

This transmutation highlighted emerging “concentrated” epidemics, and promoted policies and programmes addressing the needs of discriminated and criminalised populations using a value-neutral HIV terminology, (e.g. “men who have sex with men” (“MSM”) or people living with HIV), so as to ensure prioritisation of the needs of key populations. However, this framing has failed to account for structural inequalities suffered by other groups such as adolescent girls and young women. Efforts to challenge stigma against key populations was advanced by efforts to avoid complex social and cultural connotations by using value-neutral terms succeeded. However, the new labels reasserted themselves as identity terminology, rather than behavioural descriptions, incorporating unexposed gendered and racialised assumptions, that ended up being equally exclusionary.¹¹

Tension between the SRHR and HIV communities also grew because of siloed and restrictive distribution of funds, including through national and donor funding streams, often expressed in stark and mutually exclusive distinctions (“key populations” versus “women and girls”, HIV versus SRHR). Resources were vastly insufficient to fully finance prevention, treatment, care and support among key populations or women and girls, or for SRHR. National policies and government investments favoured ideological design and political expedience, rather than evidence and rights, although not without resistance from both the SRHR and HIV communities.

Conclusion

Overall, the HIV movement has too often ignored the significant impact of HIV on women and girls who were contracting HIV or affected by it. At the same time, women's sexual health and rights groups have sometimes offered arguments relying upon essentialist understandings of gender, casting women and girls as a homogenous group, inherently vulnerable, naïve and uncomfortable with sexuality.

We write this essay as advocates and scholars who have occupied a variety of movement locations within SRHR and HIV. We have each negotiated the tensions in these movements. We have worried about how sexual and gender diversity have been sidelined in health and human rights standards and agreements and how HIV has set itself outside of SRHR, occluding the diversity and rights of women and girls. And we have cautioned against reinvoking binary and heteronormative understandings of sexuality, gender and bodies.

As we have shown, SRHR and HIV advocates, policymakers, and service providers have been out of synch with each other. This discordance stemmed from each's unique analytical and political trajectory, separate and restricted funding

streams, and distinct policy and programming trajectories. Rather than synergy between intersecting public health and rights issues, the sexual and reproductive health field and that of HIV ended up divided. This will not suffice for the future.

The ICPD 25th anniversary commemoration offers the opportunity to reimagine and realign our approaches to SRH and HIV. As the SDGs suggest, intersectional approaches may help us divert from conflicts over resources: our best opportunity is to deepen the collaboration among movements – work that is already well-advanced. It is time to build on achievements while we address the blind spots in each movement, especially to harness the power and promise of human rights discourse, which has been at the centre of both movements for the past three decades.

Disclosure statement

No potential conflict of interest was reported by the authors. The authors alone are responsible for the views expressed in this commentary and they do not necessarily represent the views, decisions or policies of the institutions with which they are affiliated.

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