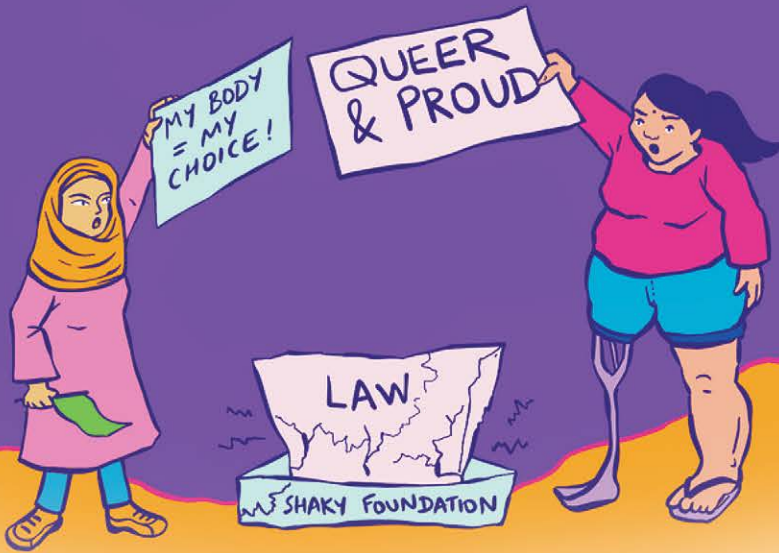


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vol. 29 no. 1 2023
ISSN 1394-4444



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published by

the asian-pacific resource and research centre for women (arrow)



published with the funding support of



REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS AND THE MOVEMENT TOWARDS REPRODUCTIVE JUSTICE

The call for reproductive justice is an answer to a world driven by deepening inequalities exacerbated by protracted crises due to accelerating climate change, arising conflicts and slowing economic and social recoveries post-COVID-19 pandemic.

History. Reproductive justice is a framework that harnesses reproductive rights with social justice—this term was first used by the Black women reproductive justice movement SisterSong in the United States.¹ These women wanted to move away from the individual-centric language of abortion rights, and attempted to redefine this as a matrix of oppression taking place in context of coercive sterilisation of women of color, access barriers to abortion, the denial to the entire spectrum of sexual and reproductive health services, as well as the right to have children. For women of colour in the United States, reproductive justice not only includes the right to be a parent, or not to be a parent, but also includes the right to parent children in safe conditions and access to care. Reproductive justice then centres the experiences of marginalised groups within the discourse of reproductive politics and considers socio-political factors that create the conditions of subjugation.

Reproductive justice addresses reproductive oppression by simultaneously applying three main frameworks at local, state, national, and international levels. These frameworks include: reproductive

health (which addresses service delivery), reproductive rights (which addresses legal issues), and reproductive justice (which focuses on movement building and social justice.)²

Reproductive Justice in Asia? How relevant is this language of reproductive justice in the context of Asia and the Pacific? Achieving this autonomy over our bodies means that we have to wrestle, not only the choices available to us, but also the forces that shape the choices that are available, including the denial or limitations on choices and decision-making. Deep-set inequalities and inequities in the regions, further exacerbated by multiple crises, call us to interrogate the structural and systemic barriers that limit autonomy and decision-making, leading to social disparities—especially if we want to attain sexual and reproductive health *for all*. The reproductive justice framework further strengthens the sexual and reproductive rights agenda by infusing it with intersectionality, unpacking the discourse on power, and roots it within social movements. Reproductive justice fortifies and makes sexual and reproductive health and rights more relevant and strategic, enabling us to fully articulate the scope of challenges and the holistic changes that are needed to ensure bodily autonomy and integrity.

The reproductive justice framework allows for activists and advocates to bring in decolonisation within the Sexual Reproductive Health movement and bring an intersectionality approach within

editorial

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our work. Intersectionality allows us to nuance the reproductive justice language and framework and further interrogate the multiple and intersecting drivers of inequality and inequity, including power relations between different groups, in sexual and reproductive health with adverse outcomes for the most marginalised women, girls and trans-persons.³

Historically in the Asia region, there is a legacy of coercive contraception especially post the Population Bomb 'movement'. Population policies and programmes of countries like China, India and Indonesia have been routinely critiqued. Mytheli Srinivas notes the undue burden of coercive contraceptive policies falling on poor women and the inherent class/caste bias as elites reproduced colonial perspectives on poorer, lesser educated, rural, indigenous, lower caste women.⁴ These coercive practices see women undergoing tubectomy and IUD insertion in camp settings which are unsanitary, undignified, and disempowering. This was hardly the liberating experience of autonomy and agency described in mainstream literature.

Class, caste, education, minority status, ability, age, marital status, sexual orientation, gender identity, migrant status and geographical location continue to beleaguer attainment of the highest possible level of sexual and reproductive health after three decades of the ICPD Programme of Action for all. Historical and present factors which influence policies, systems and institutions account for this stagnation in development achievements for the poor and marginalised in the region.

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There are limitations to the use of the Reproductive Justice language and framework as there is an absence of well-defined methodology and rigorous methods for applying the framework.⁵ In order to realise the fullest potential of the reproductive justice framework—we should endeavour to further theorise, and refine and adapt the framework which moves us closer to its radical aims and not reduce it to a ‘trend’ in funding applications. This AFC is one such attempt at building a discourse, and a framework around the application of reproductive justice.

The overarching concept of reproductive justice in Asia and the Pacific covers five key elements:⁶

- Decriminalisation
- Equity
- Violence
- Reproductive labour
- Technology

These five elements help form the axes for us to understand and interrogate discourse, data, stories, and progress in sexual and reproductive health and rights, as well as look at new ways in looking at the relationships between corresponding forms of marginalisations and oppressions. In this editorial we bring together work already done by leading organisations and researchers in the region, showing the pathway for using reproductive justice alongside reproductive health and reproductive rights frameworks.

Decriminalisation. The call for justice is also a call for us to re-look at legal frameworks which continue to perpetuate colonialist and casteist biases and assumptions, even post-independence, across different countries. Colonial laws which aimed to impose Victorian moralities on local populations resulted in laws such as the Criminal Tribes Act of 1871, which was repealed and replaced with the Habitual Offenders Act. The

vilified, denotified nomadic tribes and castes (*Vimukt jatis*) singled out in these laws suffered immeasurably. The women from these groups became particularly oppressed through state and caste violence, they were considered ‘sexually immoral’ (as they had greater freedom in sexual matters), ‘deviant,’ and unscrupulous.⁷ Abortion laws and sodomy laws are commonly mentioned and inherent in these laws are assumptions on sexuality, agency, autonomy and privacy of individuals and couples which then hinder full attainment of sexual and reproductive rights.⁸ Where abortion has been legalised, there continues to be issues of access especially with regards to term limits. It is often poorer, marginalised women who come for termination services later due to cost, distance and transport barriers. The centrality of abortion in the reproductive justice framework needs to be reinforced. An unwanted pregnancy is a result of intersecting marginalisations and vulnerabilities and failures: economics, violence, access to health systems and services, information and education, access to suitable methods of contraception, healthcare insurance that covers contraceptives and reproductive health services, as well as autonomy and agency within the family.⁹ Legislative or provider induced delays such as waiting periods, parental or spousal consent, court orders or psychiatric evaluations make it harder for those who are poorer, younger those who live in remote areas, or come from marginalised social identities such as migrant, disabled, indigenous, lower caste, trans-persons’ to access the abortion services they may need.

Recent changes in laws with regards to early age marriage and adolescent sexuality have posed challenges to adolescent access to sexual and reproductive health. Law and policy changes such as raising the age of consent to the minimum age of

marriage, which manacle sexuality within the marital, heteronormative framework; mandatory reporting of sexual activity of adolescents; resorting to court adjudication on love, romance, marriage; have increased parental and family control over adolescent sexuality and acted to strengthen regressive social norms. These new laws should also be considered from the perspective of reproductive justice.

In order to realise the fullest potential of the reproductive justice framework—we should endeavour to further theorise, and refine and adapt the framework which moves us closer to its radical aims and not reduce it to a ‘trend’ in funding applications. This AFC is one such attempt at building a discourse, and a framework around the application of reproductive justice.

Criminalisation, stigmatisation and often, pathologisation, of sexuality and gender identity which flow from inherited colonial laws see young people, adolescents, LGBT persons, drug users, and sex workers not being able to access the sexual and reproductive health services they need. Mistimed pregnancies are highest in the 15-19 and 20-24 age cohorts, and this is true in Bangladesh, India, Lao PDR, Nepal, the Philippines, Samoa, and Sri Lanka which use the DHS methodology.¹⁰ For countries that report contraceptive data on married and unmarried women, there are glaring differences around 5-10 percentage points, between married and unmarried women in the age groups 15-19 and 20-24 across Indonesia, the Philippines and Cambodia—indicating age and marital status play a determining role in access to contraception driven

by social taboos on premarital sexual activity.¹¹ In the Pacific, taboos around premarital sexuality, shame, and “fear of gossip, public shame and embarrassment” keep sexual activities secret and hidden resulting in unintended pregnancies and STIs being common amongst young women.¹² Abortion stigma—connected to sexual promiscuity and unnatural womanhood—continues to be a powerful deterrent in health-seeking behaviour and provision of safe services¹³ in India,¹⁴ Bangladesh,¹⁵ and Nepal.¹⁶ Deep-set stigma also acts to prevent even the slightest legal changes in restrictive environments like the Philippines,¹⁷ where religious conservative groups continue to prevent access to contraception for adolescents and young people.¹⁸ Stigma around premarital sexuality, same-sex sexual relations, and selling sex, influences and drives provider bias in providing and denying services to these marginalised groups.¹⁹ Migrant workers are denied employment permits based on pregnancy and HIV status in key receiver countries in Southeast Asia²⁰ and the Middle East.²¹ Decriminalisation of laws regulating abortion, adolescent sexuality, premarital sexuality, same-sex sexual relationships, gender identity, discrimination based on pregnancy and HIV status helps improve sexual and reproductive health outcomes for the most marginalised groups in our society.

Equity. Equity in sexual and reproductive health is derived from its definitions in health as the absence of systematic disparities between groups with different levels of underlying power based on social advantage/disadvantage.²² This remains a distant dream. Cost, transport, and limited and differential health care facilities continue to impinge on access to sexual and reproductive health for the poor and the marginalised. Women from the lowest wealth, social, and education quintiles, those who live in rural and hard to reach areas, from ethnic/religious minorities, castes,

and indigenous populations continue to have lesser access to SRH services whether that service is contraceptive, ante-natal, delivery, safe abortion, HIV/STD screening services or support services for gender-based violence. This results in lower rates of met need for contraception, and higher rates of maternal mortality and morbidity amongst other unfavourable SRH outcomes.

Equity in sexual and reproductive health is derived from its definitions in health as the absence of systematic disparities between groups with different levels of underlying power based on social advantage/disadvantage. This remains a distant dream.

The first piece of this equity factor in reproductive justice calls us to interrogate the overall **health ecosystem** that contributes to poorer SRH outcomes in marginalised groups. This is especially pertinent in the era of under-resourced and fragmented health systems, and austerity policies at work at the country level. A study of tribal communities of Kerala (the best performing state with regards to health indicators in India) show that maternal mortality amongst tribal women remains high for factors such as remoteness of their location, poor roads and transportation facilities, generational poverty and malnutrition but also dysfunctional health systems which do not work in the favour of marginalised, sick persons contribute to maternal deaths.²³ Without a robust and resilient health system and referral system in place, access for the most marginalised will continue to be the sword of Damocles hanging over gains made in sexual and reproductive health. With the move towards digital health, self-care and decentralised health systems, we should be vigilant that such

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systems continue to provide quality information and services, especially to marginalised groups. For example, despite widespread acceptance of MRM (menstrual regulation with medication) in Bangladesh, information on usage still poses considerable challenges especially for female sex workers.²⁴ We can also analyse elite capture in the way health systems are structured, resourced, designed, and privatised; and what type of health services and where these services are made available and to whom.²⁵ The increasing demise of public universal health care systems in the shadows of better, state of the art private facilities will make health unreachable for lower middle class and poor marginalised communities as experienced in the United States. A framework of reproductive justice in Asia and the Pacific would have to consider ways in which health systems can be built and re-oriented in order to serve the most marginalised.

Quality of services accessed is another critical aspect. Gender, and its intersection with other social inequities, translate to health inequities.²⁶ Within contraceptive services, poorer, lesser educated, rural women do not receive the three types of information needed to give informed consent according to the Demographic Health Surveys.²⁷ In Cambodia, low levels of knowledge about the availability of abortion services, and cost, distance, time and quality of care concerns are still significant barriers to overcome in ensuring women realise the right to safe abortion.²⁸ A study in Koppal notes how when marginalised women enter facilities to deliver, they continue to face discrimination, ill-treatment, delays resulting in eventual mortality and morbidity.²⁹ LGBT persons face innumerable barriers, stigma and discrimination from accessing health services in Southeast Asia. Mental health services are left out of the equation.³⁰

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In discussing equity, there are **groups which are invisibilised** in current paradigms. Older women have always been missing from the SRH equation, simply because almost all SRH datasets only survey women of reproductive age, from 15-49 years. For Asia in particular where one in four persons will be over the age of 60, with a total projected 1.3 billion persons over the age of 60 by 2050,³¹ a reproductive justice framework will have to incorporate the sexual and reproductive needs and desires of older persons. In this access to assisted reproductive technologies (ART), access to reproductive cancers screening and treatment, and sexual health services for older persons are some of the SRH services that will be required.³² Women and girls with disabilities are another invisible group in Asia and the Pacific as the prevalence of disability is underestimated, and there are an estimated 350 million women and girls with disabilities.³³ Women and girls with disabilities are 1.5 times more likely to be survivors of violence than those without disabilities. Yet, despite requirements of the Convention of the Rights of Persons with Disabilities (CRPD), women and girls with disabilities are denied basic information and services on SRH. There continues to be stigma around the sexuality of persons with disabilities, which also translates to inability to parent. Violations of their reproductive rights are disregarded, as women and girls with disabilities undergo forced hysterectomies³⁴ and abortions, or upon delivery are separated from their children³⁵ because they are deemed as not fit to be parents.

What type of SRH services should be provided? The dominant model stresses access to family planning, antenatal and delivery services and to an extent—STI/HIV services for most-at-risk populations. At the centre of this model is the poor, brown, uneducated but fertile woman whose fertility must

be controlled. The infertile woman is an anomaly and there are hardly any services to help prevent, screen, or treat her infertility. Infertility is prevalent amongst women from disadvantaged backgrounds and amongst the reasons are untreated reproductive tract infections (RTIs) and sexually transmitted infections (STIs) and menstrual issues.³⁶

Comprehensive SRH services, as per the ICPD ideal,³⁷ are still not provided across all levels of the health system. Some vulnerable identities pose different constraints, for example, the Baiga in Chhattisgarh where dwindling population numbers mean these women are turned away from contraceptive and abortion services.³⁸ Instead of improving the overall living conditions, access to social services and economic resilience of the Baigas, the policies of population increase amongst ethnic minorities has only led to more control over the reproductive decisions amongst Baiga women.

In discussing equity, there are groups which are invisibilised in current paradigms. Older women have always been missing from the SRH equation, simply because almost all SRH datasets only survey women of reproductive age.

Women and girls with disabilities are another invisible group in Asia and the Pacific as the prevalence of disability is underestimated. Yet, despite requirements of the Convention of the Rights of Persons with Disabilities (CRPD), women and girls with disabilities are denied basic information and services on SRH.

We cannot talk about equity without recognising those who live in **fragile contexts and their extreme vulnerability** to climate change and conflict. The poorest communities live in the areas most vulnerable to climate change and face increased frequency and intensity of cyclones, floods and droughts, further impoverishing them. These countries and communities are not responsible for the externalities of development and market economics but pay the highest price and bear the brunt of climate change. ARROW's work in the region shows that some of the poorest communities lack essential SRH services including family-planning services and RTI services which come from contaminated water supplies.³⁹ In times of climate disaster women from these communities may experience loss of family and children. A study in Tamil Nadu after the tsunami showed the need for access to tubal ligation reversal for women who had lost their children in the floods.⁴⁰ What becomes apparent is the need to ensure that during crisis—whether that crisis is a health pandemic or climate disaster—that marginalised groups are able to access social protection and health services, especially SRH services. The dependence of nations, donors, and UN agencies on the 'social capital' of women's and young people's networks⁴¹ and communities in order to roll out SRH humanitarian responses to disasters is not mirrored by equal investment in these very same networks and communities as part of adaptation, mitigation and resilience measures for climate change.

The gendered impact of climate change needs to be recognised holistically in addition to increased SRHR needs during climate change induced disasters.

Violence. Violence is the unfortunate reality that ties generations of women, young people, and marginalised communities. The interlinkages of violence and SRHR have been well-documented. FGM/C, in its most severe forms, contributes to maternal mortality.⁴² Violence contributes to maternal mortality, increases the likelihood of miscarriage, premature labour or delivery, and higher levels of depression during or after pregnancy amongst other effects.⁴³ “Survivors of violence report more induced abortions, miscarriages, stillbirths, low-birth weight babies, and are at greater risk for having had attempts made on their lives than non-childbearing women. They have fewer ante-natal care visits and post-natal care follow-ups; have delayed entry into ante-natal care; and some sexually transmitted infections (STI) and HIV-risk behaviour. Men who are violent towards their partners are also more likely to have multiple sex partners, which may increase risk for STIs and HIV.”⁴⁴

Evidence from the 2004 *WHO Profiling Domestic Violence: A Multi-Country Study*⁴⁵ enumerates the following health consequences for survivors which are closely inter-related with reproductive intentions and outcomes:

- A higher mean number of births in most age groups and countries.
- Less likely to say that their birth was wanted when the child was conceived, in all but one of the countries.
- Consistently higher likelihood of having a birth that is not wanted at all, in all but one of the countries.

On contraceptive use and contraceptive needs, women who experienced violence:

- Were more likely to have tried contraception, but also more likely to have discontinued it.
- Tended to have a higher total need for family planning.

- Had higher total unmet need, in seven countries in the study.
- Had higher unmet need for limiting births, in all countries.

Other health consequences were:

- More likely to have a non-live birth (due to miscarriage, abortion, or stillbirth).
- Self-reported prevalence of STIs is at least twice that among women who have never experienced violence.
- Experience of violence is associated with a delay in accessing ANC.

SRH services for women must be able to identify survivors of violence that come through their doors, and ensure they receive the full range of care and services including access to safe abortion, HIV-prophylaxis, counselling and referral to shelters and legal aid.

LGBT persons also face higher levels of violence, with trans-persons suffering the worst.⁴⁶ LGBT persons are also facing state violence in the form of discriminatory laws coming into place in conservative countries, and these laws prevent access to SRH services. Trans-women and trans-men have additional SRH needs and do not only face stigma and discrimination, but the system which is neatly divided along gender binaries in services and ward admissions may not even cater for them.

Rupali Bansode writes of the need to nuance the gender-based violence work with an understanding of caste structures and the disproportionate violence and sexual violence on Dalit women by upper caste men.⁴⁷ A study in Bihar also looks at newer forms of violence emerging for women who resist caste-based work tasks.⁴⁸ The lack of SRH services, legal services and recourse to justice for survivors of violence is an extension of structural violence.

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Reproductive Labour and Care Work.

Women and girls in Asia and the Pacific work the longest hours in the world, most of this (4.4 hours out of 7.7 hours) is in unpaid reproductive labour and care work.⁴⁹ The social division of labour amongst women and girls in Asia and the Pacific needs to look at reproductive labour and care as part of the reproductive justice framework. This includes labour activities like child bearing and rearing, cooking, cleaning and washing, caring for the elderly, and the sick and the disabled. Reproductive labour is necessary for the continuation of society, and households are as engaged in reproductive labour activities as well as ‘productive labour’ activities. Reproductive labour and care work involve hard, physical labour and mental and emotional labour and has costs in terms of time and energy. Women and girls are called to perform reproductive labour and care work out of their ‘natural’ instincts and altruistic nature and are not recognised or compensated for it. However reproductive labour and care work assigned to women and girls stems from the gender hierarchy and gendered power relations at play in society and in the family. This results in the burden of care being disproportionately borne by women and girls, but not exclusively, and not always by choice. Hence the decision to be a parent disproportionately affects the reproductive labour and care burden of women. This lack of opportunity and choice reinforces the economic subjugation of women at the micro level and the feminisation of poverty at the macro level, as well as reinforces racial, ethnic, caste, economic subordination through the persistent under-valuing of reproductive labour.

Sri Lanka, despite long years of free education and health programmes, sees the labour force participation of women at 34.9%—almost half that of men

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(73.4%). Out of an estimated 7.7 million persons categorised as “economically inactive”, 74.3% are women. Gendered power dynamics are clearly at play as 60.5% of women and 4.9% of men are found to be “engaged in housework.”⁵⁰ Both the gendered division of labour in unpaid work and gender gaps in time spent in unpaid work are observed. In the Sri Lankan studies, social obligations and expectations around family, gender roles reinforced by media as well as government policies influenced and reinforced women’s roles in unpaid reproductive labour and care work.⁵¹ The valorisation of motherhood and the subjugation of women to that self-sacrificial model has been fortified through popular, cultural, traditional lore and bolstered by policy frameworks that support this. Diane Elson’s framework⁵² to recognise, reduce and redistribute care work has been largely adopted by stakeholders to move forward the reproductive labour and care work agenda—such as raising the earnings, status and benefits for care workers; providing public services for child and elderly care; ensuring social protection; policies to redistribute care work to men through paternity leave, paternal care leave, shorter working weeks to both sexes and elevating wages for female dominant occupations.⁵³

In reality, the ability to reduce the care burden often means a redistribution of that reproductive labour and care burden to the Global South, and the development of ‘global care chains’ as described by Arlie Russell Hoschschild, and an entrenched feminisation and under-valuation of reproductive labour. Not all women can afford to reduce and redistribute their reproductive labour and care burden, and those who are more disadvantaged find themselves providing reproductive labour to others.⁵⁴

Digital health should also be viewed with an intersectional lens, and take into account increased security risks to women, girls, and marginalised people. The issue of gatekeepers, persons in control having access to the devices being able to track the usage of apps around violence, contraception, abortion services or to place surveillance apps within these devices, is of concern especially around SRH matters.

Technology. The COVID-19 pandemic accelerated the use of technology and digital health. 87% of countries said they were investing in digital health for longer term health system recovery and health service resilience and preparedness.⁵⁵ In SRHR, digital health interventions have been used for medication abortion, contraception, STI testing, supporting post-abortion contraception, improving knowledge and use of contraception, and improving safe sex behaviours and practices, and for outreach to high-risk groups such as sex workers and marginalised groups such as adolescents and young people.⁵⁶ Technology and digital health are shaping the SRHR landscape at a rapid rate especially post COVID-19 pandemic. Countries in the Global North such as Belgium, France, Ireland, and the UK have started operationalising digital health interventions for the provision of abortion services. Such interventions have also been pushed to the Global South where more marginalised populations need not only digital health interventions but also greater support in accessing and using medication abortion, such as hotlines, trainings for health providers and pharmacists, and provision of comprehensive information, amongst others.⁵⁷

Crawford and Serhal emphasise in their Digital Health Equity Framework⁵⁸ that digital health determinants such as access, literacy, values and norms interact and reiterate other existing social inequities. Digital health should also be viewed with an intersectional lens, and take into account increased security risks to women, girls, and marginalised people.⁵⁹ The issue of gatekeepers, persons in control (parents, spouses, abusers) having access to the devices being able to track the usage of apps around violence, contraception, abortion services or to place surveillance apps within these devices, is of concern especially around SRH matters. Where the law is considered grey—this also raises questions around safety, privacy and ownership of data shared with such platforms should authorities request data from the platform owners. The ability of those with power and resources to surveil those without is greatly enhanced by digital technologies and works towards further marginalising the already marginalised. Biases in design of digital apps and platforms, skewed towards white, male, models result in biased algorithms which mis-diagnose and under-estimate the health issues amongst marginalised groups.⁶⁰

Access to reproductive technologies has been raised in the context of infertility of older persons and LGBTI persons and in this, the question of surrogacy arises. Surrogacy framed from a Northern perspective sees access to surrogacy services to wealthy infertile couples performed by poor women from the Global South as a reproductive justice issue. Nadimpally asks us to interrogate this thinking with an understanding of class, labour and market economics before answering the question: Reproductive Justice for whom?⁶¹ The reproductive justice framework calls us to interrogate beyond inclusion to consider power differentials between different groups in society.

Rights and Justice. Does utilising a reproductive justice framework mean we leave the rights frameworks behind? This was a question put to us by our partners at ARROW. As earlier reiterated, we see reproductive justice as simultaneously applying the frameworks of reproductive health, reproductive rights and reproductive justice. We recognise that state accountability to international standards, as agreed upon in conventions and global policy documents, can only be upheld through the rights frameworks currently in place. We note that governments in the region are varied in their approach towards the sexual and reproductive health and rights agenda, and in different stages with regards to the domestication of the human rights conventions at the national levels. In this, we recognise that organisations, activists and advocates working on the frontlines use the frameworks and language that reflect their political vision and work to advance the agenda. All of this contributes to the ideal of realising sexual and reproductive autonomy. The reproductive justice framework is meant as a contribution to help root the SRHR agenda, seeding it alongside the many new concerns arising from grassroots and community groups, and contribute to movement building.

The arc of reproductive justice in Asia and the Pacific calls us to look at reproductive rights alongside interconnected rights. These include as in the US reproductive justice movement: the right to be a parent, the right not to be a parent and the right to parent in a safe environment. Embedded within the right to be a parent, is the right to care. The right to health emerges in the context of fragmented and under-resourced health systems, because sexual and reproductive health cannot be catered for as silo-ed services for marginalised groups and embedded within this, the right to comprehensive SRHR services throughout the life-cycle

as espoused in the ICPD. The right to health exists when health systems are robust, resilient, and fully funded. Only a whole-of-society approach to health that aims to ensure the highest, attainable, standard of health will be able to ensure greater inclusivity. The right to a life free from violence and discrimination is applicable not only to women but also many marginalised groups. The right to sexuality is also fundamental as heteronormative, marital sexuality becomes the site of discrimination and exclusion. The right to social protection at a time of economic austerity policies. The right to data privacy, to own our data, and freedom from sexual and reproductive surveillance in a digital world.

Reproductive justice can help us push for the systems change that we feminists demand from the world at large. In a time of rising ethno-nationalism and resulting anti-gender and anti-migrant ideological forces, the utilisation of the justice framework may well prevent a repeat of history and re-emergence of coercive and forced reproductive health measures on women, young people and marginalised people. Reproductive justice helps us reimagine more inclusive laws and policies, systems and institutions; help rebuild a more nuanced, strengthened SRHR movement, and recreate our politics to continuously interrogate privilege and power.

This editorial is a result of conversations and presentations in fora such as the IAFFE, the SAIGE Convention, and the ICPD+30 regional meetings.

I am indebted to a set of amazing reviewers including Suneeta Dhar, Junice Melgar, Shakira Choonara, Jeevika Shiv, TK Sundari Ravindran, and ARROW staff – Menka Goundan, Sai Jyothirmai Racherla, Smruti Sudha Behera, and Harshani Bathwadana.

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NAVIGATING REPRODUCTIVE JUSTICE: *Exploring Safe Abortion Access in Diverse Asian Landscapes*

Introduction. Reproductive justice, as a framework, underscores the critical importance of acknowledging the multifaceted nature of reproductive rights and healthcare access. Reproductive justice, coined by Black women in 1994, is the human right to bodily autonomy, encompassing the choice to have or not have children, and to parent in safe communities.¹ It goes beyond mere legality and recognises the intersections of race, gender, socioeconomic status, and geography, which shape individuals' experiences in seeking and accessing reproductive healthcare services. In the diverse landscape of Asia, the right to safe abortion services represents a complex tapestry woven with legal, cultural, and social threads.

As of 2019, Asia witnessed approximately 42 million abortions, reflecting a fundamental aspect of reproductive healthcare choices in the region.² However, within this staggering number lies a stark contrast—a significant proportion of these abortions were performed unsafely, resulting in potential harm and even death for countless individuals.³ The disparity in safe abortion access across Asia is not solely a matter of legal frameworks, but rather a reflection of the intricate web of cultural norms, social stigmas, and systemic inequalities that can either facilitate or obstruct reproductive autonomy.

This article delves into the reproductive justice landscape in several Asian countries, including India, Nepal, Bangladesh, Sri Lanka, Vietnam, Laos, Cambodia, Pakistan, Philippines, Indonesia, and Maldives. By examining

the varying legal frameworks, policies, and pertinent data, we aim to shed light on the current situation surrounding safe abortion access in the region. This analysis intends to contribute to the ongoing advocacy for comprehensive reproductive rights, recognising that these rights encompass not only the legal permission for abortion but also the broader contexts of sexual and reproductive health education, access to contraceptives, and the eradication of stigma and misinformation.

In the pursuit of reproductive justice for all, understanding the complexities and challenges faced by each of these countries becomes imperative. This article seeks to provide a holistic perspective, rooted in the principles of reproductive justice, to advocate for a future where individuals across Asia can exercise their reproductive rights free from legal constraints, stigma, or unsafe practices.

Bangladesh: Bangladesh's restrictive abortion laws lead to high rates of unsafe abortions. Induced abortion is illegal except to save a woman's life. Menstrual regulation (MR) is allowed up to 10-12 weeks, and medication-based MR (MRM) up to nine weeks. Despite available MR services, many women resort to unsafe abortions. Unsafe abortions are a pressing concern in Bangladesh, with an estimated 647,000 out of 1.2 million induced abortions in 2010 categorised as unsafe.⁴ These unsafe procedures contribute significantly to maternal morbidity and mortality, with approximately 13% of all maternal deaths in Bangladesh attributed to unsafe

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abortions.⁵ Restrictive laws and a shortage of qualified healthcare providers limit access to safe abortion services, leading many women to resort to unsafe methods, including traditional practices and unsafe medications.⁶ Amendments in 2018 expanded legal grounds for abortion, but challenges remain in ensuring access to safe services, protecting reproductive rights, and reducing maternal mortality.⁷

India: India has made notable strides in enhancing access to safe abortions with the enactment of the Medical Termination of Pregnancy (Amendment) Act, 2021. Despite these advancements, significant challenges remain in effectively implementing the new provisions and addressing the prevalent stigma associated with abortion. Recent data from 2020 reveals that an estimated 15.6 million unsafe abortions occurred in India, contributing significantly to maternal mortality rates.⁸ Unsafe abortions now stand as the third leading cause of maternal mortality in India, resulting in approximately eight women losing their lives daily due to complications arising from these procedures.⁹ A study examining the period between 2007 and 2011 found that an alarming 67% of all abortions in India were unsafe, posing a substantial threat to women's fundamental rights, including their right to life, health, and dignity.¹⁰

Indonesia: Indonesia has a complex legal framework on abortion, allowing it only in cases of rape, maternal endangerment, or fetal abnormalities. Limited access to safe and legal abortion services is influenced by conservative attitudes,

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religious beliefs, stigma, and low awareness of reproductive rights. A revised criminal code maintains restrictions on abortion, penalising those seeking or providing services outside the exceptions. In Java alone, an estimated 1.7 million abortions occur annually, with 73% self-managed.¹¹ Indonesia also faces high overall maternal mortality rates, with approximately 30% attributed to unsafe abortions.¹²

Pakistan: Pakistan's highly restrictive abortion laws lead to a prevalence of unsafe procedures. Abortions are legal only to save a woman's life or as "necessary treatment." An estimated 2.2 million unsafe abortions occur annually, with Pakistan having one of the highest global abortion rates. Contraceptive prevalence is low, and maternal and infant mortality rates are high. The Penal Code criminalises abortion with penalties for providers and women. Limited access to safe and legal abortion care results in women resorting to unsafe methods. Provider stigma and lack of clarity on safe abortion laws further hinder access.^{13, 14, 15}

Sri Lanka: Sri Lanka permits abortion only in limited circumstances, such as when the mother's life is at risk or in cases of fetal abnormalities. The Penal Code criminalises abortion with penalties for both the provider and the woman. Challenges persist in awareness, social stigma, and equitable access to comprehensive reproductive healthcare. Approximately 72% of unintended pregnancies end in abortion, with an estimated annual rate of 28 per 1,000 women. Sri Lanka has a relatively high contraceptive prevalence rate and low maternal mortality. Limited data exists on complications from unsafe abortion.^{16, 17}

Nepal: Nepal has relatively liberal abortion laws, allowing it for various reasons including socioeconomic factors, rape, incest, fetal abnormalities, and

risks to the mother's health. The 2018 law permits abortion up to 12 weeks, and up to 28 weeks in certain cases. Maternal mortality rates have reduced due to expanded safe abortion services. However, social stigmas persist, hindering access. Abortion remains a criminal offense and limited access to second-trimester abortion leads to unsafe procedures.^{18, 19, 20}



Lao PDR: Abortion is highly restricted in Laos, allowed only to save the life of a woman. Limited access to safe abortion services contributes to a significant proportion of maternal deaths. In July 2021, the Ministry of Health expanded legal indications for abortion, but limitations remain. Approximately 35% of pregnancies are unintended, with 68% of these ending in abortion. Contraceptive prevalence for modern methods is 49%, with limited access for unmarried individuals. Maternal mortality remains high.^{21, 22}

Maldives: Access to safe abortion in the Maldives is highly restricted, with abortion permitted only to save a woman's life or in cases of rape or incest. The Penal Code criminalises abortion in all other circumstances, leading to unsafe procedures and significant maternal

health risks. Approximately 13% of maternal deaths in the Maldives result from unsafe abortion complications. Stigma surrounding abortion further hinders women's access to reproductive healthcare.²³

Cambodia: Cambodia has relatively permissive abortion laws, but accessing safe services remains challenging, particularly in rural areas. The law allows abortion on socio-economic grounds, rape, incest, and fetal impairment. Unintended pregnancies decreased by 21%, while the abortion rate increased by 40%. Despite legalisation, women face stigma and limited awareness about safe abortion services due to cultural and religious factors. Limited information, social stigmas, and inadequate healthcare infrastructure create barriers to access.^{24, 25}

Vietnam: Vietnam has relatively permissive abortion laws, allowing safe and legal access to services. However, implementation and enforcement of policies are lacking, leading to disparities in access to sexual and reproductive health (SRH) services. About 59% of pregnancies are unintended, with 75% of these ending in abortion. Vietnam has a high abortion rate, particularly among adolescents and unmarried youth. Barriers to care include institutional obstacles, provider stigma, cultural taboos, sex selection politics, and cost. Access to second and third-trimester procedures is limited, especially for those in rural areas.^{26, 27}

Philippines: Access to safe abortion in the Philippines is severely limited due to restrictive laws. Abortion is completely illegal, without exceptions, leading to a high prevalence of unsafe procedures. Criminal penalties apply to those who perform or undergo abortions. The socio-political context, influenced by conservative and religious beliefs, hinders progress. Unsafe abortions contribute to a high maternal mortality rate.^{28, 29}

Discussion: Access to safe and legal abortion services in Asia is hindered by restrictive laws, social stigmas, limited healthcare infrastructure, and cultural barriers. Many countries, including Bangladesh, Maldives, Pakistan, and the Philippines, have highly restrictive abortion laws that limit women's access to safe services. These laws infringe upon women's reproductive rights and autonomy, denying them the ability to make decisions about their own bodies and reproductive health.

One of the significant barriers are the legal restrictions surrounding abortion. For example, the Philippines is one of the few countries where abortion is completely illegal, even in cases of rape, incest, or when the woman's life is at risk. This forces women to seek unsafe and clandestine procedures, leading to health risks and maternal deaths. Similarly, countries like Bangladesh, Maldives, and Pakistan restrict abortion except when the woman's life is in danger, further limiting access to safe services.

Stigmatisation and social barriers also contribute to the challenges faced by women seeking abortion services in many Asian countries. Societal attitudes surrounding abortion often result in judgment, discrimination, and social isolation for women who have abortions. This stigmatisation makes it difficult for them to access safe and supportive healthcare, leading to delays or reliance on unsafe methods.

Limited access to safe abortion services in remote areas exacerbates the inequalities faced by marginalised communities. Countries like Bhutan, Mongolia, and Vietnam struggle with providing adequate services in rural and underserved areas. This lack of access disproportionately affects women from low-income backgrounds, ethnic minorities, and those in remote locations.

Improving healthcare infrastructure and ensuring equitable access to reproductive healthcare services are crucial steps in addressing these disparities.

The widespread occurrence of unsafe abortions in nations with stringent abortion laws poses grave threats to women's health and overall well-being. Even in countries with more permissive legal frameworks, such as India and Nepal, formidable obstacles like societal stigma, limited awareness, and insufficient healthcare infrastructure hinder the pursuit of safe abortion services. These challenges are compounded for young women and individuals identifying with diverse gender identities.

Unsafe abortions loom as a predominant contributor to maternal mortality and morbidity in countries like Bangladesh, Pakistan, and the Maldives. Urgent measures are imperative in these nations, necessitating comprehensive legal reforms and enhanced accessibility to safe abortion services. These reforms are not only vital for safeguarding the health and lives of women but also for advancing reproductive justice and gender equity on a broader scale.

Recommendations: To address these barriers and promote reproductive justice, several recommendations can be made. Governments should review and repeal highly restrictive abortion laws, aligning legal frameworks with international human rights standards. Enacting comprehensive laws that guarantee women's and gender-diverse individuals' rights to access safe and legal abortion services without discrimination or stigma is essential. Efforts should be made to expand access to safe abortion services, particularly in remote areas, by training healthcare providers and ensuring adequate facilities and supplies.

Promoting comprehensive reproductive healthcare is also crucial, including access to contraception, family planning, sexual health education, and post-abortion care. Governments should invest in awareness campaigns and educational programmes to combat social stigmas and promote accurate information about reproductive health, ensuring that these initiatives are inclusive of all genders. Protecting individuals' confidentiality and privacy when seeking abortion services, as well as fostering collaboration with civil society organisations and international agencies, are important steps toward ensuring access to safe and legal abortion.

Furthermore, it is essential to leverage a human rights framework to strengthen access to safe abortion services from a reproductive justice lens. This approach emphasises that reproductive rights are human rights, applicable to all individuals regardless of their gender identity. Regular monitoring and evaluation mechanisms should be established to assess the impact of policies and interventions aimed at improving access to safe abortion services. Data collection and analysis are vital for identifying gaps, addressing challenges, and making evidence-based decisions.

By implementing these recommendations, governments in Asia can empower women, gender-diverse individuals, and pregnant persons to make informed choices about their reproductive health. This approach aims to reduce maternal mortality and morbidity while creating a society that respects and protects the human rights of all its members. Prioritising comprehensive reforms, backed by evidence-based policies, will bridge the gap in accessing safe abortion services and promote reproductive justice in the region.

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INFERTILITY, REPRODUCTIVE JUSTICE, AND HUMAN RIGHTS

Introduction. The reproductive justice movement, founded by Black women activists in the United States, has long advocated for recognition of reproductive oppression—the denial of reproductive autonomy to control and subjugate. While reproductive oppression can occur in many ways, including by compelling pregnancy, birth, and parenting in unsafe conditions, it can also occur when governments fail to prevent infertility amongst certain individuals and communities. Reproductive justice advocates have underscored the importance of addressing infertility—both where it is the intentional result of measures to prevent births and where it occurs as a result of state neglect of fertility—as a crucial aspect of ensuring reproductive autonomy and preventing

severe consequences to individuals and communities' survival and well-being.

Despite decades of global commitments to address infertility, including at the 1994 International Conference on Population and Development and the 1995 World Conference on Women,¹ infertility has continued to persist with at least one in six individuals still affected.² This article outlines several challenges that have hindered an effective global response to infertility and its treatment, and then highlights an important forthcoming report by the UN Office of the High Commissioner for Human Rights (OHCHR)³ that can be utilised by advocates to reframe advocacy for state reforms around these issues. Ultimately, this article calls for broader, more nuanced analyses of

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infertility and its prevention, with a focus on the discriminatory impacts of failing to prevent infertility.

Persistent Challenges in Addressing Preventable Infertility and Its Consequences.

Efforts to address infertility tend to be hindered by three key challenges. First, historically, there has been an overwhelming focus in sexual and reproductive health (SRH) programming on preventing births, especially in low- and middle-income countries.⁴ Due to prioritisation of population control, SRH programming has often prioritised sterilisation and contraception. Yet,

infertility is often caused by a range of preventable factors, including lack of access to SRH services and information, sexual and gender-based violence (GBV), exposure to environmental and workplace toxins, the impacts of climate change, and individual, intersectional and structural discrimination. Second, despite increasing discussion in recent years of infertility, this emphasis has typically been on treatment rather than prevention. While crucial, this focus fails to account for the suffering, medical interventions, and costs that could be spared if fertility preservation was prioritised at the outset. Further, when preventable infertility remains unaddressed, governments stand in a stronger position to determine who reproduces, in part, by controlling who has access to assisted reproductive technologies (ART).

A third key challenge has been that infertility of many groups continues to be overlooked due to narrow and biomedical definitions of infertility. For example, the World Health Organization's (WHO) infertility estimates are underinclusive as they are based on a narrow definition of infertility—"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"⁵—that is largely based on the experiences of cisgender, heterosexual, able-bodied individuals (largely women) in sexual relationships and solely addresses biomedical factors of infertility. This definition fails to account for the experiences of lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals, persons with disabilities, and single individuals⁶ who may need access to ART to have children despite not being clinically diagnosed as "infertile."

Human Rights Framework. To raise the profile of these critical issues, the forthcoming OHCHR report on preventable infertility squarely places infertility within the human rights

framework and outlines governments' obligations to address the preventable human rights causes and consequences of infertility.⁷ Set forth below, is an overview of the key analysis in this report and government obligations to prevent infertility.

a. Human rights causes and consequences of infertility. Infertility can result from a range of preventable factors, many of which amount to violations of individuals' rights to life, health, equality and non-discrimination, privacy, and freedom from torture and cruel, inhuman, and degrading treatment. Human rights violations can not only lead to biomedical infertility—disorders of an individual's reproductive organs—but can also result in social infertility—legal, social, or regulatory constraints on individuals' ability to reproduce, such as people in same-sex relationships or people coerced or forced to be sterilised.

The forthcoming OHCHR report explicitly recognises preventable infertility as often the result of governments' failure to ensure equal access to SRH information and services and comprehensive sexuality education, to prevent gender, racial, age and other forms of discrimination, to alleviate poverty, and to combat GBV and exposure to environmental and workplace toxins, among other things.⁸ The report also highlights targeted state action to prevent births among some particular groups (i.e., through sterilisation of persons with disabilities), while promoting reproduction of other "desired" groups through pronatalist policies to promote national strength, economic growth and protection from outside aggression, as well as to preserve a "national identity" (i.e., high-income individuals from particular racial backgrounds).⁹

Further, the OHCHR report highlights that while not all infertility can be addressed with treatment, barriers to ART can impede fertility in cases where pregnancy

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is still possible with medicine, services, or technology. The report notes that given the high costs of and the myriad restrictive regulations around ART—including explicit restrictions on access to ART for certain populations in many countries—access to these treatment services remains limited. Given these two realities and a general lack of political will to combat infertility, states stand in a strong position to control and limit access to particular individuals and groups.

The OHCHR report also notes that human rights violations can arise where governments fail to prevent and redress the harmful consequences of infertility, including mental health impacts (i.e., guilt, self-blame, helplessness and depression), familial and marital tension and dissolution, intimate-partner violence, familial violence and/or GBV, social alienation and abuse, and even death.¹⁰ While ensuring access to infertility treatment, including ART, alone is insufficient to address infertility, it is a critical component of necessary state interventions.

b. Government obligations to address infertility. The OHCHR report underscores that international human rights law requires governments to prevent, diagnose, and treat infertility, and prevent and redress infertility-related harms. For example, governments must ensure access to SRH care, including the very care needed to prevent or treat pregnancy-related complications (including from unsafe abortions) and STIs that often lead to infertility. Similarly, governments must ensure the underlying determinants of health, including access to a healthy environment and work conditions, access to health-related education and information, and protection from violence and discrimination.¹¹ Governments must also ensure bodily autonomy and integrity, including by prohibiting coerced or forced sterilisation.¹²



Crucially, governments also have an obligation to address gender and other stereotypes and norms that lead to discrimination and inequality, including in the enjoyment of other human rights. Gender, racial, age, disability, and intersectional and structural forms of discrimination impede individuals' ability to exercise their SRHR and are key drivers of infertility, thus implicating the right to equality and non-discrimination. Gender, racial, and other discriminatory stereotypes around "motherhood" can lead to certain individuals' reproduction being privileged while preventing or discouraging the reproduction of others. Patterns of preventable infertility may reflect governments' or societies' view of what constitutes the "ideal family" and who is worthy of forming a family.

For example, gender stereotypes and taboos around adolescent sexuality—specifically adolescent girls' sexuality—lead to denials of comprehensive sexuality education that can provide crucial information about fertility preservation and to prohibitively restrictive laws and policies that condition adolescent access to SRH care on parental or guardian consent. Racial and gender stereotypes

that certain women are "hyper fertile", lead to denial of essential SRH information and care to prevent infertility as well as denials of infertility diagnoses and treatment.¹³ Those who face intersectional discrimination, including due to race or ethnicity, caste, indigenous identity, HIV status, or disability, or gender or sexual orientation are also at greater risk of forced or coerced interventions such as sterilisation.¹⁴ Further, such groups may also face discriminatory attitudes should they seek to become pregnant, resulting in limitations on reproductive autonomy and access to quality infertility treatment and maternal health care.

The OHCHR report emphasises that human rights harms and violations related to one's inability to bear children often punish individuals—primarily women and girls—for failing to fulfill and/or for transgressing their gender role. States are obligated to address the discriminatory stereotypes that lead to such harmful consequences of infertility.

These rights, together with others, give rise to robust government obligations to ensure prevention, diagnosis, and treatment of infertility and to prevent and address the discriminatory norms that exacerbate the harmful consequences of preventable infertility.

Conclusion. All too often, global discussions around infertility solely focus on treatment, while overlooking that much of infertility is preventable. This places individuals in a position where they can only have children if and when laws and practical realities allow them to access ART, surrogacy, and/or adoption. It is critical to advocate for the availability, accessibility, acceptability and quality of ART, as there will always be a need for treatment for unpreventable biomedical and social infertility. However, it is equally important to recognise that infertility is often preventable and that governments have human rights obligations to both

prevent infertility and create enabling conditions for all people to have children and build families. The forthcoming publication of the OHCHR report provides a critical opportunity to raise the profile of governments' failure to address preventable infertility, which is often rooted in discrimination and stereotyping and can arise to reproductive oppression, and to call on governments', donors and other key stakeholders to address infertility prevention in tandem with equal access to treatment.

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- 2 See WHO, *Infertility Prevalence Estimates, 1990-2021*, p. xi, xii, <https://www.who.int/publications/i/item/978920068315>.
- 3 Office of the High Commissioner for Human Rights (OHCHR), 'The Role of Human Rights in Preventing Infertility and Redressing Infertility-related Rights Violations and Harms', 2023. [hereinafter OHCHR 2023 Human Rights and Infertility Report].
- 4 See F. Van Balen, *Involuntary childlessness: a neglected problem in poor-resource areas*, ESHRE MONOGRAPHS, Vol.2008, Iss. 1, 2008, p. 25-28; see also Arthur Greil, Julia McQuillan, and Kathleen Slauson-Blevins, *The Social Construction of Infertility*, in *SOCIOLOGY COMPASS*, 2011.
- 5 *Ibid.* at p. ix.
- 6 These individuals fall under the category of social infertility which refers to legal, social, or regulatory constraints on one's ability to reproduce. See Lisa Campo-Engelstein, *How Should we Define Infertility and Who Counts as Infertile?*, *BIOETHICS TODAY* (Apr. 20, 2015), <https://www.amc.edu/BioethicsBlog/post.cfm/how-should-we-define-infertility-andwho-counts-as-infertile>; Anna Louis Sussman, *The Case for Redefining Infertility*, *NEW YORKER* (June 18, 2019), <https://www.newyorker.com/culture/annals-of-inquiry/the-case-for-social-infertility>.
- 7 See OHCHR 2023 Human Rights and Infertility Report, *supra* note 3.
- 8 See OHCHR 2023 Human Rights and Infertility Report, *supra* note 3, at p. 2.
- 9 See Working Group on Discrimination against Women and Girls, *A/HRC/32/44* (2016), paras. 61-62.
- 10 See Abdullah S. Daar, Zara Merali, *Infertility and social suffering: The case of ART in developing countries*, in *Current Practices and Controversies in Assisted Reproduction: Report of a meeting on "Medical, Ethical and Social Aspects of Assisted Reproduction held at WHO Headquarters in Geneva, Switzerland 17-21 September 2001 (2002)*; see also WHO, *Fact-Sheet: Infertility*, 2020.
- 11 See CESCR, *General Comment 22* (right to sexual and reproductive health), UN Doc. E/C.12/GC/22, 2016, para. 7.
- 12 See, e.g., ICPD Programme of Action, para. 4.1; Convention on the Rights of Persons with Disabilities, Arts. 3, 25; CEDAW Committee, *General Recommendation 24*, para. 31(e).
- 13 Kaara Baptiste, *Well-born: Black Women and the Infertility Crisis No One is Talking About*, *CUNY Academic Works*, 2014, https://academicworks.cuny.edu/cgi/viewcontent.cgi?article=1007&context=gj_etds.
- 14 See OHCHR 2023 Human Rights and Infertility Report, *supra* note 3, at p. 18-21.

REIMAGINING SEXUALITY EDUCATION FOR YOUTH WITH DISABILITIES

There are nearly 180 to 220 million young people with disabilities¹ globally. Despite this number, there is very limited understanding of their needs, desires and even education, especially around sexuality. Even though research has shown that sexuality education for youth with disabilities would bolster their sense of self, enhance their understanding of boundaries, consent and their desires,² there is still little acceptance and inclination from families and the education system to provide them with this crucial information.

Research in India and abroad has shown that disability plays a role in the access to sexual and reproductive health information. For instance, studies and research in countries like the United Kingdom,³ Australia,⁴ South Africa,⁵ and even India^{6,7} show that there is still a lot of hesitation to provide youth with intellectual disabilities information around sexuality. There is a baseline assumption that they will not be able to process this “complicated” information and therefore it would be best to not provide it to them. In the *Sexuality and Disability* paper by TARSHI, we see many activists and advocates reinforce these ideas. Nidhi Goyal, founder and Executive Director of Rising Flame is quoted addressing the protectionism and control individuals with disabilities experience. She observes, “for people the only way sexuality work is legitimised is through violence, because we as a society still have a protection and control-based approach rather than a rights-based approach towards people with disabilities.”

Often it is assumed that youth with intellectual disabilities need protection from sexual experiences as they are desexualised⁸ while the contrarian view states that persons with disabilities feel desires acutely and cannot “control” themselves or are “hypersexual”. This is thought to be especially true for those with psychosocial and intellectual disabilities.



In 2022, during a needs assessment for a project around sexuality and the needs of young people with disabilities, we⁹ had many discussions with parents, educators and youth with disabilities. These two ideas of being not sexual and/or being hypersexual were reiterated by many voices. Our conversations uncovered many stereotypes, stigmas and falsehoods that youth with disabilities encounter and experience within their ecosystem. The conversations showed us the deep concern both parents and educators experience to protect adolescents from experiences of sexual violence. However, simultaneously at play were several practices which suppressed or restricted their sexual desires and explorations. In this duality, the voices of youth with disabilities and their individual needs were completely absent.

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In the interviews with the educators for youth with intellectual disabilities, some of them shared their current responses to explorations around sexuality (e.g., touching themselves) which included providing them with excess physical exercise to ensure they were too tired to touch themselves. This demonstrated the existing taboo of disability and sexuality.

One of them even discussed how to modify garments like pants in order for the adolescent to not be able to unzip and touch himself. Some educators even spoke about how they responded with punishment, isolation, or separation when an adolescent showed interest in the other gender or were caught holding hands. In another instance, a parent of a child with an intellectual disability shared how a doctor recommended restricting the child’s interactions with the world by keeping him at home to prevent him from masturbating in public.

In most of these situations, we see that there are underlying concerns and assumptions about acceptable and unacceptable behaviours with regards to sexuality—whether it is unzipping around others or masturbating in public or being vulnerable to violence. There is also a prevailing sense of stigma around their sexuality, especially being reinforced by those in positions of power such as doctors. It is also seen as taboo to exhibit interest in others and seek intimacy.

However, in most of these cases, educators and parents of children with disabilities were not provided with information or hands-on skills to navigate the sexuality of the adolescents with disabilities. On the contrary, we found that the educators, parents, doctors—

those who most frequently interact with youth with disabilities—felt they had to control their experiences of sexuality. Many of them firmly felt that marriage and relationships were entirely impossible for them because of the “emotional” demands of relationships which they would not be able to “manage”. In many ways, these stereotypes play into the dehumanising and restricting of their experiences, all the while making decisions for their well-being. This is not different from how many persons with intellectual disabilities are stripped of their legal capacity because of assumptions around what is deemed suitable for them and their understanding.

It is important to note that these experiences or assumptions uncovered during the fieldwork in India were neither isolated nor rare.

This protectionist lens, or even gatekeeping, was also found in a study conducted in the United Kingdom¹⁰ about persons with intellectual disabilities using the internet for making friends. The study quotes multiple experiences of gatekeeping by caregivers through the narratives of people with disabilities. One such example was: “Other participants who used personal electronic devices and internet based social media described surveillance behaviours by caregivers such as checking up on their online and social media activity. For example, Justin (22 years old) stated that his mother told him “You can’t look at pornographic stuff”. Justin told her “I don’t do that stuff”. Justin also reported that his mother checks his phone, looking for pornographic images, and told him “Don’t go onto any of those things [pornographic sites]”.”

In her piece exploring special educators and sexuality of young people with intellectual disabilities, researcher Shruti Vaidya¹¹ finds: “Importantly, their [special educators] interventions have consequences for the kinds of sexual opportunities, and more broadly,

forms of personhood made available to intellectually disabled people.” Through the process of providing care, support and education, special educators have a unique place in the lives of youth with disabilities where they can and often do act from a place of influence.

The assumptions, stereotypes and opinions demonstrate and reiterate the importance of providing comprehensive sexuality education for youth with disabilities, especially those with intellectual disabilities.

In a video of a panel dialogue at Purple Fest on Gender, Sexuality and Disability¹² Goyal spoke about the hesitancy within our communities to broach these topics of sexual experiences because of a limited understanding of what youth with disabilities need. Her videos also address the need for us to challenge these stereotypes and build a curriculum for youth with disabilities to learn about their bodies and learn to exercise their bodily autonomy.

Assumptions around sexuality and desires of youth with disabilities continue to exist because of society’s persistent belief that persons with disabilities are somehow “less than” their non-disabled peers. By placing sexuality very low on the hierarchy of what youth with disabilities need information on, we have built a system that reinforces their dependence on others. We have also furthered the understanding that sexuality isn’t for them. We have not attempted to provide the necessary information in accessible and easy to understand formats. Breaking down concepts of privacy, understanding personal and public spaces, exploring one’s desires become very important information and skills that youth with disabilities will benefit from. It would also work towards building an environment with less surveillance for them—as at present parents and educators often act entirely from a protectionist lens.

These experiences also demonstrate the need for us to build a curriculum and train educators and caregivers to unpack their assumptions, the existing stigma around disability and work towards enhancing and realising the rights of youth with disabilities. This will also enable us to equip adolescents with disabilities with skills to make friendships, intimate relationships and participate meaningfully in society.

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- 8 McCarthy, 1999; Yau, Ng, Lau, Chan, & Chan, 2009.
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RETHINKING ADOLESCENT SEXUALITY IN AFRICA: *Shifting from Cultural and Historical Perspectives to a Rights-based Approach*

Introduction. In many African countries, the approaches on adolescent sexuality primarily revolve around punishment rather than addressing the underlying structural factors that result in negative consequences associated with uninformed and unskilled sexual activity among adolescents. This can be attributed to a regulatory system that combines gendered cultural norms with some historically inherited laws governing the sexual conduct of young people in Africa.

The region needs to adopt new perspectives on adolescents and sexuality. Laws and policies concerning adolescent sexuality should conform to child rights principles if Africa is to reap the benefits of its young population and achieve the “Africa we Want”.

Cultural and Historical Perspective of Sexual Conduct Regulation in Africa.

Regulation of sexual conduct between or with children has always existed in Africa, but the age of consent under criminal laws is historically a colonial provenance and has negatively influenced Africa’s attitudes towards adolescent sexuality. The concept of adolescence as an intermediate period between childhood and adulthood, defined by a specific age range, was non-existent in the worldview of African cultures until the introduction of Western notions of childhood.

Traditionally, the end of childhood was marked by puberty accompanied by rites of passage rather than by reaching a specific age.¹ Young children are, however, constructed as asexual. Although in some cultures circumscribed forms of sexual activity are acceptable between unmarried girls and boys; sexual intercourse was an activity reserved for adults in a stable union.² For example, among the Kikuyu of Kenya, both girls and boys could engage in non-penetrative sexual activity called *ngwiko* or *ngweko*,³ but this was only for initiated boys and girls. A similar practice called *Ukumetssha* existed among the Xhosa in Southern Africa.⁴ Among the Luo of Kenya, limited sexual activity was permitted among initiated young people.⁵ Among the Maasai, circumcised boys were free to have sex with uncircumcised girls or young married girls as long as they belonged to their own age group and not to their mother’s or father’s peers.⁶

The impact of colonialism in Africa brought about the introduction of foreign cultural norms, including various laws governing sexual activity. These laws imposed a pluralistic normative environment on African communities, where multiple regulatory frameworks coexist and often compete with one another. This environment consists of formal Western-derived laws, African traditional norms, and Abrahamic religious norms. The interplay between these different frameworks has created a complex and dynamic landscape in terms

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of regulating sexual conduct in African societies.⁷ Most colonial penal and criminal codes contained age of consent provisions which were inherently patriarchal and class-based in their countries of origin, and inflected gender-stereotypical views about sexuality.^{8,9}

The interest of colonial governments in introducing age of consent laws was not to protect African adolescents from harm, but to advance imperial interests of colonial governments. The adoption of colonial age of consent laws in Africa has had significant implications on the criminalisation of consensual sexual conduct between adolescents. These laws have established strict prohibitions on sexual conduct based on age, and the prohibitions were absolute in nature. Girls were constructed as nonautonomous and sexually passive, and age of consent laws were enacted to restrain male sexual desire that was constructed as aggressive and dangerous. The age of consent law therefore has delegated control over sexual access to girls to their legal guardians, who were typically adult males. These legal guardians, such as fathers or other male relatives, were granted the authority to decide on matters related to the sexual conduct of their adolescent girl wards. This system effectively limited the agency and autonomy of girls, as their sexual decisions and choices were subjected to the control and approval of adult male figures. This power dynamic reinforced traditional gender roles and further marginalised the voices and rights of young girls in matters pertaining to their own sexuality.¹⁰

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Although the cultural systems of the coloniser and the colonised differed on how they viewed the onset of adolescent sexuality (*childhood end marked by a specific age vs. childhood end marked by puberty accompanied by rites of passage*), there were also several similarities. First, they were both gendered and patriarchal in nature which gave power to men as the regulators of the sexual conduct of adolescents, especially girls. They also valued female chastity and virginity, so that the girl was under stricter surveillance and control than the boy. A girl who was found to have had sex before marriage was considered as less pure and less desirable for a good marriage while boys were excused if they engaged in sexual activities. In both cultural systems, the responsibility was on the girl to remain “chaste and pure” rather than on the boy.

From Pluralistic Norms to Human Rights Norms. Nowadays, formal Western-derived laws, African traditional norms, as well as the Abrahamic religious norms continue to influence most African States’ approaches toward adolescent sexuality. In such multiple regulatory frameworks, the most important question is whether these frameworks are aligned with the rights of adolescents. The answer is absolutely no because both frameworks are discriminatory toward adolescent girls, do not encourage gender equitable behavior and do not promote harmonious relationships among the heterogeneous group of adolescents from an early age. The patriarchal nature of the colonial law and its resonance with cultural practices that were also patriarchal in nature might explain why some countries still retain the colonial laws, despite that it was initially introduced as one of the tools of domination and oppression of Africans. Interestingly, even countries that have abandoned colonial legislation and have transformed their laws to be aligned with human rights norms, such as



Kenya, the formulation of the new laws or their application still reflect gender stereotypical views about sexuality. Boys continue to be regarded as sexually active and the initiators of sex, whereas girls are treated as sexually passive and accorded the victim status.¹¹ The sexuality of girls is more strictly policed because girls are regarded as vulnerable and easily succumb to the sexual desires of boys and men. Unwittingly, this is the very reason several age of consent laws in Africa disempower girls and sustain discourses that undermine the agency of girls.¹²

These frameworks infringe so many rights of adolescents, especially girls, including the rights to non-discrimination, to dignity and privacy. They stigmatise adolescents’ sexuality and do not recognise the evolving capacities of adolescents and their normative development insofar as adolescent SRHR is concerned.

Human rights norms recognised in various treaties invite new ways of thinking about adolescents and sexuality. Laws and policies regulating adolescent sexual conduct should conform to child rights principles articulated in the United Nations Convention on the Rights of the Child (UNCRC) and Africa Charter on the Right and Welfare of the Child (ACRWC), as interpreted and explained by the treaty monitoring bodies.¹³ The ICPD Programme of Action of 1992¹⁴ affirms that “Responsible sexual behaviour, sensitivity and equity in gender relations,

particularly when instilled during the formative years, enhance and promote respectful and harmonious partnerships between men and women” (para 7.34).

Conclusion. If Africa wants to reap the benefits of its young population and achieve the “Africa We Want”, it’s therefore important for African governments to intentionally shift from the pluralistic normative framework to a framework that is based on the right of adolescents to be free and protected from unwanted sexual aggression in regulating their sexual conduct. This would be possible only if governments promote equal rights and ensure legal status with regard to consent and autonomy in matters relating to sex activities of adolescents, eliminate discriminatory stereotypes, and appreciate that adolescents are heterogeneously capable of engaging in sexual conduct in a manner that is respectful of each other.

Shaping sexual conduct between and among adolescents in Africa should not rely solely on penal laws as the primary means, rather governments should adopt rights-based perspectives in developing age of consent laws that both protect adolescents from harm and respect their agency and autonomy. This approach necessitates providing adolescents with comprehensive sexuality education and necessary support, from early on in their lives, to enable them to develop positive and equitable attitudes towards gender relations and sexual identities.

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COMPLEXITIES IN ADDRESSING DALIT WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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Introduction. The Rural Women's Social Education Centre (RUWSEC) is a grassroots Dalit women's rights organisation working for young people and women's Sexual Reproductive Health and Rights (SRHR). Since its inception in 1981, the vision of RUWSEC is achieving women's well-being through women's empowerment. RUWSEC's primary focus has been on enabling women to gain greater control over their bodies and lives and achieve well-being by promoting gender equality, and sexual and reproductive rights. The organisation's overall approach has motivated and educated women from poor and marginalised communities to stand up for their rights and become agents of social change. Over the years, RUWSEC's work has included women, men, adolescents, and young people towards promoting gender equalitarian relationships and SRHR.

RUWSEC conducts leadership and SRHR workshops for different target groups, including adolescents and young people, married women and men, frontline health workers and civil society organisation leaders. In addition to community capacity building, RUWSEC provides SRHR healthcare services to rural poor people with women-centred counselling on SRHR and intimate partner violence. Producing popular health education materials, research on gender and SRHR, networking and advocacy with key stakeholders are the other key activities of RUWSEC.

SRHR Situation of Dalit Women in

Tamil Nadu. Dalits are the lowest stratum of India's caste system. They were previously considered untouchables, and officially, they are called Scheduled Castes. They are a socially and economically downtrodden

community in India. Dalits in the state are predominantly landless agricultural labourers who live in rural areas. Dalits account for 20 per cent of the Tamil Nadu State population.¹

Women's sexual and reproductive health and rights include bodily autonomy and decision-making powers. They have the right to safe and healthy relationships, whereby women can exercise their right to choose their partner, sexuality, when to have children and how many children to have and the use of contraceptive methods. But this is not feasible for Dalit women due to numerous interlinking factors, poverty and caste, strong social and gender norms, lack of support from the partners and elders in the family, and lack of resources and financial constraints to access health care services. Mainly, they face the triple burden as part of the bottom-most caste

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hierarchy; they face caste discrimination; secondly, as women, they face gender discrimination; and thirdly, as poor, they face class discrimination.

Due to poverty and gender discrimination, low Body Mass Index (BMI) and nutritional anaemia are high among Dalit girls and women compared to women from other castes.^{2,3} Young girls are poorly informed about sexual and reproductive health. A recent study done with college-going Dalit girls in Tamil Nadu found that more than 44 per cent reported that they had experienced their first menstruation without knowing about it.⁴ Gender and sexual norms are still strong, and men control women's sexuality and reproduction. The under-five mortality rate is also noticeably higher among Dalits (29) than among others (18.9). The prevalence of domestic violence among ever-married women was significantly higher among Dalits, 46.6, compared to the state's average of 39.6.⁵

During the last two decades, the Tamil Nadu state government has developed a few educational support programmes for poor and marginalised girls. As a result, many Dalit girls are able to complete

their school education and work in factories as labourers. They, too, can start supporting their family financially. However, men in the family strictly control girls' mobility and decision-making once they attain puberty. When they leave home, they can interact with boys/men. But society views all relationships between young boys and girls as love. When their parents come to know about their relationship, they stop their education or work and arrange for a marriage with another man. It is also observed that love and inter-caste marriages have reportedly been increasing in the recent decade. In such cases, Dalit women are victimised in inter-caste marriages—honour killings and suicides are increasing.

In our project area, many Dalit women work in companies as wage labourers to support their families financially. Before going to work, they complete the household chores; after coming from work, they must take care of them. Domestic work and reproduction are still women's responsibility; the woman is blamed if something goes wrong. Non-consensual sex is one of the leading factors for unwanted pregnancies and

abortions among Dalit women. Men's involvement in contraception is almost nil. Women do not have sexual rights, and among married couples coercive sex is more common. When the women say they are tired or express their health-related concerns, their husbands do not listen. Instead, they blame her for not fulfilling their desires or fight with her, stating that she has an extramarital relationship in the workplace. Due to social norms, restrictions and the lack of control over their bodies, women often do not express their condition to others. Moreover, the relationship between a husband and wife is constrained within four walls, and they believe it should not be made public as this is deeply rooted in their mind; the burden and problems that Dalit women face in households and the workplace have increased multi-fold.

Over the years of working with Dalit women, we observed that they also face violence on the domestic front and problems due to the alcohol addiction of their husbands. They also face difficulties and challenges in access to sexual and reproductive health care services. Providing complete information about SRH and consent is absent in public health facilities. When it comes to Dalit women, they are looked down upon for their appearance, and discrimination—stigma and denial of certain services are reported. Public health facilities are the primary source of SRH services for rural Dalit women. When they get poor healthcare and are discriminated against, it severely affects their health and well-being. The following four narratives are examples of lived experiences of married Dalit women in rural areas (taken from the meeting reports and counselling records at RUWSEC in 2022). These reflect how their sexual and reproductive justice is violated at their household and health system levels.



Sexual and Gender-Based Violence Against Women at the Household Level.

A 45-year-old woman with three daughters has an abusive, alcoholic husband. One day while she was sleeping with her daughter, he came in the middle of the night and forced her to have sex. They fought and her children woke up, resulting in an awkward situation for them. He started hurling abuse at her and beat her badly. When her children began to learn about their father's behaviour, they started feeling bad, and she found it challenging to handle them. It led to low self-esteem and severe mental stress for her.

A 47-year old married woman with two teenage daughters has an abusive husband who drinks and beats her and their daughters. She goes to work to support her family, but her husband forcefully takes her earnings and spends them on alcohol. She decided to leave him and went to a nearby town, where she stayed in a rented house. Her husband came there and created problems for her by standing in front of the house and talking in abusive language, and he even broke the door. The house owner became furious and asked them to leave the place. Left with no choice, they had to go back to the village. The woman and her eldest daughter go to work in a van which picks them up from the village. One day, her husband caught hold of the driver and beat him badly, and told the driver not to pick her up in the vehicle. One day he burnt all of their clothes and certificates so they would not be able to leave the house. Even now, they do not have a choice; if they go out, he will follow and make their lives miserable.

Denial, Discrimination, and Lack Of Informed Consent To Provide Cut at The Health System Level. A 24-year-old woman with two daughters aborted her third pregnancy. She could not use an intrauterine device because of a reproductive tract infection. She did not

go for a contraceptive operation as she was very weak, and her haemoglobin level was very low. But her husband did not want to use any contraceptives. The health care provider neither provided her with information about other methods of contraception nor motivated her husband to use contraception. Sexual violence was a recurrent event for her. Consequently, within three months of the abortion, she became pregnant again, resulting in a miscarriage. Subsequently she became pregnant for the fifth time and delivered a baby boy; after delivery, she opted for a tubectomy operation. However, her haemoglobin level was still very low; the government doctors said they could not do it. When her son was seven months old, she conceived again for the sixth time. Then she went to the hospital and had an abortion and tubectomy operation with a blood transfusion.

A 23-year old woman had her first delivery in the district Government Hospital; after delivery, she was given Copper-T (a copper intrauterine device) without her informed consent. She thought that if they gave her the Copper-T, they would get her signature or tell her during discharge, but this did not happen. She assumed she was not given Copper-T, but after three months, she had discomfort in her lower abdomen. When she discussed it with other women from her neighbourhood, she was told that Copper-T is usually given without informed consent in the general hospital and she asked to consult the doctor. After consulting the doctor, she found out about the Copper-T and when she asked the doctor to remove it, but was told there is a rule in public health facilities to not remove it within less than two years. As she could not manage the pain, she consulted a private practitioner and removed it by paying 2,000 Rupees.

These women were counselled and provided necessary support by the

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RUWSEC counsellors and health workers. Based on our experience working with Dalit women and from the above narratives, we felt that they could not exercise their basic SRH and rights without addressing the structural factors, discriminatory practices, and strong patriarchal norms.

Dalit women do not have control over their own bodies; even though they know their rights, they cannot practice them, as their partners control all their decisions.

Conclusion. Dalit women's SRHR problems are more complex and deeply rooted in gender and social norms. They are deprived at various life stages from childhood poverty, caste and class discrimination; gender plays an important role in disempowering them. Thus, the intersections of caste, class and gender are seen, severely impacting Dalit women's SRH and rights. Dalit women do not have control over their own bodies; even though they know their rights, they cannot practice them, as their partners control all their decisions. Due to poverty and societal norms, they are forced to live with their partners despite unhealthy behaviour and extreme forms of violence on the domestic front. They could not use contraceptive methods to space out births or limit family size. Men believe it is a woman's responsibility. Although some contraceptive methods do not suit them and have complications, women are forced to use them. Married men rarely use contraceptives. Women are forced to live with partners who are perpetrators of gender-based violence. Public health facilities are the only source of health care for them. It also contributes to the poor health status of Dalit women as there is denial and discrimination of SRH services to them.

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Above all, an intersectionality and justice approach are needed to address Dalit women's SRHR. Thus, it is imperative to remove deep-rooted gender and patriarchal norms in society by educating Dalit men on gender egalitarian relations and taking responsibility for women's health. Secondly, the economic empowerment of poor Dalit women is needed to make independent decisions when facing extreme forms of domestic violence. Poor women's dignity and freedom should be protected. Thirdly, public healthcare providers should be sensitised to provide women-centred, better-quality healthcare services.

Acknowledgements: The article was developed with insights from RUWSEC staff. Special thanks to Ms. D Selvi and Ms. G Kalavathi, co-ordinators of RUWSEC, for sharing women's narratives and their field experiences.

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INACCESSIBILITY OF SRH SERVICES IN EMERGENCIES: *A Barrier to Achieving Reproductive Justice*

Medical Services Pacific (MSP) provides an integrated care service for survivors of sexual assault-related cases through formal protocols with the Government of Fiji and other stakeholders to deliver services through a One Stop Shop. MSP, through its 11 years of experience in handling and being the first responders to post-rape and sexual offence care, takes pride in being the only post-rape care facility in the Pacific that understands the need for urgency, confidentiality and a sense of privacy when dealing with survivors of sexual assault cases. MSP also partakes in creating education and awareness on Reproductive Health, Gender-Based Violence, and child protection; and provides consultation on family planning, non-communicable diseases and cervical cancer screening in the Fijian communities. MSP understands the

importance of sexual reproductive health of women, youth and children as it is emphasised in the Sustainable Development Goal (SDG) 3 with an objective to "Ensure healthy lives and promote well-being for all at all ages" by 2030.

Family planning, sexually transmitted infections, and post-care for sexual violence should be a fundamental part of access but are all too often disregarded, especially in emergency situations where difficulties arise in access to food, water, shelter, and other basic human rights. Reproductive justice acknowledges that a number of intersecting factors, including race, class, gender identity, sexual orientation, disability, and immigration status, have an impact on reproductive choices and results.

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Family planning, sexually transmitted infections, and post-care for sexual violence should be a fundamental part of access but are all too often disregarded, especially in emergency situations where difficulties arise.

Fiji is the hub of the Pacific and has been known to be susceptible to cyclones, flash floods, and political unrest. The displacement of people during these occurrences has had a significant negative impact on the social and economic conditions of individuals who have to face these circumstances.

The status quo in Fiji with regards to reproductive health typically takes a backseat because of the geographical location of the grassroots women, lack of manpower in governmental agencies

to provide basic health care services, traditional and cultural taboos pertaining to a woman having the sole right to make an informed decision on all matters involving her body, and misconceptions about family planning and its efficacy.

Fiji has ratified international legal instruments like the Convention on the Elimination on all Forms of Discrimination Against Women and Girls (CEDAW), Convention on the Rights of the Child (CRC), enacted National Laws such as the Domestic Violence (DV) Act 2009, established the National Gender Policy (NGP) 2014, implemented comprehensive Social Protection Schemes to protect children, elderly women, single mothers through financial assistance and a Nation Action Plan for Elimination of Violence Against All Women and Girls 2023-2028.

Despite Fiji's advancements in areas like education and employment, restrictive gender norms continue to be widespread and they serve as an obstruction to the creation and implementation of laws and policies that aim to address gender-based violence.

The government has taken steps to combat gender disparity on a national policy level through the National Gender Policy (2014) and other measures addressing gendered violence. In addition to addressing violence against women, the Fijian government has acted regarding women's economic participation, leadership, and the gendered impact of climate change. The Women's Plan of Action (2021-2026) an initiative by Fiji's Ministry of Women, Children and Poverty Alleviation, set out three strategic priorities; Elimination of Violence Against Women and Girls, Promoting women's economic empowerment and Protection,

Preparedness, and Resilience to Disasters. The National Action Plan to Prevent Violence Against All Women and Girls (2023-2028) was launched in June 2023 which also encompasses the need for reproductive justice.

Despite Fiji's advancements in areas like education and employment (Chattier, 2013), restrictive gender norms continue to be widespread and they serve as an obstruction to the creation and implementation of laws and policies that aim to address gender-based violence. These norms are recognisable in both iTaukei and Fijian of Indian Descent communities and have been established by colonial systems and perpetuated by the locals.

Fiji is ranked 103 out of 153 nations in the Global Gender Gap Index 2020 rankings, which evaluates inequities across economic, educational, political, and health sectors (World Economic Forum, 2019). Fijian women endure economic, political, and social disparities. Through patrilineal titles, men continue to have more access to land and resources and have a far larger earning potential. According to the 2017 census, men made up 76% of the labour force, while women made up 37.3 %. (Fiji Bureau of Statistics, 2018).

It has been established that men continue to occupy positions of supremacy over women and are seen as the heads of the household in many Fijian communities. These patriarchal systems are ingrained in both the iTaukei and the Indian-Fijian populations. Violence in marriage is still tolerated, and many people still hold the view that men should have a position of power in marriage. Due to this, women are frequently held accountable for acts of violence perpetuated on them, for failing to treat their partners with the respect they deserve, or for failing to fulfil their obligations as women and are obligated to obey their husbands and

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head of the families even regarding their own body.

Although there have been incredible efforts placed in legislation for gender inclusiveness and equality by the Fijian Government, there are still suppressing legislations within the jurisdiction that prohibit and make a dangerous environment for women by suppressing their rights to choose under the Crimes Act 2009, whereby abortion is criminalised with heavy penalties.

Ideally, it is legislated in the international conventions that access to safe abortion is a choice made by each individual for profound personal reasons that no man or state should judge or interfere with. However, in Fiji and in many international states, the conversation of free choice for abortion is still a highly controversial issue and access to such commodities is unavailable in Fiji unless it falls under Rape, Incest, Mental Health and Physical Health.

Abortion should be made available upon the request of the person who is pregnant instead of being restricted on the basis of legal justifications. Any remaining grounds should be created and handled in a way consistent with international human rights law. This mandates that abortion is an option in cases where a woman would suffer significantly from carrying a pregnancy to term, including but not limited to instances where the pregnancy is not viable. Grounds-based strategies that mandate that fatal impairments must indeed be fatal in order for abortion to be legal frustrate providers and force women to carry their pregnancies to term. Numerous human rights are violated when a pregnant woman is forced to continue the pregnancy despite the suffering it causes. Laws or policies that impose time limits on the length of pregnancy may have negative consequences for women, including

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forcing them to seek clandestine abortions and suffer social inequities.

A specific National Action Plan to ensure that first responders together with state parties prepare and plan for sexual and reproductive health services that need to be deployed and engaged during emergencies should be invested in. This also includes helping people recover from crisis by rebuilding and strengthening local health systems to provide comprehensive sexual and reproductive health services in normal circumstances so that they have the means to provide the same services in emergencies.

Preparedness efforts on SRHR and public health in emergencies through capacity strengthening of governments, local partners, and other humanitarian actors must be enhanced. Agile, rights-based, people-centred, gender-sensitive emergency response efforts guided by the minimum, and life-saving sexual and reproductive health needs should be addressed at the onset of an emergency.

Support must be given to community-based approaches that increase access to critical information, combat rumours and stigma, and address barriers to access these essential services, as well as the transition to comprehensive SRHR services in fragile and conflict-affected settings by strengthening government health systems that have been weakened by the crisis. Locally-led efforts to amplify voices, enhance accountability and shift power and resources to leaders, particularly women and adolescent girls should be supported. Gender-based Violence integration, including clinical response to rape and other sexual-related offences must also be enhanced. Its undeniable that emergency situations have a tremendous psychological and emotional impact on people and communities. In times of urgency, it's possible that mental health services—including assistance with postpartum depression, trauma



counselling, and psychological care connected to reproductive health—may not be adequately prioritised or accessible. This may make it much more difficult for people to obtain reproductive justice.

An all-encompassing strategy is needed to address the inaccessibility of reproductive justice in times of crisis. Prioritising the needs of at-risk groups, guaranteeing the accessibility of crucial reproductive healthcare services, enhancing healthcare systems, advancing gender equality, and addressing social determinants of health should be part of the framework. The maintenance and restoration of access to reproductive healthcare services and support networks during times of crisis should also be included by emergency preparedness strategies.

The reproductive justice paradigm also recognises the historical and current realities of reproductive oppression that communities have had to deal with. It promotes a comprehensive strategy for reproductive health and rights that considers the particular requirements and experiences of various people.

Reproductive justice promotes the freedom for people to make decisions about their reproductive lives without being subjected to violence, coercion, or other forms of discrimination. Reproductive justice aims to remove these institutional impediments so that everyone can make decisions about their reproductive lives without being subjected to pressure, prejudice, or injury.

The reproductive justice paradigm also recognises the historical and current realities of reproductive oppression that communities, notably people of colour, indigenous peoples, and low-income people, have had to deal with. It promotes a comprehensive strategy for reproductive health and rights that considers the particular requirements and experiences of various people. In Fiji, where language, geographical access, educational experts have to head on custodial blockages, cultural sensitivity and the patriarchal generation, emphasis on removing these barriers and having elites have an educational conversation surrounding reproductive justice and giving women the choice to make the choices pertaining to their bodies is the first step to reducing the gap in reproductive justice.

Endnote: MSP Patron – Former Head of State and Former Speaker of the House, Ratu Epeli Nailatikau | Fiji Country Director: Ashna Shaleen | Registered Charity #877.

DECRIMINALISATION

decriminalisation of laws regulating abortion, adolescent sexuality, premarital sexuality, same-sex sexual relationships, gender identity, discrimination based on pregnancy and HIV status helps improve sexual and reproductive health outcomes for the most marginalised groups in our society



MY BODY = MY CHOICE!

QUEER & PROUD

re-look at legal frameworks which continue to perpetuate colonialist and casteist biases and assumptions



REPRODUCTIVE LABOUR

women and girls in Asia and the Pacific work the longest hours in the world, most of this (4.4 hours out of 7.7 hours) is in unpaid reproductive labour and care work

work assigned to women and girls stems from the gender hierarchy and gendered power relations



gendered division of labour in unpaid work and gender gaps in time spent in unpaid work



recognise, reduce and redistribute care work

burden of care being disproportionately borne by women and girls, but not exclusively, and not always by choice

social obligations and expectations around family, gender roles reinforced by media, government reinforced women's roles in unpaid reproductive labour and care work

reproductive labour
builds on reproductive
and reproductive
addresses power
promotes movement
and is inter



VIOLENCE

maternal mortality, miscarriage, premature labour/delivery, higher levels of depression during or after pregnancy



SRH Services = safe abortion, HIV-prophylaxis, counselling and referral to shelters and legal aid



marginalised groups like women + girls with disabilities, LGBTI persons, Dalit women most at risk



HELP



EQUITY



Infertility

women and girls with disabilities

some groups are invisibilised in current paradigms - older women have always been missing from the SRH equation



under-resourced and fragmented health systems

those who live in fragile contexts and their extreme vulnerability to climate change and conflict

comprehensive SRH services as per the ICPD ideal

whilst equity to access of services is one aspect, quality of services accessed is another critical aspect

ve justice
oductive health
ctive rights.
wer dynamics.
ement building.
rsectional.

TECHNOLOGY



SRHR + Tech = medication abortion, contraception, STI testing, post-abortion contraception, safe sex behaviours and practices, outreach to high-risk groups - sex workers, adolescents and young people



DIGITAL HEALTH EQUITY: digital health determinants - access, literacy, values and norms; other social inequities are in digital health as well!

intersectionality takes security risks to women, girls and marginalised persons (indigenous, caste, disability, LGBTI persons) into account

RIGHTS & JUSTICE

state accountability

through the rights frameworks

- right to be a parent
- right not to be a parent
- right to parent in a safe environment
- right to care
- right to health
- right to comprehensive SRHR services / life-cycle
- right to a life free from violence and discrimination
- right to sexuality
- right to social protection
- right to data privacy

the reproductive justice framework helps root the SRHR agenda, address inequities, analyse power dynamics, contribute to movement building

RJ Framework = Reproductive Health + Reproductive Rights + Reproductive Justice

reproductive justice - more inclusive laws, policies, systems and institutions; rebuild + strengthen SRHR movements



ART BY @theworkplace doodler



KWS.

UNPACKING REPRODUCTIVE JUSTICE THROUGH RIGHTS AND LEGAL FRAMEWORKS

The reproductive justice framework, developed by Black feminist collective SisterSong in 1994, was inspired by their lived experiences rooted in their race, gender, sexual orientation, disability, and other identities. They sought to extend the conversations around abortion and access to women's health beyond white feminist spaces and brought an intersectional and human rights lens.¹ Reimagining sexual and reproductive health from a reproductive justice lens ensured interrogation of existing power structures with focus on choice and access to sexual and reproductive health rights (SRHR) through more comprehensive demands beyond abortion.² Inherent to the reproductive justice lens is its understanding and unpacking of structural inequalities, biases, violence and oppression. Let us take a closer look at how it advanced the human rights framework in the context of sexual and reproductive health.

Positioning reproductive health within a human rights framework offers many benefits. The first being the recognition that sexual and reproductive health and services are rooted in the basic human rights principles such as dignity and equality of every person, freedom of choice in living, expressing oneself, and that the need to satisfy basic needs is a right and not only a privilege. International human rights are characterised by the principles of universality, inalienability, interconnectedness, indivisibility and non-discrimination. Governments are then obligated to respect, protect, and fulfil these human rights beyond domestically recognised constitutional and legal norms. The rights-based

framework prioritises an individual's right to sexual and reproductive health and services with a primary focus on ensuring that abortion is legal and that there is access to contraceptives. The rights framework around SRHR is centred around a pregnant person's rights to choose and decide, to dignity, to access services, and against discrimination.

The origins of reproductive justice were based in an intersectional demand for access to sexual and reproductive health and rights (SRHR) which highlighted the health inequities that marginalised Black communities faced—it was rooted in understanding, unpacking, and fighting systemic oppressions and exclusions that were based on multiple axes of identities.³ This approach thus, takes the debate on SRHR beyond privacy, dignity and choice arguments to include the lived experiences of the people and their social realities of systemic inequalities and discrimination and prioritises intersectionality.⁴

A legal framework approach around SRHR on the other hand, would be characterised by regulation of SRHR related issues through laws and policies enacted by a government: this framework would be governed by a nation's constitution and driven by local factors including the nation's politics. Under a legal framework there is neither an explicit commitment to adopting a human rights approach nor a recognition of systemic and intersectional inequalities. This article, through case studies on abortion from India and Nepal, explores the way it was legislated and examines whether they adopted a rights framework or a legal framework. In doing so, it

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interrogates which of these frameworks has stronger potential to realise reproductive justice.

Abortion in India: Exemption from Criminal Liability or Rights Based?

Abortion in India is criminalised under its Penal Code.⁵ The Medical Termination of Pregnancy (MTP) Act, 1971 was enacted to "provid[e] for the termination of certain pregnancies by registered medical practitioners".⁶ The MTP Act essentially provided for exemption from criminal liability for medical practitioners for providing abortion. It laid down gestational limits and conditions based on which abortion could be provided. The most recent amendment to the Act in 2021 expanded the gestational limits and included unmarried women to access abortion.⁷

The legislative intent behind the passing of MTP Act seems to be geared towards population control.⁸ During the parliamentary debates before the enactment of the law, one of the reasons given by the government bringing in this legislation was to promote a 'small family' as an ideal societal component. Reasons such as increased maternal mortality rate due to unsafe abortion found no mention. Instead, some argued that women should be given a choice to abort the foetus in cases where women are at risk of giving birth to "crippled

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children.”⁹ There was no consideration for women’s bodily autonomy and self-determination or the right to choose.¹⁰ Some noted that there was no strong or well-established women’s rights movement in India around the time the law was being passed to articulate liberalisation of abortion from a women’s rights perspective.¹¹ Hence the law imagined women merely as beneficiaries of reproductive services. Although the latest amendment to the MTP Act in 2021 liberalised access to abortion by increasing gestational limits and including unmarried women in its ambit, it continued to operate within a carceral framework.¹²

Abortion in India is firmly grounded in a legal framework that lacks a rights-based approach. Abortion is legally granted as an exemption from criminal liability—there is no enumerated right to abortion.

If we recast this law from a reproductive justice lens, it would mean that abortion would be seen as a matter of right grounded in an understanding of how one’s marginalised status impacts their access to and experience of abortion, instead of merely a service governed by a legal code. It would also require that the law adopts an intersectional lens to ensure abortion is accessed by all marginalised communities irrespective of their caste, religion, class, disability, gender, sexual orientation, location, or economic status. This is exemplified in the AAAQ (Availability, Accessibility, Acceptability and Quality) framework first used in the context of service delivery on maternal health.¹³ As studies have shown, girls and women with limited access to education, from lower economic backgrounds, and from discriminated/marginalised communities face higher barriers while accessing abortion and are at a heightened risk of criminalisation.¹⁴ To take on the structural inequality and oppressions faced by marginalised communities’

access to not only abortion services but other contraceptive and family planning services must be considered.

A reproductive justice approach advances the human rights framework by addressing these concerns.

Abortion in Nepal: From Complete Ban to Constitutional Guarantee.

Like India, the Penal Code of Nepal also criminalises abortion and adopts a carceral approach to it. The complete abortion ban before 2002 correlated to Nepal having one of the world’s highest maternal morbidity rates. In 1997, an amendment Bill was sought to lift the blanket ban and provide conditional access to abortion. This was finally successful in 2002, after grassroots level movement building and advocacy. Through the 11th amendment to Muluki Ain (Country Code of Nepal) certain legal exemptions to the blanket ban on abortion were introduced.¹⁵

Later, in 2007, Nepal adopted its Interim Constitution which constitutionally guaranteed women’s reproductive rights—making Nepal one of the very few nations to do so. This was a result of sustained advocacy and a strong civil society movement. In the same year, the Nepal Supreme Court in its landmark case of *Lakshmi*,¹⁶ interpreted a woman’s right to abortion as a constitutional right guaranteed within the right to reproductive health. Following *Lakshmi*, the government has been providing abortion services free of cost in all public health facilities. Almost a decade later, in 2015, the Nepal Constitution reiterated reproductive health rights for women. In 2018, the Government passed the Safe Motherhood and Reproductive Health Rights Act (SMRHR Act). The law is progressive as it specifically recognises the right to abortion as a right to reproductive health.¹⁷

While the current legal framework in Nepal adopts a rights-centric approach, prioritising the individual’s right to choose and access abortion, it still suffers from several shortcomings. Its failure to completely decriminalise abortion has placed unnecessary burden on women. This is especially burdensome for those women who come from marginalised backgrounds on account of their class, caste, disability, and other identities. The social realities of the women do not find a place in legislation.

Conclusion. The article examined three different approaches to sexual and reproductive health including the legalistic, rights-based approach and reproductive justice approach. The case studies from Nepal and India both offer divergent and striking points of analysis. While the Indian legal framework around abortion seemed to have a legalistic approach devoid of reference to or any commitment towards rights, the Nepalese framework is strikingly progressive with explicit rights-based framing. However, both frameworks are far from fully realising reproductive justice. In most cases while focusing on an individual’s right, the factors such as their social, economic, and political clout and capital based on which that right and its access is predicated on, is missed which establishes the need for a reproductive justice approach. An individual from an urban setting, who is able-bodied, educated and with higher economic means will have a different interaction with law and access to SRHR than an individual from a marginalised community with identities that lead to further marginalisation. Reproductive justice would require the law and state actors to be conscientised to this reality, acknowledge it and work towards dismantling inherent blind spots, inequalities and bottlenecks to the accessibility of rights and services.

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IMPLEMENTING THE REPRODUCTIVE RIGHTS AND JUSTICE AGENDA – PRAXIS PATHWAYS

Historically, women in all their diversity, young people, and marginalised groups have been at the forefront of their own economic, social, political and colonial oppressive struggles in their countries, challenging colonialism, patriarchy, gendered power relations as active agents of change. Through feminist solidarity and collective actions nationally and transnationally, women's organisations, feminists, activists and advocates have been pivotal to the outcomes of key 1990 international conferences such as the International Conference on Population and Development (ICPD PoA),¹ the Beijing Platform for Action (BPfA) and Agenda 2030 for Sustainable Development around sexual and reproductive health and rights.

However, 30 years since the adoption of the International Conference on Population and Development Programme of Action (ICPD PoA), despite the roller coaster of progress and its reversal,

challenges continue in the implementation of the sexual and reproductive health and rights and justice agenda in the Asia and the Pacific region.

At the country level, these challenges are further complicated by complex historical, structural, systemic, institutional, ideological and financial barriers, resulting in inequalities within and between countries of the region. A defining example is a legacy of the colonial era that blatantly violates reproductive rights of women in all their diversity. The criminalisation of abortion, through colonial era Penal Code provisions, impacting access to the right to safe abortion. In South Asia, abortion criminalisation is a result of colonial-era penal codes. For example, in India, Pakistan, and Bangladesh, the Penal Code of 1860 introduced by the British colonial government criminalises abortion with stringent punitive measures.² These provisions continue to put women and girls and all those who can be pregnant,

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at risk of unsafe abortion practices, contributing to reproductive morbidity and in some cases maternal mortality.

As programme implementers, activists and advocates committed to advance the reproductive rights and justice agenda, an agenda understood as the right of all women and girls in all their diversity including persons who can get pregnant across economic, social political power structures, able to make healthy reproductive decisions about themselves with agency, anchored in a human rights perspective, incorporating the intersections of race, gender, class, sexual orientation and gender identity³ in the region, some practical aspects we can consider while implementing reproductive rights and justice initiatives include:

1. Laws and Policies.

The reproductive rights and justice agenda advances initiatives premised on self-determination, autonomy, equality and non-discrimination principles among others. In addition to drawing on the human rights frameworks, one approach has also been to invoke constitutional

spotlight

rights and freedoms in respective countries to advance fundamental freedoms and rights. There are positive instances where constitutional provisions have been invoked to advance sexual and reproductive rights and justice. For example, the inclusion of LGBT+ rights within the South African constitution helped to address discrimination and garnered public support for LGBT+ communities in South Africa.⁴ In Nepal the constitution commitment to gender equality provided the foundation for passage of laws such as prohibiting marital rape. Further to this, through the efforts of women groups, activists and advocates, the Interim Constitution of Nepal in 2007 and later the Constitution of Nepal in 2015, recognised reproductive rights as a part of fundamental rights, thus incorporating reproductive rights within the constitution.⁵ This approach of invoking constitutional provisions to advance reproductive rights and justice has the potential for advancing and sustaining reproductive rights and justice in respective contexts.

2. Implementation of Reproductive Rights and Justice Initiatives.

Initiatives advancing reproductive rights and justice should always be anchored on the principles of country and community ownership. The problem analysis and interventions should consider lived realities of people, and uphold their voice and agency. Programme design, implementation, follow up and review, should always include the affected communities, value their expertise as resource persons, and keep them in the centre of decision making.

Such a grounded process will also acknowledge power dynamics and place respect for plurality and diversity and devise strategies that will enhance and advance the agency of communities as active agents of change in advancing their own reproductive rights and justice.⁶



Careful risk analysis throughout the programme cycle including opposition mapping and strategising with the community stakeholders is crucial.

Further practical implementation approaches can include:

- Interrogating the programming and organisational actions from an intersectional and gendered power lens, this will help unmask privileges and oppression between and within the communities and approach marginalised groups with unique affirmative interventions. Power analysis tools should be utilised at every step of the programme cycle;
- Meaningful participation and inclusion of communities, acknowledging women and girls in all their diversity, young people, and marginalised groups are not homogenous “bodies” discounted aggregately as people lacking education, being poor, with no agency, victimised etc. At all times programme implementers should approach communities with dignity and respect and ensure marginalised groups are included;
- Building strong reproductive rights and justice networks and alliances at local, national, and regional levels and enable interactions across these platforms. Such approaches can advance solidarity, linking and learning and collective actions for change;
- Advancing capacities through value clarification on reproductive rights

and justice issues among programme implementers, stakeholders and communities themselves with enhanced agency of the communities to advance the agenda;

- Careful risk analysis throughout the programme cycle including opposition mapping and strategising with the community stakeholders is crucial. Data collected in the reproductive rights and justice initiatives, should follow ethical research protocols of informed consent, privacy, confidentiality, data protection and complaints process.

Such practical approaches when embedded within the implementation of the reproductive rights and justice initiatives can help advance reproductive rights and justice in a meaningful way within communities and countries in the region.

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Trans Rights, Healthcare, and Reproductive Justice

An Interview with Nhuun Yodmuang (Asia Pacific Transgender Network)

In this interview, ARROW spoke with Nhuun Yodmuang, Senior Human Rights and Advocacy Officer at the Asia Pacific Transgender Network (APTN), an organisation that works to enable trans and gender diverse people in the Asia Pacific to organise and advocate across many areas that affect their lives. Nhuun spoke with us on the work APTN is doing to advance the availability of trans competent healthcare across the region.

What are some of the SRHR issues that trans people face, particularly when thinking about the issues surrounding reproductive justice? When I think about what sexual and reproductive justice is and what it means to trans people, I need to stress the point that there is a serious lack of availability, accessibility, acceptability and quality of trans competent health care in this region. The health system as a whole is very binary and therefore cannot answer the question of “What are the needs of trans people in the region?” We recognise this binary as the systemic issue that we want to counter and tackle because we have found that this is what leads to institutional discrimination. There is a lack of healthcare for trans people or even discussions of what trans communities need and there is a lot of case-by-case discrimination that we have encountered as well.

Another systemic issue that I want to highlight is the privatisation of healthcare. We do not have enough doctors who are able to provide trans competent care and there is a lack of knowledge or funding to make these discussions happen, to fund research, or to create institutional resources on what healthcare trans people need and how to deal with these issues. Privatisation comes into place because of this and we’ve found that it has a double-edged sword. Today, privatisation has moved away from its original purpose of helping provide care to people. Instead, there has been a trend of monetisation,

and trans competent healthcare is not recognised as a basic need. It is only recognised as aesthetic care so the cost of these services is extremely high. These types of systemic issues lead to trans people not being able to access this care at all. Economically, trans people are discriminated against—they don’t have access to proper sources of funding and they struggle with living their own lives due to lack of money. Privatisation of healthcare has disproportionately affected trans people.

Government health structures do not include trans competent health care. Some countries in the region do receive funding from development agencies and multilateral funding from other governments to do this, but the people who are working to provide access to this form of healthcare do not have enough knowledge or awareness on how to provide services to trans people in a non-discriminatory manner. There are a lot of reported cases from trans people who have faced harassment when trying to access care that has been provided by public healthcare services. Discrimination such as misgendering and mistreatment of patients is also very common. There is a lot of knowledge that needs to be given on how to provide trans competent healthcare and I want to highlight the issue of the lack of resources because there is not enough funding being provided for this.

Most trans people cannot access the expensive services provided by private clinics and hospitals and therefore choose to go to unsafe service providers to take care of their health. Hormone therapy, which is very important for trans people, cannot be accessed by trans people through their social welfare—it is not something that is taken care of by the government and as they don’t have money to access private healthcare, they choose the unsafe option of buying it from the underground market. Though in Thailand hormone therapy may also be available in pharmacies, there is not enough information on how to take it safely and therefore there is a lot of unsupervised access to hormones. If a trans person wants to access gender affirming surgery it is very hard to access because of the cost. Gender affirming surgery is not only about genitals, it’s about the feminisation or masculinisation of your face to become who you are, it’s about hormones, and other care around sexual and reproductive health and rights such as abortion. Trans people are more likely to choose less costly, risky ways to access these services.

What other needs and rights of trans persons should also be taken into consideration with regards to healthcare? We need to talk about mental healthcare. There are a lot of trans people who face hostile situations in their countries. In the region, we can talk about Malaysia, Indonesia, India, Pakistan, and Sri Lanka, to name a few. These hostile

in their own words

situations are created due to the legal systems and religious institutions that impose risks on trans people as well. These issues do not only cause physical risks but also mental health problems. APTN has done research on what the main health issues are for trans people and one of the highlights are mental health issues. People from a young age face these mental health issues. Mental health professionals are not sensitised and tend to misgender trans people, impose their own personal beliefs and propose counseling to their patients. There are multiple layers of oppression.

Another critical issue is that of conversion therapy practices which are carried out throughout the region. We also have a research project that shows that these types of practices are perpetrated by medical health professionals. Health professionals are found to be imposing their beliefs on their patients to try and convert people to align with gender identities and expressions that fit into the binary narrative of society and fit into the gender that they were born with. This has a huge impact on people's mental health.

Reports show that the criminalisation trans persons face when accessing SRH services is a huge problem in the region too. What can you share with us about this? We need to discuss the issue of the enabling environment. We know that this is an important factor when it comes to people receiving care. There are many factors that prevent trans people from accessing the care that they need, whether it is HIV care, SRH care, or trans competent healthcare. Hostile environments perpetrated by the government and these systemic barriers of oppression prevent trans people from accessing the care they need. Criminalisation of trans people through laws that directly and indirectly discriminate against trans people are prevalent across the region, such as anti-

sodomy, anti-cross dressing, and anti-sex work laws—due to this criminalisation, when trans people access healthcare, they will need to visibilise or expose themselves and this fear prevents them from doing so. From 2008, we have been working with Transgender Europe to monitor this issue and we have found that at least 398 people have lost their lives due to transphobic hate crimes from 2008 to today. This is not the full number as we have found it is not easy to report these crimes and therefore very difficult to get this information from the police and the legal systems that do not keep records of who is and is not a trans person. This threat of violence is a huge prevention to trans people accessing healthcare.

The lack of legal protection plays into this. Not many countries in the region have laws that allow trans people to change their gender marker to their gender identities. This leads to lack of legal protection because if they are not recognised by laws then there is a lack of legal accountability mechanisms. When trans people file a complaint, they face a lot of stigmatisation, discrimination, and disbelief from the officials. A large amount of trans people in the region belong to the sex work community so when they file police reports they are then exposed to police violence. This is a bigger question on how the system as a whole is discriminatory towards trans people and also prevents them from their basic needs and access to justice.

Can you share some recommendations or best practices when it comes to how you feel we can attain reproductive justice for trans persons? APTN places a lot of importance on movement building and evidence generation. We are doing a lot of monitoring work on access to sexual and reproductive health care. We have a community led monitoring project ongoing that is led by trans communities across the region that equips people with the tools on how to monitor the health situations and

healthcare providers. This project is led by communities who know the situation on the ground, the needs of trans people, and what needs to be monitored when it comes to trans competent healthcare. At the beginning, we developed monitoring tools with the community that they could use on the ground. This is an important way to not only encourage ownership of trans people to be the drivers of change but also for them to articulate their own needs. We have been doing this for the past two years at APTN and there are more and more people engaging in these monitoring processes. We think this is one of the best practices we can demonstrate because we are able to know what issues need immediate attention. The tools are also designed to engage with policymakers along the process. Through this relationship building, they are able to articulate their needs and troubleshoot the problems along the way. This is what we want to showcase in our work and this is going to help the government pass policies that fit the needs and lived realities of trans people.

We also see a lot of good practices that are led by the community. We are all aware of the serious issue in Pakistan currently with the backlash against legal gender recognition laws and laws that will protect trans people against violent hate crimes, as well as the creation of shelters for trans people who are facing violence. The push for these laws was actually being led by the communities we are working with and this has led to a lot of the community coming together and working on their own demands. They have been able to show to the government that they don't *only* want legal gender marker change. Even though they are now facing backlash from the religious communities and the laws are being pushed back, what I want to emphasise is that the practice of knowing your demands, thinking beyond the limit of the laws and legal structure and being able to voice your needs is a great example. This can create radical change.

In Thailand and other parts of Southeast Asia, there is now a prevalence of establishing clinics that are run by trans people themselves. This has been possible through funding from outside the country but it is one of the ways to show how healthcare for trans people can be possible. This type of care is well documented and can be used to show the government that the communities can do it and it can lead to change.

A lot of the approaches used at APTN are community led—research, service provision, etc. We encourage trans communities and trans organisations in our network to do so. We also are starting a new project on monitoring hate crimes in the region and this is going to be another community-led process. We have engaged with the community to develop

the trans murder monitoring tools and the community itself will be monitoring the situation with APTN providing support in terms of safety and security. This will address the issues on hardships of documentation of these types of cases as well as the systemic barriers from the police and other legal entities. If there is no proper documentation, nothing will change and there will be no legal protection offered. This is our way of building evidence.

Any final thoughts you would like to share? Coming back to the theme of reproductive justice, what I really want to emphasise again as APTN is that what we believe in and what we are working towards is the availability, accessibility, acceptability, and quality of trans healthcare. There are so many factors

in their own words

that are preventing this from happening—it's not just about the binary system and the binary way in which healthcare is provided. We need more resources to be able to do this work. We need more sensitised doctors and care professionals to be able to provide trans competent healthcare that goes beyond HIV care. In the past, trans healthcare mostly meant HIV care, but now it means something wider—it is not about beauty or aesthetic either, it is about the livelihood of trans people. We need to move away from privatisation of healthcare and make healthcare a basic need with services that are well structured. The government needs to sponsor this—it needs to be a part of social welfare, it needs to be free and it should not be discriminatory.

Migrant Women and Reproductive Justice in Thailand An Interview with Jackie Pollock (MAP Foundation)

In this interview, ARROW spoke with Jackie Pollock, one of the founders of MAP Foundation, a grassroots NGO that seeks to empower migrant and ethnic communities in Thailand. Jackie shared some of the issues that migrant women from Myanmar face in Thailand and how this links to attaining reproductive justice for the community.

Can you share with us a little bit about the work MAP Foundation does? MAP Foundation does a whole range of work on labour rights, women's rights, and health issues. Particularly for women, MAP has a very extensive programme called Women's Exchange which was started in 1999 as a space for migrant women to meet once a month to share experiences, learn from each other and be better connected. It was probably the first safe space that migrant women had to do that and because of that, it snowballed—some of the women who attended those meetings moved and they started WomenExchange groups in new locations in Thailand. Today there are 25 Women Exchange groups taking place in 17 different provinces across Thailand.

The women have the opportunity to interact with other migrant women at their respective groups and each year representatives from all the groups spend five days together, attending a variety of workshops and creative sessions. This provides an opportunity for women from different ethnicities, working in different sectors in different places to gain strength from a larger community and to meet and interact with women facilitators and guests from Thailand and other countries in the region.

Policies for migrant workers have certainly improved since 1999, but to enjoy the benefits of better policies and to be able to provide feedback to policy-makers,

migrant women still need support for greater connectivity. The reason Women Exchange started was to break the isolation migrant women experience and that is still an issue today. Migrant women are isolated from mainstream society because of their dependency on employers for accommodation or because their worksites, such as agricultural or construction sites are distanced or cut off from the general public.

Additionally, migrants from Myanmar face greater stress and worries about their families back home, and have increased responsibilities to take care of their families since the military coup in Myanmar. I think therefore the

in their own words

fundamental issue and reason for bringing people together in safe spaces hasn't changed—the need for women to be able to share with other women, to have women they can rely on to support them if needed. It's not all about MAP supporting, the groups pretty much run themselves after some initial training and support—this is the basic issue addressed by the Women's Exchange programme.

You touched on this briefly already but, going a bit deeper, what are some of the aspects of criminalisation, and equity, which limit migrant women's access to SRH services that you have experienced? For example, migrant workers are denied employment permits based on issues such as pregnancy and their HIV status, as well as denied access to reproductive services. Can you share more on the issues that are primarily affecting migrant women with regards to SRHR?

I would say, for Thailand at least, I'm not sure it's correct to use the words "they're denied". In some countries in the region, for migrant women, pregnancy means you're denied employment but in Thailand a pregnancy test is not part of the in-country process to get a work permit. Although for migrants who apply for work through the bilateral system under the MOU, the countries of origin do exclude women who are pregnant. If migrant women working in Thailand become pregnant it is against the law for the employers to dismiss them on these grounds. But of course, as is the case in many countries, employers won't say they're dismissing someone directly because of the pregnancy but they will use other excuses. While local women may be able to pursue a legal case in such a situation; it is much more complex and riskier for migrant women to attempt.

According to the July 2023 Department of Employment figures there are a total of 2,514,087 documented migrant workers in Thailand, of whom 73% are from Myanmar including 802,394 women from Myanmar. Apart from a small number of seasonal

workers, all other migrants are eligible for social security, which includes maternity leave and child care benefits. However, a pre-COVID 19 report by the IOM, found that only 39% were registered for social security. The number of claims for benefits was reported as being very small, but two thirds of those who did claim were women claiming maternity leave and child care. The policy is therefore in place, but the implementation, which depends to a great extent on the employers, is falling far short of being successful and for women, this results in limited access to reproductive health care and rights.

There are also logistical issues that hinder women's access to maternity rights. There's not really a system in place for small and medium sized enterprises, or for employers with domestic workers, to find another worker to cover maternity leave. Although it's a little easier now for migrants to move jobs and employers, it's still not easy; requiring time and money to get the correct paper work.

While documented migrants have the right to healthcare, accessing the healthcare system involves getting time off work, organising travel, knowing where to go, as well as navigating language. Both the government and NGOs provide information in the languages of the migrants on emerging or seasonal diseases such as COVID-19, dengue, etc.—but while these public health announcements address prevention as well as treatment, there is little in the way of providing information for migrant women on prevention and early detection of cervical or breast cancer. While such screenings are available, without providing more information and improving access to migrant women, it is unlikely many migrant women would seek these services out. Without more outreach and promotion, migrant women will continue to deal with difficult menopauses by themselves or through using traditional practices. Indeed, all the policies regarding migrant

workers are premised on the assumption that they are young. But this is not the reality in Thailand, because many migrants first came when they were young but have stayed; some have started families in Thailand with their children attending Thai schools, some have nowhere to return to. Some of these elder women are the most skilled workers in their field and speak excellent Thai. But after 55 years of age, they become invisible in the policy frameworks of employment and health.

What other needs and rights of migrant women should also be taken into consideration when looking at their SRHR?

I think that we need to look at what migrant women need at different times across their lifespan, the whole range of womanhood and the different aspects of reproductive health and rights and needs across all age groups.

I think there is greater knowledge among the Thai community about migrants today and probably greater acceptance, but migrants are still treated differently as was witnessed during COVID-19, when migrant worksites were completely sealed off and there were no support services for them. This sent out a signal to people that migrants were different and "extra contagious". I don't know how much that has set back the general move to greater acceptance of migrants. The shift in attitude had happened to some extent because when Burma opened there was much greater movement of not just migrant workers but tourists and business people between Thailand and Myanmar. Due to this there was much greater interaction and that broke down a lot of the stigma that had arisen when Myanmar was a closed country for decades run by a military regime. Now that the military have taken over again, I am not sure how that will affect the integration and acceptance of migrants. Certainly, the general Thai population has empathy for the people of Myanmar, but there is no central level policy which recognises the plight of

people fleeing the desperate situation in Myanmar or that provides protection for those in need.

Can you share some recommendations or best practices when it comes to attaining reproductive justice for migrant women? I think it's really important that there are joint campaigns and activities on reproductive justice between local Thai women's groups/organisations and migrant women/organisations. As much as possible, joint programmes should be supported so that reproductive justice is justice in the true sense of justice for all. There is already coordination and collaboration among Thai and migrant women's groups but it requires more resources in order to reach women in isolation; to have

language interpretation, and to have mixed nationality staff, for example.

Jointly, women can address issues such as domestic violence which affects all communities but which brings added challenges when it happens in migrant communities. Isolated, women who are experiencing violence at home may have nowhere to go, not know who they can contact; and are afraid if they report or move, they will lose their jobs and thus their legal status.

Policy-wise, we need to look at how to move beyond Thailand's policy on paper to a policy in practice. It's really difficult because although social security and health officials are very open to meeting and talking to migrants, they will clearly

in their own words

tell them the policies, but because the policy is good on paper it gets stuck there and it's not what is actually happening in practice for the migrants on the ground. It is not in the power of the migrants to change that, but depends on the employers and on the local officials.

Again, I'd like to emphasise two points made above; there must be a focus on breaking the isolation that migrant women experience; so that migrant women can be connected to their migrant and Thai sisters and can be in a position to talk about their needs and rights, including sexual and reproductive needs. Secondly, the sexual and reproductive rights of migrant women of all ages should be addressed and voluntary age-appropriate early detection screenings should be promoted.

REPRODUCTIVE JUSTICE AND FEMINIST LEADERSHIP IN THE GLOBAL SOUTH

Reproductive justice is a feminist framework that was first coined by SisterSong, a collective of Black women as a response to United States reproductive politics. The three core values of reproductive justice are the right to have a child, the right to not have a child, and the right to parent a child or children in safe and healthy environments. To fully realise reproductive justice, all persons who reproduce should be empowered to make choices about their reproductive health, have access to the resources that help attain reproductive health, and be free from oppressions that can hinder the achievement of these choices.

In most African countries, many women, especially from marginalised communities, are impeded from fully realising their reproductive justice despite reproductive

health rights being recognised in their country's laws. Very often women face quite the opposite; Reproductive Oppression—where there is control and exploitation of women, girls, and individuals through our bodies, sexuality, labour, and reproduction.

In a context in which more than 465,000 abortions occur annually in my country, Kenya, cultural taboos prevent open dialogues at home or in school about sex. While the WHO recommendation of doctor to patient ratio is 1:300, in Kenya the ratio is 1:16,000. Those who can afford it often go to private health providers where the cost of healthcare is very high, especially the cost of services like abortion care. This means women do not access reproductive health services the same way, thereby perpetuating inequalities. Sub-Saharan Africa has the single most deaths due to

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unsafe abortion worldwide. At least three out of four abortions are unsafe. Ironically, abortion related deaths and injuries are completely preventable. What else other than injustice would you call the fact that there are safe technologies of abortion, but they are available only to the ones that have money, class or other privilege?

The role of feminist leaders in advocating for Reproductive Justice in Africa and the Global South is to join hands to keep marginalised women, girls, and people who can get pregnant from being systematically excluded from policy and implementation spaces. The best way to do this is by embracing intersectionality, which in essence is getting to the root causes of inequality by identifying unique problems faced by different communities that cause disproportionate access to their rights and freedoms.

in their own words

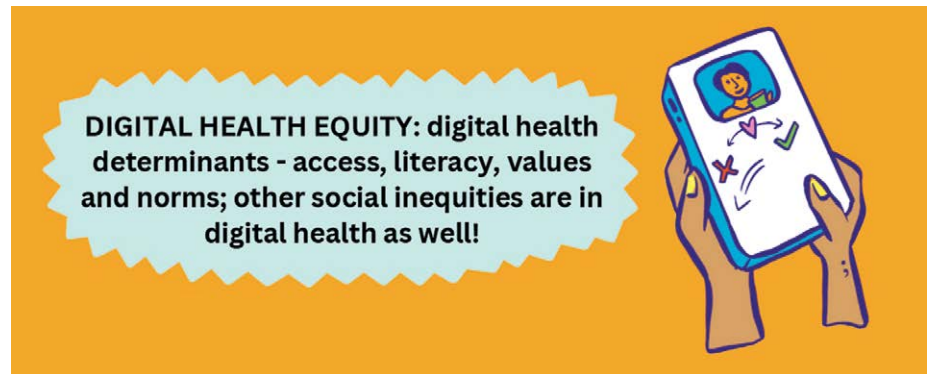
In Maya Angelou's words: "The truth is, no one of us can be free until everybody's free."

Feminist leadership needs to keep advocating for the revision or creation of policies that strengthen and protect reproductive health for marginalised communities. In their engagement with the policy-makers, feminist leaders need to constantly help them see how societal views in Africa are hindering the realisation of reproductive health autonomy and justice for women in rural Africa, and to suggest ways in which reproductive justice can be attained.

First, we need to understand that women in most African communities are not perceived to wholly own their bodies or the decisions that pertain to their reproduction. They are seen as something to be controlled by society—at a young age by their fathers, and when they grow up by their husbands and throughout their lives policed by their society. Sex and sexuality here is viewed as morally wrong and grounds for persecution. In these communities, attaining Reproductive Justice calls for a change in perception and stigma around reproductive health, therefore demystifying issues around sex and sexuality.

Secondly, even to those who are informed and aware of reproductive health frameworks and resources, services like contraception and safe abortion in Africa are out of reach for most women. Women with means can easily access services, for they can pay at high-end private hospitals or fly out of their countries to access the services in countries with more favourable laws.

It is the girls and women living in slums and rural areas, women in lower classes of society, marginalised and rural women who end up in backstreet alleys, with botched abortions. The role of feminist



leadership is to ensure these marginalised women and people who can get pregnant have equity in access to reproductive health services including safe abortion services. This equity can be achieved by advocating for more interventions for marginalised women in order for them to fully enjoy their reproductive rights.

Thirdly, we need to consider access to self-care options that put the agency and power in women's hands. Services like self-management of abortion play an important role in reproductive justice because it presents an important alternative to clinical care for those who face financial and logistical barriers due to restrictions. It provides women of all walks of life the same chance at the highest standard of health care promised in our constitutions and in international laws. This is because access to abortion with pills helps us realise several human rights, such as the right to life, to survival, to security and to sexuality, the right to non-discrimination, the right to make decisions about one's sexual and reproductive life, including the freedom to choose maternity, the right to the highest attainable standard of health and to enjoy the benefits of scientific progress, the right to be free from cruel, inhumane and degrading treatment, the right to privacy and confidentiality; and the right to health information.

By adopting a collective, collaborative, multi-stakeholder approach to advancing reproductive justice, feminist leaders support their partners to occupy and influence key arenas of governance and community development. By collaborating at all levels of decision-making, local to global, they ensure the priorities and leadership of diverse women and girls are centred in law, policy, regulatory, implementational, and financing decisions that impact access to safe abortion services.

To drive this work, the world needs feminist leadership that strategically prioritises reproductive justice and makes bold and long-term commitments that will repair the impact that marginalisation has on access to abortion to people living in our communities. We need leadership that can acknowledge and appreciate that the health of our movement comes in diversity and intersectionality.

In the Global South, countries have made remarkable gains in building and sustaining pressure on formal and informal systems to fill the needs of sexual and Reproductive Justice services which ensure access to contraception, safe abortion, and maternal care. However, the countries still operate from the margins. Having a Reproductive Justice approach and collaboration among reproductive health actors can build a collective vision and commitment across these countries to bolster feminist movements' efforts, to leverage and to transform power.

RELIGIOUS FUNDAMENTALISM AND REPRODUCTIVE JUSTICE: *The Philippines in Focus*

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Carlos Celdran was a social media influencer, artist, and passionate women's rights activist. He was actively involved in the Reproductive Health (RH) bill advocacy. In September 2010, Celdran, dressed as national hero Jose Rizal, went to the Manila Cathedral to check out an event and take pictures for social media. Inside the church, he held up a board with "DAMASO" (a fictional abusive priest in Rizal's novel on Spanish oppression of the Philippines for centuries) written on it. He was accosted by security guards and he shouted, "Don't meddle in politics!"¹

Celdran was arrested and charged under Article 133 of the Revised Penal Code (RPC), Offending the Religious Feelings, a Spanish-era law that remains untouched and clearly demonstrates Church power in the country. Celdran was convicted and sentenced to imprisonment. He exhausted all possible legal remedies but the Supreme Court upheld his conviction in March 2018. Celdran went on a voluntary exile to Spain, where he died in October 2019.

Public indignation ensued and the advocacy for the RH bill (now The Responsible Parenthood and Reproductive Health Act of 2012² was further strengthened. The law provides for rights-based and comprehensive RH education and services especially to poor and marginalised women and their families.

The Celdran case showed the harm that religious fundamentalism can do, as it permeates the legal system and wields power over the country's social and political life.

The country's culture remains patriarchal owing to religious dogma translated into cultural norms and practices. These constitute the "moral values" of many Filipinos. Consciously or not, people's positions on controversial reproductive justice issues are rooted in religion. This is true particularly for the majority with little understanding of women's rights. These perspectives are carried over to their daily social interactions.

Religious fundamentalism is defined as *"The approach of those religious groups that look for the literal interpretation of original religious texts or books believing that teachings obtained from this kind of reading must be used in all social, economic, and political aspects. Religious fundamentalists believe that only one view of the world can be true, and their view is the only one; there is no room for ambiguity or multiple interpretations."*³ Using this definition, religious fundamentalism surely thrives in the Philippines.

The country's 2023 population is pegged at more than 117 million. In terms of religion, the Philippines takes pride in being the only Asian Christian nation. According to Asia Society, around 86% of the people are Roman Catholic, 6% belong to various Christian sects, and 2% with Protestant groups. The 4% Muslim population is concentrated in Mindanao.

Religious groups, foremost, the Catholic hierarchy and its allied organisations, are politically powerful. Beyond the law on "Offending the religious feelings", the 1987 Philippine Constitution section criminalising abortion, the law on

concubinage and adultery in the RPC, and the Civil Code of the Philippines⁴ replete with provisions favoring heterosexual couples, fathers, and husbands, are legislations currently enforced, which are significantly based on religion.

Religious fundamentalism, which is common among all churches, goes against advocacy on issues like divorce and unsafe abortion, and ultimately runs counter to the advancement of human and women's rights. The rigid interpretation of faith (with each claiming to be the only true religion) comes at the expense of, particularly, the sexual and reproductive health and rights (SRHR) of women, girls, and people of diverse sexual orientation, gender identity, expression, and sexual characteristics (SOGIESC). More harshly impacted are the poor, those in rural and remote areas, with little education, and belong to marginalised sectors of society.

In contrast, rich people are able to circumvent the laws. For instance, while divorce is prohibited, rich couples opt to get married outside the country. The moneyed whose marriages have broken down are able to use the very costly annulment process to be free again. While abortion is illegal, safe abortions can be had using the expensive services of an underground network of doctors.⁵ These are options that are way beyond the means of ordinary Filipinos.

Reproductive justice (RJ), understood as the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's

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human rights,⁶ therefore, is a crucial goal pursued by feminists. This RJ definition takes into account women's diverse identities and necessitates working on their different contexts beyond legislation. Many RJ advocates also work towards SOGIESC equality.

Through time, women's rights organisations (WROs) and allies have had significant success in the advocacy for RJ through law. Most of the existing progressive legislations are the results of WROs' relentless work. However, having these laws is not enough. A case in point is the RH law passed more than a decade ago. The implementation remains weak with vital programmes, including comprehensive sexuality education which is not fully implemented. Full and proper implementation, as well as provision of education for women so they may use them to claim their rights, is necessary.

Beyond helping the implementation of the laws and carrying out women's rights education, WROs are occupied with advocacy for other RJ-related bills, and the work of destigmatising controversial SRHR topics.

The Philippines is the only country in the world besides the Holy See where divorce is illegal. This is despite the fact that divorce-like practices existed during pre-colonial times and was legal during the American and Japanese eras.⁷ Bills on divorce are consistently opposed by church-based groups using archaic views such as "what is united by God cannot be undone by man" and "the sanctity of marriage".

Unsafe abortion is another big problem. An estimated 1.1 million induced abortions happen yearly. 1,000 women die annually from post-abortion complications.⁸ Abortion is a crime owing to the 1987 Constitution's provision equally protecting the life of the mother and the unborn. This is reinforced by

the RPC through its harsh anti-abortion sections.

Culturally, abortion stigma is very strong making the advocacy for decriminalisation doubly difficult. Open and non-judgmental conversations are scarce and usually limited to urban-based advocates and feminists—the usual suspects. Stigma-busting and education initiatives involving ordinary women are severely lacking. Community-based constituency for the decriminalisation of abortion is negligible. Against religious fundamentalists who instill in people that abortion is murder and a cardinal sin, a lot needs to be done so abortion rights advocacy is strengthened.



Adolescent pregnancy is a major problem. Despite the alarming increase in the number of girls aged below 15 getting pregnant,⁹ conservative notions on adolescent sexuality remain strong. The Supreme Court decision requiring parental/guardian consent for minors to use contraceptives watered down the RH law. Moreover, many health providers refuse to provide adolescents with needed services due to biases. Presently, there is strong advocacy for the passage of the Adolescent Pregnancy Prevention bill.

On the rights of people of diverse SOGIESC, bills on Civil Partnerships and SOGIESC Equality have been refiled. Fundamentalist lawmakers and religious groups are together in thwarting the passage of these bills. During Congressional hearings, these groups, particularly legislators, resort not only to biblical verses but also tactics to silence opponents and derail the process using their political privilege and power.¹⁰ These bills aiming to realise the rights of LGBTQIA+ persons have been languishing in Congress for many years.

Few are aware that female genital mutilation or cutting (FGM/C) happens in the Philippines and is prevalent in Muslim Mindanao.¹¹ Called "*pag-Islam*", FGM/C is deeply connected to Islam and performed on girls before the onset of menstruation, or before marriage, so they are considered pure and clean. There is a culture of silence surrounding the issue, and therefore, there is a dearth of information. Although the practice is rooted in religion, there is no unity in how Muslim leaders regard this.

FGM/C is also passed on through cultural traditions by family matriarchs. There is no uniform process in performing FGM/C. Some use bamboo strips, blades, nail cutters, or small knives. Some scrape, others poke the clitoris. Because FGM/C in the Philippines is unheard of, there is an urgent need for more research and to educate stakeholders on how this practice harms girls and violates their rights.

Reproductive justice cannot be achieved in the Philippines unless religious fundamentalism is dismantled. Progressive laws will help. But strategically, a counterculture, one that centres on human and women's rights needs to evolve. Towards this, a change in people's values and mindsets is necessary. Continuing, widespread, and comprehensive rights-focused education using various platforms is vital.

Feminists and WROs play a crucial role in the evolution of this counterculture and dismantling of religious fundamentalism. Challenging the status quo, working with community women in rights-claiming, developing the skills and leadership qualities of young feminists to continue the struggle, creating alternative rights-based programmes and mechanisms—these are some ways by which a fair, just, and equitable culture is pushed by WROs.

A citizenry that gives importance to human rights and freedoms will choose progressive government leaders who will respect and uphold economic, social, and reproductive justice. The work is difficult, complex, and will take generations. However, it is only when religious fundamentalists are out of power that

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citizens, especially women, girls, and persons of diverse SOGIESC may truly actualise their human rights.

Cases like Carlos Celdran's will be no more.

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THE REGISTRY OF “CONCEIVED UNBORN” IN PARAGUAY: The “Perfect Storm” To Further Erode Reproductive Autonomy

Introduction. José Serrano defines the “perfect storm” as the way to “describe the combination and accelerated growth of phenomena that isolated are manageable, but together and under the right conditions produce unexpected results”.¹ In November 2017 Paraguay passed a law that allows unborn embryos or fetuses to be registered with a name on a death certificate. It is the first law of its kind in Latin America.

The Law and the Implications to Reproductive Autonomy. In October 2016, a group of conservative deputies presented a bill to register “conceived unborn” in the Civil Registry. The bill established that, on a voluntary basis, individuals could request the Civil

Registry to issue a death certificate with a first and last name regardless of weight and gestational age. The bill clarifies that the law “in no case modifies the regime of natural persons instituted in the Civil Code, nor grants patrimonial, inheritance or state rights” (art. 9).

A month before, in September 2016, Neydy Casillas, a lawyer from Alliance Defending Freedom, a US organisation that promotes legal strategies to oppose sexual and reproductive rights, went to Paraguay and participated in conferences and meetings with a group of Deputies.² This group later formed a “parliamentary front for life and family”³ and presented the bill. The process had as its visible faces support groups for women and

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families who had lost wanted pregnancies. The bill was initially approved by an overwhelming majority by the Chamber of Deputies and Senators. The Executive vetoed the bill with technical arguments about the bill's viability. Among other reasons, the Executive Branch questioned the fact of giving a name to someone who is not legally a person, since the name is obtained from birth. On the other hand, inconsistencies of this proposal with other laws that establish procedures for the registration of persons were questioned. The veto was rejected by a large majority of both Houses and the bill was finally approved.⁴

The main public arguments of the group of those who were the visible faces of the bill revolved around the right of

families to mourn. Among other things, its promoters stated:

*If this law is enacted, our children will no longer be treated as pathological waste, and that is a great step forward. This does not eliminate the pain, but at least we will no longer have just an empty ultrasound or an empty photo, but the children will have the identity we gave them, that name we chose with love and that we tried so hard to give them, that is very important for us.*⁵

The bill was also supported by anti-gender groups such as CitizenGo.⁶ This organisation launched a signature campaign to support the approval of the law. During the legislative treatment, several deputies spoke about “the protection of life from conception”, alluding to the fact that the foetus or embryo “is a person.”⁷

Thus, a legitimate issue of the pain over the loss of a desired pregnancy, became one more way in which anti-gender groups claimed that the foetus or embryo is a person. In a country like Paraguay, with one of the most restrictive abortion laws,⁸ this law makes the progress towards the recognition of reproductive autonomy more complicated.

After Paraguay, Chile passed the “stillbirth law” with a very similar content, with an important clarification in Article 5: “This law may not be interpreted in such a way as to hinder in any way the access of women and girls to voluntary termination of pregnancy services in cases where these are legal”.⁹

Subsequently, similar initiatives have been proposed in Argentina,¹⁰ Colombia,¹¹ Ecuador,¹² and Peru.¹³ Although it is not clear that these bills will be approved, they show that these types of initiatives

are not isolated, but part of a “perfect storm” that can impact the reproductive autonomy of women and people with the possibility of gestation.

These initiatives seek to roll back recent victories on the recognition of abortion rights by refocusing the discussion on the life of the foetus, undermining the centrality of women and people with the possibility of gestation. To this end, anti-gender groups manipulate situations as legitimate as the loss of a desired pregnancy, creating the perfect storm to further hinder reproductive autonomy.

These laws seek to deepen the idea held by anti-gender and anti-abortion groups that embryos or foetuses are persons. International human rights law has established that the right to life is not absolute,¹⁴ that protecting the right to access abortion is a state obligation,¹⁵ and that the right to life is “gradual and incremental.”¹⁶ There is no standard in international law that holds that persons can be considered as such before birth. The aim of these laws is to controvert these standards in order to, among other things, deepen the stigma around abortion and make it more difficult to discuss it in hostile contexts such as Paraguay. These initiatives seek to roll back recent victories on the recognition of abortion rights by refocusing the discussion on the life of the foetus, undermining the centrality of women and people with the possibility of gestation. To this end, anti-gender groups manipulate situations as legitimate as the loss of a desired pregnancy, creating the perfect storm to further hinder reproductive autonomy.

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THE POWER OF WOMEN AND GIRLS AND ORGANISING AGAINST VIOLENCE

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South Africa is one of the most progressive examples in the world when it comes to the provision of sexual and reproductive health and rights (SRHR) services. As early as the dawn of the new democracy in 1994, the country passed safe abortion legislation, the Choice on Termination of Pregnancy Act 92 of 1996,¹ and legalised same-sex marriage. However, these progressive gender equality rights are increasingly becoming merely symbolic due to the overshadowing prevalence of gender-based violence (GBV), femicide, and human trafficking that the nation is grappling with.

The law does make provisions to protect citizens against domestic violence, sexual harassment, human trafficking. In 2022, the President signed recent amendments to strengthen legislation e.g. the Criminal Law (Sexual Offences and Related Matters) Amendment Act; the Criminal and Related Matters Amendment Bill, and the Domestic Violence Amendment Bill. At a policy level, the government has responded to the scourge of GBV in the country through the National Strategic Plan of Gender-based Violence and Femicide 2022-2030 as its' guiding course of action. However, at the ground level, do women, girls and key populations really have control of their bodies? Are we safe? Do we really have freedom? Are our bodies respected? Are we respected? The chilling answer is no.

Moreover, workplaces, universities and even schools are witnessing a rise in exploitation and sexual violence,

perpetuated by power dynamics that often favour perpetrators. There are regular accounts of the inhumanity women experience reported in the media which casts a grim shadow over these policy and legislative ideals. Reports of pregnant women being murdered, and university students being raped, kidnapped and killed are frequent. Women and girls are being bludgeoned, burnt and having their limbs cut.² It is a daily, terrifying and inhumane occurrence.

There is rarely justice for GBV survivors, both those who report the crime and those who don't. I spoke to many survivors during a research project I conducted in South Africa a few years ago, and the stories were traumatising. Survivors mentioned being raped a second time by law enforcement while trying to seek help at a police station, and this trend is increasingly on the rise.³ Inadequate evidence collection from both law enforcement and medical professionals severely hampers a woman's chances of seeking justice. Survivors rarely report the crime and face multiple barriers to reporting and seeking justice. It is inhumane and impractical to expect traumatised individuals to navigate inefficient public health and legal systems.

Recently, the glimmer of hope we have seen is the rise of the Total Shutdown Movement in South Africa in 2018⁴ where thousands of women marched against GBV to the Union Buildings in Pretoria. In the country, we witnessed that women were making a stand collectively. The

immediate wins were attention from policy-makers, leading to a Presidential Summit on GBV, the National Strategic Plan on GBV and Femicide 2020-2030 (outlined above) and a GBV Fund being allocated R128 million (approx. USD \$6 million).⁵ However, have any of these actions translated to more safety, better response mechanisms, and stronger long-term solutions? Unfortunately, the answer remains no.

What the Total Shutdown movement points towards is the power of women and girls, the power of organising for our bodies, our dignity and our lives. Across the African continent we are seeing women, especially young women, rising and taking control. For instance, the recent protests against the taxation of menstrual health products in Ghana⁶ in July 2023 is another great example of this movement.

Addressing these systemic issues requires sustained investment, coordinated efforts, and mass movements such as the Total Shutdown movement that go beyond one-time protests. Consistency is vital to achieving our demands and ensuring reproductive justice. The fight is a united continental endeavour and one we as women and girls will have to lead to stop GBV from being a daily occurrence in South Africa. In doing so, we can seek historical justice for women raped multiple times during the Rwanda genocide,⁷ women being raped in Tigray, Ethiopia,⁸ refugee women from Libya⁹ being raped, and stand up against the forced sexual relations of child brides on the continent.

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SAIGE: Advancing Reproductive Justice and Safe Abortion Access in the Global South

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Introduction. Established in 2018, the Safe Abortion Advocacy Initiative Global South Engagement (SAIGE) is a collaborative platform that unites advocates, activists, academics, and service providers from the Global South. SAIGE's central objective is to champion safe abortion as a fundamental human right. This initiative strives to amplify Global South voices, particularly those of young women, fostering solidarity, knowledge-sharing, capacity-building, and evidence-based advocacy for reproductive rights. SAIGE's work is set against a backdrop of concerning statistics, with approximately 25 million unsafe abortions occurring annually between 2010 and 2014, resulting in dire consequences. Developed regions report 30 women's deaths per 100,000 unsafe abortions, which escalates to 220 in developing regions and a staggering 520 in sub-Saharan Africa, where the majority of unsafe abortion-related deaths persist.¹ Developing countries bear the burden of 97% of all unsafe abortions. More than half of all unsafe abortions occur in Asia, most of them in south and central Asia. In Latin American and Africa, the majority (approximately 3 out of 4) of all

abortions are unsafe. In Africa, nearly half of all abortions occur under the least safe circumstances.²

Global South Movement Building and the Role of SAIGE. The imperative for women in the Global South to reclaim the narrative around safe abortion access cannot be overstated. SAIGE stands as a pivotal platform dedicated to mobilising and engaging organisations and individuals in the pursuit of safe abortion rights. It accomplishes this by facilitating targeted interventions, sharing invaluable knowledge and expertise, and nurturing a powerful movement that aims for tangible change in the realm of safe abortion access across the Global South. SAIGE has made significant strides since its inception, amassing over 200 members spanning 37 countries within the Global South Region. This dynamic network serves not only as a source of support during challenging times but also as a hub for the exchange of insights and expertise. Members draw from successful initiatives across regions, tailoring them to their own unique contexts, thereby fortifying the collective movement for safe abortion rights. SAIGE also

collaborates closely with other networks and organisations committed to advocating for safe abortion access from the Global South Region.

SAIGE has been instrumental in facilitating linking and learning exchanges between Latin America and the Caribbean, Africa, and Asia. These exchanges have cultivated an enriched understanding of interlinkages, shared opportunities, and common challenges. Key areas of focus include evidence-based advocacy, increasing access through self-managed abortion, strategies for decriminalising safe abortion, and combating abortion stigma.

Challenges. SAIGE acknowledges the enduring challenges in the field. Governments' reluctance to adopt comprehensive health and rights approaches leaves women across the Global South vulnerable to unsafe abortions, particularly in regions with restrictive laws. Even in places where abortion is legal, limited access to affordable services remains a critical barrier to progress. Additionally, the

deeply rooted stigma surrounding abortion continues to jeopardise women's safety, often forcing them to prioritise secrecy over their own well-being.

Reimagining Reproductive Justice.

The Reproductive Justice framework underscores a fundamental truth: a woman's ability to determine her own reproductive destiny is intricately tied to the circumstances in her community. Reproductive Justice is the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.³ This insight dispels the notion that reproductive choices are solely a matter of individual

access and decision-making. Instead, Reproductive Justice confronts the stark social reality of inequality, specifically addressing the disparities in opportunities that individuals have to control their reproductive futures.

At the SAIGE Convention in Pattaya, Thailand, held in 2022, a one-day workshop was dedicated to reimagining reproductive justice from a Global South perspective. Our mission revolves around the core principles of Reproductive Justice, particularly its applicability in the Global South. We endeavour to comprehend the intricate interplay of social, political, and economic forces that significantly impact SRHR.

SAIGE recognises the Reproductive Justice framework as a powerful strategy to guide our work effectively. By embracing this framework, we aspire to facilitate more equitable access to SRHR services, ensuring that the rights and well-being of individuals and communities are protected in a world marked by diversity and complex challenges.

Notes & References

- 1 Global Abortion Policies Database. (2021). World Health Organization. <https://www.who.int/news-room/fact-sheets/detail/abortion>.
- 2 Ibid.
- 3 SisterSong. Reproductive Justice. <https://www.sistersong.net/reproductive-justice>.

resources

RESOURCES FROM THE ARROW SRHR KNOWLEDGE SHARING CENTRE

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ARROW's SRHR Knowledge Sharing Centre (ASK-us) hosts a special collection of resources on gender, women's rights, and sexual and reproductive health and rights (SRHR) to make critical information on these topics accessible to all. ASK-us is also available online at <http://www.srhr-ask-us.org/>. Please email: keshia@arrow.org.my.

ARTICLES AND BOOKS

Bagenstos, Samuel R. "Disability and reproductive justice." *Harv. L. & Pol'y Rev.* 14 (2019): 273. This essay offers a fuller consideration of the intersection of disability and reproductive rights. It does so by considering the legal and societal treatment of fetuses and children with disabilities alongside the legal and societal treatment of parents with disabilities and it does so by bringing to bear insights drawn from two distinct social movements: the disability rights movement, and the reproductive justice movement.

Bakhru, Tanya Saroj, ed. *Reproductive justice and sexual rights: Transnational perspectives*. Routledge, 2019. This book takes an intersectional, interdisciplinary, and transnational approach, presenting work that will provide the reader with a nuanced and in-depth understanding of the role of globalisation in the sexual and reproductive lives of gendered bodies in the 21st century. *Reproductive Justice and Sexual Rights: Transnational Perspectives* draws on reproductive justice and transnational feminism as frameworks to explore and make sense of the reproductive and sexual experiences of various groups of women and

marginalised people around the world. Interactions between globalisation, feminism, reproductive justice, and sexual rights are explored within human rights and transnational feminist paradigms. This book includes case studies from Mexico, Ireland, Uganda, Colombia, Taiwan, and the United States.

Fixmer-Oraiz, Natalie, and Shui-yin Sharon Yam. "Queer(ing) reproductive justice." In *Oxford Research Encyclopedia of Communication*. 2021. The history, principles, and contributions of the reproductive justice (RJ) framework to queer family formation is the nexus

monitoring national and regional activities

that connects the coalitional potential between RJ and queer justice. How the three pillars of RJ intersect with the systemic marginalisation of LGBTQ people—especially poor queer people of colour—helps clarify how the RJ framework can elaborate the intersectional understandings of queer reproductive politics and kin.

Foster, Diana G. “The Turnaway Study: Ten Years, A Thousand Women, and the Consequences of Having—or Being Denied—an Abortion.” Scribner. 2020.

The Turnaway Study is a prospective longitudinal study examining the effects of unwanted pregnancy on women’s lives. The major aim of the study is to describe the mental health, physical health, and socioeconomic consequences of receiving an abortion compared to carrying an unwanted pregnancy to term. The main finding of The Turnaway Study is that receiving an abortion does not harm the health and wellbeing of women, but in fact, being denied an abortion results in worse financial, health and family outcomes.

Gondouin, Johanna, Suruchi Thapar-Björkert, and Mohan Rao. “Dalit feminist voices on reproductive rights and reproductive justice.” *Economic and Political Weekly* 55, no. 40 (2020): 38-46.

Previous research has addressed questions of reproductive justice and the stratifications of Indian women’s reproductive lives in terms of class position and economic status. However, the question of caste has received little attention in the literature and there has been a lack of research on assisted reproductive technologies and caste along with the absence of Dalit feminists speaking out on reproductive technologies. This paper attempts to begin exploring the significance of caste by drawing on in-depth interviews with Dalit feminists who challenge dominant understandings of surrogacy in both international and national debates on reproductive technologies. It highlights

how an insistence on the wider socio-economic context of women’s lives challenges notions of reproductive rights, replacing them by reproductive justice.

Hyatt, Erica Goldblatt, Judith LM McCoyd, and Mery F. Diaz. “From abortion rights to reproductive justice: a call to action.” *Affilia* 37, no. 2 (2022): 194-203.

As aggressive cultural and legislative attacks on abortion rights and access continue, this article call upon social workers to pursue the liberatory aims of the reproductive justice (RJ) movement. The authors argue that the RJ framework, rooted in feminist theory, aligns with social work’s social justice ethos and goals, appropriately guiding advocacy and intervention. After outlining the central aims and tenets of the RJ movement, the article considers policies that impair RJ and those that could promote RJ, focusing on enhancing body sovereignty, childbearing, and parenting. It concludes with concrete recommendations for how social workers can pursue RJ professionally and personally.

Kim, Sunhye, Na Young, and Yurim Lee. “The role of reproductive justice movements in challenging South Korea’s abortion ban.” *Health and Human Rights* 21, no. 2 (2019): 97.

This paper examines how issues related to abortion have historically been influenced by population control policies in South Korea and how the contemporary reproductive justice movement in South Korea has contributed to social change. On April 11, 2019, South Korea’s Constitutional Court ruled that the ban on abortion was unconstitutional. As a result, South Korea’s legislature must revise the 66-year-old anti-abortion law by December 31, 2020. This historic decision was closely related to the advocacy of a number of feminist groups, doctors’ organisations, disability rights groups, youth activists, and religious groups in South Korea, who collectively formed

the Joint Action for Reproductive Justice (Joint Action) in 2017. This paper describes the activism and actions of Joint Action as a key part of reproductive justice movements in Korea. Joint Action was initiated by an organisation for women with disabilities, and once formed, they worked collectively to frame abortion as a social justice issue that goes beyond the pro-choice versus pro-life binary. By focusing on the composition, strategies, and main agenda of Joint Action, this paper analyses how Joint Action influenced the Constitutional Court’s 2019 decision to decriminalise abortion in South Korea and how the court established that it is the government’s responsibility to ensure every individual’s reproductive health and rights.

Liddell, Jessica L., and Celina M. Doria. “Barriers to achieving reproductive justice for an indigenous gulf coast tribe.” *Affilia* 37, no. 3 (2022): 396-413.

Reproductive justice is increasingly being utilised as a framework for exploring women’s reproductive health experiences. However, this topic has not yet been explored among Indigenous state-recognised tribes who do not utilise the Indian Health Service, and little research explores what other factors impact women’s ability to reach their reproductive goals. A qualitative descriptive research methodology was used to explore experiences of reproductive justice among members of an Indigenous state-recognised tribe in the Gulf Coast. Data were collected through qualitative semi-structured life-history interviews with female tribal members. Several key themes emerged illustrating barriers related to women achieving their reproductive desires. These included: (a) High Prevalence of Hysterectomy or Sterilisation; (b) Experiences with Infertility Common; and (c) High Frequency of Polycystic Ovary Syndrome or Endometriosis. Findings of this study reveal that Indigenous women

face multiple barriers to achieving reproductive justice. This study is unique in exploring the family planning desires and goals, and the barriers experienced in achieving these reproductive desires, for women in a Gulf Coast, non-federally recognised Indigenous tribe. These results contextualise national trends and suggest that Indigenous women in this study experience reproductive injustices that harm their ability to achieve their reproductive desires.

Luna, Zakiya. *Reproductive rights as human rights: Women of color and the fight for reproductive justice.* NYU Press, 2020. How did reproductive justice—defined as the right to have children, to not have children, and to parent—become recognised as a human rights issue? In *Reproductive Rights as Human Rights*, Zakiya Luna highlights the often-forgotten activism of women of color who are largely responsible for creating what we now know as the modern-day reproductive justice movement. Focusing on SisterSong, an intersectional reproductive justice organisation, Luna shows how, and why, women of color mobilised around reproductive rights in the domestic arena. She examines their key role in re-framing reproductive rights as human rights, raising this set of issues as a priority in the United States, a country hostile to the concept of human rights at home. An indispensable read, *Reproductive Rights as Human Rights* provides a much-needed intersectional perspective on the modern-day reproductive justice movement.

McGovern, Terry. “Sexual and reproductive justice as the vehicle to deliver the Nairobi Summit commitments.” *High-Level Commission on the Nairobi Summit on ICPD25 Follow-up.* 2022. <https://www.nairobisummitcpd.org/publication/sexual-and-reproductive-justice>. Marking the third anniversary of the landmark 2019 Nairobi Summit, this report calls

for better services and maps a far-reaching justice agenda. Entitled Sexual and reproductive justice as the vehicle to deliver the Nairobi Summit commitments, the report urges unwinding social, political, economic and other disparities that hamper advancement on a spectrum of global and national commitments to sexual and reproductive health and rights.

Mukherjee, Trena I., Angubeen G. Khan, Anindita Dasgupta, and Goleen Samari. “Reproductive justice in the time of COVID-19: a systematic review of the indirect impacts of COVID-19 on sexual and reproductive health.” *Reproductive Health* 18, no. 1 (2021): 1-25. Despite gendered dimensions of COVID-19 becoming increasingly apparent, the impact of COVID-19 and other respiratory epidemics on women and girls’ sexual and reproductive health (SRH) have yet to be synthesised. This review uses a reproductive justice framework to systematically review empirical evidence of the indirect impacts of respiratory epidemics on SRH.

Price, Kimala. “What is reproductive justice? How women of color activists are redefining the pro-choice paradigm.” *Meridians* 19, no. S1 (2020): 340-362. Frustrated by the individualist approach of the “choice” paradigm used by the mainstream reproductive rights movement in the United States, a growing coalition of women of color organisations and their allies have sought to redefine and broaden the scope of reproductive rights by using a human rights framework. Dubbing itself “the movement for reproductive justice,” this coalition connects reproductive rights to other social justice issues such as economic justice, education, immigrant rights, environmental justice, sexual rights, and globalisation, and believes that this new framework will encourage more women of color and other marginalised groups to become more involved in the political movement for reproductive freedom.

resources

Using narrative analysis, this essay explores what reproductive justice means to this movement, while placing it within the political, social, and cultural context from which it emerged.

“Reproductive Justice Media Reference Guide.” 2017. *Forward Together.* December 21, 2017. <https://forwardtogether.org/tools/media-guide-abortion-latinx-community/>.

This Reproductive Justice Media Guide is intended to be used by members of the media seeking to learn about or expand their knowledge of reproductive justice particularly when reporting on abortion and the Latinx community. It is not intended to be an all-inclusive encyclopedia of issues within reproductive justice, nor is it intended to limit coverage to the issues highlighted herein. It hopes to be a conversation starter to yield more nuanced discussions and reporting about abortion and reproductive justice more broadly.

Selberg, Rebecca, Marta Kolankiewicz, and Diana Mulinari. “Struggles for Reproductive Justice in the Era of Anti-Genderism and Religious Fundamentalism.” (2023): 263. This book engages with the concept of reproductive justice by exploring case studies of struggles around abortion in the context of rising anti-genderism, religious fundamentalism, and ethno-nationalism. Based on rich qualitative data offering in-depth analyses from different geographical, political and cultural contexts, the book explores how reproductive justice is understood, contested and given meaning. Chapters further develop the Black feminist concept of reproductive justice in a critical dialogue with postcolonial theory and explore the strength of transnational feminist practices. This book thus offers a fresh approach to the issue of abortion by engaging with contemporary political and cultural processes, and it expands the narrow notions of women’s rights,

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particularly notions of property rights over bodies, towards an analysis of the political economy of social reproduction and how it affects bodies that can be pregnant.

Sreenivas, Mytheli. “Reproductive Politics and the Making of Modern India.” University of Washington Press. (2021). <https://www.jstor.org/stable/j.ctv1q3xffw>. This book demonstrates how colonial administrators, postcolonial development experts, nationalists, eugenicists, feminists, and family planners all aimed to reform reproduction to transform both individual bodies and the body politic. Across the political spectrum, people insisted that regulating reproduction was necessary and that limiting the population was essential to economic development. This book investigates the often devastating implications of this logic, which demonised some women’s reproduction as the cause of national and planetary catastrophe.

Unnithan, Maya. *Fertility, health and reproductive politics: Re-imagining rights in India*. Routledge, 2019. Drawing on ethnographic research over the past eighteen years among poor Hindu and Muslim communities in Rajasthan and among development and health actors in the state, this book contributes to developing analytic perspectives on reproductive practice, agency and the body-self as particular and novel sites of a vital power and politic. Rajasthan has been among the poorest states in the country with high levels of maternal and infant mortality and morbidity. The author closely examines how social and economic inequalities are produced and sustained in discursive and on the ground contexts of family-making, how authoritative knowledge and power in the domain of childbirth is exercised across a landscape of development institutions, how maternal health becomes a category of citizenship, how health-seeking is socially and emotionally determined and

political in nature, how the health sector operates as a biopolitical system, and how diverse moral claims over the fertile, infertile and reproductive body-self are asserted, contested and often realised.

Zavella, P. (2020). *The Movement for Reproductive Justice: Empowering Women of Color Through Social Activism* (Vol. 5). NYU Press. In this book, the author draws on five years of ethnographic research to explore collaborations among women of color engaged in reproductive justice activism. While there are numerous organisations focused on reproductive justice, most are racially specific, such as the National Asian Pacific American Women’s Forum and Black Women for Wellness. Yet, many of these organisations have built coalitions among themselves, sharing resources and supporting each other through different campaigns and struggles. While the coalitions are often regional—or even national—the organisations themselves remain racially or ethnically specific, presenting unique challenges and opportunities for the women involved. The author argues that these organisations provide a compelling model for negotiating across differences within constituencies.

OTHER RESOURCES

FILMS/DOCUMENTARIES

Abortion: Add to Cart (2022) is a documentary exploring self-managed abortion with mifepristone and misoprostol and the emergence of telehealth. With self-managed abortions already being the norm with so many clinics, one group brings the lifesaving option to the digital world: the ability to order safe abortion pills online in the United States. **Abortion: Add to Cart** is a

short snapshot into the experiences and lives of people who have had abortions, sharing why accessing these pills with the click of a button is a revolutionary step towards safe and equitable healthcare for people across the country. Learn more about the film at <https://www.abortionaddtocart.com/>.

Aftershock (2022) is an award-winning documentary which unpacks the disproportionate rate at which American Black women die in or after childbirth. When two Black mothers die after giving birth, their partners and families come together, demanding that attention is given to the unsettlingly high Black maternal mortality rates, and systemic healthcare neglect. They rally for change with the determination to prevent any more people from losing their life in often preventable pregnancy-related deaths. Capturing the beauty and the pain of Black motherhood, the emotional impact of the stories and facts this film brings to the screen is hard to shake and should be required viewing for anyone entering the healthcare profession. More on the documentary here: <https://www.aftershockdocumentary.com/>.

On The Divide (2022) follows the story of three Latinx people living in McAllen, Texas who, despite their views, are connected by the most unexpected of places: the last abortion clinic on the U.S./Mexico border. **On the Divide** captures an intense and emotional look into what happens when people of color in a conservative state are on the ground, in the trenches at their final frontier for Reproductive Justice. More on the film here: <https://www.onthedividemovie.com/>.

Looking for a particular resource material?

ASK-US



DEFINITIONS

Assisted Reproductive Technology:

“Any fertility-related treatments in which eggs or embryos are manipulated. Procedures where only sperm are manipulated, such as intrauterine inseminations, are not considered under this definition. Additionally, procedures in which ovarian stimulation is performed without a plan for egg retrieval are also excluded from the definition.”¹

Bodily Autonomy: “Bodily autonomy is defined as the right to make decisions about your own body, life, and future, without coercion or violence. It includes deciding whether or not to have sex, use contraception, or go to the doctor. Bodily autonomy has long been recognized as a fundamental human right.”²

Comprehensive Sexuality Education:

“Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.”³

Health Equity: “Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being.”⁴

Intersectionality: “The concept of intersectionality describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination “intersect” to create unique dynamics and effects. All forms of inequality are mutually reinforcing and must therefore be analysed and addressed simultaneously to prevent one form of inequality from reinforcing another. Intersectionality brings our understanding of systemic injustice and social inequality to the next level by attempting to untangle the lines that create the complex web of inequalities. It is also a practical tool that can be used to tackle intersectional discrimination through policies and laws.”⁵

Reproductive Health: “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.”⁶

Reproductive Justice: “Reproductive Justice as the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities. It is about access, not choice. Mainstream movements have focused on keeping abortion legal as an individual choice. That is necessary, but not enough. Even when abortion is legal, many women of color cannot afford it, or cannot travel hundreds of miles to the nearest clinic. There is no choice where there is no access. It is not just about abortion. Abortion access is critical, and

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women of color and other marginalized women also often have difficulty accessing: contraception, comprehensive sex education, STI prevention and care, alternative birth options, adequate prenatal and pregnancy care, domestic violence assistance, adequate wages to support our families, safe homes, and so much more.”⁷

Reproductive Rights: “[E]mbrace certain human rights that are already recognised in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in human right documents.”⁸

Notes & References

- 1 Center for Disease Control and Prevention (CDC). “What is Assisted Reproductive Technology?” <https://www.cdc.gov/art/whatis.html>.
- 2 MSIUnitedStates. “My body, my choice: Defending bodily autonomy.” <https://www.msiunitedstates.org/my-body-my-choice-defending-bodily-autonomy>.
- 3 United Nations Educational, Scientific and Cultural Organization (UNESCO). “International technical guidance on sexuality education: An evidence-informed approach.” <https://www.unfpa.org/sites/default/files/pub-pdf/ITGSE.pdf>.
- 4 World Health Organisation. <https://www.who.int/health-topics/health-equity>.
- 5 Center For Intersectional Justice. <https://www.intersectionaljustice.org/what-is-intersectionality>.
- 6 United Nations, “Programme of Action Adopted at the International Conference on Population and Development Cairo,” 5–13 September 1994, 20th Anniversary Edition (New York: UNFPA, 2014), para 7.2, http://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf.
- 7 SisterSong, <https://www.sistersong.net/reproductive-justice>.
- 8 United Nations, “Programme of Action,” para 7.3.

HOW CAN WE MEASURE JUSTICE?

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In the development sector the saying goes—what gets measured, gets funded. Will sexual and reproductive justice remain in the ambit of the academics and not translate to change on the ground? In this article we endeavour to tie together our principles in pursuing the reproductive justice approach and our intention that the justice approach will ensure sexual and reproductive health and rights (SRHR) becomes more inclusive, more politicised, and move the field towards systems and institutional changes.

ARROW and its partners have been monitoring the progress of governments towards fulfilling SRHR through the ICPD, Beijing, CEDAW, UPR and SDG frameworks. Monitoring is a powerful tool for accountability. In the past decade

we have primarily worked on SRHR indicators to hold governments accountable to the standards set, agreed upon and signed onto. As we head to the 30-year anniversaries of Cairo, and Beijing, as well as the 10-year anniversary of the SDGs—including a reproductive justice framework and reproductive justice indicators become essential to create the change the world desperately needs.

The articles in this AFC edition have demonstrated the dimensions in which reproductive justice indicators can be organised around – decriminalisation, equity and access including fragile settings, gender justice and reproductive labour. This factfile presents—by no means—a final and exhaustive list of indicators, but an attempt to demonstrate how this can be done.

Current indicators on laws and policies monitor achievement of sexual and reproductive health service and rights (which are legalised) and gaps in legal frameworks which hinder access to SRH. From the justice angle we can consider policies that explicitly exclude groups— for example, if policies specifically talk about married women’s access to contraception, this creates barriers to other groups. Decriminalisation of laws and policies aims to broaden the ambit of services and rights and creates more rights holders from marginalised groups. Decriminalisation of laws around youth and adolescent sexuality, abortion, sexual orientation and gender identities, migrant SRH status come to mind and can be examined and monitored.

TABLE 1

REPRODUCTIVE HEALTH & RIGHTS INDICATORS (CURRENT)		REPRODUCTIVE JUSTICE INDICATORS (PROPOSED) DECRIMINALISATION DIMENSION	
1.	Total Fertility Rates, Wanted Fertility Rates	14.	Do laws/policies specifically give access to SRH services only to married women? Who is left out and what is the impact on those groups?
2.	Contraceptive Prevalence Rates	15.	If laws/policies are silent—is there systematic exclusion of any group at the implementation level? For example, LGBT persons, unmarried adolescents?
3.	Method mix in contraception	16.	Is there criminalisation of pregnancy status of any particular group i.e.: migrant workers, female students, HIV positive women? Does this result in discrimination against these groups receiving pregnancy services?
4.	Unmet need and Met need for contraception	17.	Is there compulsory testing of all pregnant women for HIV? Is there adequate counselling given, consent obtained, and support if they find out they are HIV positive?
5.	Informed choice around contraception	18.	Is adolescent sexuality criminalised in laws? Which laws and how?
6.	Male contraception	19.	Criminalisation of homosexuality/adultery/sex work?
7.	Mistimed pregnancies	20.	Access to safe abortion—removed from Penal Code, term limits on abortion (who is affected), third party authorisation/additional requirements
8.	Access to emergency contraception		
9.	Adolescent pregnancies		
10.	Access to SRHR services & CSE for young people		
11.	Unsafe abortion rates, percentage of maternal mortality attributed to unsafe abortion		
12.	Legal status and changes in law, abortion data (incidence, unsafe abortion, methods of abortion)		
13.	Access to medical abortion		

The second dimension in the reproductive justice theme which we are looking at is equity. Equity can be considered from different aspects: injustice in outcomes, drivers of injustice and groups experiencing injustice. To a certain extent, injustice in outcomes is already being covered by ARROW and its partners and also other data stakeholders including government and UN agencies in particular to the degree that SRH outcomes for poorer, lesser educated, rural and those living in hard-to-reach places is being covered by large datasets such as DHS. What is lesser known is the access to quality services for these groups: for example, IUDs and tubal ligation administered in camps resulting in poor quality services. Access to full information on contraceptive methods and the obtaining of informed and understood consent can also be considered within the purview of quality services. Lack of privacy and confidentiality for poor and marginalised women as well as breaking of confidentiality for adolescents and LGBT persons can also be considered as aspects of poor-quality service provision.

Do these marginalised women have access to other methods of contraception or ‘method switch’ that urban, wealthier and better educated counterparts do? Are some SRHR services only available in the private sector? That is services are available and accessible but unaffordable due to privatisation policies or skewed allocation to hospitals rather than primary care.

Within services, there is an absence of all services for specific groups. SRH services identify women of reproductive age 15-49 as the key target population, and women beyond 50 are left out of the data, and ‘age out’ of services. Older women may also be targeted for specific treatments such as hysterectomies, ART and HRT in the private sector but not for sexual health services. WHO’s Study on Global Ageing and Adult Health (SAGE) Wave 1 study left out SRH services for older persons, whilst the WOPS study carried out in South Africa and Uganda looked at five HIV specific indicators in which three indicators were around adult children’s HIV status. Other STIs and sexual health services as well as IVF are

not aimed at older persons though they continue to have sexual lives and may have reproductive intentions.

A derivative from the decriminalisation lens is if SRH services are available only to married women, then this leaves out various groups such as unmarried adolescents and young women, as well as trans and MSM groups from sexual health services and gender-affirming services for trans-persons. On the flip side, the rights of intersex persons are often violated—with compulsory surgeries assigning a specific sex being carried out either soon after birth or before the age of consent.

The right to parent is also part of the reproductive justice framework. SRHR for women and girls with disabilities is severely limited as they are not seen as ‘able’ and ‘capable’ for sexual and reproductive decision-making. Consent for SRHR is given by parents and guardians and involve violations such as forced permanent contraception, hysterectomies, and forced abortions.

TABLE 2

REPRODUCTIVE HEALTH & RIGHTS INDICATORS (CURRENT)		REPRODUCTIVE JUSTICE INDICATORS (PROPOSED) EQUITY DIMENSION	
	Disaggregated by income, education, urban/rural, and where available, caste and minority status:	11.	Absence of services for men and boys; older women; women and girls with disabilities; LGBT
1.	TFR vs WFR	12.	Poor quality services—who have been the recipients? Data on obstetric violence, other forms of discrimination in SRH service delivery – involuntary IUD insertion or sterilisation or misleading women to have a hysterectomy
2.	CPR	13.	Availability of referral and treatment for uterine prolapse, fistula, miscarriage, post-partum depression
3.	Method mix	14.	Women and girls with disabilities (reproductive rights violations also driven by health sector (involuntary sterilisation, hysterectomy)
4.	Unmet need/ Met need	15.	Access for survivors of violence – counselling, EC, abortion, HIV prophylaxis.
5.	Informed choice	16.	Health system driven inequities – inclusion and availability of services in primary health care; public insurance coverages; third-party authorisation
6.	Male contraception		
7.	Mistimed pregnancy		
8.	MMR		
9.	Ante-natal, post-natal, post-partum access		
10.	Skilled birth attendance		

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The third dimension is to look at the interlinking of gender justice, reproductive labour with reproductive justice. In this, two systemic issues are covered: gender norms and gender roles on care.

Gender norms in health that continue to be perpetuated hinder justice. Sexuality continues to be framed in policies as contained within heteronormative and marital frameworks and continues to exclude and prolong discrimination and violence against the unmarried, young, and LGBT persons. Even when married, women do not own their 'sexuality' or decision-making around SRHR. Control of female sexuality is seen as drivers behind practices such as early age marriage and FGM/C. The gender norm of motherhood continues to extend stigma around abortions. The reproductive role and care role mutually reinforce gender roles and these roles are not always performed out of the willingness of women and girls.

Government interventions to compensate for care roles are useful to an extent and need to be supplemented by interventions to change these roles.

Society's inherent bias of race, age, ability, and sexual orientation and gender identity also needs to be recognised within gender norms and roles. The Black reproductive justice movement called for the right to parent in a safe environment looking at the targeting of Black boys by the criminal justice system. The right to parent in a safe environment can also be considered from violence reduction lens (both at home and at school), for specific racial, ethnic and religious minority groups, for migrant families and for those living in climate vulnerable areas. Not all women are considered able, capable and deserving of reproduction. Older women, disabled women and LGBT couples are often denied the right to have children and form families.

This list does not constitute the universe of reproductive justice indicators. This is only an attempt to show that justice should not be relegated to the realm of philosophy and politics but made concrete to make a difference in the lives of those marginalised by the systems, policies, and institutions meant to serve them.

Gender norms in health that continue to be perpetuated hinder justice. Sexuality continues to be framed in policies as contained within heteronormative and marital frameworks. The gender norm of motherhood continues to extend stigma around abortions. The reproductive role and care role mutually reinforce gender roles and these roles are not always performed out of the willingness of women and girls.

TABLE 3

REPRODUCTIVE HEALTH & RIGHTS INDICATORS (CURRENT)		REPRODUCTIVE JUSTICE INDICATORS (PROPOSED) GENDER JUSTICE, REPRODUCTIVE LABOUR DIMENSION	
1.	Paid maternity leave	5.	Government efforts to change gender norms—sexuality of unmarried people recognised in some way; trans/LGBTQI laws/policies/programmes
2.	Early age marriage – drivers i.e., religious norms, early sexual activity, marry the rapist	6.	Government efforts to remove third-party authorisation e.g. spousal consent for permanent contraception and abortion
3.	FGM/C prevalence, drivers	7.	Removal of third party authorisation for example spousal consent for permanent contraception/abortion
4.	Violence – incidence and prevalence rates, types of violence including online violence	8.	Paid paternity leave
		9.	Recognition of minority group women to raise a family in a safe environment
		10.	Right to be a parent – women with disabilities, older women, women living with HIV, LGT access to IVF
		11.	Comprehensive SRH services for survivors of violence including emergency contraception, safe abortion, HIV prophylaxis, counselling and legal aid
		12.	Acceptability of violence (DHS)
		13.	Government efforts to recognise and reduce violence (laws, availability of one stop crisis centres)

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We would also like to thank the following individuals who contributed their ideas during the conceptualisation of the bulletin: **Anjali Sheno, Biplabi Shrestha, Evelynne Gomez, Deepa Chandra, Garima Shrivastava, Harshani Bathwadanage, Indah Yusari, Keshia Mahmood, Menka Goundan, Momota Hena, Nur Hazwani Husin, Sai Jyothirmai Racherla, Shamala Chandrasekaran, Shiwa Karmacharya, Sivananthi Thanenthiran and Smruti Sudha Behera.**

ARROW for Change (AFC) is a peer-reviewed thematic bulletin that aims to contribute a Southern/Asia-Pacific, rights-based, and women-centred analyses and perspectives to global discourses on emerging and persistent issues related to health, sexuality, and rights. AFC is produced twice-yearly in English, and is translated into selected languages several times yearly. It is primarily for Asian-Pacific and global decision-makers in women's rights, health, population, and sexual and reproductive health and rights organisations. The bulletin is developed with input from key individuals and organisations in Asia and the Pacific region and the ARROW SRHR Knowledge Sharing Centre (ASK-us!).

This publication is made possible by funding support from The David and Lucile Packard Foundation.



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