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**CREA and partners submission to the**

**Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity,**

**for the IE’s Report to the Human Rights Council on the realisation of the right of persons affected by violence and discrimination based on sexual orientation and gender identity to the enjoyment of the highest attainable standard of physical and mental health**

Submitted 7 February 2022

**Background and Contact Details**

CREA is a global feminist human rights organization, led by feminists from the global South. CREA’s work draws upon the inherent value of a rights-based approach to sexuality and gender equality. CREA promotes, protects, and advances human rights by building feminist leadership, strengthening feminist organizations and movements, expanding sexual freedoms for all people, addressing structural causes for gender-based violence, and expanding and defending civic space.

Contact:

Subha Wijesiriwardena | subha@creaworld.org

**How, where and with whom we work**

CREA works at the community/local, national, regional and international levels. Since its foundation by Indian feminists in 2000, CREA maintains a strong connection to feminist movements South Asia. CREA has also worked for a decade in East Africa, in Kenya and Uganda, where we work at community and national levels. We also enjoy partnerships with feminists in the Middle East and North Africa region, and have strong partnerships with feminists and women’s human rights defenders in Mesoamerica, as well as engagement with feminist organizations in many other countries.

**Terminology and framework: Sexual and gender diversity, and diversity of sex characeristics**

In this submission, we respond to the Independent Expert’s call for inputs on “**Access: ensuring that LGTBI and GNC people have access to health care”**.

We interrogate:

A) challenges faced by diverse constituencies (as outlined below) when seeking access to health services, in the contexts where we work,

B) the impact on those communities, of being blocked from accessing healthcare,

C) the long-term impact of facing pathologization, stigma, and criminalisation on the health and well-being of these communities.

CREA brings a global South feminist lens to the struggle for sexual rights, reproductive freedom and gender equality for all people. We believe that when the state or a society acts to uphold or maintain norms based on sex, sexuality and gender through exclusion, discrimination, violence or control, it should concern us all.

In this document, while we give primacy to the framing above, rather than to specific identities, we at times, use the acronym **LBTIQ** to refer to lesbian and bisexual women, and trans, intersex, nonbinary and queer persons; we use **LGBTIQ** for lesbian, gay, bisexual, trans, intersex, nonbinary and queer persons; we use **GNC** to refer to gender non-conforming and nonbinary persons.

We also include here the concerns of sex workers, young people who are often the subjects of discrimination and penalisation based sexual and gender norms. We center experiences of persons with disabilities who are sexual and gender diverse, or of diverse sex characteristics. This is especially important due to the historical analytical separation between sexual and gender diversity and diversity of sex characteristics, and disability rights.

**Methodology**

We spoke to partners in Kenya, Uganda, Sri Lanka, India, Bangladesh, and Egypt. Their insight and contributions form the main body of this submission. The submission also benefited from desk research and the contributions of many people at CREA.

**Partners / experts consulted in the development of this submission:**

1. Niluka Gunawardena, Sri Lanka, disability and queer rights advocate, educator and researcher
2. Thenu Ranketh, Sri Lanka, trans rights activist and founder of Venasa Trans Network, a grassroots transmasculine-led trans rights group
3. All India Network of Sex Workers (AINSW)
4. National Transgender Advocacy Network of Kenya
5. Uganda LBQ Network
6. Grace Banu, anti caste and trans rights activist, India,
7. Ondede collective, India
8. An LGBTI organization in Bangladesh, who did not wish to be named
9. **Pathologization: how ableism, homophobia and transphobia work together, and its impact on health**

Frequent and pervasive pathologization of persons who are sexual and gender diverse or of diverse sex characteristics, subjects these communities to frequent human rights violations. The pathologization paradigm casts persons of diverse sexualities, genders and sex characteristics cast as “afflicted”, and in need of “treatment”.

Often, expressions of intersexphobia, homophobia and transphobia feature underlying ableism, where families, medical professionals and policymakers, are driven to “cure”, by a fear of variation and difference. This *perception* of ‘disability’, linked to a fear of non-normativity, can harm diverse people, including people with disabilities and those of diverse sexualities, genders and sex characteristics, and those who are both.

Niluka Gunwardena, in Colombo, Sri Lanka points to pervasive and unique forms of pathologization, “It is not just the medical pathologization that happens, but in a context like Sri Lanka, there are a host of other beliefs attached to those who are disabled and those who are LBTIQ. There is a strong belief that you are born disabled if you have sinned in a former life, and have accumulated ‘bad karma’. So there's this underlying ‘immoralisation’ of disability – i.e ‘you were born this way because you did something immoral’. And this applies also to those who are queer, trans or GNC, because those are considered afflictions. You are expected to win back ‘good karma’ by performing meritorious acts. Being queer *and* disabled is a double-bind!”, she says.

She points to how psycho-social disability and queerness are also conflated when a pathologization approach is taken, “My psycho-social disabilities are seen as a result of my being ‘sexually confused’, they are attributed to my queerness. But my family therefore believe that my psycho-social disabilities should be ‘cured’ by me being able to ‘live my life’, as should my queer desires, i.e. I should ‘get it out of my system’ – they’re confused when they see my psycho-social disabilities are an ongoing part of who I am, as is my queerness”.

Legal gender recognition

In many contexts, legal gender recognition criteria for trans persons require (pathologizing) medical tests and interventions, such as psychiatric diagnoses, mandatory hormone treatment, surgery, or sterilization. India’s 2019 Transgender Rights Act also makes it mandatory for trans people to undergo surgical procedures in order to be legally recognized as belonging to their gender, by the state. However, the law also provides a mandate to the state to provide gender-affirming treatments and surgeries to trans people, and necessary health insurance schemes that cover these treatments. Many advocates consider this to be progress, even with its limitations.

It is frequently seen that to ‘lean in’ to a pathologizing approach can have positive, pragmatic results for communities. Thenu Ranketh, a trans activist in Sri Lanka explains, for example, that in his context, from 2015, through two government circulars, and not legislation, the path to legal gender recognition has been won. The regulations require that trans person visit a psychiatrist at a government hospital, who then examines their history in order to certify them a “transgender person”. The psychiatrist has to see them over a period of about 6-8 months. Only by undergoing all the psychiatric sessions, can a trans person qualify for new identity documents, such as a birth certificate or national ID card with accurate gender markers. This eases the burdens on trans persons in Sri Lanka in navigating public services significantly, but it could be seen as an uncomfortable trade-off.

But Thenu thinks there is an up-side to this process. “There are arguments for self-certification”, says Thenu. “And from a human rights-angle, that is the right way”, he agrees. “However, transition can be a complicated process, it needs to be given the right amount of time, and people need to have the right guidance. That, we want to ensure,” Thenu says. “People who are trans or GNC are often suffering from a lot of trauma, having been impacted by stigma. We need healthcare which can address that. There are a number of social issues that need to be resolved, outside of the transition process”, he says. “Not all issues faced by trans or GNC people can be resolved by transitioning”.

“If we don’t take a very holistic approach to LGBTIQ healthcare, including allocating resources to mental healthcare, we put people in a very dangerous position. We hear of cases where people, especially young people, sometimes go towards the process of transition to avoid social stigma and discrimination in their lives, without really undestanding what it means. For example, I know of cases where young lesbian women think that transitioning might shield them from the intense stigma associated with same-sex desire we see here in Sri Lanka”, says Thenu. “They need healthcare services and social support which tells them that it is OK to be a lesbian, not to be forced into transition,” he says.

In Kenya, ‘leaning in’ to the pathologization of trans people, similar to sex workers, as a “key population affected by HIV/AIDS”, has also led to interesting gains and losses. It is considered a ‘win’, because this recognition means more state resources have been directed towards programs for trans people. The National Transgender Advocacy Network of Kenya also advocated for inclusion of transgender populations in the Kenya AIDS Strategic Framework (KASF), 2021-2025, which is seen as a bold step towards state recognition that transgender people really exist, even as limited to a sub-category of ‘key populations.’

A pathologization approach may provide acknowledgement. It can, however, expose trans and GNC persons to various dimensions of discrimination. Grace Banu, an Indian trans rights and anti-caste activist said, “Dalit bahujan and Adivasi persons are treated as testing labs by doctors who are not well-informed about gender-affirming procedures, especially as many of them cannot afford private healthcare”, pointing to how caste and other structures intersect to persistently exclude trans and GNC persons from receiving high-quality healthcare.

Coerced intersex surgeries

Another extreme form of discrimination and violence is surgery performed on intersex newborns. These surgeries are a part of coercive change efforts against persons with diverse sex characteristics, and are often done in formal medical settings.

A baseline study on Intersex Realities in East Africa by SIPD (Support Initative of People with Congenital Disorders), found that, “Culture, religion and morality are used by sections of communities”, to condemn “intersex people as a population haunted by witchcraft, whose redemption lies in the same. As a result, access to education, health care, legal services and justice becomes a challenge.”[[1]](#footnote-1) The study found that in up to 30% of cases, mutilations would be performed *without a single test* to understand whether the intersex condition would have any long-term health implications for the infant. African intersex activists have repeatedly called for an end to the violence against intersex infants and people[[2]](#footnote-2).

Intersex activists in Nepal[[3]](#footnote-3) have also repeatedly called for the state to act in favour of the rights of intersex people. They note that intersex children can be subjected to infanticide and child abandonment, genital mutilation, forced marriage, discrimination, abuse and bullying, among other forms of violence. In one succesful effort, in 2019 the State Government of Tamil Nadu, a state in south India, issued an order banning ‘sex reassignment surgeries’ (SRS) on intersex infants and children except in life-threatening situations[[4]](#footnote-4) [[5]](#footnote-5).

Stigma, shame and discrimination

Due to pathologization, trans and GNC persons in India report experiences of shame, ridicule and discrimination in public healthcare settings, with most private healthcare settings being inaccessible to them. They are denied treatment and care in alignment with their needs and with their gender, and in cases where they are living with HIV/AIDS, they face double discrimination[[6]](#footnote-6) [[7]](#footnote-7).

This affirms our findings that trans people are at high risk for becoming infected with HIV, due to a number of structural reasons, where the most effective response is to ensure adequate comprehensive sexuality education, access to health services and freedom from discrimination and violence. Trans activists Ondede also said, “Transgender persons face discrimination and invasive questioning during medical examinations in hospitals. Doctors exhibit great curiosity, want to see our private parts, and ask rude questions about breast implants, surgery, voice therapy, hormone therapy etc., which is unacceptable.”

Health services for trans people

Grace Banu told us, “Transgender and gender non-conforming persons have multiple health needs, including transition-related (external hormones, gender-affirmative surgeries), sex related (information on safe sex, ART services) and healthcare services for old trans persons”. Banu also said, “Most of the state’s focus is on ART needs, even though trans persons have had horrifying experiences with gender-affirmative surgeries including infection, scarring etc.”

Activists at Ondede told us, “Most healthcare professionals do not have adequate information on gender affirming procedures including ‘sex reassignment’ surgery. They are not even aware of who a transgender persons, signaling a failure of the government in creating awareness.” This is important to note in light of the recently passed Transgender Persons (Protection of Rights) Act, 2019 which mandates appropriate governments to take measures for realization of the right to health of transgender persons[[8]](#footnote-8).

Another persistent issue of concern is lack of access to the full suite of reproductive and sexual health services for trans persons. “We have almost no sexual and reproductive healthcare, when it comes to trans and GNC persons, in Sri Lanka,” says Thenu. “The knowledge about SRHR for trans persons is very low among hospital staff, even in hospitals where they are known for supporting trans persons in transition”, he says.

Researchers and activists in Sri Lanka[[9]](#footnote-9) noted in a study that trans people are almost never a part of the debate and the discussion about access to abortion. Trans people in Sri Lanka noted the need to have reproductive options discussed with them. One respondent said, “As a trans person transitioning medically, it is my experience that not a single doctor will ever ask you, ‘Do you want to preserve your eggs?’ The idea is, ‘Oh, now you’re a man.’ No one talks you through the options. We are left with no avenues to produce offspring”[[10]](#footnote-10).

Health services for LBQ women

Ableism and homophobia and transphobia are also seen working together when disabled LBTIQ people are seen as being devoid of sexuality, including sexual desire, and as devoid of gender identity and expression. “Disabled LBTIQ people are seen as asexual beings, or at most, are assumed heterosexual”, says Niluka.

Niluka also spoke about the extreme vulnerability that LBTIQ-identifying disabled people find themselves in, when trying to avail themselves of healthcare services, even mental healthcare services. “I have been to mental health professionals who have told me that marrying a man would ‘cure’ me of all my problems. I have also faced sexual harassment by certified mental health professionals, upon disclosing that I was queer”, she says of her experiences in Sri Lanka.

Conclusions: The Convention on the Rights of Persons with Disabilities[[11]](#footnote-11) and the Convention Against Toruture both see forced or coerced treatments are seen as a violation of human rights. The Yogyakarta Principles[[12]](#footnote-12) + 10, developed in 2017, Principle 32 explicitly states: “Everyone has the right to bodily and mental integrity, autonomy and self-determination irrespective of sexual orientation, gender identity, gender expression or sex characteristics.”[[13]](#footnote-13) The Independent Expert on SOGI has stated, in his report to the Human Rights Council in 2021, that forced surgeries on intersex infants, and other coerced change efforts were a violation of the fundamental human right to bodily autonomy[[14]](#footnote-14).

1. **Who has the right to consent?: Conceptualizing legal capacity, autonomy and consent, and their impact on health**

Consent is central to the health and wellbeing of all persons, and is central to the achievement of full sexual rights, reproductive rights, and gender equality. Consent is guaranteed by recognizing all individuals as autonomous subjects who are equal in their rights to fully informed decision-making. Unfortunately, families, communities and the state deem some people as incapable of making informed decisions about their own lives and health. Sex workers, young people, people with disabilities, and sexual and gender diverse persons and persons of diverse sex characteristics (and those who are more than one of those) often fall into this category.

In these cases, ‘guardianship’ models, and other substitute decision-making mechanisms are introduced, even if they refuse to acknowledge the person’s capacity for decision-making. This puts the legal responsibility of making decisions about a person’s health and life in the hands of others – most often, one’s natal family or state-appointed guardians.

Legal capacity and disability

The denial of legal capacity comes formally (through courts) and informally (in practice) with wide-ranging impacts on a person’s ability to access healthcare and justice more generally.

For example, The Mental Health Bill of Uganda recognizes the right to exercise legal capacity but puts in place a substitute decision-making regime in which other people can make decisions on behalf of persons with disabilities, and those *perceived* to have a disability, which can, as we have shown, include persons of diverse sexualities, genders and sex characteristics.

In Kenya, Section 129 of the Penal Code Uganda and Section 146 Penal Code creates the offence of “defilement of an imbecile”. The underlying assumptions of these offences, is that a person with disability cannot ever fully consent to sex. This is explicit in Section 43(4) (e) of the Sexual Offences Act, that states that people with ‘mental impairment’ cannot give consent for intimate sexual relationships. This is used to justify, for instance, forced sterilization of women with disabilities (as has been reported in Kenya). Legal guardians, rather than the individual themselves, provide this consent to sterilization. Forced sterilization, as well as other forms of forced treatment, is a grave human rights violation[[15]](#footnote-15).

These legal provisions pave the way for a dangerous shifting of decision-making power into the hands of legal guardians, doctors and natal families. As Niluka puts it, “Especially if you have a psycho-social disability in this country (Sri Lanka), you are deemed not able to take responsibility for your life. On top of that, being queer, it’s a very dangerous combination”.

The denial of rights is further exacerbated by the reality of institutionalization. As Niluka comments, “How do you even begin a conversation about sexuality and gender identity in an institutional setting? In institutional settings, the talk of sexuality, if any, would be very limited to rudimentary exercises, such as archaic ‘sex-ed’ talks etc. These assume heterosexuality”, eliminating the possibility of safe spaces to “talk about queer realities, or non-normative behaviours or identites”, says Niluka. “This is why forced sterilizations are seen as an ‘efficient’ and ‘expedient’ way of dealing with ‘the problem’; we see this continuous infantilization of disabled LBTIQ people''.

Legal capacity and trans identity

The erasure of autonomy and individual consent of sexual and gender diverse people and persons of diverse sex characteristics, in policy and legislation, is also seen in legislation and policy about trans and GNC persons. For example, in India’s Transgender Persons (Protection of Rights) Act of 2019, the law gives the courts the power of sending trans persons to ‘rehabilitation’ homes, if members of the natal family (family defined as related by blood, marriage or legal adoption), are ‘unable to care’ for the said trans person[[16]](#footnote-16), indicating the assumption that the natal family are best-placed to care for trans persons.

India’s 2018 ‘anti-trafficking’ Bill, categorized even the administration of hormones for early sexual maturity, a practice common among young trans and GNC persons, as an aggravated form of trafficking, once again reflecting the state’s refusal to recognize individual consent and autonomy in the case of certain groups.

Legal capacity and sex work

Sex workers are also seen as having diminished ability to give or withdraw consent, and make decisions about their lives. In many contexts, sex workers are seen as being either in a permanent state of consent to sex or a permanent state of victimhood. Sex workers from AINSW told us, “Though there has been some improvement in how police officers and medical professionals respond when sex workers file rape or harassment complaints, there is still a lot of stigma and blame placed on sex workers. This is especially true in the case of transgender sex workers who are blamed for violence they face. Officials often make remarks suggesting that sex workers cannot be raped, or asking who would bother to rape a sex worker, negating their consent.”

Conclusions: Countries where the CRPD has been ratified must abolish substitute decision-making regimes and put in place supported decision-making models[[17]](#footnote-17).

1. **Sexual and gender diversity and carceral systems: criminalization, stigma and and the long-term impact on health of LBTIQ persons**

Carceral and punitive policies and practices are widely adopted and used by states to punish, curtail and restrict behaviours deemed outside the bounds of the social contract. These can include incarceration, policing, and other forms of surveillance and punishment.

An underlying discomfort with difference – the same forces which drive pathologization – is often understood by scholars and practitioners to be the driving force behind carceral and punitive systems and approaches, which aim to ‘correct’ social elements (including behaviours and individuals) deemed disruptive to a perceived natural order -- i.e ‘the way things should be’[[18]](#footnote-18).

Criminalization of sexuality and identity refers to formal or informal control over a person’s gender, sexuality or profession, restricting their right to bodily autonomy. Often the criminalization of sexuality and identity is done with the pretense of ‘protecting’ – women, LGBTIQ people, sex workers, and young people – from violence. Alternatively, it is used to ‘protect’ society from transgressive elements. Far too often, criminalization in the name of protection does not advance rights but to the contrary results in discrimination, violence, harassment, extortion and incarceration.

“When you live in a context where same-sex sex is criminalized, and psycho social disabilities and intellectual disabilities are also heavily criminalized, certain groups of people are especially vulnerable to the effects of criminalisation and incarceration” Niluka said to us of her experience in Sri Lanka.

Legal frameworks for incarceration and institutionalization

Virtually every country in the world uses criminal law[[19]](#footnote-19) to deter and punish sexual conduct deemed violent, coercive, or otherwise ‘morally objectionable’, thus criminalizing non heteronormative sexuality and gender expression and identity. In many countries across the global South, colonial-era ‘anti-sodomy’ laws have survived long beyond independence.

For example, in Kenya, sodomy laws and laws about “gross indecency” are effectively seen as criminalizing non-normative sexual acts and behaviours, punishable with imprisonment, under penal codes 162 and 165. In India, until 2018, similar British-era penal code known as Section 377 was effectively seen as ‘criminalizing homosexuality’; in Sri Lanka, the same laws under Sections 365 and 365A criminalizes “carnal intercourse against the order of nature".

Trans persons are penalized through various provisions, even if not technically deemed criminal, for example through cross-dressing laws, or other laws which regulate public space. In India, the state criminalises many avenues of income for trans persons, such as begging, through ‘anti-begging’ laws, and ‘public nuisance’ laws, leaving trans people vulnerable to arrest, abuse at the hands of law enforcement and incarceration.

Sex workers, transpersons and LBQ persons are quite likely to be at risk of being incarcerated, especially if they are poor, homeless, disabled, or otherwise structurally excluded, and face high volumes of violence when in custodial care. Restrictions in legal capacity also have direct links to forced treatments and carceral practices such as forced detention or involuntary institutionalisation.

Legal frameworks reinforce this such as in the Constitution of Uganda which permits the deprivation of liberty of persons on the basis of their disability through forced detention and involuntary institutionalization.

Criminalisation and incarceration of trans persons

Once incarcerated, trans persons can face unique forms of violence. In many contexts, court verdicts and government policies have clear provisions for placing trans persons in the wards of their choosing, rather than assigning them to a ward in alignment with the sex assigned to them at birth (e.g. NATIONAL LEGAL SERVICES AUTHORITY (NALSA) VS. UNION OF INDIA judgment in India, (2014) 5 SCC 438). However, we find that across the board, trans persons are subjected to invasive examinations at the outset and often placed in the ward aligning with the sex assigned to them at their birth[[20]](#footnote-20) [[21]](#footnote-21).

“A lot of trans people may be perceived or seen as homosexual, since law enforcement or state officials have no desire to recognize trans identity,” says Thenu, about Sri Lanka. “So even though trans identity is not technically criminalized, we are sometimes still brought in under Sections 365 or 365A, which are the laws which criminalize same-sex sexual conduct”, he says. “We also have Section 399, which is the criminal law which forbids ‘impersonation’. Sometimes this law is used by law enforcement against trans persons,” says Thenu.

“We have a big problem when trans people face incarceration in Sri Lanka, especially those who have not undergone surgical interventions. They are placed with the inmates whose gender aligns with their sex assigned at birth. Either way, trans people are in a definite bind once they go to jail or prison, because they face abuse or violence no matter which ward they’re placed in, and they’re considered a danger to others, by other inmates and the prison guards, no matter what”, Thenu says. In addition to being abused in prison, many trans persons also report not being treated humanely, like through not being given access to necessary medication and medical therapies once they are incarcerated. Being denied hormone replacement therapy as required, for example, can have devastating consequences for trans persons, as has been documented in prisons in India[[22]](#footnote-22).

Criminalisation and incarceration of sex workers

Laws which criminalize aspects of sex work (such as ‘anti-trafficking’ policies) are harmful and are used to criminalize or penalize LGBTIQ persons, especially those who are socially and economically vulnerable, such as trans and GNC persons, young LGBTIQ persons who are homeless, and those having had to flee their natal families due to family violence, who may choose sex work. Sometimes, LGBTIQ persons are penalized using anti-sex work laws (e.g. the 2018 ‘anti-trafficking’ bill in India, see page 9), *even if they are not engaged in sex work*, due to pervasive stereotypes which cast all LGBTIQ persons as sex workers.

The 2021 version of an ‘anti-trafficking’ bill in India has been deemed dangerous by critics and activists. Activists and critics note that ‘trafficking’ is not carefully defined, leaving it open to abuse, and further that, “Particularly concerning is the bill’s over-reliance on criminalisation as a method of deterrent.[[23]](#footnote-23)”

If incarcerated, sex workers are treated inhumanely due to pervasive harmful stereotypes and stigma about sex workers. AINSW told us that in India, “Many sex workers are detained or arrested under the Immoral Traffic Prevention Act, 1956, and other criminal law provisions. They face violence, rape and harassment within prisons. They do not have access to menstruation related products, not even sanitary pads are provided”.

The stigma of being a criminalized group often impedes accessing healthcare. AINSW told us, “Sometimes sex workers are made to mandatorily undertake HIV testing” when in a medical setting, though this practice has been clearly stated to be a rights violation by UNAIDS[[24]](#footnote-24) and UNHCR[[25]](#footnote-25), and “Doctors look at sex workers with disgust, their gaze makes it feel like the sex workers are animals,” they said.

Long-term impact on health and wellbeing

Not only does being criminalized, and repeatedly stigmatized, mean that LBTIQ people face severe challenges in accessing healthcare – being criminalized, incarcerated, policed and penalized also carries with it long-term health impact.

In a meta-study conducted by the Global Network of Sex Work Projects (NSWP), they found that there were severe long-term consequences to sex workers’ health by being criminalized, policed and penalized. For example, they found that sex workers who had experienced repressive policing were three times more likely to experience incidences of violence, and twice as likely to have HIV or an STI infection. Three studies that examined mental health showed that recent incarceration, arrest, and increased police presence were associated with poorer mental health[[26]](#footnote-26).

Our partner in Egypt has noted that persons of diverse sexualities and genders, and diverse sex characteristics, face many “existing challenges in access to health, because they often face  obstacles in accessing this right due to stigma, discrimination, pathologization, and  criminalization. The multiple and intersecting vulnerabilities experienced by LGBTIQ people place them at higher risk of developing mental health  issues, including anxiety, depression and self-harm for which there is often little to no  access to specialised psychosocial services.”[[27]](#footnote-27)

Incarceration is a catalyst for worsening health[[28]](#footnote-28), and numerous studies show that being incarcerated even once can have resounding effects on many stages of one’s life, even after release. In contexts where sexual and gender diverse persons are criminalized and are highly vulnerable to state violence, studies show the long-term devastating mental health impact, akin to what is known as “minority stress” (though we refute the idea that LGBTIQ people are a minority).

Many experts also now believe that the impact of being criminalized, penalized or incarcerated can stretch beyond one’s own lifetime. In the Discussion Paper on “Re-thinking criminalization: drugs, sex work, same-sex relations, and HIV” by the UN Special Rapporteur on the Right to Health (2021, Handover Dialogues[[29]](#footnote-29)), they state, “Criminalisation’s impact on the right to health goes beyond direct impacts on physical health and access to healthcare. It has health consequences that transcend individuals and cross generations… Research shows the intergenerational negative impact of the incarceration of parents on families, including consequences for social inclusion, educational attainment, housing status, and, ultimately, health.”

Criminalisation of surrogacy

In addition to holding criminalized identities, people of diverse sexualities, genders and diverse sex characteristics also face other barriers created by criminal laws, when it comes to making health decisions, especially reproductive health decisions. While the criminalisation of abortion has been shown to have adverse effects on the right to health for many diverse people, the criminalisation of surrogacy also needs to be thoroughly examined for its consequences.

For example, a new bill in Kenya, dubbed the Assisted Reproductive Technology Bill, 2019[[30]](#footnote-30), passed last November by the National Assembly seeks to assist individuals, including intersex people or couples unable to bear children due to infertility, to procure surrogates. Kenyan lawmakers are now debating replacing the term “couple”, with “husband and wife”, a move widely seen by Kenyan LGBTIQ activists as aiming to exclude lesbian and gay persons[[31]](#footnote-31).

In 2019, CEDAW (the Committee for the Elimination of al forms of Discrimination Against Women) concluded that Cambodia, who had criminalized surrogacy in 2016, had to abolish its laws criminalizing surrogacy, citing the harassment and criminalisation of tens of women[[32]](#footnote-32). The committee they were “particularly concerned that such an obligation creates an additional financial and emotional burden on women who are in precarious situations, which led them to act as surrogates in the first place… and that they face discrimination and stigma from their families and communities for having acted as surrogates.”

Surrogacy has always been central to people of diverse sexualities, genders and sex characteristics forming families. But the criminalisation of surrogacy is essential to our analysis because it is simply another frontier on which bodily autonomy and sexual and reproductive autonomy are being regulated, criminalized and curtailed, and non-normativity is being challenged. Any debate about surrogacy which presumes that those who choose to become surrogates lack the decision-making ability to do so, is hindered by a bias which doesn’t recognize every person’s right to autonomy and legal capacity. An emphasis on structural and root causes is urgently needed, as CEDAW noted, over punitive measures and criminal sanctions.

In India, where commercial surrogacy had thrived for many years, and which had been considered a ‘haven’ for those seeking surrogates, new laws may sound a death knell for potential surrogates and would-be parents alike. The main thrust of the new laws (2021/2022) is that the government aims to prohibit commercial surrogacy in India henceforth; accepting funds for surrogacy services will become a non-bailable offence. Indian feminist activist Prabha Kotiswaran, among others, has strongly criticised this, saying that “The SRA [Surrogacy Regulation Act] renders women’s reproductive labour entirely invisible”[[33]](#footnote-33).

Single men, cohabiting heterosexual couples, same-gender couples and persons of diverse sexualities and genders cannot access these services, according to these laws, which “go against the tide of several path-breaking Supreme Court decisions which recognize the right of same-sex couples to have legal relationships as well as a woman’s right to reproductive right to autonomy which is part of her guaranteed right to privacy”, says Kotiswaran[[34]](#footnote-34).

Conclusions: The criminalisation of surrogacy, or the retraction of laws which allowed and regulated surrogacy in some contexts, signals the broader trend globally towards the restriction and curtailment bodily autonomy and sexual and reproductive rights, with a clear disregard for the right of sexual and gender diverse persons and persons of diverse sex characteristics to form families. It is essential for the Independent Expert on SOGI to address surrogacy as an issue of bodily autonomy and reproductive rights, to contribute to, and challenge discourses at the United Nations which conflate surrogacy practices with the sale, exploitation and trafficking of children, and to call for non-punitive, non-carceral, human rights-based approaches from states.

1. Baseline Survery on Intersex Realities in East Africa: <https://sipdug.org/wp-content/uploads/2019/03/SIPD-Baseline-Survey-on-Intersex-in-East-Africa.pdf> [↑](#footnote-ref-1)
2. Public Statement by African Intersex Movement: <https://www.astraeafoundation.org/stories/public-statement-african-intersex-movement/> [↑](#footnote-ref-2)
3. Report to CEDAW, Nepal: <https://intersexasia.org/wp-content/uploads/2019/09/2018-CEDAW-Nepal-NGO-Intersex-IGM.pdf> [↑](#footnote-ref-3)
4. CLPR: <https://translaw.clpr.org.in/legislation/tamil-nadu-government-order-banning-surgeries-on-intersex-infants-2019/> [↑](#footnote-ref-4)
5. The Order relies on WHO’s Report on [“Sexual Health Human Rights & Law”](https://www.who.int/reproductivehealth/publications/sexual_health/sexual-health-human-rights-law/en/) which highlights institutional violence and forced interventions. Many interventions are irreversible with life-long consequences, and are often medically unnecessary. [↑](#footnote-ref-5)
6. ‘How could you have been raped?’: New study on how India’s transgender people face bias from doctors: <https://scroll.in/pulse/856285/transphobia-among-indian-doctors-study-aims-to-uncover-reasons-for-bias-against-transgender-people> [↑](#footnote-ref-6)
7. Interview with Ondede [↑](#footnote-ref-7)
8. See Section 15: “The appropriate Government shall take the following measures in relation to transgender persons, namely:— (a) to set up separate human immunodeficiency virus Sero-surveillance Centres to conduct sero-surveillance for such persons in accordance with the guidelines issued by the National AIDS Control Organisation in this behalf; (b) to provide for medical care facility including sex reassignment surgery and hormonal therapy; (c) before and after sex reassignment surgery and hormonal therapy counselling; (d) bring out a Health Manual related to sex reassignment surgery in accordance with the World Profession Association for Transgender Health guidelines; (e) review of medical curriculum and research for doctors to address their specific health issues; (f) to facilitate access to transgender persons in hospitals and other healthcare institutions and centres; (g) provision for coverage of medical expenses by a comprehensive insurance scheme for Sex Reassignment Surgery, hormonal therapy, laser therapy or any other health issues of transgender persons” [↑](#footnote-ref-8)
9. “Acts of Agency”: <https://www.researchgate.net/publication/345337282_Acts_of_Agency_Exploring_a_Feminist_Approach_to_Abortion_Research_in_Sri_Lanka> [↑](#footnote-ref-9)
10. *Ibid*  [↑](#footnote-ref-10)
11. As stipulated by the Convention on the Rights of Persons with Disabilities (CRPD) in Article 25 (Health) and Article 14 (Liberty and security of the persons), coercive and forced health interventions are prohibited, and any and all health services require a person’s consent. [↑](#footnote-ref-11)
12. A set of international legal principles on the application of international law to human

rights violations based on sexual orientation and gender identity [↑](#footnote-ref-12)
13. Yogyakarta Principles+10: <http://yogyakartaprinciples.org/wp-content/uploads/2017/11/A5_yogyakartaWEB-2.pdf> [↑](#footnote-ref-13)
14. <https://undocs.org/A/HRC/47/27> [↑](#footnote-ref-14)
15. Convention on the Rights of Persons with Disabilities Articles 25 (Health) and 14 (Liberty and security of persons with disabilities). [↑](#footnote-ref-15)
16. A Critique Of Transgender Persons (Protection Of Rights) Bill, 2019: <https://feminisminindia.com/2019/08/05/critique-transgender-persons-protection-of-rights-bill-2019/> [↑](#footnote-ref-16)
17. In General Comment One on CRPD Article 12 (Equal recognition before the law), denial of legal capacity and detention against one’s will without their consent or the consent of their supported decision-maker is equal to arbitrary deprivation of liberty. [↑](#footnote-ref-17)
18. *“The reach of carcerality extends far beyond formal incarceration itself, which includes but is not limited to state and federal prisons, local jails, immigrant and juvenile detention centers, military prisons, and carceral programs of probation and parole. The concept of carcerality captures the many ways in which the carceral state shapes and organizes society and culture through policies and logic of control, surveillance, criminalization, and un-freedom”* [University of Michigan’s Carceral State Project: Introduction](https://sites.lsa.umich.edu/dcc-project/) [↑](#footnote-ref-18)
19. Criminal law is understood to include penal codes and provisions, criminal procedural codes, and evidence laws. [↑](#footnote-ref-19)
20. Lost Identity (Commonwealth Human Rights Initiative): [https://www.humanrightsinitiative.org/download/1606377171Lost%20Identity%20Transgender%20Persons%20in%20Indian%20Prisons.pdf](https://www.humanrightsinitiative.org/download/1606377171Lost%2520Identity%2520Transgender%2520Persons%2520in%2520Indian%2520Prisons.pdf) [↑](#footnote-ref-20)
21. Manifold challenges faced by imprisoned transgender persons in South Asia: <https://www.southasiamonitor.org/spotlight/manifold-challenges-faced-imprisoned-transgender-persons-south-asia>; <https://p39ablog.com/2021/02/10/existing-beyond-constitutional-rights-transgender-persons-in-indian-prisons/> [↑](#footnote-ref-21)
22. Misgendering, Sexual Violence, Harassment: What it Is to Be a Transgender Person in an Indian Prison: <https://thewire.in/lgbtqia/transgender-prisoners-india> [↑](#footnote-ref-22)
23. India’s new trafficking bill: <https://www.opendemocracy.net/en/beyond-trafficking-and-slavery/indias-new-trafficking-bill-undermines-access-to-work-and-labour-rights/> [↑](#footnote-ref-23)
24. UNAIDS policy on testing: <https://data.unaids.org/publications/irc-pub03/counselpol_en.pdf>= [↑](#footnote-ref-24)
25. Refugees and AIDS: <https://www.unhcr.org/406d65284.pdf> [↑](#footnote-ref-25)
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access to services? (NSWP): <https://www.nswp.org/sites/nswp.org/files/health-impacts-of-sex-work-criminalisation-review_policy-brief_final.pdf> [↑](#footnote-ref-26)
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Submission on ‘Violence and its impact on the right to health’, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, January 18, 2022. [↑](#footnote-ref-27)
28. Incarceration as a catalyst for worsening health: <https://healthandjusticejournal.biomedcentral.com/articles/10.1186/2194-7899-1-3> [↑](#footnote-ref-28)
29. Handover Dialogues, discussion paper on rethinking criminalisation: <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2469/2021/12/Discussion-Paper_HD3_final.pdf> [↑](#footnote-ref-29)
30. [http://www.parliament.go.ke/sites/default/files/2021-03/The%20Assisted%20Reproductive%20Technology%20Bill%20%20%28National%20Assembly%20Bill%20No.%2034%20OF%202019%29.pdf](http://www.parliament.go.ke/sites/default/files/2021-03/The%2520Assisted%2520Reproductive%2520Technology%2520Bill%2520%2520%28National%2520Assembly%2520Bill%2520No.%252034%2520OF%25202019%29.pdf) [↑](#footnote-ref-30)
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34. *Ibid* [↑](#footnote-ref-34)