

***Notes on a theme: Indirect discrimination on bases including sexual orientation and gender identity in the context of health and in light of commitments to cross-movement solidarity\****

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INTRODUCTION: Health, health justice, and the multi-directional operations of indirect discrimination claims

Here, we build on the “centrifugal and movement thinking” of Ali Miller’s earlier paper for this workshop series,<sup>1</sup> which asked whether the ways in which we identify, define, and document the doctrinal and narrative aspects of sexual and gender rights (including, but not limited to, rights arising in the sexual orientation and gender identity (SOGI) framework) tend to open or close the possibilities for coalitions and joint advocacy work among rights groups. As our discussion in the fall made clear, indirect discrimination almost always implicates the rights of more than one group and the consequences of such discrimination are often multiple and distinct across different populations, including for those within the SOGI world.

This commentary centers health, and a health justice approach,<sup>2</sup> as particularly revealing of the potential and pitfalls presented by the multi-directional operations of indirect discrimination claims because health encompasses so many distinct processes at the individual body, intra- and inter-personal, and institutional level. Health justice is both a field of work and an analytic framing:

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\* If we had more time, this would be shorter [apparently per Cicero, Pascal, and Mark Twain]

<sup>1</sup> Alice Miller, “Indirect Discrimination: Turning a Regressive Space into a Site for Coalitional Action” (paper presented at the Workshop on Indirect Discrimination and Sexual Orientation and Gender Identity, Harvard Law School, 16 October 2020), available at [http://hrp.law.harvard.edu/wp-content/uploads/2021/05/IndirectDiscrimination\\_WorkshopProceedings\\_October2020.pdf](http://hrp.law.harvard.edu/wp-content/uploads/2021/05/IndirectDiscrimination_WorkshopProceedings_October2020.pdf).

<sup>2</sup> Emily A. Benfer, “Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Justice,” *American University Law Review* 65 (2015): 275; Angela P. Harris and Aysha Pamukcu, “The Civil Rights of Health: A New Approach to Challenging Structural Inequality,” *UCLA Law Review* 67 (2020): 758; Amy Kapczynski, “The Right to Medicines in an Age of Neoliberalism,” *Humanity: An International Journal of Human Rights, Humanitarianism, and Development* 10, no. 1 (2019): 79-107; Gregg Gonsalves and Amy Kapczynski, “The New Politics of Care,” *Boston Review*, 27 April 2020, <http://bostonreview.net/politics/gregg-gonsalves-amy-kapczynski-new-politics-care>.

here, we use the frame to enable us to consider law-associated discriminations as both a *cause and a consequence of ill-health*.<sup>3</sup> We begin, for example, with a case study of the gendered quarantine measures implemented in some Latin American countries and cities as an example of indirect discrimination arising in COVID times that highlights not only the harms to gender-diverse individuals but also the fact that these measures derive from and perpetuate gender stereotypes in a way that harms a wider range of individuals, especially cis-gender women. We argue that the gendered quarantine measures reveal the potential and even the need for joint advocacy work on gender to address the ways that COVID-19 regulations and other societal responses to crises invoke and entrench stereotyped norms.

Our paper then departs from the context of COVID-19 to discuss the way in which indirect discrimination arises when trans individuals are denied access to medical services. We refer to the human rights standards for the availability of healthcare that advocates for access to abortion and contraception fought to secure to illustrate the potential to build coalitions around the access to sexual and reproductive health services. We also argue that discrimination against trans individuals arises not merely out of inter-personal, “personal animus,” in an institutional setting, but that it is rooted in the underlying ideologies dominant in most medical training (i.e., faith in the binary categories of M/F). This argument again overlaps with the claims of sexual and reproductive health advocates who have pushed the human rights community to recognize that *healthcare is part of a health system* that must be competent to respond to health needs without discrimination *as a system*, regardless of any individual provider’s beliefs. The specific experience of abortion advocates also underscores that professional training is an ideological (and not exclusively scientific) component of all health systems that requires review and alteration.

Our final case study considers the ways in which infertility is differentially (and, we argue, discriminatorily) created amongst LGBTI persons as they confront provider care that is indifferent toward them or incompetent to address their needs, as well as legal frameworks that impede rather than facilitate diverse persons’ access to information or services relevant to fertility. Infertility can also result from the operations of criminal law (here, prostitution law as well as laws criminalizing same-sex sexual conduct or gender-non-conforming expression) when individuals are afraid to seek healthcare because of their “criminal status.” Infertility has distinct rights ramifications across differently gendered, raced, or classed persons, and work here from a SOGI perspective can productively connect to broader reproductive justice frameworks.

Our conclusion reflects back on the case studies. We propose a preliminary three-part framework to guide analysis of and research into indirect discrimination in the context of health and pull out some cross-cutting themes around law as a structuring and constraining power for visibility, social

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<sup>3</sup> Alexander C. Wagenaar and Scott C. Burris, eds., *Public Health Law Research: Theory and Methods* (San Francisco: Jossey-Bass, 2013).

connection, and disease in the context of sex and gender norms. We then further reflect on these themes as sites for coalitional work.

### CASE STUDY 1: Gendered Quarantine Measures (engaging with some of the questions raised by Hypothetical No. 7)

We draw on the example of the gendered quarantine measures implemented in Peru, Panama, and Colombian cities such as Bogotá and Cartagena in April 2020, to show that an effective response to indirect discrimination against gender-diverse individuals requires broader work toward transformative gender equality. Since the measures were born out of gender essentialism, not only did they exclude and make vulnerable gender-diverse individuals, but they also stereotyped and constrained “gender normative” persons in ways that harmed cis-gender women in particular and presumably reified norms around cis-gender men. Although all of the gendered quarantine measures were eventually withdrawn,<sup>4</sup> the design and implementation of these sex-segregated regimes reveal profound and lasting prejudices that remain to be addressed while illustrating the need for joint advocacy work on gender.

On April 1, 2020, the Panamanian government implemented gendered quarantine measures in response to the arrival of the COVID-19 pandemic in Latin America.<sup>5</sup> The measures divided the week into three days in which women could leave home for essential goods and three other days in which men could do the same. No one could leave home on Sundays. Peru implemented almost identical gendered quarantine measures on April 3.<sup>6</sup> On April 13, the Colombian cities of Bogotá and Cartagena followed suit, implementing gendered quarantine measures that assigned men and women separate days on which to leave home for essential goods, basing their regimes on even- and odd-numbered days and on the last digit of national identification numbers, respectively.<sup>7</sup>

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<sup>4</sup> Note that Panama withdrew its gendered quarantine measures in August 2020, but authorized their reinstatement should COVID-19 cases rise. Ministerio de Salud, “Resolución No. 1078,” *Gaceta Oficial Digital* No. 29111-A (11 September 2020): art. 3, [https://www.yomeinformopma.org/static/dash/docs/decretos/Decreto\\_Ejecutivo\\_N\\_1078.pdf](https://www.yomeinformopma.org/static/dash/docs/decretos/Decreto_Ejecutivo_N_1078.pdf).

Additionally, in January 2021, Panama introduced a new set of gender-based COVID-19 restrictions that fall outside the scope of this paper. “The IACHR Calls on State of Panama to Guarantee Human Rights of Trans and Gender-Diverse People during Partial Restrictions on Mobility during the COVID-19 Pandemic,” *Inter-American Commission on Human Rights*, 4 February 2021, [https://www.oas.org/en/IACHR/jsForm/?File=/en/iachr/media\\_center/PReleases/2021/024.asp](https://www.oas.org/en/IACHR/jsForm/?File=/en/iachr/media_center/PReleases/2021/024.asp).

<sup>5</sup> Ministerio de Salud, “Resolución No. 360,” *Gaceta Oficial Digital* No. 28992-A (30 March 2020): art. 2, [https://yomeinformopma.org/static/dash/docs/decretos/Resolucion\\_No\\_360.pdf](https://yomeinformopma.org/static/dash/docs/decretos/Resolucion_No_360.pdf).

<sup>6</sup> Presidente de la República, “Decreto Supremo No. 057-2020-PCM,” *El Peruano* (2 April 2020), <https://busquedas.elperuano.pe/normaslegales/decreto-supremo-que-modifica-el-articulo-3-del-decreto-supre-decreto-supremo-no-057-2020-pcm-1865326-2>.

<sup>7</sup> La Alcadesa Mayor de Bogotá, D.C., “Decreto No. 106” (8 April 2020): art. 2(5), <https://bogota.gov.co/mi-ciudad/salud/coronavirus/conoce-el-decreto-106-y-las-nuevas-restricciones->

The gendered quarantine measures constituted indirect discrimination on the basis of gender identity and gender expression.<sup>8</sup> The Panamanian government made no mention of gender-diverse individuals and the Peruvian government stated that no discriminatory intent motivated the measures<sup>9</sup>, while the Colombian cities attempted to address the concerns of gender-diverse individuals by training police officers on diversity<sup>10</sup> and by clarifying in the measures themselves that trans individuals could comply with the quarantine measures in accordance with their gender identities<sup>11</sup>. Yet, in all three countries, the gendered quarantine measures had a severe discriminatory effect on gender-diverse individuals. Trans individuals, for example, were hurt and harassed by both police officers and private individuals regardless of whether they left home on the day corresponding with their gender identity or the sex marker on their national identification card.<sup>12</sup> They were subjected to fines and arrests for noncompliance and barred from accessing essential goods and services.<sup>13</sup> For example, one transgender woman in Panama left home for a

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para-salir-la-calle; El Alcalde Mayor del Distrito Turístico y Cultural de Cartagena de Indias, “Decreto No. 0539” (13 April 2020), <https://www.cartagena.gov.co/Documentos/2020/Coronavirus/Decretos/Decreto%200539%20de%2013%20abril%202020.pdf>.

<sup>8</sup> Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, *Violence and Discrimination Based on Sexual Orientation and Gender Identity during the Coronavirus Disease (COVID-19) Pandemic*, A/75/258 (28 July 2020): ¶ 43.

<sup>9</sup> Alberto Ñiquen G., “Martín Vizcarra, el primer presidente que incluye a los trans en un mensaje desde Palacio,” *LaMula.pe*, 2 April 2020, <https://redaccion.lamula.pe/2020/04/02/martin-vizcarra-el-primer-presidente-que-incluye-a-los-trans-en-un-mensaje/albertoniquen>. The trans community welcomed the President’s recognition of their existence but continued to express concern about the gendered quarantine measures. See, e.g., Gahela Tseng Cari Contreras, “Sr. @MartinVizcarraC nos preocupa cómo se garantizará el derecho de las personas Trans si hasta ahora quienes más han vulnerado nuestros derechos son los efectivos?,” Twitter, 1:18 PM, 2 April 2020, <https://twitter.com/CariGahela/status/1245807717077352450>.

<sup>10</sup> Ana María Montoya Z., “No cede la violencia contra la comunidad trans en Bogotá,” *El Tiempo*, 2 July 2020, <https://www.eltiempo.com/bogota/violencia-de-genero-no-cede-violencia-contra-comunidad-trans-en-bogota-513742>.

<sup>11</sup> La Alcadesa Mayor de Bogotá, D.C., “Decreto No. 106” (8 April 2020): art. 2(5), <https://bogota.gov.co/mi-ciudad/salud/coronavirus/conoce-el-decreto-106-y-las-nuevas-restricciones-para-salir-la-calle>.

<sup>12</sup> Julia Symmes Cobb, “Transgender People Face Discrimination, Violence amid Latin American Quarantines,” *Reuters*, 5 May 2020, <https://www.reuters.com/article/us-health-coronavirus-latam-lgbt/transgender-people-face-discrimination-violence-amid-latin-american-quarantines-idUSKBN22H2PT>; “Panama: New Trans Discrimination Cases under Covid-19 Measures: Government Needs to Clarify Gender-Based Quarantine System,” *Human Rights Watch*, 13 July 2020), <https://www.hrw.org/news/2020/07/13/panama-new-trans-discrimination-cases-under-covid-19-measures>; “Recepción de quejas sobre vulneraciones a los derechos humanos de personas trans,” *Defensoría del Pueblo*, 16 April 2020, <http://www.defensoriadelpueblo.gob.pa/portal/recepcion-de-quejas-sobre-presuntas-vulneraciones-a-los-derechos-humanos-de-personas-trans>.

<sup>13</sup> Juan Manuel Reyes Fajardo, “Hombre trans fue expulsado de supermercado en medio de la jornada de pico y género,” *Publímtero*, 15 April 2020, <https://www.publimetro.co/co/noticias/2020/04/15/hombre-trans-fue-expulsado-supermercado-medio-la-jornada-pico-genero.html>; “Panama: Government Takes

doctor's appointment on a day designated for women when two police officers stopped her and placed her under arrest. She recalled being detained for half an hour at a police station where "there were seven officers and they were laughing at me . . . I was wearing make-up and they were mocking that."<sup>14</sup>

While the harm to gender-diverse individuals was the most severe and most visible discriminatory effect of the gendered quarantine measures, these measures should also be understood as growing out of and contributing to structural discrimination and thus also harming the very "gender conforming" people for whom they were designed.

The gendered quarantine measures may not have been born directly out of an intent to discriminate against gender-diverse individuals, but they were born out of sex and gender essentialism. Panama's Ministry of Health, for instance, justified the use of sex segregation in quarantine measures as "[t]he simplest method of cutting the circulation of the population in half,"<sup>15</sup> implying that "men" and "women" are natural, neat categories. A member of Panama's COVID-19 advisory committee, meanwhile, said that "separating men and women appeared to be the easiest way to maintain control,"<sup>16</sup> implying that "men" and "women" are oppositional categories such that law enforcement could tell at a glance, based on a person's gender expression, whether they were in compliance with the gendered quarantine measures. Not only did these justifications ignore the existence of gender-diverse individuals, they also reflected historic limitations on the possibilities of identity and expression for people who do identify as "men" and "women." Ironically, the gendered quarantine measures failed in Peru, not only because of the harm to the gender-diverse, but because their essentialism claimed a false equality which was quickly exposed: traditionally gendered men do not do the shopping.<sup>17</sup> Women continued to be disproportionately burdened with domestic labor, only with fewer days to accomplish that work.

The gendered quarantine measures not only reflected but also perpetuated structural discrimination. Sex segregation increased pressure to conform to gender stereotypes, as in the case of one non-binary Bogotano who said "If you don't go out with make-up on, with a skirt . . . If you

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Steps to End Quarantine Gender Discrimination: Protect Transgender People from Police, Security Guard Abuse," *Human Rights Watch*, 18 May 2020, <https://www.hrw.org/news/2020/05/18/panama-government-takes-step-end-quarantine-gender-discrimination>.

<sup>14</sup> "Panama: New Trans Discrimination Cases Under Covid-19 Measures," *Human Rights Watch*, 13 July 2020, <https://www.hrw.org/news/2020/07/13/panama-new-trans-discrimination-cases-under-covid-19-measures>.

<sup>15</sup> Ministerio de Salud de Panamá, "Nuevas medidas para la cuarentena absoluta," Twitter, 2:20 PM, 31 March 2020, <https://twitter.com/MINSAPma/status/1245098676290301952?s=20>.

<sup>16</sup> Lioman Lima, "Coronavirus en Panamá: cómo se convirtió en el país de Centroamérica con más muertos y más casos de covid-19," *BBC News Mundo*, 2 April 2020, <https://www.bbc.com/mundo/noticias-america-latina-52130235>.

<sup>17</sup> Tania Tapia Jáuregui, "Las lecciones que dejó el (fallido) intento del 'Pico y Género' en Perú," *Cerosetenta*, 15 April 2020), <https://cerosetenta.uniandes.edu.co/las-lecciones-que-dejo-el-fallido-intento-del-pico-y-genero-en-peru>.

don't comply with those stereotypes and gender roles then you can't identify yourself or be in a public space.”<sup>18</sup> It also reinforced traditional gender roles, especially the gendered division of labor. Crowding in Peruvian grocery stores on the days assigned to women led the President to withdraw the gendered quarantine measures and a member of Peru's COVID-19 task force to suggest the measures should have assigned women four days to circulate and men only two.<sup>19</sup> Panama, meanwhile, did implement an imbalanced regime in a later iteration of the gendered quarantine measures, assigning women three days and men two days to circulate in five of its provinces.<sup>20</sup> The gendered quarantine measures not only reproduced gender inequality, they required it.

Thus, analytic clarity on gender roles not only can produce resistances to a gender binary as a form of indirect discrimination against gender non-conforming persons, it can usefully be part of exposing the gender stereotyping upon which the constraints and discrimination arising out of unarticulated reliance on “women's roles” depends.

#### CASE STUDY 2: Trans Individuals' Access to Medical Care (Hypothetical No. 4)

We turn next to the scenario presented in Hypothetical No. 4 as an opportunity to highlight the possibility to draw on work already done by sexual and reproductive health advocates, and importantly also to suggest this as terrain for joint advocacy work on gender because the denial of sexual and reproductive healthcare is a concern trans activists share with cis-gender women. Advocates for abortion and contraception access, for example, have helped to establish human rights principles for the availability of care that easily translate to the situation of the transgender woman and the gynecologist in this hypothetical, and their continued fight to secure compliance

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<sup>18</sup> Julia Symmes Cobb, “Transgender People Face Discrimination, Violence amid Latin American Quarantines,” *Reuters*, 5 May 2020, <https://www.reuters.com/article/us-health-coronavirus-latam-lgbt/transgender-people-face-discrimination-violence-amid-latin-american-quarantines-idUSKBN22H2PT>.

<sup>19</sup> Ministerio de Economía y Finanzas del Perú, “10/04/20 Desde Tumbes, el presidente Vizcarra informa sobre la situación del Estado de Emergencia,” *Youtube*, 10 April 2020, <https://www.youtube.com/watch?v=WX9nUM16S4Y>; “Matuk sobre restricción de circulación por género: ‘Me equivoqué por exceso de igualdad,’” *Canal N*, 9 April 2020, <https://canaln.pe/actualidad/matuk-sobre-restriccion-transito-genero-exceso-igualdad-me-equivoque-n410638>; “Perú cancela salida diferenciada de hombres y mujeres por coronavirus,” *Infobae*, 10 April 2020, <https://www.infobae.com/america/agencias/2020/04/10/peru-cancela-salida-diferenciada-de-hombres-y-mujeres-por-coronavirus>.

<sup>20</sup> Presidente de la República, “Decreto Ejecutivo No. 869,” *Gaceta Oficial Digital* No. 29071-B (17 July 2020): art. 6, [https://yomeinformopma.org/static/dash/docs/decretos/Decreto\\_Ejecutivo\\_No.\\_869.pdf](https://yomeinformopma.org/static/dash/docs/decretos/Decreto_Ejecutivo_No._869.pdf); Presidente de la República, “Decreto Ejecutivo No. 873,” *Gaceta Oficial Digital* No. 29076 (23 July 2020): art. 6, [https://yomeinformopma.org/static/dash/docs/decretos/Decreto\\_Ejecutivo\\_No.\\_873.pdf](https://yomeinformopma.org/static/dash/docs/decretos/Decreto_Ejecutivo_No._873.pdf).



with these standards makes them key allies in the struggle against indirect discrimination based on gender identity in the provision of health services.

The human rights standards for availability of sexual and reproductive healthcare are most clearly articulated by the Committee on Economic, Social and Cultural Rights (CESCR) in its *General Comment No. 22 (2016) on the right to sexual and reproductive health*.<sup>21</sup> Availability, according to the CESCR, means States are responsible for “[e]nsuring the availability of trained medical and professional personnel and skilled providers who are trained to perform the full range of sexual and reproductive healthcare services,”<sup>22</sup> which presumably includes the medical advice and treatment the transgender woman in the hypothetical seeks from the gynecologist, since gynecologists specialize in reproductive organs. For instance, the trans woman in the hypothetical might see a gynecologist about metabolic diseases, prostate or breast cancer, or HIV.<sup>23</sup>

The CESCR further clarified that “[u]navailability of goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, must not be a barrier to accessing services. An adequate number of healthcare providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach.”<sup>24</sup> The ideology that might lead an individual gynecologist to deny medical advice and treatment to a trans woman therefore cannot be the ideology underlying State policies and practices. Whether medical education is privately provided and regulated by private health associations (as it is in the United States) or publicly regulated, it is the responsibility of the State to train medical professionals so they are competent to provide care to trans individuals, require that medical professionals provide this care, and monitor medical professionals’ service provision to ensure that this care is available not only in law but also in practice throughout the country.

Discriminatory barriers to competent fertility-related care can also be usefully analyzed through the care lens. A large majority of healthcare providers lack critical information on the fertility-related needs of non-cis-gender, non-heteronormative people. For example, healthcare providers

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<sup>21</sup> Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, E/C.12/GC/22 (2 May 2016): ¶¶ 12-14. State obligations to make available sexual and reproductive health care have also appeared in the work of the Human Rights Committee (the case of *KL v. Peru*) and the Committee on the Elimination of Discrimination against Women (CEDAW Committee). Human Rights Committee, *K.L. v. Peru*, CCPR/C/85/D/1153/2003 (22 November 2005); CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, A/54/38/Rev.1, chap. 1 (1999): ¶ 17.

<sup>22</sup> CESCR, *General Comment No. 22*, ¶ 13.

<sup>23</sup> Cécile A. Unger, “Care of the Transgender Patient: The Role of the Gynecologist,” *American Journal of Obstetrics and Gynecology* (2014).

<sup>24</sup> CESCR, *General Comment No. 22*, ¶ 14.

often lack accurate information on the impact of hormone treatment for transgender people on fertility, leading to improper counseling and side effects.<sup>25</sup> As a result, LBGTI individuals not only lack access to comprehensive and acceptable health information and services for purposes of fertility preservation, but also face barriers when seeking information and medical support to bear children. We will discuss fertility and indirect discrimination in greater detail in our third case study below.

Notably, the idea of “trans-incompetent care” (both in regard to the presentation of bio-medical research on transcare and the scope of needs over the life course, and in regard to counteracting bias) is increasingly on the agenda of a number of advocacy groups, especially associations of medical students and younger faculty seeking to change medical curricula.<sup>26</sup> This move to alter medical education can be understood as a key component of meeting the “AAAQ care” standard (acceptability, accessibility, availability and quality),<sup>27</sup> and resembles the efforts of sexual and reproductive health advocates to intervene in medical curricula to ensure that enough physicians are competent to perform abortion as provided for in law.<sup>28</sup> Trans advocates can therefore draw not only on the human rights standards initially established to ensure the availability of health services such as abortion, but can also join in current efforts of abortion advocates to reform medical school curriculums so as to increase State compliance with these standards.

### CASE STUDY 3: Infertility (contribution by Jaime Todd-Gher and Payal Shah)<sup>29</sup>

While infertility is commonly and narrowly conceived as an issue that predominately impacts cis-gender heterosexual women, it is also a site where LGBTI individuals face both direct and indirect discrimination, opening the possibility of joint advocacy work. LGBTI persons’ inability to exercise their rights to form a family and to determine the number and spacing of their children,

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<sup>25</sup> Expert interview for OHCHR research report on infertility, November 6, 2020; Khadija Mitu, “Transgender Reproductive Choice and Fertility Preservation,” *AMA Journal of Ethics* 18 (2016).

<sup>26</sup> S. E. James et al., *Report of the 2015 U.S. Transgender Survey: Executive Summary* (Washington, DC: National Center for Transgender Equality, 2016); see also Juno Obedin-Maliver et al., *Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education*, *JAMA* 306 (2011). These references are drawn from Yumna Ali (DO Candidate at UNTHSC Texas College of Osteopathic Medicine, AP MPH YSPH '21), “How The U.S. Healthcare System Fails Its Transgender Patients” (unpublished manuscript, December 2020), typescript (on file with Miller).

<sup>27</sup> For a infographic on the AAAQ framework, which has evolved into a globally accepted assessment tool for health services and materials, see “Availability, Accessibility, Acceptability, Quality: Infographic,” *World Health Organization* (2016), <https://www.who.int/gender-equity-rights/knowledge/AAAQ.pdf?ua=1>.

<sup>28</sup> Emily Bazelon, “The New Abortion Providers,” *The New York Times*, 14 July 2010, <https://www.nytimes.com/2010/07/18/magazine/18abortion-t.html>.

<sup>29</sup> This section is drawn from a larger research paper currently being prepared by Jaime Todd Gher and Payal Shah for the UN OHCHR. MS on file with authors



among other rights, can be the result of both biomedical infertility<sup>30</sup> and social infertility—the latter of which arises from broader structural constraints on reproductive decision-making such as discriminatory laws and policies, lack of social safety nets, systemic barriers to healthcare for marginalized groups, sexual and gender-based violence (GBV), and/or criminalization of sexual and reproductive actions, health status, and certain forms of gender expression.<sup>31</sup> All of these concerns can be analyzed through indirect and direct discrimination arising out of gender stereotypes that undergird normative reproduction and family life policies.

Lack of access to assisted reproductive technologies (ART)<sup>32</sup> is a common barrier to LGBTI individuals' ability to bear children. The violation is often inherent in law and policy, notably in the biological and gendered assumptions built not only into laws, but also arising in individual clinic practices and policies determining access to ART. ART, including in vitro fertilization (IVF), can be critical for specific populations such as HIV sero-discordant couples and LGBTI people.<sup>33</sup> In addition to barriers such as cost and lack of insurance coverage, LGBTI individuals, same-sex couples, couples in which one or both partners are transgender, and/or people living with HIV often face both direct and indirect discrimination when seeking to access ART.<sup>34</sup> For example, ART laws can explicitly prohibit access to these individuals and groups or indirectly discriminate against them through facially neutral requirements to access ART (e.g., legal marriage, HIV-negative status, diagnosis of biomedical infertility)<sup>35</sup> that have a disparate impact across SOGI.

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<sup>30</sup> The World Health Organization defines infertility as “a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.” F. Zegers-Hochschild et al., “International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) Revised Glossary of ART Terminology, 2009,” *Fertility and Sterility* 92 (2009): 1522. The biomedical infertility of LGBTI individuals is often overlooked due to the focus on social infertility arising from laws excluding LGBTI people from accessing ARTs. However, both areas must be addressed. Several of the examples highlighted reveal how indirect discrimination (often in the form of omission of specific mention of LGBTI individuals from laws/policies) may lead to biomedical infertility.

<sup>31</sup> Expert interview for OHCHR research report on infertility, October 19, 2020. (information on file with J.Todd-Gher/P. Shah)

<sup>32</sup> WHO defines ART as “all treatments or procedures that include the in vitro handling of both human oocytes and sperm or of embryos for the purpose of establishing a pregnancy. This includes, but is not limited to, in vitro fertilization and embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, tubal embryo transfer, gamete and embryo cryopreservation, oocyte and embryo donation, and gestational surrogacy.” F. Zegers-Hochschild et al., ICMART and WHO Revised Glossary of ART Terminology, 1521.

<sup>33</sup> Ann M. Starrs et al., “Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–*Lancet* Commission,” *Lancet* 391 (2018).

<sup>34</sup> Martha F. Davis and Rajat Khosla, “Infertility and Human Rights: A Jurisprudential Survey,” *Columbia Journal of Gender and Law* 40 (2020): 6-7.

<sup>35</sup> This ground for concerns arises in the case of laws that do not allow social infertility to be sufficient for access to ART, such as in Argentina.

These laws are also rife with gender stereotypes and thus provide a basis for thinking strategically across groups subordinated by sex and gender norms.

Criminal law is another structural factor that, perhaps unexpectedly, leads to indirect discrimination against LGBTI individuals in the context of infertility.<sup>36</sup> The criminalization of same-sex sexual activity, sex work, and drugs, for example, can deter individuals from seeking preventative healthcare due to stigma and fear of punishment, and/or lead to individuals being denied care or harassed when they do seek healthcare.<sup>37</sup> Criminalization also has the effect of suppressing the development of positive policies to ensure preventative healthcare for targeted communities,<sup>38</sup> including healthcare necessary to prevent infertility, such as access to information and services to diagnose and treat reproductive tract infections.<sup>39</sup> In addition to creating barriers in access to sexual and reproductive healthcare, criminalization also results in incarceration of non-gender or non-heteronormative populations, which further impedes their access to such sexual and reproductive health services. While incarcerated, one's ability to engage in reproductive activity is severely curtailed, if not fully eliminated.<sup>40</sup>

LGBTI individuals also face indirect discrimination when seeking access to information about fertility. Without such access, individuals may not understand the importance of prevention and treatment of STIs to prevent complications that cause infertility.<sup>41</sup> To the extent sexuality education is included in school curriculum in certain areas, fertility awareness is often not included.<sup>42</sup> Rather, sexuality education is typically taught from the perspective of prevention of pregnancy,<sup>43</sup> to promote population control or abstinence until marriage.<sup>44</sup> For LGBTI individuals who may transgress gender norms, overarching barriers to fertility awareness and sexuality education are further compounded by taboos around sexual orientation and gender identity, as well as social presumptions that LGBTI individuals would not want to or should not reproduce. LGBTI health, wellbeing, and fertility issues are largely absent from sexuality education, thus impeding

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<sup>36</sup> Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Physical and Mental Health, Anand Grover, A/HRC/14/20* (27 April 2010): ¶ 2.

<sup>37</sup> *Ibid.*, ¶¶ 17-19.

<sup>38</sup> *Ibid.*, ¶ 18.

<sup>39</sup> Maya N. Mascarenhas et al., "National, Regional, and Global Trends in Infertility Prevalence since 1990: A Systematic Analysis of 277 Health Surveys," *PLOS Medicine* 9 (2012).

<sup>40</sup> Jess Whatcott, "No Selves to Consent: Women's Prisons, Sterilization, and the Biopolitics of Informed Consent," *SIGNS: Journal of Women in Culture and Society* 44 (2018).

<sup>41</sup> Expert interview for OHCHR research report on infertility, November 12, 2020. (in MS on file with J. Todd-Gher and P. Shah.)

<sup>42</sup> *Breaking the Silence around Infertility: A Narrative Review of Existing Programmes, Practices and Interventions in Low and Lower-Middle Income Countries* (Share-Net International, 2019).

<sup>43</sup> Expert interview for OHCHR research report on infertility, November 9, 2020. (in MS on file with J. Todd-Gher and P. Shah.)

<sup>44</sup> Expert interview for OHCHR research report on infertility, November 12, 2020. (in MS on file with J. Todd-Gher and P. Shah.)

LGBTI individuals’ understanding of their own fertility and how to prevent infertility in the future. Gender stereotyped perspectives in sexuality education, and their multiple discriminatory effects, feature as key concerns across a range of children’s and women’s rights movements and present possibilities for coalitional work.<sup>45</sup>

GBV, which is disproportionately targeted at persons for gender and sexual non-conformity or identities, should be considered in any review of factors leading to indirect discrimination. GBV, in general, can lead to STIs, unsafe abortions, or higher risk pregnancies, which can in turn impact fertility. For example, LBQ women who do not want (or are perceived not to want) to marry and/or bear children can be subjected to “corrective rape.”<sup>46</sup> Violence and mistreatment in healthcare facilities can also lead to reluctance to seek preventative healthcare or treatment for medical conditions that impact fertility.<sup>47</sup> For some individuals, the trauma from sexual violence can also create difficulty in being sexually active later in life, which may eventually interfere with their ability to become pregnant. While laws on GBV may either be gender-specific (direct discrimination) or appear facially neutral (indirect discrimination), either may lead to lack of preventive measures and avenues for accountability and redress for LGBTI individuals. Feminist and women’s rights advocates share an interest in preventing and redressing GBV, making this another potential site of coalitional analysis and advocacy—even though, as has addressed elsewhere by Miller, there are tensions within movements about the scope of “gender” in GBV.<sup>48</sup>

## CONCLUSIONS, and some ways forward

The examples discussed above consistently show the multiple processes by which discrimination—direct and indirect—arises in health, particularly at the intersection of gender and sexuality norms and stereotypes. The issue- and practice-based case studies described above demonstrate the many modes by which discrimination can arise: correlated with underlying conditions that affect exposure to risk (which in health are often analyzed through structural determinants research); informal policies that distribute risk/harm according to gendered and other stereotyped beliefs; and practices such as the care that one receives (including in regard to the access to care, as well as determined by the training of one’s caregivers).

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<sup>45</sup> John S. Santelli, and Leslie M. Kantor, “Human rights, Cultural, and Scientific Aspects of Abstinence-Only Policies and Programs,” *Sexuality Research & Social Policy* 5 (2008); Alice M. Miller, and Rebecca A. Schleifer, “Through the Looking Glass: Abstinence-Only-until-Marriage Programs and Their Impact on Adolescent Human Rights,” *Sexuality Research & Social Policy* 5 (2008).

<sup>46</sup> OHCHR Anglophone Africa Focus Group Discussion, November 12, 2020 (in MS on file with J.Todd-Gher and P.Shah); Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, A/HRC/31/57 (5 January 2016): ¶ 57.

<sup>47</sup> Expert interview for OHCHR research report on infertility, November 20, 2020.

<sup>48</sup> Ali Miller, “Fighting over the figure of gender,” *Pace Law Review* 31 (2011).

### The ‘why, how, and so what’ of indirect discrimination in our health-related case studies and hypotheticals

We chose these case studies because they help us to think about laws and other measures, as well as the role of structural determinants like access to care, criminalization, and education, as forms of indirect discrimination in the context of health and gender/sexuality-related issues. These analyses reinforce the need to consider carefully the way difference operates across different modes of “becoming well” or facing illness. In this reflection, however, we expand on additional particularities of treating health as a site of justice work.

Communicable and chronic diseases, as well as reproductive health, implicate some common and some radically different ways of analyzing needs for health. In the early phase of the AIDS pandemic, both the association of HIV with same-sex behavior and the lack of real treatment options tended to drive gay rights advocacy away from health systems thinking; conversely, the attention to reproductive health drove the women’s rights movement toward revitalizing health systems to reduce maternal morbidity and mortality.<sup>49</sup> Both, however, used a non-discrimination framework, and as first anti-retroviral treatments and then preventive medicines/PrEP became more effective, the HIV/AIDS world turned toward concerns for adequately resourced, accessible, and accountable public health policies and health systems. Gaps and antagonisms between the movements nevertheless remain even as their rights claims consistently overlap in juridical and movement articulations of norms and remedies.<sup>50</sup>

Our examples are meant to push the analysis of discrimination—here indirect discrimination—beyond access to services so we can recapture/refocus on some of the strongest insights of the original health and human rights frame about the “inextricable links” between rights and health.<sup>51</sup> Once we accept that “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”<sup>52</sup> and, critically, that the bulk of health is not produced by healthcare but by the conditions in which we live (housing, environment, education, access to resources including food, clean water, and importantly, conditions of respect and equality),<sup>53</sup> then one can ask an ever-widening set of sex- and gender-related discrimination questions, while being

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<sup>49</sup> Mark Heywood, and Dennis Altman, “Confronting AIDS: Human Rights, Law, and Social Transformation,” *Health and Human Rights* 5 (2000); UN Millennium Project, *Who’s Got the Power? Transforming Health Systems for Women and Children* (London: Earthscan, 2005).

<sup>50</sup> Alice M. Miller, “Sexual but Not Reproductive: Exploring the Junction and Disjunction of Sexual and Reproductive Rights,” *Health and Human Rights* (2000); Dianne Otto, “International Human Rights Law: Towards Rethinking Sex/Gender Dualism,” *The Ashgate Research Companion to Feminist Legal Theory* (2013).

<sup>51</sup> Jonathan M. Mann et al., “Health and Human Rights,” *Health and Human Rights* 1 (1994).

<sup>52</sup> *Constitution of the World Health Organization* (1946).

<sup>53</sup> Elizabeth H. Bradley, and Lauren A. Taylor, *The American Health Care Paradox: Why Spending More is Getting Us Less* (New York: Public Affairs, 2013).

especially attentive to the ways that this harm is exacerbated by racial or class status.<sup>54</sup> The analysis of the role of law in health can arise in the domains of the intra-personal (as the management of stigma)<sup>55</sup>; inter-personal at family or community level; institutional (media, healthcare, religious institutions); and State interactions.

A provisional multi-part framework for identifying sites, causes and consequences of discrimination, including indirect discrimination, in health

Based on our study of indirect discrimination in the health context, we argue that a comprehensive analysis of the relationship between law and health is comprised of at least three different approaches to identifying sites and processes of direct and indirect discrimination:

1. Analyzing **direct State action on public and private life in the name of health—as implicated in quarantine, isolation and rules regulating social actions and interactions**. This provides a classic entry point for health justice inquiries into direct—and indirect—discrimination on the basis of sex, gender, sexual orientation, and gender identity. Here quarantine measures and the pretextual application of physical/social distancing rules can figure in the analysis, with attention to potential violations of the right to health, the right to participate in public life, and more.
2. Asking how **law and legal frameworks mediate access to health services** including with regard to their acceptability, accessibility, availability, and quality (AAAQ). These standards apply to public and private health services and the AAAQ must be guaranteed by the State as a matter of its obligations. Elements include education of healthcare providers and insurance schemes that have only binary categories of M/F.
3. Attending to **law and legal frameworks as structural determinants of health** with negative impacts through (indirect) discrimination, such as housing regulations, educational access decrees, and criminal laws that are neutral on their face but have a disparate impact on LGBTI individuals, women, etc. The work here is to track the pathways by which the legal frameworks affect health in an adverse manner, as with the case study on infertility.

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<sup>54</sup> Nancy Krieger, “ENOUGH: COVID-19, Structural Racism, Police Brutality, Plutocracy, Climate Change—and Time for Health Justice, Democratic Governance, and an Equitable, Sustainable Future,” *AJPH* (2020): 1620-23; Cary P. Gross et al., “Racial and Ethnic Disparities in Population-Level Covid-19 Mortality,” *Journal of General Internal Medicine* 35 (2020).

<sup>55</sup> Ilan H. Meyer, and David M. Frost, “Minority Stress and the Health of Sexual Minorities,” in *Handbook of Psychology and Sexual Orientation*, ed. Charlotte J. Patterson and Anthony R. D’Augelli (New York: Oxford University Press, 2013).

Notably, COVID-19 presents a new set of concerns for SOGI rights. On the one hand, some of the first principles in health as a human right arise from Article 12 (2)(c) ICESCR, which locates State obligation in “[t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases,” such that gay rights’ first encounters with health rights were with the subjects and objects of epidemic disease which spread through sexual (read “private/intimate”) contact. SARS CoV-2 spreads as a matter of respiration, which is to say, shared public and private space. Unlike HIV, which presented as a disease cloaked in morality and fear of the dangers born in the unnatural, scandalous private lives of others,<sup>56</sup> COVID-19 fears track the specter of the “infected other” in public life, such as in the grocery aisle or on a bus or train. The fact that COVID-related restrictions have been discriminatorily applied to LGBTI gatherings in public life,<sup>57</sup> as well as the analysis we present on the gendered quarantine measures, tell us that authorities are aware of the presence of gender and sexually-diverse persons in public life: the pretextual use of COVID restrictions is an invitation to consider more deeply the modes of gender organization of public life, social networks, etc., as aspects of anti-discrimination work, consonant with other rights moves by feminists and anti-racist advocates.

Moreover, in twenty-first-century pandemics, the control of diseases is commonly understood to require States to act individually and together with all relevant technologies, to improve epidemiological surveillance and data collection on a disaggregated basis, and carry out strategies of testing, contact tracing, and immunization.<sup>58</sup> Each of these practices: data collection, surveillance, and outreach (for testing or immunization), will be fraught spaces for stigmatized groups (sex workers, immigrant workers, sexual or gender non-normative folks) who have little reason to trust the State, even or especially when garbed in the white coats of medical interventions.

As Lynn Freedman wrote almost two decades ago, “[a] vision of ‘defining and advancing human well-being’ ultimately requires overturning deeply-rooted social and political structures that produce ill health and that prevent all people . . . [from] fulfilling their highest potential as human beings . . . . The structures that now obstruct human well-being must be changed into modes of social organization and interaction that will promote and support it. The disciplines of public health

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<sup>56</sup> *Public Scandals: Sexual Orientation and Criminal Law in Romania* (New York: Human Rights Watch and the International Gay and Lesbian Human Rights Commission, 1998), <https://www.hrw.org/legacy/reports97/romania>.

<sup>57</sup> Neela Ghoshal, “Uganda LGBT Shelter Residents Arrested on Covid-19 Pretext,” *Human Rights Watch*, 3 April 2020, <https://www.hrw.org/news/2020/04/03/uganda-lgbt-shelter-residents-arrested-covid-19-pretext>.

<sup>58</sup> See, e.g., “Introduction to Public Health Surveillance,” *CDC*, 15 November 2018, <https://www.cdc.gov/training/publichealth101/surveillance.html>.



and human rights offer ways of thinking, of working, and of organizing that can ultimately give expression and concrete direction to that endeavor.”<sup>59</sup>

Modes of social organization premised on gender and sexuality definitionally affect—and in our commentary are shown to discriminate—against a wide array of persons facing subordination under gender/sexuality norms, often exacerbated by other social fault lines of race, class, place, etc. This expansive quality may scare courts: as one participant in the October workshop emphasized, findings of indirect discrimination may have broad reach, far beyond the defendant or issue in the case presented, and this may lead to judicial reluctance to embrace indirect/disparate impact discrimination claims. What is necessary for solidarity across movements may indeed be in tension with individual case success, but the more honestly we confront this point, the more inclusive the compromises may be at both movement and individual case decision levels. Participating in using law to overturn unjust social structures, in the context of health as here or more generally, however, requires nothing less than both the honesty and the work.

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<sup>59</sup> Lynn P. Freedman, “Reflections on Emerging Frameworks of Health and Human Rights,” *Health and Human Rights* (1995).