

REPRODUCTIVE LIFE
HER-STORIES

TRACKING DISCRIMINATIONS AMONGST MARGINALISED COMMUNITIES USING INTERSECTIONAL APPROACHES TOWARDS REPRODUCTIVE JUSTICE

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asian-pacific resource & research centre for women

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2026

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ASIAN-PACIFIC RESOURCE & RESEARCH CENTRE FOR WOMEN (ARROW)

1 & 2 Jalan Scott, Brickfields, Kuala Lumpur, Malaysia 50470

Telephone	+603 2273 9913/9914/9915
Fax	+603 2273 9916
E-mail	arrow@arrow.org.my
Web	arrow.org.my
Bluesky	arrowomen.bsky.social
Facebook	ARROW.Women
Instagram	@arrow_women
Youtube	@ARROWomen
LinkedIn	arrowomen

PRODUCTION TEAM

AUTHORS

Case Stories	SAHAJ (Society for Health Alternatives) and Rural Women's Social Education Centre (RUWSEC) in India; Youth Advocacy Network, Sri Lanka (YANSL) and Sarala Emmanuel (independent researcher) in Sri Lanka; Faculty of Public Health, University of Health Sciences (UHS) in Lao PDR; Likhaan - Centre for Women's Health and Athea Jade S. Victori, Independent Researcher in the Philippines; Centre for Creative Initiatives in Health and Population (CCIHP) in Vietnam; and the James P. Grant School of Public Health, BRAC University in Bangladesh
Content and Analysis	Anjali Shenoi and Sundari Ravindran
Reviewers and Editors	Sundari Ravindran, Sivananthi Thanenthiran and Sarojini N.
Copy Editor	Anuradha Bhasin
Layout	Saurav Thapa Shrestha
Cover Photo Credit	Shutterstock

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CHAPTER 1

GROUNDING REPRODUCTIVE JUSTICE: INTERSECTIONAL REALITIES AND DATA GAPS IN THE ASIA-PACIFIC

INTRODUCTION

Reproductive justice as an analytical and political framework extends beyond the scope of sexual and reproductive health and rights (SRHR) to interrogate the structural conditions that enable or constrain individuals' reproductive autonomy. Grounded in intersectionality,[1] this framework has emerged from the organising and scholarship of African-American women in the United States, centring race, class, and gender as interlocking determinants of reproductive experiences.[2] It encompasses the right to bodily autonomy, the right to have children or not have children, and to parent in safe and enabling environments, situating these rights within broader socio-economic and political contexts.[3] However, the application of this framework in the Asia-Pacific region necessitates a contextual reinterpretation. Women and young people, in all their diversities, face a range of challenges in accessing their SRHR, which is further compounded by their multiple identities and contextual factors. In the region, axes of marginalisation such as caste, class, gender, ethnicity, religion, migration status, disability, age, geographic location, and sexual orientation, gender identity and expression, and sex characteristics (SOGIESC), amongst others, interact in distinct ways to shape reproductive lives, and cannot be understood through narrow measures or aggregate indicators alone.[4] Yet these realities remain largely invisible in mainstream data and policy frameworks, leaving marginalised communities excluded from progress narratives.

Through this publication, ARROW and her partners make a call for a shift from abstract commitments to lived realities by grounding and developing sexual and reproductive justice indicators in life-course narratives or 'reproductive her-stories' that capture dignity, autonomy, and resilience. By centring these voices through indicative and community-documented case stories of women and girls from marginalised communities, we make a case for the move towards inclusive, ethical data systems that hold states accountable and ensure no one is left behind.

INTERSECTIONAL CHALLENGES IN THE ERA OF A POLYCRISIS[5]: A CONTEXT

Although the Asia-Pacific region has been held as an example of economic success, there are many inequities and inequalities that persist across and within countries. Poverty continues to haunt the most marginalised and most vulnerable. Asia and the Pacific is home to 54% of the global urban population, more than 2.2 billion people.[6] By 2050, Asia's urban population is expected to grow by 50%, adding 1.2 billion people.[7] Variegated spaces within urban areas and differential contexts mean that the unique needs of vulnerable urban populations, such as residents of informal settlements and other low-income urban areas, street children, urban refugees, and migrants, need special consideration. Sexual and reproductive health risks for the urban poor include high rates of unwanted pregnancies, sexually transmitted infections, poor maternal and child health outcomes, and high rates of gender-based violence (GBV).[8] Urban areas also have a higher prevalence of HIV, particularly in sub-Saharan African cities, with heightened risk in informal settlements and other low-income urban areas. Yet, the interconnectedness of various social and economic factors and the ways in which social systems, power, and identity directly affect SRHR outcomes in urban areas remains underexplored.

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.[9] Women and girls with disabilities are 1.5 times more likely to be survivors of violence than those without disabilities.[10] Yet, despite requirements of the Convention on the Rights of Persons with Disabilities (CRPD), women and girls with disabilities are denied basic information and services on sexual and reproductive health (SRH). There continues to be stigma around the sexuality of persons with disabilities, which also translates to an inability to parent. Violations of their reproductive rights are disregarded, as women and girls with disabilities undergo forced hysterectomies and unsafe abortions, or upon delivery are separated from their children because they are deemed as not fit to be parents.[11]

Similarly, older women have always been missing from the SRH equation, simply because most SRH datasets only survey women of reproductive age, from 15 to 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,[12] any research on older persons' SRH and desire will have to also include a study of their life trajectories, and the interplay of various factors as a part of these trajectories that make their current needs even more complex.

Other vulnerable groups that live in remote areas and geographies, most affected by climate change, including agricultural communities, and Indigenous and ethnic minority communities such as forest tribes, and mountain and island communities, face the increased burdens of climate disasters, not only leading to further impoverishment through the loss of livelihoods, assets, and resources, but also to an increase in morbidity and mortality, and the marginalisation of SRHR due to severe restrictions on access to healthcare, particularly SRH services during the time of crises. Ethnicity, and its intersection with indigeneity, thus remains an under-named axis of marginalisation in the region: ethnic conflict and displacement bear disproportionately on Indigenous women's reproductive autonomy, restricting their access to SRH information and services, and rendering their experiences largely invisible within both humanitarian responses and mainstream SRH data systems.[13] The Asia-Pacific region is highly susceptible to climate change impacts and related disasters, with many countries appearing at the top of global vulnerability assessments. According to estimates by the UNESCAP Asia-Pacific Disaster Report in 2019, the Asia-Pacific region has an annual loss of USD 675 billion due to disasters.[14] The ramifications of climate change also impact food security and trigger conflicts over key resources: arable land, water, and food and energy sources.

This polycrisis extends beyond climate change alone: the expansion and proliferation of foreign military bases across the region have heightened geopolitical anxieties, often driving regional tensions rather than fostering peace and security. As governments respond by directing greater public spending towards militarisation, this has resulted in greater economic volatility, scarcer essential resources, as investments are correspondingly diverted away from public health and universal health coverage, including sexual and reproductive health, further straining already fragile health systems and deepening the vulnerability of marginalised communities. Conflict looms as a shadow over the region, and unsurprisingly serves to reinforce ethnic and religious identities, and bring about a resurgence of anti-rights and anti-gender narratives and realities. A direct fallout of this is invariably on gender justice and bodily autonomy and integrity, with increased attacks on women, young people, and marginalised communities, systematic sexual and gender-based violence, and the collapse of public and social systems, including health services.

Taken together, these snapshots point to a common thread that caste, class, religion, migration status and statelessness, and SOGIESC diversities, amongst others, are as central to reproductive marginalisation in the region as the axes profiled above. Caste-based discrimination continues to shape access to reproductive health services and to expose Dalit and other caste-oppressed women and girls to heightened risks of reproductive violence, including coerced sterilisation and denial of care, yet caste rarely appears as an explicit category in regional SRH data or programming. Religious minorities and stateless communities face parallel forms of exclusion, often compounded by the absence of the legal identity documents needed to access public health entitlements. Queer, trans, and non-binary people are similarly all but absent from the profiles above: reproductive justice scholarship increasingly places SOGIESC diversity and queer reproductive experiences at the centre of the framework rather than treating them as an addition to it, yet mainstream SRH data collection in the region continues to assume binary disaggregations at best. What connects these otherwise disparate experiences of caste, class, religion, migration status and statelessness, ethnicity, disability, age, and SOGIESC diversity, amongst others, is a shared structural pattern where each is rendered invisible in mainstream data and policy frameworks, not as an oversight specific to any one group, but as a recurring feature of how reproductive lives are counted, or left uncounted, across the region. It is this pattern of data invisibility, cutting across all these axes of marginalisation, that a reproductive justice and intersectional lens is best placed to make visible, and that we turn to next.

MEASURING WHAT MATTERS: TOWARDS INTERSECTIONAL DATA FOR REPRODUCTIVE JUSTICE

Measurement is not a neutral act. Indicators determine what is counted, who is visible, and which lives are considered within the ambit of progress. For women and girls from marginalised communities in Asia, data on their lives is too often not disaggregated, or is disaggregated along a limited set of axes, such as sex and urban/rural residence, that fail to capture critical lines of disadvantage such as caste, statelessness, migratory status, or sexual orientation. Even where indicators exist, the methods and data sources used, including national surveys and administrative records, systematically exclude

or miscount populations who are harder to reach, or who are rendered invisible by legal or social marginalisation. Much available data measures outputs, such as the number of schools built or the proportion of households with electricity, without interrogating whether marginalised groups can access these services equitably. This distinction between what is measured and the lived experiences of women and girls, particularly from marginalised communities, is critical. While many countries in the region have enacted legislation against gender-based violence, for instance, available data rarely captures implementation gaps, survivor experiences, or systemic barriers to justice.

This invisibility has real consequences. It perpetuates structural exclusion, as policies designed on incomplete data tend to benefit only those already visible to the system, misallocating resources and bypassing the people who need attention the most. In reproductive health and rights, a domain of life where social stigma, legal restriction, and power imbalances are acute, invisibility in measurement translates into failures in service delivery, protection from violence, and the recognition of reproductive autonomy. National averages may suggest progress in maternal health or education, but Indigenous women in remote areas, or migrant girls in resettlement colonies and other poorer urban areas, continue to face disproportionate risks that remain hidden without disaggregated data.

Data on intersectional areas like reproductive justice and gender justice remains scarce and often held in silos. Intersectional data on climate justice and its impact on reproductive rights, for example, may be recorded at a local level, but comparable data and indicators across countries are not easily available. The availability of gender data more broadly has improved significantly over the last five years in the Asia-Pacific, including data on gender's intersection with education, health, sanitation, and menstrual health at the regional and national level. But gaps and spaces of silence remain: data on reproductive health indicators for gender non-binary individuals is still largely limited to sexually transmitted infections and HIV, and data on abortion, teenage pregnancy, and unsafe or illegal abortion remains restricted to what civil society players and researchers working directly in these areas are able to document.

New modes of measurement have become more pertinent, particularly in a post-pandemic world defined by polycrisis, where multiple challenges lie at the intersections of access to SRHR with violence, climate crises, care burden, digitisation, a lack of political will around human rights, and increasing authoritarianism, fundamentalism, and conservatism. With the sweep of right-wing politics in the Global North as well

This polycrisis extends beyond climate change alone: the expansion and proliferation of foreign military bases across the region have heightened geopolitical anxieties, often driving regional tensions rather than fostering peace and security.

as in many countries in the South, feminist movements and women's rights organisations have been generating evidence on heightened gender disparities, statelessness, and gender-discriminatory laws that obstruct reproductive justice and increase levels of GBV, particularly tech-facilitated GBV and structural and systemic forms of violence, especially amongst marginalised communities. Holistic and honest reporting on progress on gender equality going forward will need to be cognisant of all of these emerging issues, ensuring that data, evidence, and interventions in these areas remain both relevant and strategic to women and girls in all their diversity on the ground. It is precisely this gap that new, intersectional, and reproductive-justice-oriented indicators are needed to fill.

BRIDGING THE DIVIDE: FROM INDICATORS TO LIVED EXPERIENCES

Women's rights organisations, particularly those working on research and data on gender and its intersections, are keenly aware of the importance of what gets measured and have been advocating for the inclusion of strategic indicators to broaden and deepen the work and investments of governments and donors in gender equality.

Towards this end, ARROW and her partners have been developing periodic national and regional advocacy reports (since the early 2000s) that track progress on three major global frameworks: the Beijing Platform for Action (BPfA), the International Conference on Population and Development (ICPD) Programme of Action, and the Sustainable Development Goals (SDGs). Each framework represents a cornerstone of global commitments to gender equality, women's empowerment, and SRHR. The Beijing Platform for Action, adopted in 1995, set out a comprehensive agenda for advancing women's rights. The ICPD Programme of Action, agreed in 1994, emphasised the centrality of reproductive rights and health in development. The SDGs, adopted in 2015, provide a universal roadmap for sustainable development, with gender equality and health woven throughout.[15]

These reports are particularly significant because they have bridged the gap between state commitments made at international forums and the lived realities of women and girls

in all their diversity. Governments often report progress in terms of policies, laws, and statistical indicators. But through their reports, ARROW and her partners have consistently advocated for state accountability to be measured against how these commitments actually affect people's lives. This means listening to and documenting the experiences of women and girls, including adolescents, Indigenous women, women with disabilities, LGBTQ+ persons, and those from other marginalised communities, whose voices are often excluded from official narratives. This ensures that these monitoring reports and subsequent advocacy efforts reflect diverse realities and capture nuances that official indicators alone cannot, while also empowering communities by validating their experiences and positioning them as key stakeholders in accountability processes. These efforts also provide evidence-based advocacy tools for civil society to push for policy reforms, better resource allocation, and stronger implementation of commitments. Second, they also contribute to regional and global dialogues by offering insights into how commitments are being realised (or not) in practice. This strengthens solidarity across movements in different countries and helps identify common challenges and strategies.

Taking these efforts one step further, in 2024 ARROW conducted a mapping exercise to identify the different indicators of women's rights organisations and networks working on gender and data at the global, regional, and national levels. The mapping study began with an initial comprehensive data search using keywords gender* data, organisations mapping gender* data, SDG and gender data, indicators of gender data*region (Asia, Latin America, Africa). An initial search resulted in a list of 51 organisations. These organisations were listed, and their details were gathered on an Excel sheet under category, name and description of the organisation, any definition of gender data, thematic areas of data/ gender data, indicators of gender data, methodology/ databases used, number of countries covered, regions, and sources/links to access/URLs. Further, a detailed review of each organisation was undertaken which served as a snowballing method to identify other linked organisations, for example, Equal Measures 2030 has a coalition of other regional organisations which map regional data on thematic areas and gender. These were included in the list. In addition, organisations had research studies that quoted and mentioned other linked organisations which were recorded, researched, and listed.

In this manner, the list was expanded to a dataset of 94, and later to 100 organisations. An initial analysis of this listing was done to identify some analytical categories to describe this landscape; some of these categories were: do they define gender data? Is it only a mention of data disaggregation by sex or "data seeking to uncover and untangle the power imbalances within data ecosystems" or, "data feminism which involves challenging standard data practices, paying attention to power and privilege, rejecting binaries, and understanding how gender, race, disability, class, sexuality, age, religion, geography and other factors come together and shape people's experiences and opportunities? This means data feminism brings to light important insights that might otherwise be concealed or overlooked."[16]

Some of the initial emerging analytical categories/ways to sort and make sense of the data identified by researchers were:

ANALYTICAL CATEGORY 1

Gender and Intersections

1a. Those who have data on gender, e.g., equity, norms, such as care-related data, redistribution of care, e.g., fatherhood reports, Gender Equity Movement in School from ICRW, or gender-based violence (GBV).

1b. Those which had data on Gender*Thematic areas: education, climate, health, sexual and reproductive health (SRHR), menstrual health, adolescent health, food, water, sanitation, electricity, employment, leadership, labour rights, law, media, digital access, mobility, agriculture, human rights and peace, migration, refugees, freedom of expression, marriage, adolescents, youth, demographics, inclusion, family planning, HIV/AIDS, finance, and poverty.

1c. Those that mapped gender and intersectional data, for example, Dalit women, Indigenous women, women with disabilities, LGBTQAI+, etc.

ANALYTICAL CATEGORY 2

Data by type of organisations: those conducting research, multilaterals, working on women's rights, regional policy, coalitions/networks.

ANALYTICAL CATEGORY 3

Methodology-based segregation: Organisations which are aggregating data, or producing new analytical frameworks to analyse existing data, such as the analysis of ODA data from how much is spent on care infrastructure, health, etc.; those which are generating data and narratives or identifying gaps in data, type of gender data, sex-disaggregated data, feminist data, i.e., using participatory methods or the idea of open data sets, policy-level data, and the analysis of policies from a gender lens to identify areas of focus and missing spaces.

ANALYTICAL CATEGORY 4

The analysis looks at the geographical focus of the organisations: regional/global/country-level focus to adequately cover Latin America, Asia Pacific, and Africa.

Some analysis and gaps that emerged from this exercise:

1. There is a lot of work on gender-based violence at the global, regional, and local levels.
2. Data is, however, scarce in areas like mobility and gender, digital access and gender, menstrual health especially menopause, mental health and gender, and in gender across occupations/trades, apart from agriculture.
3. There are different ways the available data can be disaggregated: gender-disaggregated data, using a gender lens to analyse data, new data that is being generated through studies/indexes mainly.
4. Intersectional data on SRHR and its intersections remain scarce.

INDICATORS DEFINED BY LIVED EXPERIENCES AND REPRODUCTIVE JUSTICE

Achieving gender justice in the current era of polycrises requires attention to multiple domains of women's lives, including the fulfilment of basic and essential needs and rights, access to decent work, social security, rights-based health systems, and inclusive legal and policy frameworks. These domains collectively underpin bodily autonomy and integrity, both of which, as mentioned above, are increasingly vulnerable in contexts of systemic instability. Employing a justice framework in conjunction with an intersectional lens facilitates the generation of evidence that highlights the ways in which gender inequality is reproduced and how women and girls, particularly those from marginalised communities, experience violations of autonomy and integrity. Research in this area seeks to draw upon the lived experiences of structurally excluded groups, operationalised through indicators that enable the measurement and monitoring of impacts in settings where rights are already precarious. Such an approach allows for the identification of systemic factors, the analysis of how crises disproportionately affect women, young people, and marginalised populations, and the development of policy and programmatic responses that uphold bodily autonomy and integrity.

Understanding the intersections of these factors is essential not only for identifying root causes but also for adapting dialogues and strategies to address the multiple layers of vulnerability experienced by women and young people in diverse contexts.

The reproductive justice movement situates intersectionality and human rights at the core of its mission, thereby creating opportunities for marginalised groups to participate more fully in political movements for reproductive freedom. As the Asian Communities for Reproductive Justice (2005) articulates, this framework provides an integrated analytic approach and a holistic vision, accompanied by comprehensive strategies that challenge structural and societal conditions responsible for persistent marginalisation.[17] Furthermore, reproductive justice offers methodological promise for research and evidence generation, emphasising structural inequalities and the interplay of systems of domination. By situating micro-level experiences associated with social identities such as race, caste, gender, sexuality, and class, within broader macro-level structures of inequality, the framework enables a nuanced understanding of interlocking systems of oppression and their implications for bodily autonomy and integrity.[18]

Thus, this further makes the case for the urgent need for inclusive, ethical, and community-owned data systems based on a reproductive justice indicators framework. Towards this end, ARROW and her partners are attempting to develop these indicators by documenting life-course narratives of reproductive lives, or as we prefer to call it, reproductive 'her-stories' of women and girls in all their diversity, particularly those from marginalised communities, as an essential methodological and moral practice to ground indicators in lived experience.

Through this exercise, we hope to demonstrate that reproductive justice indicators can be meaningfully drawn from life-course narratives, as these stories reveal how structural inequalities shape reproductive lives over time. By listening to women and girls in all their diversities, especially those from marginalised communities, we can trace patterns of access, denial, resilience, and agency across different stages of life. The narratives highlight not only pregnancy, childbirth, or contraception, but also broader social conditions, such as poverty, social discrimination, disability, migration, conflict situations, gender-based violence, domestic and sexual violence, climate crises and disasters and conflict and wars that influence reproductive choices and outcomes. These lived experiences provide qualitative indicators of justice: autonomy in decision-making; non-discrimination; safety in healthcare encounters and within the family and workspace; and dignity in reproductive transitions.

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Importantly, the life-course narratives capture intergenerational and intersectional dimensions of reproductive justice. For example, the reproductive experiences of adolescent girls, migrant women, or Indigenous communities often reflect systemic barriers that persist across generations. Indicators drawn from these accounts can measure whether policies and health systems respect cultural identities, reduce inequities, and uphold reproductive rights beyond clinical outcomes. In this way, narrative-based indicators move beyond narrow biomedical measures to encompass social, emotional, and political realities, offering a more holistic framework for evaluating reproductive justice and, in turn, holding our states accountable to the commitments they have made in different global and human rights charters.

Towards this end, ARROW has partnered with women's rights organisations to: (i) document the experiences of key SRH milestones amongst women and girls from marginalised communities through their life-course, including their experiences of violations and acts of resilience thereof; (ii) study the barriers to, as well as the enablers of access to SRH services and care during these experiences and plot a vulnerability map based on these life experiences in a graphic manner; and finally (iii) draw out key domains of reproductive justice and make a case for potential indicators, while identifying the significant gaps that remain in cross-country comparable data, particularly for the domains most consistently overlooked by mainstream frameworks, with the aim of enabling conceptual clarity, practical guidance, and programmatic direction for researchers, policymakers, civil society, and communities seeking to measure progress and state accountability more equitably and meaningfully towards ensuring reproductive justice for the most marginalised.

CHAPTER 2

REPRODUCTIVE HER-STORIES: LIVING AT THE INTERSECTIONS FROM STRUCTURALLY EXCLUDED COMMUNITIES

ARROW partnered with eight of her national partners [SAHAJ (Society for Health Alternatives) and Rural Women's Social Education Centre (RUWSEC) in India; Youth Advocacy Network, Sri Lanka and Sarala Emmanuel (independent researcher) in Sri Lanka; Faculty of Public Health, University of Health Sciences (UHS) in Lao PDR; Likhaan- Centre for Women's Health in the Philippines; Centre for Creative Initiatives in Health and Population (CCIHP) in Vietnam, and the James P. Grant School of Public Health, BRAC University in Bangladesh] from six countries to document case stories based on in-depth interviews conducted with women from the communities where these organisations work. While each organisation carried out 2–3 interviews, a select group of stories from each organisation was picked to highlight a range of experiences, some unique to their vulnerabilities and marginalisations. In all, the report documents 15 stories, each with a graphic representation of its own vulnerability map.

The partners worked together to arrive at a methodology and interview guidelines to facilitate the in-depth and immersive interviews conducted in a safe, comfortable setting chosen by the participant while maintaining the highest standards of ethics. A 're-storying' method was then used by the organisations to transform all interviews into the stories used herein. A special effort was made to completely familiarise the researchers with the transcripts, to ensure the chronology of events was well plotted and translated, being true to the tone of the participants' feelings and respectful of their perspectives and experiences.

As mentioned above, robust ethical safeguards underpinned every stage of the research process. Informed consent was treated not as a one-time formality but as an ongoing process: it was sought, explained and reaffirmed in participants' own local languages, using accessible and non-technical framing, and was revisited at multiple points during the engagement rather than being confined to a single signature at the outset.

Interviews were scheduled around participants' own free time and conducted in settings that participants themselves identified as safe and comfortable, so that taking part would not add further burden of risk, nor cause any disruptions to their daily lives. Wherever institutional mechanisms allowed, partner organisations sought ethical review and approval before data collection began, in recognition of the highly intimate and personal nature of the material being shared. Psychosocial and other forms of support were made available to participants whenever the need arose, both during and after the interviews. This was possible in large part because the partner organisations were not external or one-time contacts, but had in fact worked within these communities over several years, building relationships of trust well before the interviews took place. This long-standing engagement allowed the research to be grounded in familiarity, mutual respect and continuity of care, rather than a single extractive encounter.

Informed consent was treated not as a one-time formality but as an ongoing process: it was sought, explained and reaffirmed in participants' own local languages, using accessible and non-technical framing, and was revisited at multiple points during the engagement rather than being confined to a single signature at the outset.

To ensure safekeeping, all stories have also been anonymised, including the participants' names and other identifiers such as their locations and the names of communities. In the chapters that follow, the stories are documented country-wise and an attempt has been made to provide brief socio-economic contexts to the status of the communities that the participants belong to. A graphic designer and visual researcher was engaged to plot the vulnerability map for each of the stories.

her-stories

BANGLADESH

BANGLADESH

MARGINAL LIVES AT THE EDGE OF CLIMATE CRISIS

BANGLADESH — Country Context Indicators	
A. ECONOMIC INDICATORS[19]	
National poverty rate	5.91% extreme poverty (< USD 3/day); national poverty line: 18.7%
Rural vs. urban poverty	Rural poverty rate approximately twice the urban rate
Gini coefficient	34.5 (rise in urban areas from 30.9 in 2022)
Women workforce participation rate	41.2% labour force participation rates amongst females; 64% of women are in vulnerable employment 20.9% seats in parliament held by women (2023)
B. KEY GENDER AND HEALTH INDICATORS[20]	
Gender Gap Index[21]	0.775 ranked 24th/148 countries; Human Development Index – 130/193 countries
Maternal mortality ratio (MMR)	115 per 100,000 live births, declined by over two-thirds since 2000; estate/embankment community rates not separately reported
Adolescent birth rate (ABR)	92 births per 1,000 women aged 15–19; child marriage rate: 13.4% of women married by age 15 and 47.2% by age 18
Contraceptive prevalence	73.5% of married women in the 15–49 year age group
Population with at least some secondary education	43.2% of women aged 25 or older
C. LEGAL FRAMEWORK — SEXUAL AND REPRODUCTIVE HEALTH	
Abortion[22]	Illegal under the Penal Code of 1860, except to save a woman's life; permitted for 'menstrual regulation' (MR) as part of national family planning programme since 1979; abortion-related complications remain a significant cause of maternal deaths
Gender-based violence (GBV)[23]	76% of ever-married women have experienced intimate partner violence in their lifetime; 15% of women experienced physical violence; and 2.2% face sexual violence from non-partners from the age of 15; marital rape not explicitly criminalised
LGBTQI+ communities[24]	Same-sex relations criminalised under Section 377 of the Penal Code; penalty up to life imprisonment. The Hijra community is recognised as a 'third gender' by government policy (2013); legal recognition is limited in practice. No comprehensive anti-discrimination law. Transgender persons face social stigma, exclusion from public services, and police harassment.
D. GEOGRAPHIC AND SOCIAL STRATIFICATION[25]	
Uneven geographic development	Southwestern coastal belt (Khulna, Satkhira, Bagerhat divisions) amongst the most climate-vulnerable and economically marginalised regions
Caste and ethnic stratification	Scheduled castes (Dalits), including the Rishi community, face intergenerational poverty, exclusion from public spaces, and occupational stigma; comprise ~7% of population but have no separate disaggregated national statistics
Climate vulnerability[26]	Ranks 31st amongst the most climate-vulnerable countries on the Climate Risk Index

Note: Data reflect most recent available estimates. Rural/urban and caste-based data disaggregation remains limited. Figures for the Rishi and other Dalit communities in southwestern Bangladesh are not separately reported in national statistics.

Within the above socio-political-economic context of Bangladesh, the two case stories documented by the national partner, James P. Grant School of Public Health, BRAC University, highlight the challenges and lived experiences of women and girls from the 'Rishi community' residing on the southwest embankments which have experienced repeated flooding over the last few years.

The southwestern region of Bangladesh is home to several Indigenous and ethnic communities. Compared to other regions, this area experiences significant socio-economic disparities arising from a lack of economic opportunities beyond the agricultural sector. Despite the long history of caste-based discrimination in the region, Dalit communities continue to remain underrepresented in existing scholarship.[27] In this context, the Rishi community are Hindus who have historically been stigmatised as 'untouchables' in the region due to their engagement in 'traditional occupations' (associated with impurity) such as sanitation work involving sewage and/or dead animals. Caste-based discrimination, while limiting socio-economic mobility, has also left them vulnerable to poverty and precarious livelihoods.

Despite access to basic services and the right to public space being gained through NGO interventions over time, the majority of its members remain dependent on low-paying informal work: they mostly work as agricultural labourers, barbers, or own small businesses in carpentry and metal-welding. The proximity of Rishi settlements (situated historically in lowest-lying areas) to canals and water bodies, adds a spatial dimension to their marginality, as the risk of flooding and water-logging remains high. Health outcomes for women remain especially poor, with limited access to healthcare compounded by stigma, resulting in untreated illnesses and chronic malnutrition.[28]

Furthermore, Southwestern Bangladesh is one of the most climate-vulnerable regions globally. The International Centre for Climate Change and Development (ICCCAD) notes that cyclones, salinity intrusion, and flooding are recurrent threats, undermining livelihoods and displacing communities. Repeated cyclones have devastated infrastructure and homes, while rising sea levels have increased soil and water salinity, making agriculture increasingly unviable.[29] Bangladesh ranks amongst the top countries in the Climate Risk Index, with millions affected annually.[30] For the Rishi community, climate crises compound existing vulnerabilities. Their precarious livelihoods are further eroded by climate disasters, with opportunities in agriculture severely curtailed by salinity intrusion and flooding. Housing and food insecurity is also acute. Settlements near embankments are repeatedly destroyed by cyclones and floods, forcing families into cycles of rebuilding with scarce resources. Salinity intrusion contaminates drinking water, leading to widespread health issues such as skin diseases, hypertension, and reproductive health problems.[31] Women bear disproportionate burdens: managing household survival during disasters, coping with water scarcity, and facing heightened risks of violence and exploitation in displacement contexts.[32]

PAROMITA'S STORY

Paromita is a 30-year-old woman from the Rishi community, residing in one of the inland coastal areas in southwestern Bangladesh. She works as an agricultural labourer. Despite the high temperatures and oppressive humidity that characterise the region's weather for most of the year, Paromita, like many other women, resolutely tends to crops on others' farmlands. She receives a nominal daily wage of 200 taka (USD 1.63), 50–100 taka less than men who labour alongside.

CHILDHOOD

Paromita grew up in a large family, one of six children. Her parents struggled to provide proper food and education for all their children. They worked as daily farm labourers, harvesting paddy, making hay, or planting crops. But landowners often delayed paying wages or never paid properly.

> *"My father was not able to manage to feed all six of us. If he brought one kilogram of rice and all six children brought their plates at the same time, he had to give one fistful of rice to each."*

Poverty compelled her parents to send some of their children to relatives' homes or put them to work in more well-off homes. Paromita spent some time in an aunt's home nearby, where she had a small window of opportunity to attend school, but she could not complete her primary education. She has fond memories of school, lovingly recalls her friends, and how she had won prizes at various competitions.

Growing up, Paromita saw how discrimination, hierarchy, and power relations dominated and shaped village life: Muslim households (the majority) simultaneously depended on and exploited the labour of poorer Hindu scheduled caste communities (the minority), while also mistreating them and banning them from public spaces.

MARRIAGE AND MENARCHE

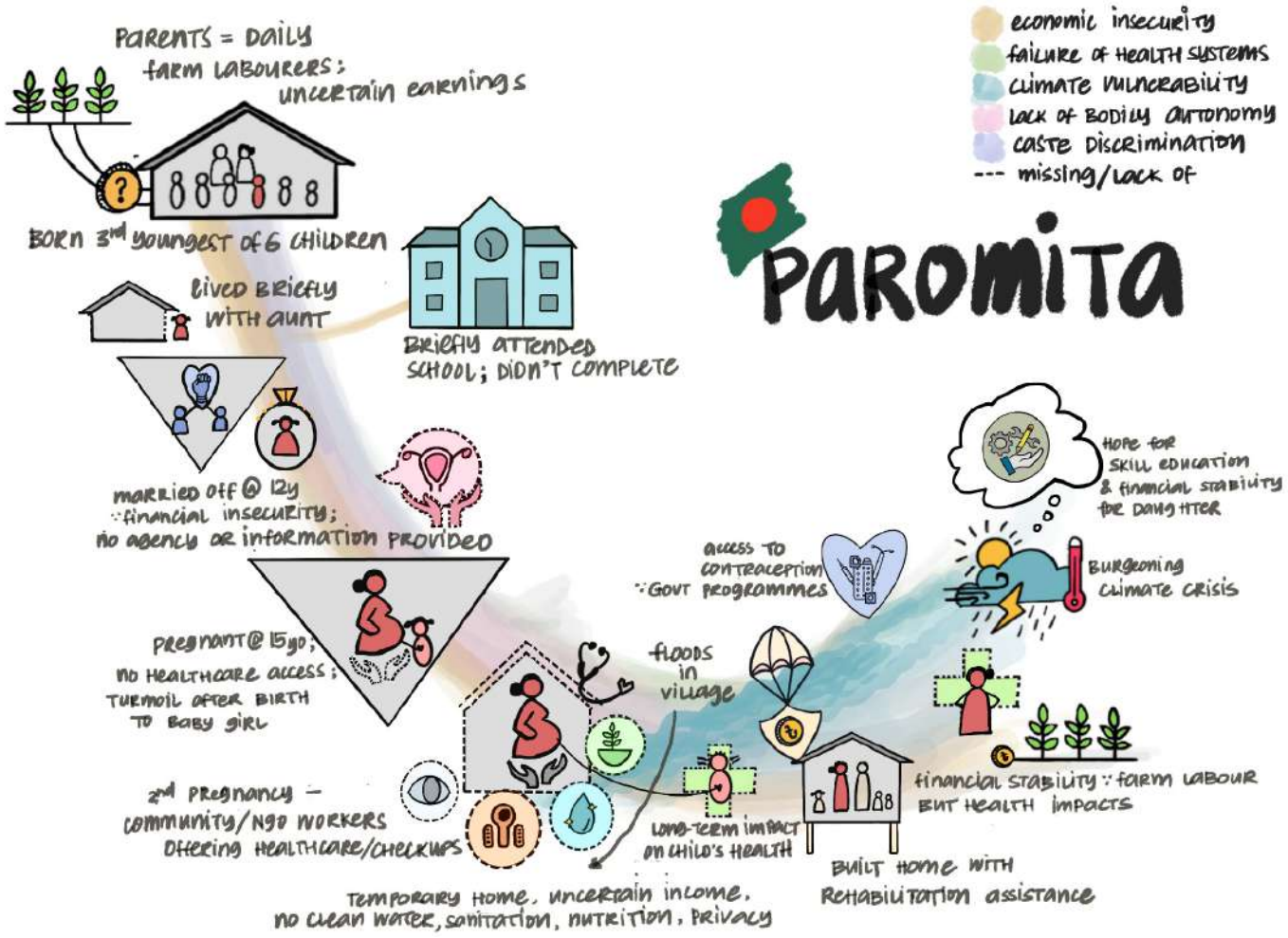
Paromita was married at the age of 12, a month before she began menstruating. No one sought her consent. Her mother merely informed her that they were proceeding with her wedding preparations as it was becoming difficult to meet the family's daily expenses.

Paromita was married into the same family as her older sister, and became the youngest daughter-in-law. Her in-laws were better off than her natal family, owning a small shop in the village and a small plot of land on which they grew betel leaf.

Once she began menstruating, she was expected to perform her 'duties' as a wife. She was shy and scared of being left alone with her husband. She was too young to understand what sexual relations meant. She experienced pain the first few times she had intercourse.

> *"Initially I cried, then it got better with time. I felt bad, thinking, why is this happening to me. My sister-in-law said you have to have sex if you don't want your husband to marry someone else. If one is hungry, we must give them some rice to eat, mustn't we? No matter how much I cry, they won't leave it, will they?"*

Access to community health workers or facilities for reproductive health was neither available in and around their village, nor was it considered necessary. She relied on the women



around her—her sisters-in-law, cousins, and younger aunts—for information about how to cope and what to do to keep herself well.

PREGNANCY AND CONFLICTS IN THE FAMILY

At 15, Paromita conceived her first child, but was not aware of pregnancy symptoms before that.

> *"At that time we wouldn't visit doctors. I was having stomach pain (but no periods) and feeling unwell. I had stopped doing household chores properly, and my mother-in-law would complain all the time. When she saw me vomiting, she was the one who told me I was pregnant."*

Paromita had never visited a healthcare facility nor consulted community health workers. Luckily, her pregnancy was smooth, with no health problems. However, the postpartum period was marred by conflict in the family when she gave birth to a girl.

> *"I had experienced pain for six days [when labour began]. My daughter was born at home. We managed it ourselves as we had a relative living around the area who was a midwife. When my daughter came out, my husband and mother-in-law began arguing with me, saying that it should have been a boy, why had I birthed a girl child? My husband left me alone at home and my mother-in-law stopped helping me with chores. I had to do everything myself and faced horrific conditions."*

Paromita also had to contend with her husband's infidelity during this difficult time.

Despite her emotional turmoil and physical exhaustion, she took up the burden of care work and chores right after her delivery, as it was expected of her. When her daughter was almost a year old, her period had stopped once again. At first, she thought this was normal because she had a limited

understanding of postpartum effects on her health. It was only when she began vomiting every day that she realised she was pregnant.

While Paromita had not visited a healthcare clinic for check-ups, or even an ultrasound, during her first pregnancy, her second pregnancy was markedly different in this regard. Increasing numbers of NGOs were now actively engaged in work in the more remote areas of the southwestern region. Community health workers visited women door-to-door, providing advice on food intake, referring them for check-ups to nearby clinics, and distributing supplements free of cost. Paromita went for check-ups to the sub-district health complex, mainly because she experienced exhaustion and frequent fainting.

CHILDBIRTH AND POSTPARTUM PERIOD DURING A NATURAL DISASTER

In the eighth month of her pregnancy, Paromita's village flooded suddenly.

"There was a heavy downpour, and the area flooded almost overnight. Homes went underwater. Water rushed in; it was at least up to our waists. I stayed inside the house. We elevated the bed by putting bricks underneath it. There is nowhere else to go, I thought. But then Sudha didi spoke to us. She said I could catch a cold and things could go wrong. I could not be kept there. The neighbours insisted, 'There's no need to keep her in the water... It would be a disaster if she were hurt by a wall falling on her.'"

Paromita's son was born in 2011, during one of the worst floods in the region which displaced more than 1.25 million people and caused significant damage to crops, infrastructure, and livelihoods. All the clay houses in Paromita's village had collapsed, belongings were washed away, and the poultry and cattle perished. Her husband tried to rent a house on higher ground, but failed because families with more money had already rented such houses. So they built a temporary house with bamboo sticks, plastic, and tin sheets on higher ground, near the government school. Paromita and her husband's earnings dwindled, as agricultural work was suspended for months, and the meagre income from their small plot also shrank. All this prevented them from making proper preparations for the birth of their second child.

As her delivery time approached, Paromita faced dire conditions: no access to proper sanitation facilities and limited potable drinking water, as well as household responsibilities and childcare duties. When her water bag broke, she was alone. Fortunately, a relative called a health worker, and then other women came to help.

"At the time, people from the NGO or the government had come to list down families to provide rations. This happened right beside the place I was giving birth. The women asked people to move, but to no avail. I gave birth in conditions where people could see me. What shame, what shame."

Paromita could not visit the hospital for a postnatal check-up given the strained circumstances of her family. It was very difficult to live in conditions of displacement, with a toddler and a newborn, with no proper shelter, no privacy, and no basic sanitation facilities. Hence, her family decided to move her back to their house even though the waters had not subsided. Paromita spent sleepless nights and was constantly worried about her newborn's well-being.

"He would not stop crying. A car would go by, and he would get frightened and scream. I couldn't sleep properly either. During the day the baby would scream, and during the night no one slept properly because we feared for our safety."

Their area remained under stagnant water for almost eight months, exacerbating the risk of disease and sickness.

"It was just my boy at home and me during the day. My husband would stay with us at night. I used to stay inside on the bed. My husband had to go up to the makeshift bathroom he had assembling bricks and a concrete slab. It was cold most of the time because the water was not going down, and my child soon caught a cold. But at least I could get him to sleep and I could rest."

Paromita's village, located in a more low-lying area, continued to be waterlogged for much longer than the surrounding areas. The Rishi community was compelled to advocate for themselves and demand rehabilitation. At the behest of community

leaders and local NGOs, governmental and non-governmental rehabilitation was finally extended, allowing households that had been devastated by the floods to rebuild their homes and acquire some form of livestock.

Even though Paromita's family eventually received assistance from the government programmes, they had to spend their own money to rebuild their home properly.

> *"The government only recently helped us build this home, but they helped us build only the bare structure. We had to invest 20,000 taka to rebuild the roofs, bathroom, and shed for the chicken and ducks."*

AFTERMATH OF THE DISASTER

After the floods, the Rishi community in the area gained greater access to flood relief under governmental and non-governmental programmes. They rebuilt to make their homes more flood-resilient, received healthcare information, and were able to access public and private healthcare facilities, thanks to advocacy by local NGOs which sought to address the outright exclusion of Dalit communities from assistance programmes.

Nevertheless, Paromita blames the disaster for her son's poor health, contending that his birth in a slum area and the family's displacement during the floods have affected his neurological development, noting that he has been unable to learn how to speak properly.

> *"I couldn't eat properly back then. That's why he has problems with his brain. I needed milk, eggs, good fish, and meat, vegetables, but I didn't get any of it. We were given relief supplies. They cooked lentils and sometimes brought aubergines [eggplants], but they weren't always available because the fields were flooded. I ate what I could. We tried growing plants, but everything was underwater. There was no work and no money. How could my husband bring food? What could he do?"*

But the floods also made Paromita more resolute. She actively sought contraceptives from their community's healthcare volunteer, Sudha, and saved for her children's education and other needs.

> *"I tried many different contraceptives, but the injections and pills caused me nausea and pain. So now I use the capsule [implants in the upper arm]. It means I don't get my period at all, but for now, this is better than not using anything. I can go to the clinic on my own in the bazaar and get the method when I need it."*

Paromita wants to ensure that her daughter will be educated and, if needed, able to support herself financially, and plans to enrol her in tailoring and embroidery courses. She has put her faith in the skill development programmes run by BRAC and other NGOs in the area. Nevertheless, her hopes for her daughter's independence and financial security are accompanied by fears about the effects of the ever-worsening climate crisis.

> *"The heavy rainfall this year [in mid-August] has meant there is water in many farmlands now. Where do we get work? We have been sitting at home for a week now. Even when there is work, it is becoming increasingly difficult to work in the heat [during summer and early autumn]."*

Paromita complains of chest pain, excessive itching, and exhaustion from working in the field all day. Even though physical labour is hard, she needs to work to supplement her husband's earnings. Extreme temperatures in the summer and autumn have become more frequent in the past few years. As weather patterns become more erratic and temperatures more extreme, Paromita foresees her source of income at risk and wonders what the future will bring.

KAVITA'S STORY

Kavita is a woman with disability, in her 40s from the Rishi community. Her life began in the shadow of hardship, separated during pregnancy, her mother had to return to her maternal home, where her status as an 'abandoned woman' resulted in social rejection, worsened by lack of familial support. When Kavita was just seven or eight months old, an accidental fall into a pit hole left Kavita with a permanently paralysed leg and her mother bedridden from her injuries. Despite attempts to seek treatment from multiple healthcare facilities, her mother passed away within a week, leaving Kavita disabled and orphaned in the care of her relatives.

"After that fall, my hands and legs became weak. Even a 10- or 15-day-old baby can move their limbs, but I couldn't move after that accident."

The only supportive figure in her family, her grandmother, raised Kavita. She began attending school at 6 and faced difficulties walking to school due to her disability.

"Since I am disabled and my mother had passed away, people at school would mock me. Sometimes they would tease me about how I walked. I would become angry; it hurt me, and because of that, I didn't get along well with them. Some of them were nice, but some would pretend to walk like me, making fun of me. They would do things like that... and many times when I went to school, they would say, 'You go. Why have you come?... because of this mess, we're getting late.'"

Kavita's grandmother supported her treatment immediately after her injury up until she was around 14–15 years old. Due to her grandmother's worsening health, increasing medical expenses and caregiving requirements furthered the pressure on her family. Kavita's uncles, while continuing to care for their mother, could not afford to continue Kavita's treatment owing to limited resources.

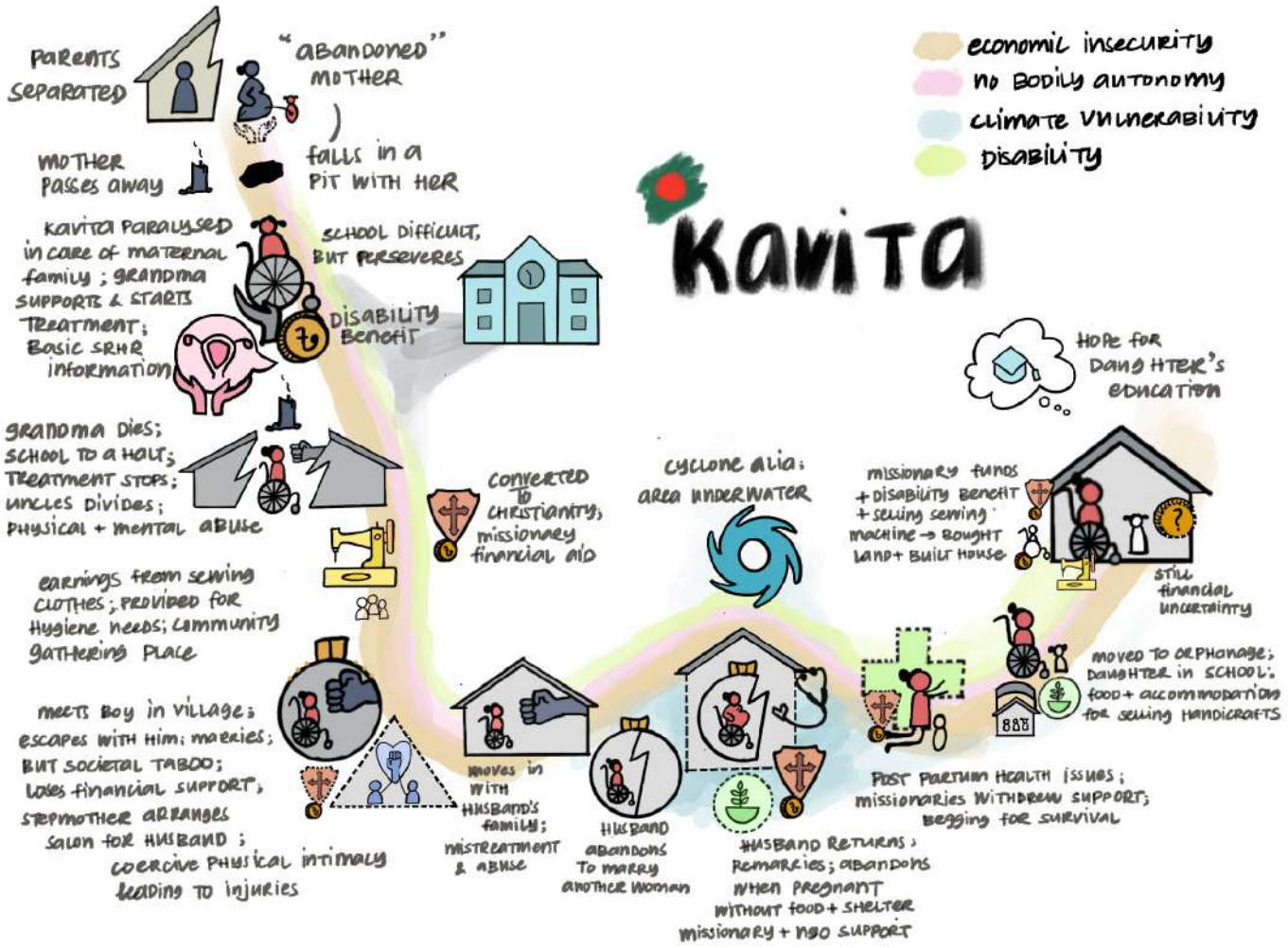
The end of her treatment meant the end of her chances of improving her mobility.

Despite these difficulties, her grandmother ensured Kavita's name was registered in the government's disability list, enabling her to receive a small monthly stipend of 600 taka, which offered a glimmer of hope in her otherwise challenging childhood.[33]

MENSTRUAL CHALLENGES AND EARLY MARRIAGE

Kavita's transition into puberty came with confusion, fear, and the weight of cultural practices. One morning when she was in class 9, she found her pants stained with blood. She was terrified and thought she might have been injured. Her grandmother, noticing her distress, gently explained that this was a normal part of growing up and a sign of her first menstruation. With patience, her grandmother taught Kavita how to manage this new phase of life.

Though Kavita resumed her schooling, managing menstruation added another layer of difficulty. Locomotor challenges while travelling to school only worsened during menstrual cycles. Having to wear layers of fabric instead of sanitary pads also caused severe sores and rashes. She also had to discreetly



hide the soiled clothes in a polythene bag inside her school bag and carry spare clothes for changing, compounding the physical and mental strain. These cultural taboos, combined with her disability, made even ordinary tasks overwhelming. But Kavita persevered, her determination undeterred by the obstacles she faced.

Despite her hardships, Kavita managed to continue her education until class 10.

However, after the passing of her grandmother, Kavita's studies came to a permanent halt. This was followed by mental and physical abuse from the maternal family. Her uncles, now living in two separate households, refused to offer any financial support to Kavita. Amid this adversity, a small opportunity arose when Kavita received a sewing machine, with the help of her uncle and a local Christian missionary. This was also the period when Kavita converted to Christianity: a decision driven by the monthly financial aid provided by the missionaries.

"Because I had no parents, and for the sake of studying, I converted out of necessity."

As a disabled woman facing extreme poverty, her conversion was readily accepted by her uncle's family. With her new sewing machine, Kavita was able to earn money by sewing clothes at very low prices. Despite making insufficient earnings, she managed to give some money to her maternal family for food and meet her own sanitary needs.

The local youth started gathering frequently at Kavita's sewing shop. Eventually, a boy from the village turned his affection towards her and proposed marriage without any conditions. The proposal, however, was not acceptable in her community and she faced pressure from the maternal family to end the relationship. This propelled her to elope with the boy and reach out to her stepmother for support, who lived in a neighbouring village.

"You know, when a girl is alone, and someone is treating her well, talking nicely to her, showing affection, her heart goes towards that person. So, I started loving him too. We continued loving each other, and we escaped together. I didn't go to his place after that, as his family

was not ready to accept a disabled woman as their son's bride."

Her disability made marriage a significant societal taboo. Despite this, Kavita's stepmother arranged their marriage, and they began their life together at her father's place. Unfortunately, the marriage came with consequences. However, marrying a Hindu boy and reverting to Hinduism resulted in Kavita losing financial support of the missionaries. Her stepmother helped her husband earn an income by arranging a small barbershop for him.

EXPERIENCE OF VIOLENCE AND PREGNANCY AND CHILDBIRTH DURING A CLIMATE CRISIS

While initially pleasant, Kavita's marriage became challenging as her husband's increasing demands for physical intimacy turned coercive. He would frequently force her into intercourse, resulting in vaginal injuries that left her bleeding for days.

"Many times, when he got upset, I had to let it pass. He used to say, 'Come now.' And I used to reply that I was cooking. I had no choice since he was my husband. I would get irritated; I could go without finishing cooking. But sometimes, after working all day, I would express my desire, but he'd get annoyed and say that he worked all day outside."

Eventually, under societal pressure, Kavita's in-laws invited the couple to move in with them. However, upon shifting to her marital home, her husband's behaviour changed significantly, as he joined his parents in torturing Kavita on a daily basis. Despite the abuse, she refrained from speaking out, holding onto the belief that her husband, as her life partner, would eventually stand by her. However, after seven months of marriage, he divorced her.

Her husband remarried again, and his second wife left him after their child was born. Despite her maternal family's disapproval, Kavita and her ex-husband married again, and Kavita conceived a child. Kavita refused to terminate the pregnancy, seeing her baby as her future caregiver. After her first trimester, she was abandoned by her husband again and found support after rejoining the Christian missionary programme. Her neighbours and community health workers also helped with antenatal check-ups until her second trimester. Then, Cyclone Aila hit the Satkhira District. During the disastrous flood, her neighbours rescued her and relocated her to a roadside shelter. She survived with support from local NGOs.

"I received a lot of help from the people around me. Even though I was in a difficult situation, the people in the area, especially those from the community, would provide me with meals."

While in these precarious conditions, she began labour pains, and help came only after 3 days of agonising pain. Both the missionaries and the NGOs could not locate her, and Kavita was left without access to basic health services required during childbirth. Due to the relentless efforts of local community health workers, Kavita was finally admitted to a local hospital and gave birth to a healthy baby girl.

POSTPARTUM

Despite the safe delivery of her child, Kavita's health took a severe turn, and she developed a cervical infection.

"So then, they performed the surgery (C-section) on me. After the surgery, I had a daughter…Soon, I developed an infection; I could feel the pain getting worse. I stayed there for 15 days, but I had no one to look after me."

Kavita and her child were eventually relocated by the missionaries who paid her medical bills and helped her return home. However, malnourished and weak, she was unable to breastfeed her baby and could not get any more support from the missionaries. Left with no choice, she began begging on the roads for survival. Kavita's health continued deteriorating as her daughter grew, and she suffered significant gynaecological issues.

"I had a tumour in my abdomen, and the uterus had an ulcer as well. Seven years after my daughter was born, I went to Dhaka for a surgery."

Once again, Kavita sought support from the missionaries, who provided financial assistance for the surgery.

OVERALL POOR HEALTH AND WELL-BEING FROM POVERTY

After the procedure, Kavita and her young daughter moved to an orphanage run by a missionary in Dhaka. There, her daughter was admitted to a missionary school, while Kavita worked in making handicrafts that the organisation sold. Though she received no direct financial support, she was provided with food and accommodation.

Eventually, the missionaries supported her in purchasing a small plot of land in her village, with a livelihood improvement grant. Coupled with some support from her maternal uncle and the proceeds from selling her sewing machine, she got the land registered. Gradually, she managed to secure a disability allowance under the government's social protection scheme, and saved enough to build a one-room tin-roof cement house, which she moved into with her daughter recently.

Kavita's challenges, however, continue to persist. As employment of any kind stays beyond reach, she often begs for food or borrows from the local shops. She is deeply concerned about the education of her daughter, who is now in class 9 at a local government school and requires private tuition for SSC exams. She takes pride in her daughter's membership in the BRAC education programme *'Shapno Sharthi'*, which provides sanitary pads monthly, ensuring her daughter can maintain menstrual hygiene.

Though financial struggles dominate Kavita's life, she dreams of a brighter future for her daughter and a life free from the hardships Kavita herself has endured. Her greatest hope is to fulfil her daughter's basic needs and ensure she has the education and opportunities to thrive.

her-stories

SRI LANKA

SRI LANKA

BEYOND THE MARGINS: INTERSECTIONAL REALITIES OF GENDER, CONFLICT, AND EXCLUSION

SRI LANKA — Country Context Indicators	
A. ECONOMIC INDICATORS[34]	
National poverty rate	2.71% extreme poverty (below USD 3/day); 16% below the National Poverty Line (2025)
Gini coefficient	38.5 (2023); income inequality exacerbated by the economic crisis; estate sector workers and conflict-affected populations face the largest gaps
Women workforce participation rate	32% female labour force participation; 5.3% of seats in parliament[35] held by women
B. KEY GENDER AND HEALTH INDICATORS	
Gender Gap Index	0.684 ranked 122/148 countries[36]; Human Development Index: 0.780 — ranked 78/168 countries; Gender Inequality Index: 0.401 — ranked 90/170 countries[37]
Maternal mortality ratio (MMR)	18 per 100,000 live births nationally,[38] one of the lowest in South Asia; estate sector and conflict-affected areas report significantly higher rates
Adolescent birth rate (ABR)	15 births per 1,000 women aged 15–19[39]
Modern contraceptive prevalence	61% [40]
Population with at least some secondary education	Female literacy: 92.9%; near gender parity in literacy, but occupational segregation and wage gaps persist[41]
C. LEGAL FRAMEWORK — SEXUAL AND REPRODUCTIVE HEALTH	
Abortion	Amongst the most restrictive in the world. Penal Code (1883, amended 1995) prohibits abortion except to save the woman's life; rape, incest, and foetal abnormality are not legal grounds for abortion; estimated 700 unsafe abortions per day[42]
Gender-based violence (GBV)	Domestic violence criminalised under the Prevention of Domestic Violence Act (2005); marital rape not recognised as a criminal offence; enforcement weak; conflict-related sexual violence perpetrators have not been prosecuted; 20.4% of women in Sri Lanka have experienced intimate partner violence in their lifetime[43]
LGBTQI+ communities	Sections 365 and 365A of the Penal Code criminalise 'carnal intercourse against the order of nature' and 'gross indecency'; interpreted as criminalising consensual same-sex conduct; penalties up to 10 years; Section 399 ('cheating by personation') and the 1841 Vagrants Ordinance used to target transgender persons; no legal gender recognition; a decriminalisation bill submitted to parliament (2023) had not been voted on as of 2024[44]
D. GEOGRAPHIC AND SOCIAL STRATIFICATION[45]	
Caste and ethnic stratification	Sinhalese (74.9%), Sri Lankan Tamil (11.2%), Malayaha/Indian Tamil (4.2%), and Sri Lankan Moors (9.2%); Malayaha estate workers have the lowest wages, most restricted housing, and poorest health outcomes in the country
Conflict-affected areas	Northern and eastern provinces disproportionately affected by 30-year civil conflict (ended 2009); female-headed households prevalent; persistent militarisation restricts women's mobility and service access
Climate vulnerability	Economic crisis compounded by climate shocks; acute shortages of medicines and food disproportionately affected women and marginalised groups; Sri Lanka ranks 52 on the Climate Risk Index[46]

Note: Sri Lanka's 2022 economic crisis significantly worsened poverty rates; pre-crisis indicators do not reflect current conditions. Data on conflict-affected northern/eastern provinces and the estate sector are inconsistently disaggregated in national statistics.

Sri Lanka's socio-political landscape reveals persistent inequalities that disproportionately affect women and girls across their diversities. Structural hierarchies of caste, ethnicity, class, and gender intersect, compounding vulnerabilities for women in marginalised communities. These groups face systemic barriers to education, healthcare, and livelihoods, along with restricted access to SRHR. The legacies of colonial plantation economies, the absence of legal recognition for gender diversity, and the enduring impacts of war and militarisation are amongst the vulnerabilities that converge to reinforce exclusion. In the context of economic crises and weakened social protection, these challenges are not isolated but interconnected. The case stories in this chapter document the lived experiences and structural challenges faced by women and gender-diverse people from four such marginalised communities.

THE MALAYAHA COMMUNITY

The Malayaha community, descendants of Indian-origin plantation workers, continues to face systemic socio-economic exclusion. Estate-based labour remains the primary source of income, with wages that are amongst the lowest in the country. Women and girls are disproportionately represented in this workforce, often combining paid labour with unpaid domestic responsibilities. Historically excluded by public health systems and educational institutions, intergenerational poverty continues to persist. SRHR services are particularly inadequate: maternal mortality rates are higher in estate areas than the national average, and access to contraception and reproductive health information is restricted. These conditions reflect the intersection of caste-based marginalisation, ethnic minority status, and gendered labour exploitation.[47]

WOMEN AFFECTED BY CONFLICT AND MILITARISATION

Women and girls affected by the civil conflict continue to experience the long-term impacts of displacement, militarisation, and trauma. Many households are female-headed due to the loss and disappearance of male family members during the war, yet livelihood opportunities remain limited. War widows and survivors of sexual violence faced stigma and surveillance; their mobility in militarised regions was restricted for many years.[48] Access to justice for conflict-related sexual violence remains minimal, and women continue to face social stigma.[49] SRHR challenges were acute: conflict-affected areas had decades of inadequate maternal health services, limited psychosocial support, and persistent barriers to reproductive autonomy. The intergenerational effects of conflict—such as disrupted education, poverty, and psychosocial trauma—further constrain the rights of girls and young women.[50]

TRANSGENDER COMMUNITY

Trans persons in Sri Lanka face barriers to legal recognition, healthcare, and employment.[51] The absence of comprehensive gender recognition laws restricts access to identity documents, limiting participation in formal labour markets and public services. Trans persons are often excluded from mainstream employment and face heightened risks of violence and harassment.[52] Healthcare systems lack gender-affirming services, and discrimination in medical settings undermines access to SRHR. These challenges are compounded by social stigma and heteronormative norms, which isolate trans individuals and restrict their ability to claim rights and protections.[53]

The two stories, documented by YAN-SL and Sarala Emmanuel (an independent researcher), each illustrate how intersectionality shapes exclusion. Across these groups, patriarchal norms, weak social protection, and discriminatory policies converge to perpetuate inequality. The ongoing economic crisis in Sri Lanka has intensified these vulnerabilities, deepening food insecurity, eroding access to healthcare, and pushing marginalised women into precarious labour.

MATHUJA'S STORY

Mathuja is a 43-year-old single woman living with her four children. After years of severe sexual and domestic violence, she separated from her husband and filed for divorce. Mathuja lives in a rented house and earns an income by cooking and selling breakfast food. There is no clean drinking water at her home, so she fills water from the tap at the nearby school. Mathuja's eldest daughter is 18 years old; her second daughter is 11, and her twins (a son and a daughter) are five years old.

Mathuja lives with the long-term impact of disabilities from wartime injuries. Her spinal injury makes it difficult to pass urine, squat, stand and walk, and she experiences severe pain in her back and legs. One of her hands is also not functional. Shell fragments remain lodged in Mathuja's chest, affecting her breathing, and in her head, where they cannot be surgically removed. These injuries have increasingly limited her ability to manage daily activities.

CHILDHOOD AND MENSTRUATION

Mathuja grew up as the youngest child in a very poor family in rural Batticaloa. Their mud house had no water, toilet, or electricity. As a child, she worked in the paddy fields to help her family. She completed only class 9. When Mathuja was 10, her father developed a mental illness. As her four older siblings were married and she and her parents had nowhere to live (except with one of her siblings), she increasingly felt like a burden.

At this time, the Liberation Tigers of Tamil Eelam (LTTE), a militant movement leading an armed struggle for a separate Tamil homeland in the north and east of the country, were recruiting young people in the area. A young woman militant approached Mathuja, promising food, opportunities to train and study, and care and protection. At 14, Mathuja ran away from home with five classmates and joined the LTTE. Although her mother and one of her brothers came looking for her, she refused to return.

Nine months after joining the movement, Mathuja got her first period. She had no prior knowledge of menstruation and was taught about it by a young woman cadre trained in nursing, who also showed her how to use a sanitary napkin. In the forests, limited access to menstrual hygiene facilities meant that she sometimes had to go long periods without changing her pads or dispose of them discreetly. Mathuja said that sometimes they would tie the pads high up in the trees.

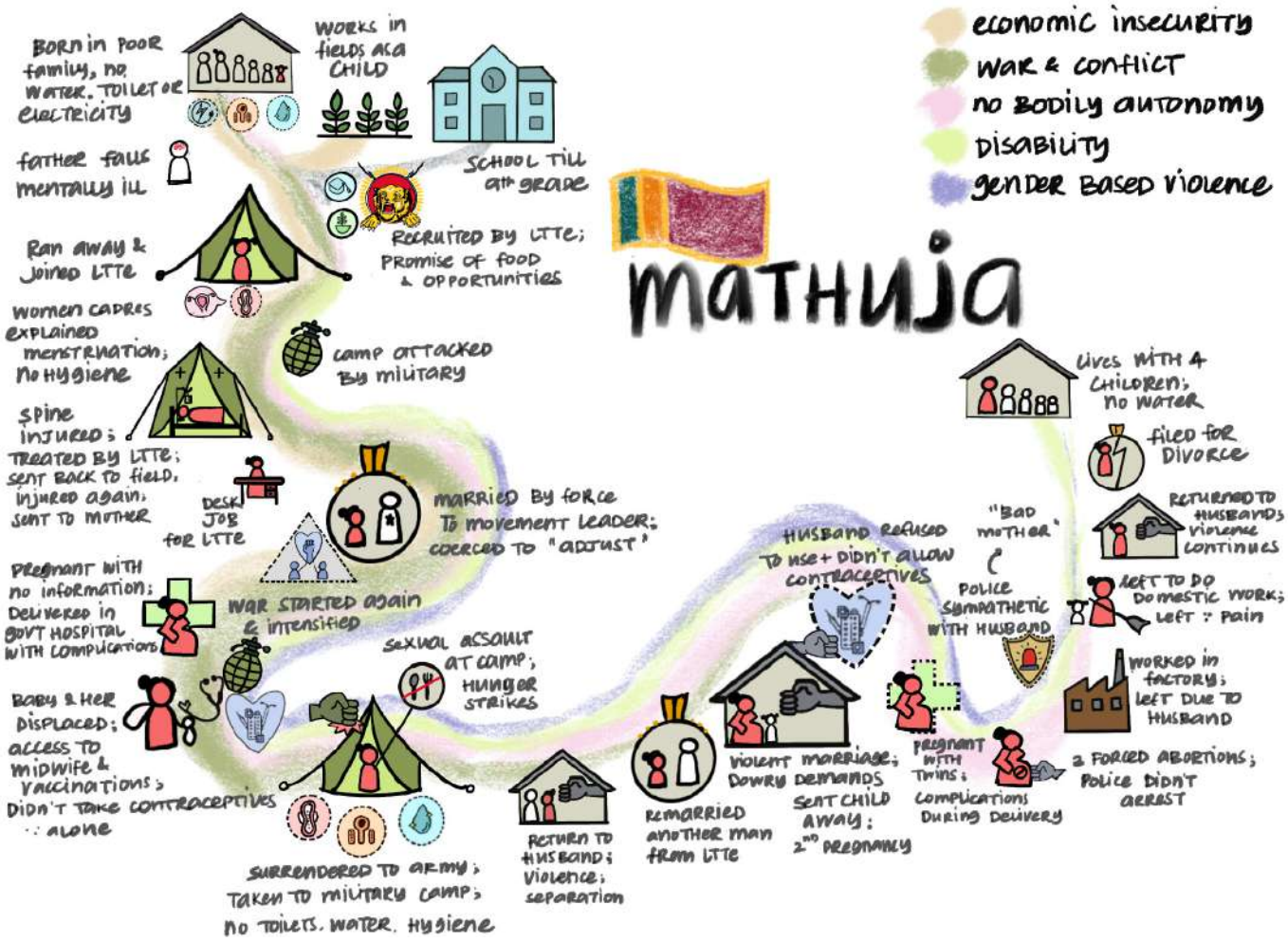
FIRST INJURY

Mathuja was first injured in 1999 when she was 17 years old, when her camp was attacked by the military, killing around 140 cadres. She was treated at the hospital run by the LTTE, and she was bedridden for more than a year and a half with a spinal injury. Having become close to her fellow fighters, whom she considered her family, she had little contact with her biological family and did not want to return home. After she recovered enough to walk, she was sent back to the battlefield, where she sustained another injury to her leg and was eventually sent home with her mother.

At Batticaloa, she worked with the legal section of the movement. She had a desk job registering complaints of disputes that were brought to the movement to be resolved. She was encouraged to study law, and learnt how the LTTE police should function and how cases could be filed within LTTE courts.

MARRIAGE AND PREGNANCY

In 2002, during a ceasefire between the Sri Lankan military and the LTTE, Mathuja returned home to her mother and



worked from home while continuing to support her through her Rs 6,000 salary from the movement. A movement leader, 15 years her senior, asked her mother for permission to marry her. Mathuja did not want to marry him, but the movement's leadership ordered her to do so. She ran away and went into hiding, but was found, detained in a bunker for 15 days, and ultimately forced to marry him. Several movement leaders attended and signed the marriage.

After her wedding, Mathuja said she had to "adjust" to sexual relations with her husband despite resisting him. A few years later, she became pregnant. Unaware of the signs of pregnancy, she sought help from an LTTE nurse after missing her period for three months, who confirmed the pregnancy. Mathuja received antenatal care from a government midwife and, given her spinal injury, was advised to rest. She was transferred by ambulance from a rural hospital to a larger hospital for delivery. Her baby was born prematurely at seven months, and she experienced heavy bleeding and required forceps delivery. When the military began searching for her at the hospital, Mathuja was hurriedly transferred back to an LTTE-controlled rural hospital, where she and her baby remained for two and a half months and received medical care.

Three months after the birth of her baby, the war started again and Mathuja had to return to the Vanni, an LTTE-controlled area in the north. The LTTE had by then split into eastern and northern factions, and Mathuja lived in daily fear as both the breakaway eastern faction and the military searched for her. In 2006, the war intensified, and heavy shelling forced her and her baby to flee several times. Her husband had seen their child only once before leaving to join the northern faction of the LTTE. Mathuja eventually made her way north with her baby and mother. There, she regularly visited the midwife's clinic, where her daughter received all her vaccinations, and she was counselled on family planning. As she was living alone at the time, Mathuja chose not to use any method.

SURRENDERING TO THE ARMY—ZONE 4 CAMP

During the final years of the war, Mathuja was displaced several times, and her daughter was injured by shelling and began experiencing seizures. Mathuja surrendered to the army on May 17, 2009, one day before the war officially ended. She and her baby were taken to the Zone 4 military camp, while her husband was taken to another camp. There was no water, toilets or sanitary materials for menstruation. Women in the camp were subjected to sexual assault, forced to strip during

interrogations, and some were taken away and never seen again. Two women became pregnant following sexual assault. Mathuja and other women went on hunger strike to protest the continued abuse, but were beaten by members of the faction, tied up and left outside for two days without food or water. Medical personnel and the International Committee of the Red Cross (ICRC) were not permitted to enter the camp.

After several months, Mathuja was released from the military camp, and she started searching for her husband. He had been moved to several undisclosed camps and badly tortured. She kept searching for him, until finally he too was released. However, once they came back home, things were not easy for Mathuja, as her husband was violent towards her. She returned to her mother's house, and he went to live with his mother in the north. After some time, he married another woman from his village, and Mathuja later heard that he had passed away.

SECOND MARRIAGE, PREGNANCY, AND CHILDBIRTH FOLLOWING VIOLENCE

Mathuja was then contacted by another man she knew from the LTTE. He had just returned from living abroad for many years, and expressed an interest in starting a life with her. This time, the marriage was with her full consent, and they initially had a good relationship. In 2013, she became pregnant with her second child. This relationship too began to turn violent. Her husband's family kept demanding a dowry and saying she was not pretty. He was not only violent towards her but also started beating her first child. She finally put her first child in a children's home for the child's safety.

Her second childbirth in 2013 was uncomplicated, and she gave birth in a hospital. Afterwards, her husband refused to use contraception and prevented her from doing so, while frequently demanding sex and monitoring her menstrual cycle. When Mathuja secretly obtained a contraceptive injection and her periods stopped for three months, he beat her and accused her of having sex with other men.

When she became pregnant again, her husband forced her to take tablets to abort the pregnancy. Unaware of what the tablets were, she took three doses in one day, after which she fainted and was hospitalised for eight days. Although hospital police threatened to arrest her husband, Mathuja pleaded with them not to. She lost the pregnancy.

The next time Mathuja became pregnant, her husband deliberately tripped her, causing her to lose the pregnancy. She was hospitalised for six days, where doctors explained the risks of further pregnancies. Mathuja told them she did not want more children, but her husband opposed permanent contraception. After he left, she persuaded medical staff to insert a contraceptive implant. When he discovered this, he beat her arm so severely that the implant broke and her arm turned blue. Mathuja reported the violence to the police, who sent her to hospital by ambulance but only warned her husband rather than arresting him.

When Mathuja became pregnant again, this time with twins, she feared for her life. When her water broke, she was taken to the local hospital, where staff identified the risks recorded in her clinic book, including her spinal injury, previous abortions and high blood pressure. She was transferred by ambulance to the larger hospital in town.

> *"One twin, Kutti Amma, was born in the ambulance while we were crossing the Kalladi Bridge. The other baby was born only an hour and a half later. It was a son. The doctors kept talking to her and used forceps to pull him out. Her daughter weighed one and a half kilos only."*

After a while, her husband left her. Mathuja began working at a nearby garment factory. Although the police had assured her that he would not trouble her after her complaint, he repeatedly came to her workplace, verbally abused her and pressured her to return, saying he wanted a son before leaving abroad for work. Due to his continued harassment, Mathuja was forced to stop working.

> *"I was like a machine for him. I used to say no, but he would force me and rape me. He has burned me. He hit me on my spine where I was injured."*

Even after the twins were born, she often faced sexual and domestic violence. With her previous injuries and disabilities, the repeated sexual violence caused her further physical strain. Finally, she decided to leave home with only her eldest daughter.

> *"He beat me after forcibly removing my clothes. I was naked in front of my children. He was beating me. I couldn't bear it any more. That's why I took my oldest daughter and left to work as a domestic worker in the north."*

After she left, her husband mobilised support by accusing Mathuja of abandoning her young children, while government officials sympathised with him as a father caring for them alone. Meanwhile, Mathuja struggled to work as a domestic worker while managing her own disabilities and pain. Social service officers repeatedly urged her to return, and her husband promised to stop the violence.

Unable to sustain her work, she returned home, but the violence continued despite state services being aware of it. She was again branded a "bad mother." Mathuja eventually filed for divorce; although she initially withdrew the case due to his threats, she is now determined to leave the relationship and build a better life for her daughter.

SRIYA'S STORY

Sriya is a 52-year-old woman activist from the Malayaha Tamil community of Sri Lanka and lives in Kandy. Currently working in the development sector, Sriya is one of the few women activists who actively speak up about the issues that her community faces. As the sole breadwinner for her family, she is proud of her accomplishments in life. Through her own efforts, she has built her house, educated her children, and supported her family.

CHILDHOOD AND EDUCATION

Although her life has taken a positive turn now, she had a difficult childhood and an even more challenging youth. She was the youngest child in her family, with one brother and three sisters. They lived in a tea estate in the Hanthana region, where her parents worked. When the state acquired the estate, her parents lost their livelihood. In fact, her entire community was displaced and pushed into poverty. To survive, her father took up odd jobs, and her mother worked at the university farms for as long as Sriya could remember.

Sriya grew up in a tough neighbourhood. She was born in a small 10x10-foot line room, grew up there, and got married there. Unlike typical line quarters, theirs was a mixed community. Sinhalese and Tamil people lived together. Nobody had stable jobs.

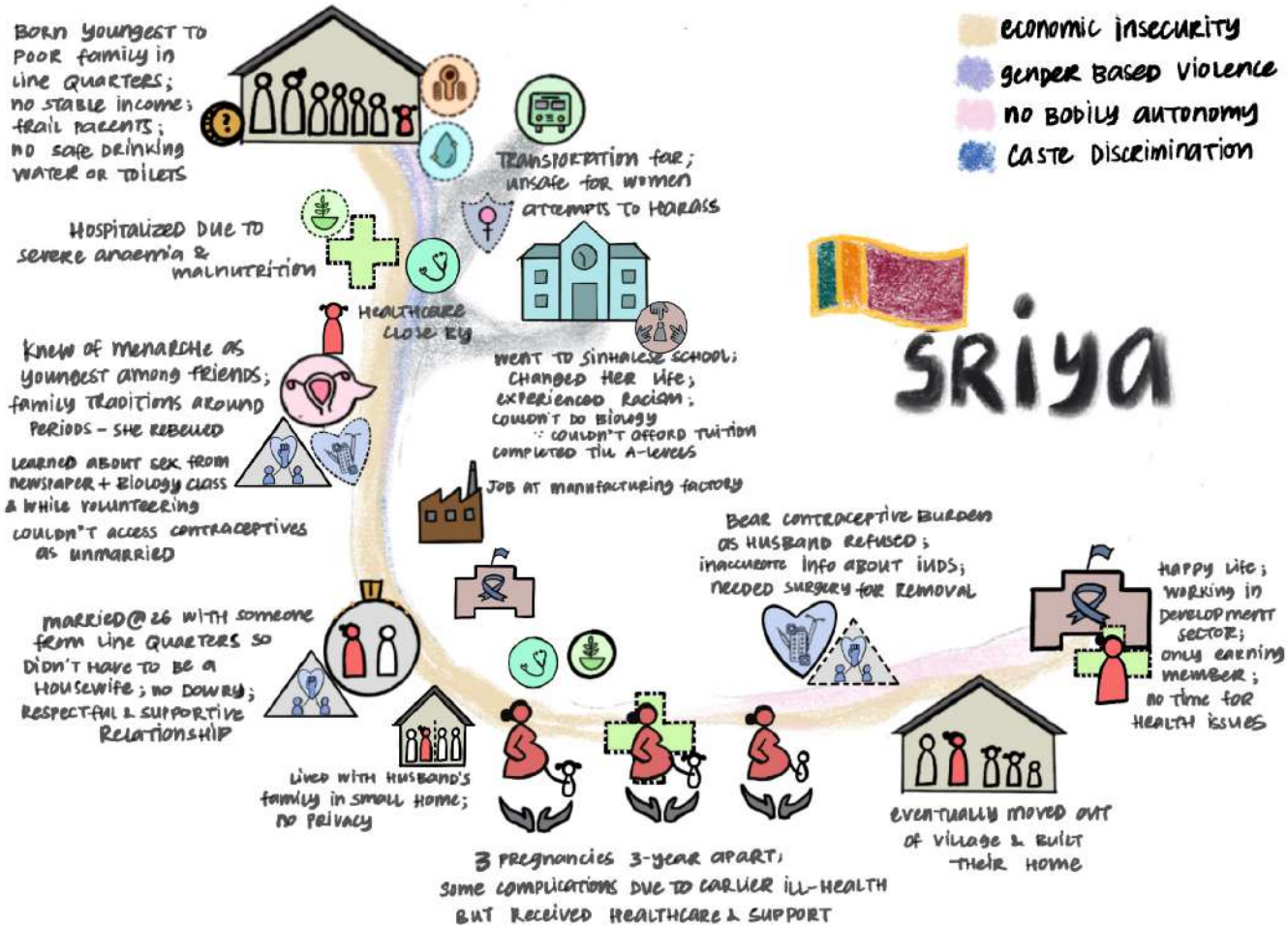
They had poor infrastructure and sanitation facilities, which worsened after the university's acquisition. People in the village used a nearby stream for defecation and other sanitation needs.

There was no guarantee the stream water was safe for human consumption. Toilet conditions were unhygienic and unsafe for countless reasons. Girls could not go to the toilet alone; they went in groups and could not go at night. Sriya remembers holding back the urge to go to the toilet at night and waiting until morning. The stream was also quite a long walk from her home. Sriya and everyone in the community felt that they were being marginalised by society and forced to live in undignified conditions not fit for human beings. Within the village, there was a sense of normalcy, as everybody faced the same problems. But when they stepped outside the village into wider society, they felt ashamed. It was even more challenging for Sriya to manage her periods discreetly amidst all this.

Travelling to and from the village was also difficult. There was a village bus, but its service was erratic. People often had to walk back and forth, sometimes carrying their belongings on their heads. Moreover, the road was always deserted, and Sriya recalls many incidents where the safety of women and girls was compromised. She herself narrowly escaped sexual assault twice while walking down that road.

Education changed the course of Sriya's life. While all her siblings went to a Tamil-medium school, her parents enrolled her in a Sinhala-medium school close to her neighbourhood. She walked to school with the other children in the village and, unlike the rest of her family, learned to speak Sinhala fluently. As one of the very few Tamil students, she recalled the racism she faced during the 1980s, a period marked by widespread anti-Tamil violence in Sri Lanka. She failed to understand why her schoolmates discriminated against her, but she eventually became good friends even with those who had treated her badly.

Sriya was academically gifted. She comfortably passed her O-level exams and managed to get admission into a school in Kandy to study biology for her A-levels. However, after her siblings married and moved out, she had to care for her frail and ageing parents. Struggling financially, she could no longer afford the extra tuition classes and found it very difficult to



pass the exams. Soon, she lost interest in her studies and moved to Colombo to find a job. She worked shifts in a factory until 1997 and lived with two friends in a boarding house. Even though far removed from the life she had once imagined, it was a pragmatic start. Looking back wistfully, Sriya shares that she had always wanted to be a nun, feeling a deep connection to the Catholic Church from her childhood.

Yet, alongside this early religious calling was a rebellious, independent streak. Sriya recalls being intensely self-willed as a young girl. Whenever her mother forbade something, her immediate impulse was to do it anyway. She is not quite sure where that rebellious streak came from, but she believes that it was this mindset that helped her come this far in life. That independence became integral to her worldview and identity. Being of mixed descent, caste never mattered to Sriya. Her father never spoke about caste, but her mother was very particular that Sriya did not mix with people outside her caste.

MENSTRUATION AND FIRST SEXUAL EXPERIENCE

Sriya knew about menarche because all her friends had started their first period before her. She was 14 years old when she got her first period. Her family told her what to look out for, and she was prepared. At the time, in accordance with the family's traditions, she was kept in a separate corner of the kitchen for 16 days. During that time, relatives brought her food. Due to financial constraints, her family could not have a 'big-girl' ceremony, a community tradition. Sriya did not use sanitary pads because all the girls in her family used rags. Her mother and her English teacher at school taught her how to manage her periods. Much later, Sriya took pains to teach her own children, as well as other youngsters around her, about personal hygiene and safety, which she had not known as a child or as a young woman.

Life changed soon after her first period. She was told to refrain from engaging in strenuous physical activities and to avoid interacting with boys and men. But as usual, the rebel in her did everything that she was told not to do. She was generally safe, although some people around her tried to harass her.

She got to know about sex through her friends. There was no sexuality education in school; she was formally introduced to the subject while studying biology as an A-level student. She learned about contraception and other SRHR-related topics during a training session while volunteering for the family health services.

Sriya was only 17 when she had her first sexual experience with her first boyfriend, who was a little older than her. Lacking prior awareness about sex, she recalls the moment passing quickly, overshadowed by fear and a strong sense of urgency to just get it over with. Being unaware of the risks, they never used contraceptives during their relationship, and besides, they rarely saw each other. Unfortunately, even after she became sexually active while still unmarried, social barriers kept her from accessing clinics that provided crucial SRHR information and services. This pattern of unprotected sex only changed after marriage, when she began using contraceptives consistently.

MARRIAGE AND SEXUAL PLEASURE

Sriya got married at 26. Her husband was a social worker and lived in the same village. Her parents strongly opposed her marriage because they felt that by marrying him, she would never be able to leave the village. But Sriya thought differently—that if she married someone with more means than her, she would have to stay home and take care of the family. She did not want to be a housewife. She was passionate about her work and thought she and her partner could work together to build something of their own. So, she went ahead with the marriage without her family's consent, and they eventually came around to accepting him.

Her parents could not give her a dowry, nor did her in-laws demand one. By then, Sriya had started working with an NGO and was earning a decent salary, but life after marriage was difficult. She merely moved from one 10x10-foot accommodation, in which she grew up, to an identical one of her in-laws, in the same line of quarters that she had longed to escape. With her father-in-law and brother-in-law sharing the space, privacy was reduced to an old saree hung across as a partition.

The first years were particularly agonising in that cramped space. The couple had no sense of what sexual pleasure could be like. In fact, she wistfully recalls that she didn't experience her first orgasm until after the birth of her second child.

After 18 months of marriage, Sriya and her husband moved out of the village, initially into a small hut, then to their own house, which had separate rooms. She considers having her own home to be one of her greatest achievements since it provided her with the privacy that she lacked all her life.

PREGNANCIES AND CONTRACEPTION

Even though her married life was not free of challenges, Sriya feels her husband has always respected and supported her. He was not controlling, nor did he resort to violence. She became pregnant with her first child at 27 and thereafter maintained a three-year gap before conceiving her second and third children. During her first pregnancy, she was in Hanthana (her village) and had easy access to the Ministry of Health office there. The midwife also visited her from time to time, and she regularly received government-provided supplements (Thriposha). She visited two clinics every month, one in the village and one in the hospital.

Their first child was a daughter, born through a normal delivery, while her second daughter was born by caesarean section. Disappointed at having another girl, she refused to see her face or hold her and convinced her to take the newborn in her arms. Sriya recalls that the moment she saw her daughter's face, all her anger vanished and was replaced by love. However, even to this day, she regrets how she initially resented her child.

Their third child was a son. Before conceiving him, Sriya and her husband visited a Suwa Piyasa[54] clinic, where the staff advised them on how to conceive a male child, although she is not completely sure if their guidance actually helped. Some of the advice included tips about diet, exercise, and even sexual positions to favour conceiving a boy.

Only the first of her three pregnancies was a normal delivery. Sriya did not experience contractions or labour pains even after her due date. She waited in the ward for several days till the hospital staff finally decided to induce labour. It was the same with her second daughter, who was a large baby, and in the days leading up to her birth, Sriya experienced much discomfort. The doctors eventually decided to do a caesarean section. For the third baby, she had no option but to go for a caesarean section. The surgery went smoothly, and she returned home the following day. She resumed work shortly after each birth, with her mother-in-law stepping in to assist her with childcare.

Sriya's low haemoglobin problems had an impact on her pregnancies. She needed blood transfusions during her second pregnancy. She continued working through her pregnancies and, in the process, learned about the importance of nutrition for pregnant women. She always focused more on eating a balanced diet and feeding her children nutritious food than on superstitions like horoscopes. She feels proud that she was able to keep up to date with their vaccinations and watch all her children achieve their developmental milestones.

By the time Sriya and her husband decided to start a family, Sriya had acquired some knowledge about family planning. Since her husband did not want to use a condom, she had to

bear the entire burden of contraception. For some time, Sriya took Depo-Provera before switching to pills. However, she experienced unpleasant side effects. To address her distress, the couple visited a Suwa Piyasa, where the doctors advised her husband to undergo a vasectomy. But he was vehemently opposed to it, being under the misconception that it would impair his sexual performance and physical strength.

Finally, Sriya had an IUD inserted for ten years. Although it was an effective method of contraception, she experienced pain after it was inserted. After seven years, she wanted the device removed, but the clinic told her she would have to wait ten years before she could have it taken out. She suspected this was because the doctors found it inconvenient to give her another long-term contraceptive. When she went to have the IUD removed after ten years, it had adhered to her cervix and could not be removed normally, so she had to undergo a surgical procedure to remove the device.

Sriya is passionate about her work and believes it helped her recover more quickly from her pregnancies. Her colleagues were also very supportive. They would bring work to her when she was unable to travel after childbirth. Although Sriya currently lives a happy life, years of hardship and neglect have taken a huge toll on her physical health. She suffers from chronic fatigue and weakness. When she sought treatment for low haemoglobin, she discovered she also has high cholesterol, fatty liver, and gallbladder stones. Her work requires her to travel so frequently that she hardly has time to look after her health. Moreover, with children still in school and a husband who no longer works, she bears the entire financial burden for her family. She has no choice but to put her work before her own well-being.

FATHIMA'S STORY

Fathima is a 48-year-old working-class woman living in Batticaloa. Her life has been affected several times by war and loss. For several years, she earned an income by making and selling breakfast snacks. Ten people live in her small two-roomed house, which has a kitchen and a toilet: her husband; her eldest son; her daughter-in-law and their two children (an 8-year-old girl and a 3-year-old boy); her second daughter and her husband, and their 3-year-old son; and her youngest daughter, aged 19. Another son is a migrant worker in West Asia.

CHILDHOOD

Fathima grew up in the town of Batticaloa. She had six sisters and a brother, the youngest. They lived near the main Batticaloa market, where her father ran a clothing store. In 1990, in retaliation for the killing of a policeman by the LTTE, the army attacked the shops in the market, where her father's store was, and burned them down. Fathima, who was 14 at the time, was working at the shop with her older sister.

> *"My sister and I hid there (uncle's shop) with many people. The shop behind us was set on fire. One soldier knocked on the shop door and asked us for a matchbox! We said we didn't have a matchbox. He seemed like a good person; he said to keep the door closed. The army then burned the shop two doors down. The shop behind our shop was also burned. I saw limbs, heads, and feet strewn everywhere. I was so young. It was night when we were finally able to leave."*

After this, the family was forced to move to a nearby town, where an elderly Muslim woman sheltered them and gave them a tent in her compound. Fathima's father was later killed in a bomb blast in Batticaloa town in 2000.

MENSTRUATION

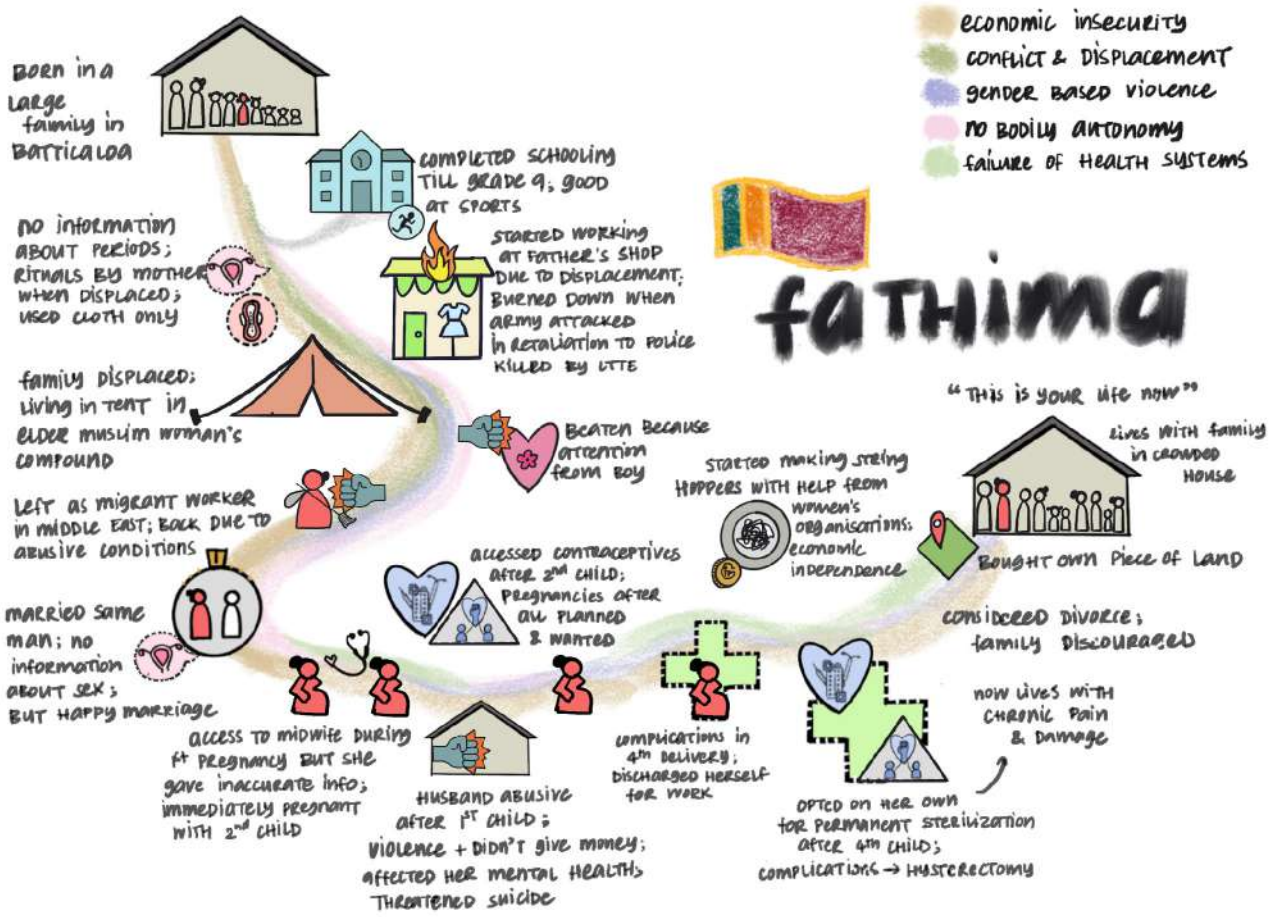
When Fathima was 14, she got her first period. She did not know what was happening, thinking she had been injured. She told her mother, who gave her a white cloth to place inside her undergarments. Fathima continued to use cloth during her periods until she learned about sanitary napkins when her eldest daughter got her first period. Fathima's mother told her she had become a 'big girl' and gave her an iron bar to keep beside her for protection.

> *"In our culture, when you become a big girl (first period), no one should see you. No man should see you for seven days. There were no vehicles because of the violence. So they covered my head, and we walked, my father, my mother, and all my siblings, including my baby brother. I was in a black purdah."*

Fathima walked, clutching the piece of iron in her hand. When they reached the home of the Muslim woman, she was kept in a room for seven days. They did not tell any family members or relatives.

> *"Even my own father should not know that I have become a big girl. I should behave like that. So, we don't do big functions."*

During her periods, she would wash the soiled cloths near the toilet in the compound. Many things became taboo for



her during menstruation: she was not allowed to keep a fast during fasting time, go to the mosque during festivals, or touch the Quran.

EDUCATION

Fathima's two elder sisters completed their O-levels, but she was only able to study up to grade 9, while her younger sisters studied up to grades 8 and 5. Following multiple displacements, losses and the war, she and her younger sisters began working in their father's shop, limiting their education. Despite this, Fathima excelled in sports and represented her school at provincial and national competitions in Colombo, often coming first in the 100-metre race.

SEXUAL HARASSMENT AND VIOLENCE AT HOME

When Fathima was 16, a young man in her village was mistakenly believed to be interested in her. Although she repeatedly denied any interest and told him she was not interested, he began following her after school. Many in the neighbourhood would tell her parents about it. Fathima's mother did not believe her and regularly beat her. This led to serious violence at home.

> *"Once I had removed my school uniform and was in my bra when my father beat me."*

Finally, to escape the situation and to support her family, Fathima migrated to Dubai, West Asia, as a worker at the age of 17 after their economic difficulties. She worked as a domestic worker in Dubai, earning 500 Dirhams a month. There were eight people in the house, and her employer was physically violent and abusive. The work was very hard, and Fathima returned home after a year.

MARRIAGE, SEX, AND INTIMATE PARTNER VIOLENCE

A year after Fathima returned home, the same man came to her house with representatives from the mosque. They spoke with her father and arranged her marriage to him. Fathima did not know about sex when she got married and hesitated to ask her older sisters, mother, or married friends. She believed her husband would have some knowledge from his behaviour towards her. He was only 21 years old when they married. His parents had wanted him to wait a few years, but he did not listen to them. In the early days of her marriage, the lack of privacy at home meant that she and her husband had to have sex when others were not at home.

"I didn't let him get close to me. I said no. He had told his friends that I was refusing to be with him. He then told me I won't hurt you (while having sex). Then it happened without pain."

Fathima reflected that later she did not discuss sex even with her own daughters when they were getting married. She felt that talking about sex would lead to 'bad behaviour'.

The marriage was happy until their first child was born, after which the violence became frequent. Her husband would go out to gamble and lose money. He did not give her money for household expenses and beat her up when she asked for money for the home or the children. The violence and financial control severely affected Fathima's mental health, and she attempted to take her own life.

"Once I jumped into the well. Another time, I poured kerosene to set myself on fire. I also drank DDT[55] once. He would just go away, saying, 'Kill yourself!'"

"He (husband) used to work in a vegetable shop. Sometimes he would give me 50 rupees. Then, with the support of Suriya (the local women's organisation), I started making and selling string hoppers. I had to pound the flour, carry the firewood, tend to the fire, and carry everything. I make around 2,000 string hoppers every day. Till today, this is what I do. It's really hard work. I need to stop now."

PREGNANCY

Fathima had no problems during her first three pregnancies. During her fourth pregnancy, the medical officers kept telling her she had a katti (growth) and not a baby, as they could not hear a heartbeat.

"There were no scans those days. They told me I don't have a baby. Then one elderly doctor checked me and said it's a healthy baby. He could find a heartbeat."

After the birth, Fathima started having 'fits' and was hospitalised. However, she could not afford to buy the formula milk for her baby, who was at home, so she discharged herself from the hospital and returned home to work. Subsequently, she had continuous bleeding for six months and constant headaches. She finally got a CT scan at the government hospital, which referred her to the neuro-clinic, where she was prescribed medication that she continues to take.

The violence at home continued even while she was pregnant. Sometimes her neighbours intervened, and her daughters helped make the food she sold. In January 2023, Fathima decided to file for divorce but was discouraged by her family, so she withdrew the case from the Quazi courts.

ACCESS TO REPRODUCTIVE HEALTHCARE AND INFORMATION

During her first pregnancy, Fathima was regularly visited by the midwife. After her baby was born, she did not menstruate for a few months. The midwife had told her she would not get pregnant for two years.

"I believed her and didn't take contraception. Then I got pregnant with my second child within 40 days of my first child's birth. I didn't even know I was pregnant until I was five months pregnant, when I could feel the baby moving. I then checked and found out I was pregnant. After this experience, after my second child was born, I had the injection within 40 days!"

Fathima has used the injectable once every three months for 12 years and has taken control of her own family planning.

"After three and a half years, I stopped the injection and had my next child. Then I would start the injection again. So, I spaced my next children three and a half years apart. All my children were planned and wanted pregnancies."

However, after the fourth pregnancy, Fathima decided to go for sterilisation. She had to work very hard to earn an income, collecting firewood, transporting it over long distances, and then carrying the food she cooked to sell door to door.

"I made all these decisions by myself. I didn't tell my husband, and I didn't even talk to the midwife about this. I was having a lot of side effects from the contraceptive injection. It

would affect my period, and I started gaining weight. I didn't want to take the tablet. In case I missed one, it would have led to so many problems. I wanted to do the operation (permanent sterilisation). I wrote a false letter to the doctor and got it done. This was two years after my last child was born."

However, after her sterilisation, Fathima developed several health problems. She experienced continuous bleeding, and a scan showed that her womb was 'swollen' and had 'descended'.[56] Medication did not help, and she eventually underwent a hysterectomy. However, due to further complications (and possible medical negligence), she was advised to undergo another surgery. Fearful of another procedure, she did not do so, and continues to live with chronic pain and other side effects that make even going to the toilet extremely painful. Despite these health problems, she had to continue working.

"I have put on so much weight. There is no sex at all now. Sex is very painful for me. I had spoken to a doctor about all this. He has told me he has to do the surgery. But I am scared."

Fathima had once hoped to become a sportswoman, PT teacher, or successful businesswoman. When she faced difficult circumstances, her family did not support her, saying, "This is your life now, you have to live it." With support from a local women's organisation, she started her own income-generating activities.

"With the money I have earned, I have bought a piece of land to live in peace. That's my plan now."

VINURA'S STORY

Vinura is a 35-year-old trans man living in Colombo, with his wife, Ridmi. He is close to his wife's family (her parents and her brother). His own parents are no more and he has two brothers. He has a Higher National Diploma (HND) in civil engineering, but after transitioning, he abandoned that career path and currently works for an NGO.

CHILDHOOD

Vinura's mother was a housewife and his father was a successful businessman who exported cane furniture and owned a shipping and transport business. His family led a very comfortable life, and he had nothing to complain about as a child. He was assigned female at birth, but did not conform to conventional gender roles, behaving more like a boy as he grew up. People around thought this was because he had two elder brothers. He received a lot of love and affection as a child.

Vinura struggled with his gender identity from a young age and felt uncomfortable in his body as a girl. When he watched movies, read books, or dreamed about his future, he always pictured himself as a male character. He attended a leading girls' school in an affluent part of the city. He disliked wearing the school uniform and was often reprimanded for uniform-related violations and was considered a 'tomboy'. He was very uncomfortable changing clothes in the common changing room and preferred the privacy of the toilet. As an adolescent, he naturally gravitated towards wearing more masculine clothes. He did not know about the possibility of transitioning to a different gender identity.

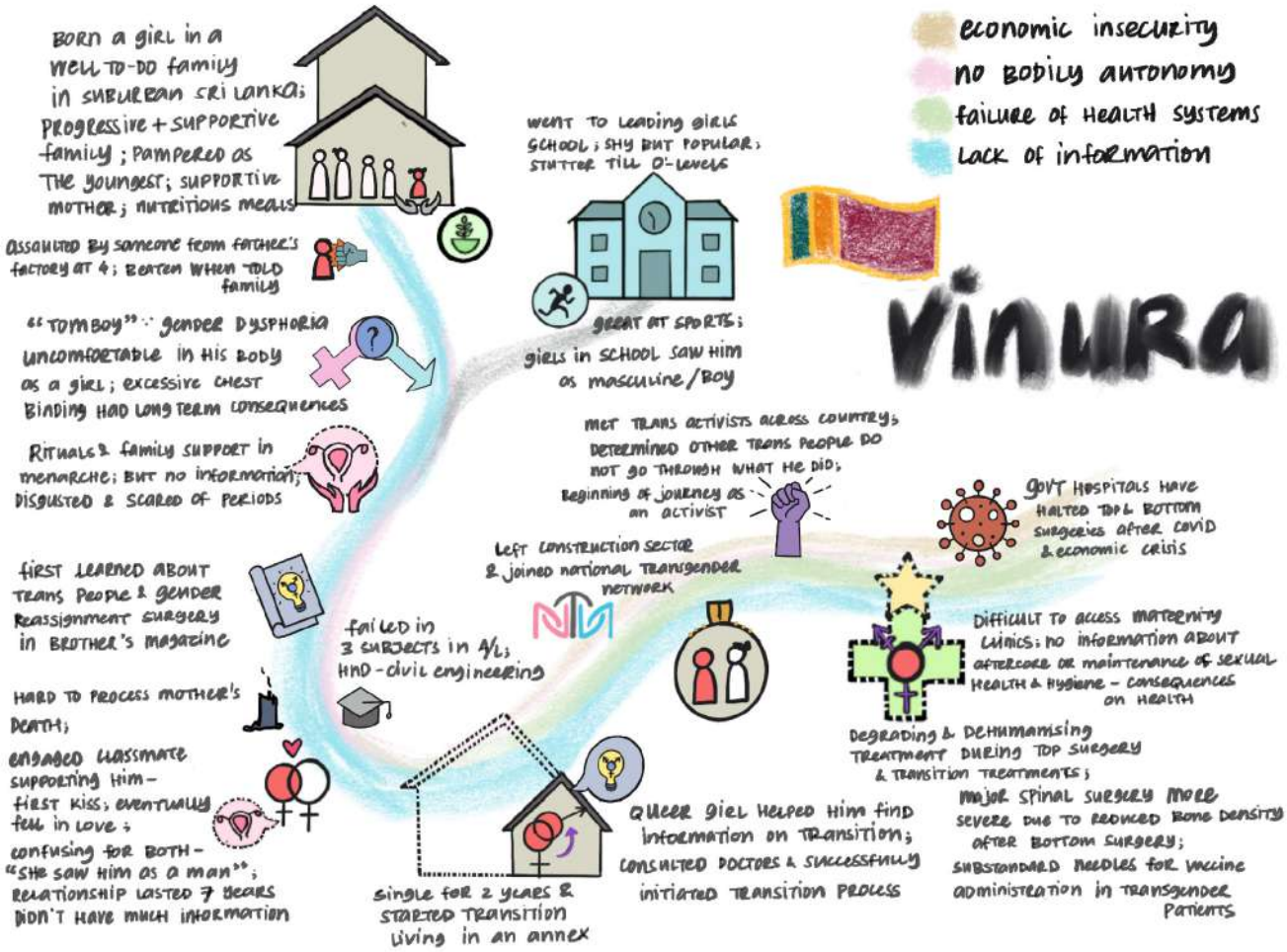
As a teenager, Vinura had a muscular frame and a muscular 'six-pack' abdomen, much to his classmates' fascination. Unlike his classmates, his breasts developed late. He bound his chest tight to flatten his breasts. His mother bought him different types of bras, but he never wore them, preferring sports bras instead. Later, when he had his top surgery during his transition, his doctor told him that the tight binding had damaged his breast tissue, and, consequently, the surgical scar was more prominent.

MENSTRUATION AND GENDER IDENTITY

Vinura began menstruating when he was 14, the last amongst his classmates to do so. He had no idea of what was happening, as nobody had told him he would start bleeding. His mother discovered he had started his period while he was changing. During his first period, Vinura's family observed the customary rituals, and he was isolated in a room for five days. His periods became his worst nightmare. His menstrual cycle was very irregular, taking place once every three months. Medicines to regulate his period made it worse. Later, he learned that he had naturally high levels of testosterone in his body. Even before his transition, by the time he was 17, he had a very prominent beard and shaved every day before school. When he began his transition, he could start with 1 ml of testosterone right away. Usually, people transitioning start with a smaller dose and build it up.

The topic of 'sex' confused Vinura a lot. Well into his adolescence, he believed, based on scenes in movies, that kissing could lead to a pregnancy. While he had been somewhat certain about his gender from a very young age, he was not sure about his sexual orientation until later in life. By grade 7, his classmates were sexually aware and discussed boys, but he was just not interested in sex.

All he knew was that he was not attracted to either girls or boys. Vinura discovered the existence of trans people when he was 15 years old, thanks to a magazine article on gender reassignment surgeries in Thailand. He realised that this was the change he needed and resolved to go abroad to change his gender.



Vinura attributes his lack of interest in sex partly to his religious and spiritual bent, and at one point had even considered becoming a Buddhist priest. His first sexual experience was unexpected and took place without his consent, at a time when he was most vulnerable. He was grieving his mother's death when his best friend at that time forced him to have sex. Vinura did not know how to react, as it happened without his consent. The experience was deeply confusing.

His mother's death affected Vinura deeply, but he was only able to weep two years after her funeral. Soon after her death, he joined a technical college for his HND, but was depressed and would often fall sick. An older classmate, who was his closest friend, helped him cope and manage his health and studies.

Vinura topped his batch at the end of the technical college course, and their friendship continued. It eventually turned into a romantic relationship and taught him to explore his sexuality. She was the first person to whom he was emotionally and sexually attracted. The relationship lasted seven years. Although his girlfriend never saw him as a girl and always considered him a man in their relationship, it was confusing for both, as they were both assigned female at birth.

EXPERIENCE WITH TRANSITIONING AND MEDICAL VIOLENCE

During this time, Vinura sought information about transitioning and about transgender people, but could not find anything helpful. He believes that one reason his relationship ended was that he could not begin his transition. After the end of this relationship, the second most difficult thing he had to face after his mother's death, he remained single for two years. During this time, he began his transition. He moved out of his home to avoid scrutiny from his neighbours and relatives. He also left construction work and began working with a transgender network. During this very difficult time, he attempted to take his life a few times. This tough period ended when he met his now wife, Ridmi.

In his transition, Vinura could not find any useful information on his own. Fortunately, a queer girl who was attracted to him helped him with his research. With her help, Vinura learned that gender reassignment surgeries were performed at Colombo South Teaching Hospital, Kalubowila. He consulted the doctors there and successfully initiated his transition process. Because he already had a high level of testosterone in his body, his transition happened quickly. His voice changed within the first month, while other changes followed more slowly.

Because top surgery is classed as cosmetic, Vinura had to visit a plastic surgery clinic, where he was treated cruelly. On learning he was a trans man, the doctor tried to dissuade him, took his phone to inspect his old photos, and called the surgery a waste. She then summoned male doctors and staff, kept him there until other patients had gone, and joined them in claiming that trans people corrupt young people and criticising his psychiatrist. They even asked the support staff whether they could tell at a glance that he was trans. The humiliation lasted at least an hour and a half.

He experienced even greater hostility, resistance, prejudice, and ignorance when he was admitted for surgery. First, the doctor who had assigned him a surgery date tried to prevent him from being admitted on the day of the surgery. She took him to every bed in the ward to show him the condition of each person, while threatening to reveal the reason for his visit to the ward inmates. She concluded this brutal 'ward tour' by saying, "Are you asking us to waste our time on your nonsense surgeries, when there are other people who need the surgeries more than you do?" This was one of the most dehumanising experiences Vinura had undergone, and he left the ward determined to take his own life. The senior doctor who had supported his transition later came to Vinura's house to apologise and explained that the hospital bureaucracy had prevented him from intervening.

Subsequently, Vinura searched for a hospital that would accept him and, in the process, met other transgender activists across the country. He was determined to ensure that other trans people did not have to suffer the pain and humiliation he had gone through. This was the beginning of Vinura's journey as an activist.

LACK OF POST-SURGERY CARE AND GUIDANCE

Vinura visited the De Soysa Maternity Hospital for Women for a hysterectomy and bottom surgery. After the surgery, trans men receive no guidance on aftercare or the maintenance of their sexual health and hygiene. After his surgery, he was discharged without a word, and he had no idea if he had to take any supplements, etc., to maintain his health. Later, when he suffered a major spinal injury, he discovered that the surgery had led to significant calcium and vitamin D deficiencies in trans men, which in turn affects bone density.

Despite efforts to combat hardships faced by other trans people, Vinura said that the situation has not changed much since his surgery in 2019. With the COVID-19 pandemic and the economic crisis that engulfed Sri Lanka, government hospitals have completely stopped providing surgeries for transgender people. What is commonly termed a TG clinic in Sri Lanka is usually a general psychiatric clinic that trans people can access to receive services and start the process of getting their gender recognition certificates. These clinics do not provide any trans-community-specific healthcare services or support.

For issues related to their reproductive health and for bottom surgeries, the only hospitals they can rely on in Colombo are the De Soysa Maternity Hospital for Women and Lady Ridgeway Hospital for Children. Vinura encountered overt discrimination when he visited a maternity clinic as a man, being subjected to rude and probing questions. In his words, before he enters a hospital, he leaves his dignity at the gate. Similarly, for top surgery, most trans men, including himself, have gaping scars on their chests due to the lack of or poor quality post-surgery care.

MARRIAGE

Vinura met his wife, Ridmi, after completing his transition. They were best friends before becoming lovers. Vinura's coworker and fellow activist introduced them. Both were very awkward and did not really interact during their first meeting. Once Ridmi learned that Vinura was a trans man, she sought him out on social media, and they started chatting. Knowing that her family would not accept Vinura as a trans man, for the next four years, they worked hard to build the life they wanted and got married in 2022 without telling their families.

Vinura dreams of having a child with Ridmi, but is doubtful about their child's future within their family. He also wants to have a house of their own and a stable income before they start trying for a baby. He is aware that having a child as a trans person is not easy. There are no fertility clinics for them, and fertility care in the public health system is limited, so they will have to explore options within the private healthcare sector, which can be very expensive.

Even though trans people are now increasingly visible in society, they still face major challenges in receiving non-judgemental, professional, and high-quality healthcare. When Vinura suffered a spinal injury, he asked to be admitted to a private hospital. However, because of the severity of his injury, he was immediately transferred to a government hospital. There, he shared his status as a trans man to facilitate procedures such as insertion of a catheter. The hospital staff stood around his bed looking at him as if he were a zoo animal. He received treatment only after he explained to the doctor what it means to be a trans person, doing all this while being severely injured and in great pain.

Vinura says that as long as he advocates for himself, most healthcare service providers have sometimes been receptive, albeit reluctantly. Yet many trans people are marginalised and denied proper treatment because they are unable to advocate for themselves.

her-stories

INDIA

INDIA

INVISIBLE LIVES IN VISIBLE ECONOMIES: INTERSECTIONAL REALITIES OF MARGINALISED WOMEN

INDIA — Country Context Indicators	
A. ECONOMIC INDICATORS	
National poverty rate	5.25% extreme poverty (< USD 3/day);[57] large variation across states: Tamil Nadu ~3.5%, Gujarat ~6%
Gini coefficient	25.5; however, India's income-based Gini coefficient is 62, ranking it amongst the most unequal countries[58]
Women workforce participation rate	32.4% female labour force participation; vulnerable employment amongst women is 78.2%;[59] 13.7% of seats in the Lok Sabha held by women[60]
B. KEY GENDER AND HEALTH INDICATORS	
Gender Gap Index	0.644 ranked 131/148 countries;[61] Human Development Index: 0.644, ranked 134/193;[62] Gender Inequality Index: 0.437, ranked 108/193[63]
Maternal mortality ratio (MMR)	80 per 100,000 live births nationally; Tamil Nadu: 54, Gujarat: 57; Dalit and Adivasi women face significantly higher MMRs; data not disaggregated by caste[64]
Adolescent birth rate (ABR)	14 births per 1,000 women aged 15–19; child marriage: 23% of women aged 20–24 were married before 18[65]
Modern contraceptive prevalence	56.5%[66]
Population with at least some secondary education	88.3% of girls completed lower secondary school;[67] ~23 million girls drop out due to menstruation-related stigma and lack of WASH facilities[68]
C. LEGAL FRAMEWORK — SEXUAL AND REPRODUCTIVE HEALTH	
Abortion	Legal under the Medical Termination of Pregnancy (MTP) Act 1971 (amended 2021): up to 20 weeks on broad grounds; up to 24 weeks for vulnerable categories. In practice, conflation with the PCPNDT Act (prohibiting prenatal sex determination) creates access barriers, particularly for Dalit, rural, and poor women.[69]
Gender-based violence (GBV)	29.3% of ever-married women aged 18–49 have experienced intimate partner violence in their lifetime. Marital rape remains legal. Enforcement gaps significant, particularly for Dalit women whose complaints are frequently not registered.[70]
LGBTQI+ communities	Section 377 of IPC struck down for consensual adult same-sex relations. Transgender Persons (Protection of Rights) Act (2019) provides limited legal recognition, but criticised for requiring screening committees and not protecting marriage or family rights. Supreme Court declined to recognise same-sex marriage (2023).
D. GEOGRAPHIC AND SOCIAL STRATIFICATION	
Caste stratification	Scheduled Castes (Dalits ~16.6%) and Scheduled Tribes (Adivasis ~8.6%) face persistent discrimination. Most Backward Classes (MBCs) such as Odda Chettiar (in Tamil Nadu) face comparable socio-economic exclusion; caste-based violence documented under SC/ST Atrocities Act
Uneven geographic development	Southern states (Tamil Nadu, Kerala) have higher HDI and lower MMR than the BIMARU[71] states. Within Tamil Nadu, Dalit settlement areas have lower infrastructure and service access despite state welfare schemes.[72]
Climate vulnerability	India ranks 15th on the Climate Risk Index of countries most affected by extreme weather events; agricultural communities in Tamil Nadu vulnerable to drought; heat stress increasingly affects informal sector workers[73]

Note: India has the largest population in the world (1.4 billion). Data presented are national figures; Tamil Nadu and Gujarat state-level figures and caste-disaggregated data are provided where available. Caste-based disaggregation is absent from most international databases.

Tamil Nadu and Gujarat are often cited as examples of India's economic dynamism, with Tamil Nadu's welfare-oriented governance and Gujarat's industrial growth shaping national narratives of progress. Yet, when viewed through the intersectional lens of reproductive justice, these models reveal deep exclusions.[74] The stories in this chapter highlight these challenges faced by Dalit and other 'backward' caste communities in Tamil Nadu, and urban poor women in Gujarat, who remain structurally marginalised despite their states' economic achievements. Their realities highlight the gap between policy commitments and lived experiences, underscoring the need for justice-based indicators that go beyond aggregate growth.

Tamil Nadu's social welfare legacy includes schemes for maternal health, nutrition, and education, aligned with national commitments under the National Health Mission (NHM) and global frameworks like the ICPD and SDG 3 (health and well-being).[75] However, women from marginalised caste communities often encounter caste-based and other structural discrimination in accessing these services. Policies that emphasise universal coverage fail to address the intersectional barriers of caste, class, and gender. This disconnect between policy design and ground realities illustrates how structural inequities persist even within progressive welfare regimes.[76]

In Gujarat, the emphasis on industrial growth and urban expansion has overshadowed investments in inclusive health systems.[77] Although the state has adopted national programmes on reproductive health and non-communicable diseases, as highlighted here, urban poor women, particularly those from ageing populations navigating menopause and other fertility-related issues, remain largely invisible.[78] Menopause is rarely recognised within SRHR frameworks, which continue to prioritise fertility and maternal health.[79] For women in informal settlements, the absence of targeted interventions means untreated symptoms, lack of psychosocial support, and exclusion from broader health entitlements. This invisibility reflects a policy blind spot: the failure to integrate life-course approaches into SRHR, as envisioned under SDG 5 (gender equality) and SDG 10 (reducing inequalities).[80]

The dichotomy between economic progress and social exclusion becomes stark when juxtaposed with these realities. Policy frameworks that emphasise aggregate indicators, such as GDP growth or maternal mortality reduction, risk obscuring the uneven distribution of benefits. The stories documented by national partners, RUWSEC in Tamil Nadu and SAHAJ in Gujarat, highlight how women from marginalised groups in these two states are systematically excluded from the gains of development, despite formal commitments to equity and inclusion. The stories cover themes of restricted bodily autonomy and reproductive choices; structural violence, particularly with regard to access to healthcare and health systems; lack of information and sexuality education; and safety at workplaces.

RADHA'S STORY

Radha is 27 years old and lives in a village in Tamil Nadu with her family of four: her husband, five-year-old daughter, mother-in-law, and sister-in-law. They live in a one-storey concrete house owned by her mother-in-law. Unlike many other homes in their settlement, their house has a bathroom and a toilet. Radha holds a nursing certificate and has worked at a local NGO clinic for the past eight months. She earns Rs 6,000 (USD 68) a month. Her husband, Muthu, has had only six years of schooling and works as an agricultural wage labourer for daily wages. Her mother-in-law owns some land and pitches in to meet the household expenses.

Radha belongs to the Dalit (formerly 'untouchable') caste. Members of the same caste predominantly inhabit the settlement in which they live. Her village has two other settlements, each separated by farmland. One is a settlement of members of another Dalit caste, and the other is a settlement of MBCs (Most Backward Classes—socially and economically as deprived as the Dalits but never treated as 'untouchables'). Radha's settlement has a proper road, piped water supply, and electricity. There is also a government childcare centre and the village has a health sub-centre. The government's '100 days' work' scheme provides work for those from impoverished households for 100 days in a year.

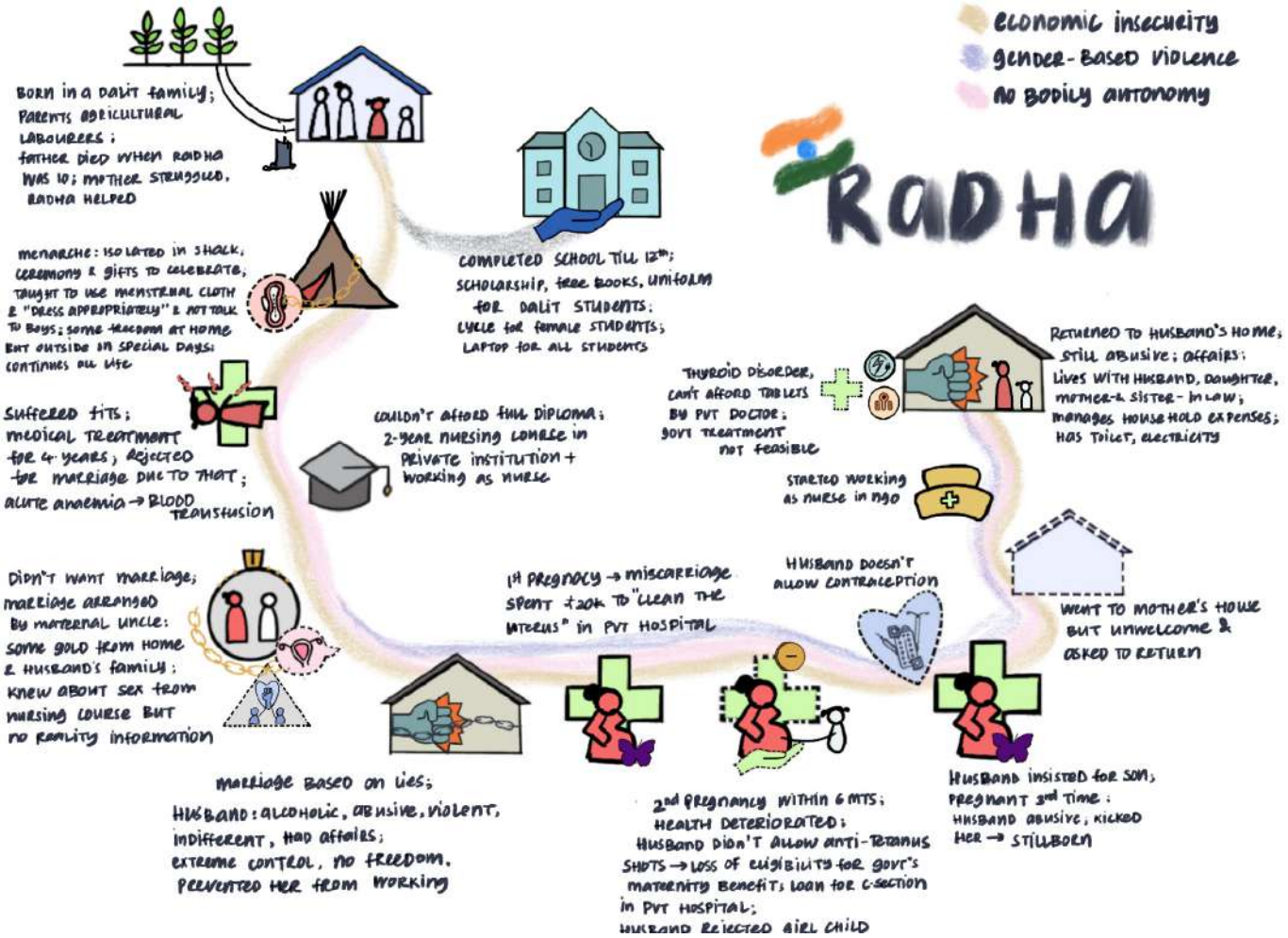
Radha's childhood was marked by hardship. Her parents worked as agricultural labourers, and her father died of jaundice when she was 10, leaving her mother to raise her and her younger brother alone. Radha helped her mother with agricultural work whenever she could. Despite the hardships, her mother did not treat her any differently from her younger brother. Radha completed her schooling at the government school near her village. She received a scholarship, free books, and a uniform available to all Dalit students. In class 11, she received a cycle to commute to school under a government scheme for female students; she also received a laptop for her schoolwork, along with all the other students in her class.

After completing school, Radha wanted to study nursing. Her mother could not afford to pay the fees for the three-and-a-half-year diploma course, so she completed a two-year nursing course in a private institution and started working as a nurse in a small private health facility.

MENSTRUATION AND MARRIAGE

Radha had her first period when she was in class 9. At that time, she had to stay in a shack outside the house for seven days, after which a ceremony was held to mark her menarche. Her maternal uncle and paternal aunt gave her clothing and a gold chain as gifts. Her mother taught her how to use a cloth for menstrual protection and how to dress 'appropriately' as a growing girl. She was told not to talk to boys in her class or any grown men outside the home.

Unlike in many other households, Radha did not have to live separately during her periods. She moved freely around the house, except on festivals when rituals were performed at home. On these occasions, she had to stay outside the doorstep of her house and sleep on a mat. Her mother would sleep close to her, on the other side of the doorstep. The same practice continued in her marital home—she did all the household work during her menstrual periods but had to stay outside during festivals. Radha felt strongly about the way girls were treated during their periods—kept aloof, given a separate plate and cup, and treated as 'untouchables'. "Menstruating girls are treated as if they have committed a crime," she says.



When Radha was in class 12, she began experiencing 'fits' (seizures) and was on medication for four years, after which the problem did not recur. When she was about 20 years old, she was diagnosed with severe anaemia, with a haemoglobin level of only 3 grams per decilitre (g/dL), and had to undergo a blood transfusion.

Radha had no romantic relationships before her marriage. She came close to marrying someone, but it did not happen. A colleague at work had a relative whom he felt would make a good husband for Radha, and he brought him to meet her at her workplace. Radha liked him, and he was also interested in her. The marriage was almost fixed when someone told the man's family that she sometimes suffered from 'fits'. The boy's mother said, "She is a sickly girl. She gets fits. She may not be able to bear children." With that, the marriage proposal did not move ahead.

Although she had learnt about sexual relationships in her nursing course, Radha had no idea what it would be like in reality until she got married. She was 22 years old then, and her husband, Muthu, was 26 or 27 years old. It was an arranged marriage.

> *"I did not want to get married at that time. I wanted to take care of my mother. But my mother was a widow and anxious to see me 'settled'. I agreed because I did not have a father, and people would blame my mother."*

Her mother gave her ten sovereigns of gold and some articles for setting up a household; her husband's family paid for the wedding and gave her a thali (a pendant worn by women that is a symbol of marriage) and a gold chain.

EXPERIENCE OF VIOLENCE

At first, Radha had expected a loving relationship from her marriage, in which the two of them would talk freely, discuss household matters, and do things together. She was instead met with disappointment and violence. Muthu was frequently absent and would abuse and hit her if she asked about his whereabouts. He rarely spoke to her. She had to cook for him and take care of the household. He never cared for her or bought her anything, and he gave her very little money for household expenses. All he wanted from her was sex. If Radha said she was tired or was not feeling well, he would abuse

her and force himself on her. He would also often come home drunk and abuse her both verbally and physically. He would say:

> *"What did I marry you for? I paid lakhs for the marriage; I am not asking you for a favour."*

He also curtailed Radha's freedom. She could not go out without telling him where, why, and when she'd return, or go out alone. He couldn't tolerate her laughing and talking with friends, fearing it would make her "too free," and often suspected she'd leave him for another man. He also prevented her from working as a nurse, repeatedly forcing her to resign. She soon came to know that Muthu was having an affair with a married woman from the same village.

POOR REPRODUCTIVE HEALTH

Radha has had three pregnancies. Her first was soon after marriage, but it ended in a miscarriage. When Radha started bleeding in her fifth month of pregnancy, her mother took her to a private hospital. They had to spend Rs 20,000 to 'clean her uterus' (suggesting she needed to have a dilatation and curettage [D&C] procedure). The second pregnancy occurred six months after the miscarriage. Already of delicate health, Radha's health deteriorated further because of Muthu's violent behaviour:

> *"There were many days when I did not feel like eating after a fight with him. He would wash his hands in the vessels containing food, making them unfit to eat. Sometimes he would vomit all over the house or urinate inside. I would feel disgusted and lose my appetite."*

Muthu did not allow Radha to receive the anti-tetanus shots as part of antenatal care, believing they had caused the first pregnancy loss. Not being immunised resulted in the loss of eligibility for the government's conditional maternity benefit of Rs 12,000. Radha had to go to a private doctor for regular check-ups. She had high blood pressure during this pregnancy, and the baby girl was delivered by 'operation' (C-section) at a private hospital. Radha wanted to go to the government hospital, but Muthu objected.

> *"You want to save your mother's money and go to a government hospital? She has to look after you. Let her take you to a private hospital."*

The baby girl was not welcome. Muthu had wanted a son, and he came drunk to the hospital and created a ruckus. He did not even hold the baby. He did not take care of Radha, bring her food, or give her money. Radha's mother had to be with her in the hospital, then go home to cook and bring food for Radha. Radha had to stay in the hospital for ten days. It cost almost Rs 100,000; her mother and brother had to take loans to pay the hospital bill. Radha contributed to paying off the loans when she later worked as a nurse.

Life became hell after the birth of their baby girl. Radha did not want to get pregnant again, but her husband insisted that she bear him a son. Even her mother-in-law began saying that if Radha did not have a son, Muthu might have to consider marrying another woman who could bear a male child. Eventually, Radha became pregnant for the third time.

> *"Those were difficult times. We were constantly fighting. He was with another woman, and we fought over it. He would hit me badly, push me out of the house, and ask me to leave. One day, he even disconnected the gas cylinder and threatened to set me on fire."*

When Radha was in her seventh month of pregnancy, Muthu kicked her during a quarrel. Radha started bleeding the next day. Her sister-in-law took her to a private hospital. The doctors said the baby was in danger and that she had to be operated on immediately, but the baby was stillborn.

After the stillbirth of her third child, Radha went to her mother's house. She stayed there for over a year and a half and even started working as a nurse with an NGO. But after a few months, her mother made her feel unwelcome, saying she could not stay indefinitely. Her brother also said that her place was with her husband and that she should return home.

Radha felt deeply hurt and unsupported. But she also worried about her daughter's future: What would happen when her daughter grew up? Who would arrange her daughter's marriage? What would people say? So, when Muthu asked her to come back, she returned for her daughter's sake.

Radha now lives in her husband's house. He continues to be in a relationship with another woman. She is a nurse, manages the household expenditures, and cares for her daughter. Her mother-in-law also helps with the expenses. Muthu refuses to spend money on their daughter, even for her education.

Although Radha does not want to get pregnant again, she does not use any contraceptive methods because Muthu does not let her and she does not want to have another confron-

tation with him. She hopes she will not get pregnant again, because she and Muthu rarely have any physical intimacy. She has recently been diagnosed with a thyroid disorder, but has not been able to afford the expensive tablets prescribed by the private doctor. Treatment at a government hospital would be affordable but time-consuming and not feasible for Radha, who has a full-time job in addition to household responsibilities.

Amidst all the difficulties, her daughter has been a source of happiness for Radha. She fondly remembers her daughter's first birthday, cutting the cake and celebrating with many relatives and neighbours. She takes pride in qualifying and working as a nurse. Her work gives her peace of mind. Although her husband and mother have been unsupportive, her workplace has been supportive. She enjoys her job and has many well-wishers and friends in the NGO.

LAKSHMI'S STORY

Lakshmi, aged 26, lives with her husband, Ramu, and their three children in a village in Tamil Nadu. Her two daughters are aged 7 and 4 years, respectively, while her son is 3 years old. They belong to the Odda Chettiar community, which is listed as a 'Most Backward Class' (MBC) in the Tamil Nadu government's list of Backward Classes. Traditionally, they are well-diggers.

Traditional well-diggers have immense generational knowledge of the soil and water conditions in their region as well as techniques of constructing wells. However, their occupation is in rapid decline. Today, Lakshmi's family leads a hard life with barely enough earnings to make ends meet. Their house stands on a piece of land which they own, but it is a tin shack with mud floors. They have piped water supply outside their home, but no toilet facility. For their basic sanitary needs, they have to walk to 'kaattuppakkam', an area outside their settlement, which is used for open defecation.

There are several government welfare schemes to help low-income households, but Lakshmi cannot access many of them because the family does not have a 'ration card', which enables them to access subsidised food and serves as proof of identity and residence for official purposes. Neither do they possess 'Aadhaar' cards, which are more useful nowadays for all official needs. She has applied for one but has not received it yet.

CHILDHOOD

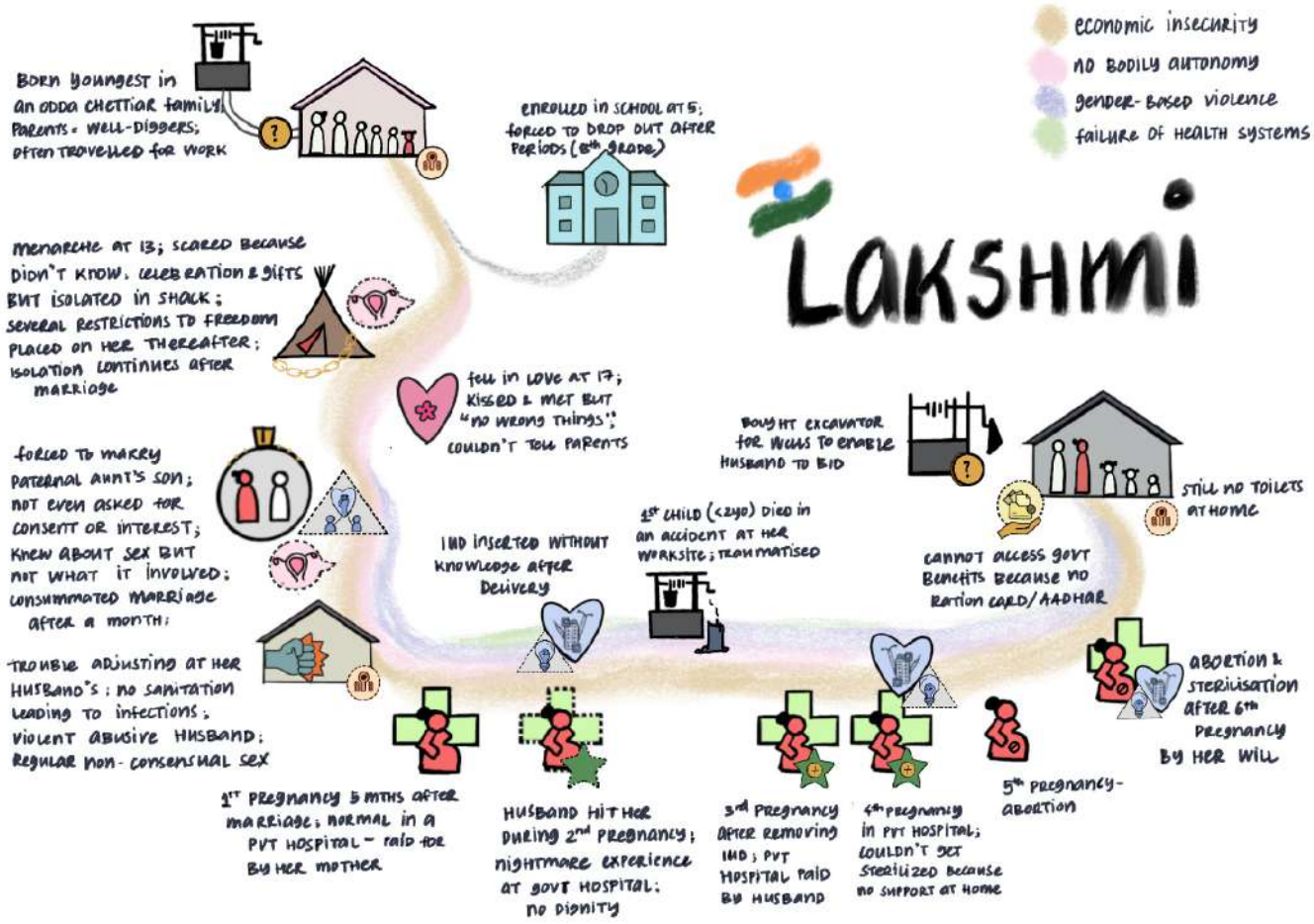
Lakshmi was the youngest of four siblings. Being traditional well-diggers too, her parents travelled frequently in search of work and spent long stretches of time away from home. The siblings grew up largely with their grandparents. When she was 5 years old, Lakshmi was enrolled in a local government school. She studied there up to class 8. Her parents stopped her education after she 'came of age', which was the usual practice amongst her community. The common perception was, "What is the point of studying a lot? After all, you will be digging wells."

In general, Odda Chettiars are poor and have limited education, but they consider themselves to be above the Dalits in the caste hierarchy. Growing up, Lakshmi and her siblings were told to maintain strict physical distance from Dalit households, which included refraining from accepting food, water, or gifts. However, people of her caste, including her parents, had no problems digging wells for Dalit households or accepting money from them.

MENSTRUATION, ROMANCE, AND MARRIAGE

Lakshmi was 13 years old when she had her first period. She was terrified to see blood in her panties and wept inconsolably when she told her grandmother about it. Lakshmi's grandmother told her parents, who immediately began the menarche rituals. According to the custom, she had to stay isolated for 15 days in a palm-leaf shack outside their house. Following this, the family organised a ceremony to which all her relatives and neighbours were invited, and everyone brought her gifts that Lakshmi enjoyed.

During every subsequent period, Lakshmi was told that she "cannot play, talk (to boys, outsiders), and cannot go anywhere." She had to stay isolated for those three days every month, a practice that continued even after her marriage. Furthermore, menstruating girls were required to use separate plates and cups and were not allowed to engage in household chores. Any physical contact with them during their menstrual periods was considered polluting.



At the age of 17, Lakshmi fell in love. Although her boyfriend came from another village, he was from her caste. They met frequently and were physically close. They often hugged and kissed each other, and Lakshmi said, "but I did not do anything else, any wrong things. My parents strictly told me not to do wrong things." They intended to get married, but things did not work out that way.

> *"In our community, no one should 'love' before marriage. We have to marry whoever our parents choose for us. If we say we like someone, they will not agree."*

Lakshmi had to marry her paternal aunt's son when she was 18. She did not dare to refuse her father's and her aunt's decision:

> *"What can I say? How could I go against their wishes? They have taken care of me since my childhood. Can I say I will marry who I wish to? So, I said, 'Whatever you wish, my wish is the same.' And they got me married off. If they had asked even once, 'Do you have someone in mind?' I would have told them."*

When Lakshmi and Ramu married, she was 18 and he was 20. Lakshmi found it difficult to adjust to life in Ramu's house, which was cramped and unlike the house she grew up in. It had no toilet or bathroom. She had to walk 5–10 minutes to find a suitable place to relieve herself. Getting used to going out in the open was not easy, and managing her periods under these conditions proved equally challenging. Shortly after her marriage, Lakshmi started experiencing itchy, foul-smelling vaginal discharge. It is possible that poor menstrual hygiene caused a vaginal infection.

> *"I have had white discharge all the time, since my marriage. My husband took me for treatment, and I was given tablets for a month. When I stopped the tablets, it (the discharge) started again. After a few episodes, I stopped taking treatment."*

Though Lakshmi was aware of sexual relations in marriage, having seen them as a teenager, she had no real understanding of what it actually involved. Soon after the marriage, when Ramu called her to bed, she refused his advances. Outraged, he beat her and sent her back to her parental home. It was her sister-in-law who eventually reasoned with her, explaining, "This is life. Once you are married, you have to sleep with him." A month after their marriage, Lakshmi and Ramu finally consummated their marriage.

Lakshmi says she has no complaints against her husband. She is free to take decisions about the household, and Ramu does not mind either. She can go out on her own; she just has to tell him and go. They go out together. He supports her when they are with others, and she never talks ill of him to outsiders. The only problem is that he forces her to have sex even when she does not wish to.

"If I don't want to, he should leave me alone. I tell him that. But even then, he forces me. If he calls, I have to go. If I don't, he will tear my panties and petticoat and force himself on me. He will force even when I say I don't like it."

There have also been instances of physical violence by her husband in the early years of their marriage. Lakshmi can never forget an incident during her second pregnancy when her husband and mother-in-law assaulted her badly after a quarrel. She is also worried that her husband does not manage money well and that they lack funds to build a 'decent' house for themselves.

EXPERIENCE OF PREGNANCY AND OBSTETRIC VIOLENCE

Lakshmi has been pregnant six times and has borne four children. She became pregnant within five months of her marriage and delivered normally in a private hospital. Unfortunately, the child died in an accident when he was less than two years old. When he was nine months old, Lakshmi conceived again. She had her second delivery at the government district hospital. Fearing high expenses, Lakshmi had opted to have it there because it was free of charge. It was, however, a nightmare.

"Here I am, screaming in pain. And they are slapping and pinching me on my thighs and telling me to shut up, 'You have no problems sleeping with him, but it pains when you have to deliver the baby?' They kept saying such cheap things and yelling at me. I decided I would never return to that hospital again."

The third pregnancy came a little over two years after the second delivery. Due to Lakshmi's last experience of abuse and ill-treatment in a government hospital, she preferred to go to a private hospital. The delivery went quite smoothly. However, within the next seven months, she found she was pregnant again. She delivered this child in the same private hospital.

Her husband paid for all the deliveries except the first, when her mother spent Rs 50,000. The private hospital where she had her third and fourth deliveries was cheaper; they charged about Rs 10,000–13,000 per delivery. Lakshmi's experience in the private hospital was much better. There was always someone around when she was in labour. It was far less chaotic than the government hospital, where many women in the labour room were moaning and screaming at the same time.

Lakshmi was diligent with her check-ups and scans during all her pregnancies. However, she had little time to rest and had to work till late in her pregnancy. Working on the grinder all day left her feet heavily swollen, and on more than one occasion, her labour pains began while Lakshmi was at work. Postpartum was not easy either.

"After all four deliveries, my mother came over and spent three days with me and then left. After that, I had to manage everything by myself. Apart from taking care of the infant and the other children, I had to cook and wash clothes. Is taking care just for three days enough?"

After her fourth delivery, Lakshmi wanted to have a tubectomy, but she could not, as no one was available to take care of the children or handle household work while she was in the hospital. After her second delivery in the government hospital, the doctor had inserted an IUD without her knowledge or consent. When she came home after the delivery, she noticed the thread from the IUD dangling from her vagina. Worried that something was wrong, Lakshmi called the government nurse, who reassured her that nothing was wrong and that it was an IUD that would protect her from conceiving too soon. After two years, Lakshmi removed the IUD but became pregnant immediately. However, the experience had made her wary of any temporary method of contraception, as it had led to two subsequent unwanted pregnancies.

A fifth pregnancy followed when her fourth baby was eight months old. Lakshmi did not want any more children. She told

her husband, and he too agreed that she should terminate the two-month-old pregnancy. They went to the chemist and asked for abortion pills over the counter. He gave them five tablets with instructions on how to take them. The tablets cost about Rs 2,000. After taking the tablets as instructed, she aborted. Although she bled for a few days, there were no other problems.

Her sixth pregnancy occurred recently, nearly three years after her abortion. This time, Lakshmi went to a government hospital, underwent an abortion, and then sterilisation. She incurred only minor incidental expenses. She was discharged from the hospital after three days and returned on the ninth day to have her stitches removed.

"I'd already had one abortion with the tablets. I simply could not manage another child. Three children are enough. Ramu said, 'Let it be' (carry on with the pregnancy). But I told him, 'I cannot take care of another child. You will go away to work, you are not going to take care of the child. I want to have an abortion and operation—are you coming with me?' He agreed."

UNSAFE WORKPLACE AND THE DEATH OF HER FIRSTBORN

Lakshmi still lives with the trauma of her firstborn son's accidental death, which occurred while she and her husband were engaged in well-digging. Well-digging requires an entire team. One person takes the contract for Rs 5–7 lakh and recruits several couples to work in his team. The money is shared amongst all the team members. While school-going children are left behind with their grandparents or relatives, younger children often go to the workplace with their parents. The teams stay at a site for several weeks in temporary sheds, cook their food, and work all day. Babies are kept in cloth cradles hung from tree branches.

It was on one such trip that Lakshmi's son met with an accident and died. It was the end of the working day. Ramu was inside the well. The excavator was running, and he asked Lakshmi to switch off the machine. She does not know what happened. All she remembers is that the wheel of the machine ran over her son's head. She screamed for help. Her husband lifted the baby, and they ran towards the nearest health centre. Halfway through, they hitched a ride on a motorbike. From the health centre, they were referred to the medical college hospital and sent there in an ambulance. The doctors at the medical college hospital told the parents that the baby had no heartbeat.

The death of her baby is a tragedy she has not been able to overcome to this day. She wishes no mother had to go through such an experience.

Although life has not treated her well, Lakshmi sees herself as someone who remains cheerful and popular.

"I think I am happy every day. Everyone likes me. They like to talk to me. They never leave me alone when they see me. I make everyone laugh. I joke a lot. People say, without you, the place looks empty."

One of her achievements has been buying an excavator to support their well-digging work, enabling Ramu and Lakshmi to bid for direct contracts. She has many more dreams like buying a motorbike, building a concrete house and educating all her children well.

RAMA'S STORY

Rama is 54 years old and lives with her husband of 37 years in a low-income area in Vadodara city in Gujarat. They belong to the Darbar community (open/general caste) and have no children. Her husband works as a driver in the city and earns Rs 12,000 per month. Rama has an APL (above poverty line) ration card but receives subsidised wheat and rice rations under a government scheme she has enrolled in. She also has a Jan Dhan account with the Punjab National Bank, which she uses to take out loans.

CHILDHOOD AND ADOLESCENCE

Rama was born in Vadodara, but she and her family later settled in a suburb on the city's outskirts, where she and her five siblings, three sisters and two brothers, were raised. Her father worked at a pharmaceutical company, while her mother supplemented the household income by working as a domestic worker. Her siblings continue to live in the same city, but her parents are no longer alive.

Rama has fond memories of her childhood. At her natal home, she was responsible only for cleaning utensils. By the time she was in class 7 or 8, she started working with her mother as a domestic worker to help with household expenses while continuing her schooling. She was 15 when her father retired from the pharmaceutical company.

When she was in class 8, Rama had her first period. She was unaware of what was happening and thought she had been injured. Her mother and friends explained how to use cloth pads during menstruation. She recalls that her mother made her shiro (a sweet treat) when she had her first period and said,

"Even now, when a girl from the neighbourhood gets her first period, I cook a 'shiro' for her and send it to her home. It is believed that once a girl gets periods, her life would be blessed. Because if she does not get periods, she is regarded as incomplete."

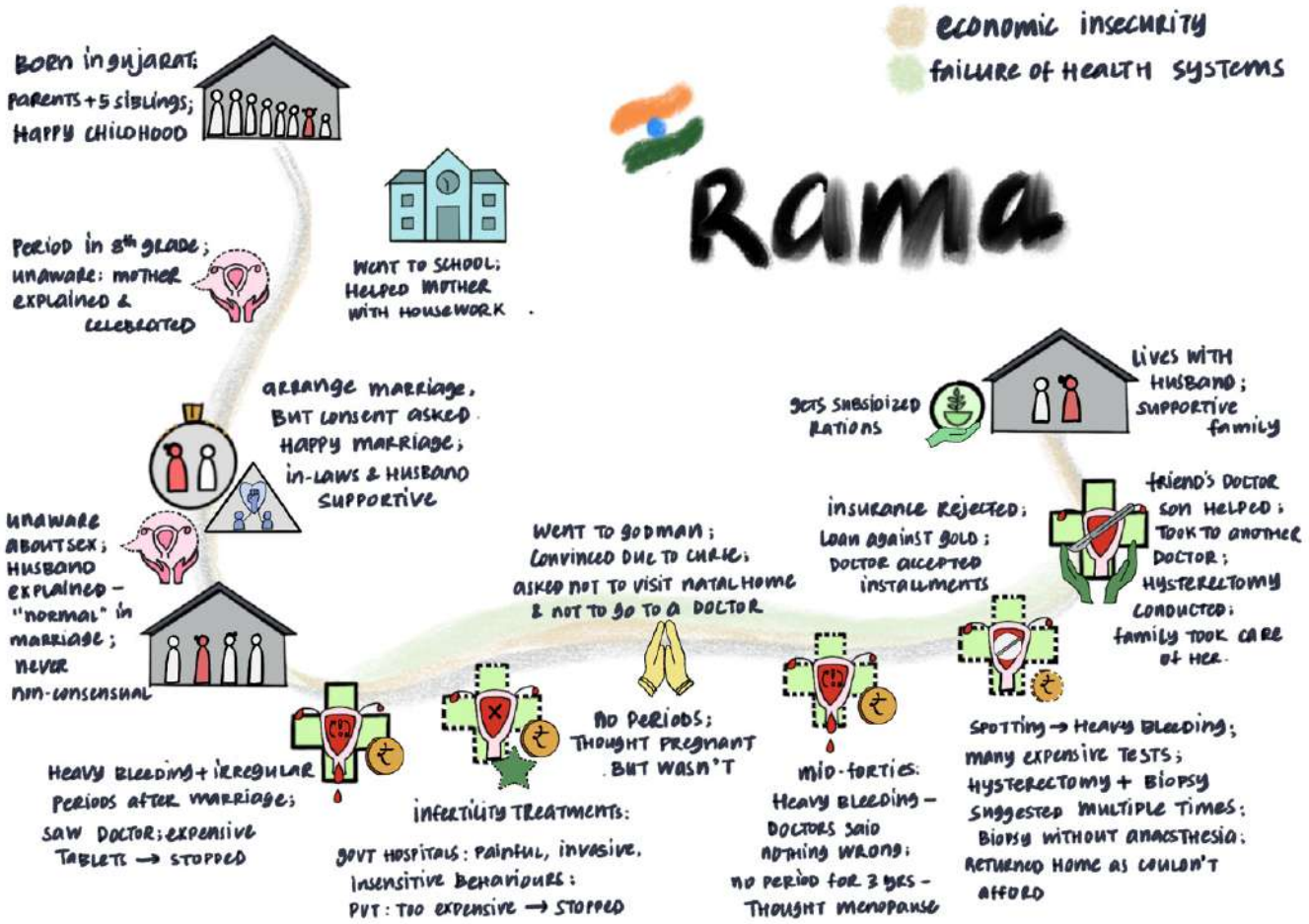
MARRIAGE

Rama was married around 18, shortly after she met her husband, who had first come to see her during her class 10 exams. Her father asked whether she consented, and she agreed. He worked as a driver. It was an arranged marriage. Rama belongs to a community that practises dowry, but her in-laws did not ask for anything. After she married, she and her husband lived with his parents in the staff quarters of a government hospital, where her mother-in-law worked as a cleaner and her father-in-law as a rickshaw driver. The financial burden of caring for his parents and household expenses fell entirely on Rama and her husband. After his mother retired, they received some support from her pension.

Rama was very fond of her in-laws, who took good care of her and treated her like their own daughter.

"He (father-in-law) would say, 'She has been cooped up at home the whole day; take her out.' He spent money from his earnings to send us for trips and pilgrimages. He encouraged us to go out and enjoy."

Rama was completely unaware of sex and had no idea what a 'suhagraat' (consummation of marriage) meant. When her husband first tried to have sex with her, she was scared and kicked him away.



Rama's first sexual experience occurred about a month after her marriage, and she had mentally prepared herself for it. It was painful and frightening, and she bled a lot. Her husband allayed her fears and reassured her. Her husband has always initiated sex. He has never forced her to have sex without her consent. At times, she has refused because of ill health or other problems. She has also told him that she does not like it when he touches her breasts, as she had read that excessive touching enlarges the breasts.

EXPERIENCE OF INFERTILITY

After marriage, Rama's periods became irregular. They would sometimes come after nine months, and she would have heavy bleeding during her periods. She consulted a doctor at a private hospital, who prescribed two tablets—one costing Rs 300 and another Rs 4,000. After taking these tablets, her bleeding would stop the next day. After that, she would not get her period for six to seven months, after which there would be heavy bleeding during her period for two to three cycles.

In the first few years of their marriage, Rama and her husband did not feel the need to seek treatment for her heavy bleeding. However, after a few years, when they did not conceive, they began consulting doctors about possible infertility treatment.

> *"The doctor would ask us to have sex at 7 am and then come to the clinic at 4 pm on the same day for a follow-up check-up. How is this possible?"*

Doctors conducted tests on them, and the results were normal. They also suggested managing the fertility cycle and provided a schedule.

Once, Rama went to a government hospital for a sonography. A student performed the procedure while other students stood around watching. According to Rama, the student inserted her hand into Rama's vagina, pulled out Rama's uterus, then used a pair of tongs (possibly a speculum) or some equipment to push it back in. After that, the senior doctor told the student to let Rama remain lying down and examined her. Rama was extremely distressed and could not sleep due to the pain from the procedure.

After this painful experience, Rama decided to seek treatment at private hospitals for her other medical problems, but the

cost of treatment there was a deterrent. At one hospital, where she had gone for an investigation, she was placed on a stretcher to wait for an injection before she could be taken in for the investigation; the doctor demanded she pay Rs 80,000 before being taken in. She could not pay and had to leave. Every doctor she consulted made her repeat the same tests—sonography, and even CT scans and MRIs. Often, when she did not have the money, she and her husband would return home without the treatment or test. Rama consulted various doctors in the hope of finding a solution and endured invasive, painful procedures and insensitive behaviour. Over the years, the treatment had become very expensive and the couple eventually stopped the 'treatment'.

ACCESSING ALTERNATIVE HEALING

"When I came to my husband's home after marriage, my kaki-sasu (husband's aunt) did black magic on me. She cut my saree and tied a knot so that I would not get pregnant. She gave me prasad (blessed food from rituals), which only men are supposed to eat. This is why my menstrual bleeding goes on and on, and I can never get pregnant. She cursed me because she didn't get along with my mother-in-law."

About eight or nine years after her marriage, Rama's mother-in-law and others in the family decided to consult a bhuva (godman). They had heard of other couples who had benefited from such consultations. However, the godman convinced Rama that her infertility was due to a curse from a family member. He was invited home to perform a ritual to remove the bad effects, for which he was offered plenty of food, clothes, and money. He also made Rama promise not to visit her natal home for four years, or to eat food or drink water from her natal family. Rama followed this diligently: "even though my mother stayed so close by, for four years, I did not go to her house." He also told her that she should not consult a doctor when she conceived.

After consulting the godman, Rama did not get her period, which pleased her mother-in-law and extended family. Her abdomen looked distended, and Rama, too, believed she was pregnant. "Every day my mother-in-law would ask if I could feel the baby moving, but I would say, 'No.'"

After seven months without her period, on the suggestion of her sister-in-law and with permission from the godman, Rama consulted a doctor, who conducted an ultrasound and informed the family that she was not pregnant.

MENOPAUSE AND HYSTERECTOMY

In her mid-forties, Rama began experiencing severe vaginal bleeding during her periods, requiring 60–70 pieces of fabric a day, and the bleeding would continue for two to three months. "I told myself it was all the waste from my body that was being expelled, and that after this blood from my own body would start." Once, Rama had a sudden episode of excessive bleeding: "suddenly so much blood came out that it would have filled a bucket." She took a rickshaw to a private hospital and got herself admitted. Then she messaged her mother, asking her to be with her in the hospital. A laparoscopic examination showed there was nothing wrong with her.

After this, Rama did not have a period for three years and believed she had reached menopause. She was close to 50; her mother had also reached menopause around the same time. When Rama reached menopause, she felt free; earlier, she had worried about her periods starting. She was especially concerned because of her experiences with irregular menstruation and heavy, prolonged vaginal bleeding.

However, after three years, she noticed some spotting. At first, she did not tell her husband about it and took no action. About 15 days later, when the bleeding worsened, she discussed it with her husband and decided to consult a doctor. The doctor performed a sonography and diagnosed thickening of her uterine walls, recommending a hysterectomy. Since the doctor knew Rama's case and financial status, he referred her to another centre where she could have the surgery at a lower cost. However, at that time, Rama had no one who could stay with her in the hospital, and she refused.

She consulted a few other doctors, all of whom, after conducting a sonography, referred her for a CT scan. However, the CT scan, which cost Rs 5,500, was inconclusive as well.

A few months later, Rama underwent a sonography at the government hospital. She had to undergo a vaginal sonography, a painful and harrowing experience for her. The senior doctor told her she would need an immediate hysterectomy and advised her to be admitted the same day. When she consulted her husband, he told her not to get admitted, and she returned home.

Two years after the post-menopausal vaginal bleeding began, on the suggestion of a family member, Rama went to another doctor, who informed her that a hysterectomy would cost less and that, if there was a camp, she could get it done for free. Her sister and a niece accompanied her. The doctor conducted another vaginal sonography and again advised a CT scan. Rama was told that there were lumps the size of mustard seeds on the 'rim of the uterus'/cervix. The doctor suggested

a biopsy, with the sample to be analysed in Ahmedabad, more than 100 km away, after which a decision would be made about a hysterectomy. Due to Rama's financial constraints, the biopsy was attempted without anaesthesia. Rama could not tolerate the pain when the doctor started plucking at the lumps, and she screamed. The doctor suggested that she would need general anaesthesia, but Rama did not have the money for it and refused. The doctor also said that Rama would need a fresh CT scan before he could decide on the surgery. Rama discussed this with her husband; once again, her husband asked her not to undergo any procedure and to return home.

Finally, on her friend's suggestion, Rama visited her friend's son, who is a doctor. He said he would help her and took her to another gynaecologist, who reviewed all her reports and agreed with the prognosis of an urgent biopsy. When Rama explained her financial limitations, the doctor agreed to perform a hysterectomy and send the samples for biopsy to Ahmedabad.

Rama was informed that the procedure would cost Rs 80,000. When her husband said he could not afford it, the doctor, the acquaintance's son, told them not to worry about the money but not to delay the surgery. Rama took a loan from a financial company against her gold chain and paid a deposit of Rs 25,000. Though she had medical insurance coverage of Rs 1 lakh, she could get only Rs 25,000 through her insurance. The operating doctor agreed to accept instalments of Rs 5,000 to cover the remaining Rs 30,000 in surgery fees. "I am grateful to my friend's son who vouched for me. It is only because of him that the doctor agreed to take my fees in smaller instalments."

Rama's hysterectomy was finally performed in March 2024. Her sister-in-law was in the hospital with her at the time. Her friend's son looked after her during the two days of post-operative care before she was discharged. After her discharge, Rama's husband took care of her. He fed her, bathed her, and looked after her. A nephew and his wife, who lived nearby, provided meals for them while she recuperated, and neighbours and nieces helped with household cleaning and other chores.

"Now I am free. Now, I do not have any tension. Free. I can go wherever I want to. Earlier, I used to be scared—will my periods start? And I have this irregular one—nothing is sure about it. Even if there has been bleeding for two months, still two days later, it would start… Now I am free, without any tension. Whichever temple I want to go to, I can enter."

In addition to her menstruation-related conditions, Rama had an encounter with the health system when she experienced sudden vision loss. One night, as she climbed down from the terrace where she was sleeping, she felt dizzy and could not see. She thought it was due to low blood sugar. But when the situation did not improve, she crawled back upstairs to wake her husband. He took her to a nearby private hospital. She was given an injection. The CT scan and MRI showed that her blood pressure was high, that she had diabetes, and that her 'blood had become thick' and was not reaching her brain. She has been taking medicines since then.

Rama is extremely grateful for her husband's love and affection through all her health issues. "I would not have found a man better than him even if I had looked hard. He is not like others," she repeats several times. She is also grateful to her marital family for their empathy towards her medical needs and the fact that she has not had any children. She is aware that this is an atypical situation and that she could have been deserted and not cared for.

SEEMA'S STORY

Seema lives in an informal settlement in a low-income area in the city of Vadodara, Gujarat, with her husband and four children. Like the other houses in the neighbourhood, her home has bare brick walls and a tin roof. The three small rooms separated by doors with grills are dark and barely furnished. There is a small wash area and a toilet outside the kitchen. The area has municipal (state-provided) water supply, pumped twice daily for an hour. Like the other women in the neighbourhood, Seema fills up water for their household needs.

Seema's husband works as a lathe operator in a factory. His job requires him to stand for long hours, which makes him tired and irritable. He earns Rs 7,000 (USD 83) per month. He is also a 'godman' who offers solutions to other people's problems through the 'goddess' he claims possesses his body. Several people from Seema's neighbourhood and from his factory consult him for their problems.

Seema works in a school as a cleaner and also serves mid-day meals, a job she has been doing for the past 20 years. After a full day's work, she starts on the household chores. Seema earns Rs 6,000 (USD 71) in cash for cleaning, and Rs 1,300–1,400 (USD 15) for serving meals. She saves her earnings in her bank account and feels good about her ability to earn. Her husband allows her to work.

Seema's eldest daughter has completed her college education and works in an NGO. She supports the family financially and emotionally, manages household expenses through her salary, and pays school fees for her two younger siblings.

Her second daughter had no interest in education; she passed class 10 on her third attempt and then discontinued her education. She is on tuberculosis treatment and regularly needs blood transfusions and IV fluids. Seema's third child, a son, started college two years ago, and her fourth child, her youngest daughter, started college a year ago.

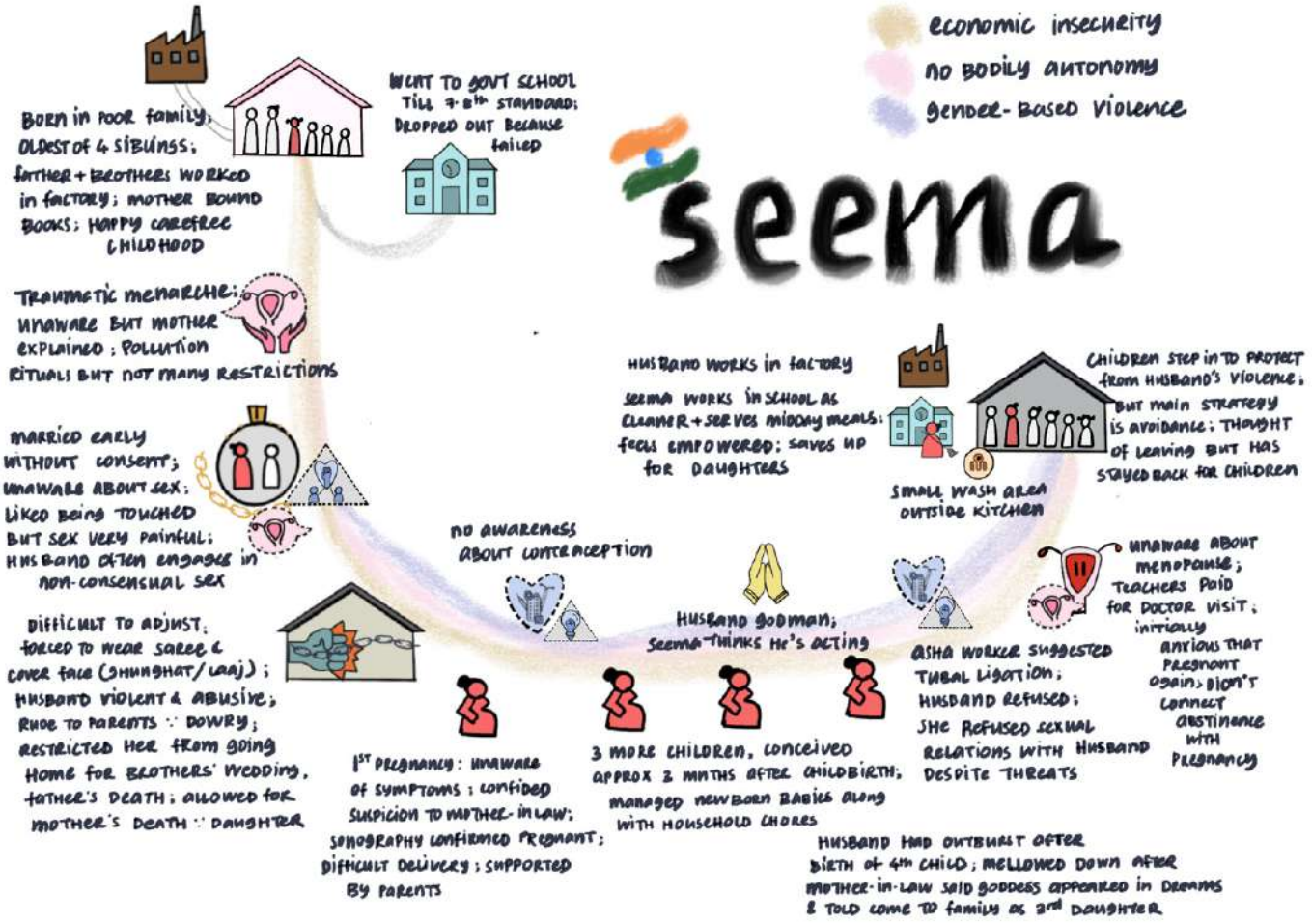
CHILDHOOD

Seema spent her childhood and youth in Ahmedabad, where her parents lived. She was the eldest of four siblings, the only sister to three younger brothers. She fondly remembers her childhood. Her parents were poor; her father worked in a factory, and her mother assembled pages for binding. Seema started helping her mother after school, while she was still in class 6 or 7. The house they lived in was initially a small room. But her parents worked hard and expanded it into a three-storey structure to provide space for her brothers' families, Seema explains with pride.

MENSTRUATION

Seema's first experience with menstruation was traumatic, as she had no idea about it. She was 11 or 12 when she got her first period. She remembers being at home, suddenly noticing something wet, her dress stained red. Her mother explained what was happening and gave her an old cloth to place inside her underwear. She also explained what little she knew about menstruation. Still, Seema was scared during her first two or three periods; she experienced discomfort and did not know what was happening to her. She had pain in the pelvic area. Her menstrual cycle was regular.

Both her natal and marital families followed stigma-driven menstruation-related practices. During her periods, she was



asked to sit in a corner, not enter the kitchen, and not perform puja. However, Seema was allowed to go to school and could go out if she wanted to.

During her periods, she observed seclusion in her marital home—not entering the kitchen, etc., as long as her mother-in-law was alive. After her mother-in-law's death, Seema did everything except puja or touching the temple. She has not forced her daughters to follow these practices.

MARRIAGE

Marriage drastically changed Seema's life. She was married young and against her wishes, which marked the end of her happy days. She was about 17 when she got married. She always knew she would have to marry, but had never thought about the kind of partner she would like or what married life would be like. She was rushed into marriage after being told that the groom's mother was not keeping well. Her parents also told her that the groom was the only son and that the family would look after her well.

After her marriage, Seema moved to her marital home in Vadodara, a place neither she nor her parents had visited before. She was shocked to see goats inside the two-roomed house. Her in-laws slept in the front room, and she and her husband slept in the inner room, which was separated from the front room by a metal grill door. At the time of marriage, her name was changed, as was the custom in their communities.

After her marriage, Seema had to leave behind the things she loved: a family who loved her, work she loved, and clothes she enjoyed wearing. Before her marriage, she wore salwar kameez, and even today she loves to wear them. After her marriage, her husband forced her to wear a saree, which her mother-in-law showed her how to drape. She even had to cover her face (ghunghat/laaj) while her father-in-law was alive.

Another thing that hurts Seema even now is her husband's rude behaviour towards her parents. After marriage, he punished Seema for not bringing enough jewellery by preventing her from going to her natal home for her brothers' weddings, when her father and brother were on their deathbeds, and even after their deaths. Seema visited her mother on her deathbed only because her youngest daughter kept asking to

see her grandmother. After that, her husband allowed her to visit her natal family once a year, for Raksha Bandhan.

SEXUAL RELATIONS AND CONTRACEPTION

At the time of her marriage, Seema did not know about sexual relations. She learnt only after her first intercourse. She has mixed feelings about sexual relations. Her husband always initiated sex. He would tell her when he wanted to have sex, and 'I would let him'. In the initial period after marriage, she liked how her husband 'touched her' and described it as his way of 'loving her'. However, the penetrative aspect has always been unpleasant and painful. She experienced intense pain in her pelvic region. She was apprehensive about the pain and discomfort she felt while sitting, sleeping, and doing chores. This made her avoid intercourse.

Seema never thought about seeking medical help for this, nor did she talk about it with other (women) relatives or friends. She tolerated the pain because she was fearful that her husband would leave her if she told him. She learnt to live with it—"it would hurt for some time and then go away." She did try refusing her husband's demand for sexual relations, but he would not listen. Seema's refusal to have sex led to his abusing her verbally and physically.

Seema had no knowledge of contraception, nor was she given any information about it by the ASHA [81]from her area, nor by the doctors or nurses from the hospitals where she delivered with short gaps between births. After the birth of her fourth child, she started refusing her husband's demands for sex, saying that they should focus on their four children and not have any more. Her refusal angered him.

After the birth of her youngest child, the ASHA from her area asked her to undergo tubal ligation. She offered to take her to and from the hospital for the procedure, assuring Seema that her husband would not even notice she had undergone it. However, Seema was scared of her husband's anger and did not want to have the tubal ligation without his consent. She broached the topic once, but he refused. She never brought it up again.

She and her husband have not had sexual relations in the past two or three years. She no longer has the desire and wonders why she should engage in sexual relations when she already has four children. Even her eldest daughter advised Seema to say no to sexual relations, that the children were now grown up, and that it did not look good. She asked Seema to wake her and call her if her father (Seema's husband) approached her for sex.

CONCEPTION, PREGNANCY, AND CHILDBIRTH

Seema does not have a clear recollection of the gap between her marriage and her first pregnancy. She was unaware of the changes in her body during pregnancy and had no idea that the absence of periods could be associated with pregnancy. Seema suspected pregnancy when her belly began to show, probably after two or three months of conception.

The first person she confided in about her suspicions was her mother-in-law, who took her to the hospital for a sonogram, which confirmed her pregnancy. She and her mother-in-law were happy to hear the news. Her husband was informed when he returned from work.

Seema's first two deliveries took place at her natal home in Ahmedabad, and her parents paid for them. During her first pregnancy, her father-in-law was unwell, and her mother-in-law asked her parents to take her to Ahmedabad. Her parents took her home in her third trimester. She delivered at a private hospital. It was a difficult delivery, and she remembers excruciating pain and losing consciousness during the process. Her daughter was delivered using forceps. Her parents were with her; her husband and mother-in-law came to see her after the baby was born. They were happy to see the girl. Seema returned to her marital home when her baby was six weeks old.

Seema did not talk much about her second delivery. Her third and fourth children were born at the government hospital in Vadodara. After returning to her marital home with each newborn, Seema had to care for the baby and manage the household chores. She received some help from her mother-in-law but none from her husband. She would feed the baby, put it to sleep in the cot, and complete her chores while the baby slept.

After the birth of their third daughter, her husband was very disappointed and angry with Seema for having another girl. He had an outburst at the hospital—shouting at Seema, the doctors, and everyone around. His behaviour deeply hurt Seema. For several days, he would not even look at their child or touch her. Seema's mother-in-law then told him that the 'goddess' had come to her in a dream and said she had come to the family in the form of the third daughter. Hearing this, her husband mellowed.

MENOPAUSE

As with menarche, intercourse, and conception, Seema had no knowledge of menopause. Before her periods stopped completely, she went through a phase of heavy menstrual bleeding, followed by a period of significantly less bleeding. When

her periods stopped, she confided in her eldest daughter and her colleagues at the school, who advised her to consult a doctor. Her colleagues also gave her Rs 500 for travel to the clinic and a half-day's leave because she had a fever that day. At the clinic, the doctor first conducted a pregnancy test. Seema did not tell the doctor about her abstinence from sex and was extremely anxious about the possibility of another pregnancy, the delivery pains, and the struggles of raising another child. She was relieved when the doctor explained that she was not pregnant but menopausal—at an age when periods stop.

EXPERIENCES OF VIOLENCE

Seema's relationship with her husband is defined by the violence she has faced since marriage. She believes he cared for her in the early years of marriage. But soon after the birth of her second daughter, the violence began. It would start when he came home from work, and he would begin finding fault with her. His complaining and yelling would escalate into physical violence. He would regularly beat her, leaving her with injuries—a swollen face, arms, and legs. Seema sums it up: "I was happy before marriage, and when I came here, after marriage, he started beating me, and I have been unhappy since then."

Though her husband did not beat her during her pregnancies, the violence would resume when the children were a few months old. In addition to the physical violence, Seema has also experienced sexual violence in the form of being forced to have sex against her wishes, being prevented from using contraception, and being forced to have a pregnancy.

"He threatened me—if I refused sexual relations with him, he would be angry with me, beat me, and leave me. He used to grumble and blame me, saying, 'You must be having relations with someone else…' He threatened to go away with someone else if I refused. I did not respond. But I was adamant and refused to have any sexual relations with him. What else can we do if we have a husband like him?"

Seema has never sought help to stop the violence. Her parents had passed away when the beatings started, and she did not think her brothers could help, so she did not tell them. While her mother-in-law was alive, she tried to protect Seema from her husband's violence. After her mother-in-law passed away, her husband's behaviour improved for a while, but soon the violence resumed and became a regular feature of Seema's life. Now, her eldest daughter and son intervene to protect her from her husband. Seema's eldest daughter once even picked up a knife to threaten her father when he would not stop beating Seema.

Seema's strategy to protect herself from violence is now just avoiding him. When he starts an argument, she does not give him water or food—the children do. When he comes home, she withdraws to a corner. This, too, irritates him, but for Seema, it is the only way to avoid triggering violence.

"Yes, we communicate, but I don't feel like talking with him when he starts arguing or complaining. Don't even feel like going out with him anywhere. Because he starts complaining or grumbling—you can't walk properly on the road, you don't want to learn, nor do your children want to learn, and goes on and on…on the road also."

Seema has often thought of leaving home—but stays because of her daughters. After particularly severe beatings, when she starts packing her clothes, her eldest daughter begs her to rethink. Seema cannot bear to see her daughter helpless and in tears, and stays back.

Seema's eldest daughter is her main support, confidante, and adviser. She is Seema's emotional anchor. Seema has modest expectations for her future. She hopes her son will find a good job, marry a good girl, and look after her in her old age. But she worries about her daughters' futures, especially her second daughter, who has a fragile temper (and possibly a chronic health condition). She hopes her eldest daughter finds a good match, a man and a family who will cherish her and not ruin her life as Seema's husband ruined hers.

"I wish we came across a good boy and a good family. My daughter should not suffer as I did. She should be able to live happily."

her-stories

LAO PEOPLE'S DEMOCRATIC REPUBLIC

LAO PEOPLE'S DEMOCRATIC REPUBLIC

NAVIGATING ADOLESCENT PREGNANCIES AND SRHR CHALLENGES AMONGST INDIGENOUS COMMUNITIES IN REMOTE AREAS

LAO PDR — Country Context Indicators	
A. ECONOMIC INDICATORS	
National poverty rate	National poverty line: 15%[82]; poverty disproportionately concentrated amongst ethnic minorities and remote highland communities
Gini coefficient (income inequality)	25.51; inequality rising despite economic growth[83]
Women workforce participation	42% female labour force participation;[84] 22% of seats in parliament held by women (2023); 81.2% are in vulnerable employment[85]
B. KEY GENDER AND HEALTH INDICATORS	
Gender Gap Index	0.733, ranked 54/148 countries;[86] Human Development Index: 0.620, ranked 139/193 countries; Gender Inequality Index, ranked 120/170 countries[87]
Maternal mortality ratio (MMR)	Significant decline since 2000; estimated at 112 per 100,000 live births; rural and ethnic minority rates substantially higher; many deliveries still without skilled attendance[88]
Adolescent birth rate (ABR)	89 births per 1,000 women aged 15–19 nationally (2023); 136 in rural areas One-third of women aged 20–24 were married before age 18; rates reach 48.5% amongst the most economically disadvantaged populations; 36.3% in rural areas
Modern contraceptive prevalence	75% users use modern methods; 9% unmet need[89]
C. LEGAL FRAMEWORK — SEXUAL AND REPRODUCTIVE HEALTH	
Abortion	Technically illegal under the Penal Code (Articles 201–202); however, Ministerial Approvals (July 2021) clarified wide legal circumstances under which abortion is permitted, including health grounds, rape, foetal abnormality, and social/economic reasons; implementation remains inconsistent and culturally constrained; cultural stigma significant[90]
Gender-based violence (GBV)	30.3%ever-married women have experienced physical, sexual and/or emotional violence in their lifetime.
LGBTQI+ communities	No legal gender recognition framework; no anti-discrimination protections based on gender identity; same-sex sexual activity is not explicitly criminalised; societal discrimination in employment and healthcare is documented; transgender persons face the highest levels of stigma[91]
D. GEOGRAPHIC AND SOCIAL STRATIFICATION	
Ethnic diversity and stratification	Lao PDR has 49 officially recognised ethnic groups; the Hmong and Lao Theung groups face compound disadvantages: lower educational attainment, higher poverty, and restricted access to health services
Geographic development gap	95% of urban women have skilled birth attendance vs. 75% in rural areas; 77% of urban women access postnatal check-ups vs. 59% of rural women (Lao Statistics Bureau, 2023); mountainous and remote provinces (Phongsali, Houaphanh, Xiengkhouang) have the highest poverty and lowest service access[92]
Climate vulnerability	Frequent flooding, droughts, and landslides disproportionately affect highland ethnic minority communities; climate events disrupt SRH service access and agricultural livelihoods. Lao PDR ranks 24th on climate vulnerability in the Climate Risk Index.[93]

Note: Ethnic minority data (Hmong, Lao Theung, and other groups) are frequently not disaggregated in national statistics. Rural-urban differentials are large and systematically underrepresented in national averages.

Within the socio-political-economic context of Laos, the two case stories documented by the Faculty of Public Health, University of Health Sciences in Lao PDR, on the lived experiences of Indigenous girls, highlight the depth of these challenges and the complex realities of the sexual and reproductive lives of rural adolescent girls in these areas, particularly during climate crises.

The Lao People's Democratic Republic (Lao PDR) is one of Southeast Asia's most ethnically diverse countries, with the Hmong as its third-largest ethnic group. Distinct language, culture, and religion shape Hmong gender roles, often leading to multiple forms of discrimination against women and girls. Education is a key area of exclusion: while national enrolment rates are moderate, nearly half of Hmong girls either never enrol or drop out early. Cultural norms prioritise male education, expecting girls to shoulder household responsibilities instead. Language barriers further exacerbate dropout rates, as many Hmong children struggle with Lao, the official language of instruction. These structural and cultural constraints severely limit Hmong girls' opportunities for advancement.[94]

Beyond education, the traditional clan system reinforces patriarchal values that curtail women's autonomy. Hmong daughters are often viewed as temporary members of their birth families, destined to marry into another clan. This perception discourages investment in their education or personal development, as any benefits are believed to accrue to their husband's family. Marriage is thus a pivotal milestone, often occurring at an early age, and is accompanied by expectations of childbearing. These norms perpetuate cycles of adolescent pregnancy, limited schooling, and constrained life choices. The lack of communication about SRH within families, combined with low health literacy, leaves many young Hmong women unprepared to make informed decisions about their bodies and futures.[95]

The Hmong and Lao Theung, another major ethnic group, face similar challenges rooted in poverty, geographic isolation, and entrenched gender roles.[96] Women contribute significantly to household economies through farming, childcare, and domestic work, yet remain excluded from decision-making in village politics and public affairs.[97] Patrilineal customs reinforce male authority, with property and land passed down through male lineage.[98] Marriage practices such as arranged unions and patrilocal residence further limit women's autonomy. Traditional beliefs surrounding pregnancy and childbirth often prevent women from accessing professional healthcare, leaving them reliant on untrained attendants and vulnerable to maternal mortality. Structural barriers, including inadequate antenatal and postnatal care, compound these risks.[99]

Climate crises have intensified these inequalities, particularly for Indigenous women living in mountainous and remote areas. Floods and droughts disrupt access to SRH services, damage infrastructure, and deepen poverty and food insecurity. Women, responsible for securing household water, face heavier burdens and heightened risks of waterborne diseases. Longer journeys to collect water also expose them to physical and sexual violence. In disaster contexts, immediate survival needs take precedence over investments in reproductive health, further marginalising women and girls. These dynamics illustrate how environmental stressors intersect with gender, ethnicity, and poverty to undermine reproductive rights and health outcomes.

MI-HER'S STORY

Mi-Her is a 17-year-old Hmong woman living in a remote rural area with her husband, two young daughters, mother-in-law, and an extended family. She was born into a Hmong family of five in a mountain village lacking basic modern conveniences. Her family is involved in agriculture, growing rice, ginger, and vegetables. They also have some poultry and gather wild food to augment their family needs. Although the family usually meets its basic needs, financial insecurity persists, especially when healthcare costs are high. Mi-Her's husband controls household finances, leaving Mi-Her with little economic autonomy. Like most villagers, her family practised traditional Hmong 'ghost' traditions.[100] Until just four or five years ago, her family and community lived without electricity or running water, and she walked nearly 5 km to school each day.

Mi-Her, like many girls in her community, left school after grade 3 and acquired only basic Lao skills. In her social context, girls' education was not considered important beyond basic household and farm chores. Women were expected to marry young, raise children, and care for their husband's family.[101] These gender norms also shaped her understanding of relationships and her future role as a woman.

MENSTRUATION AND SEXUAL AWARENESS

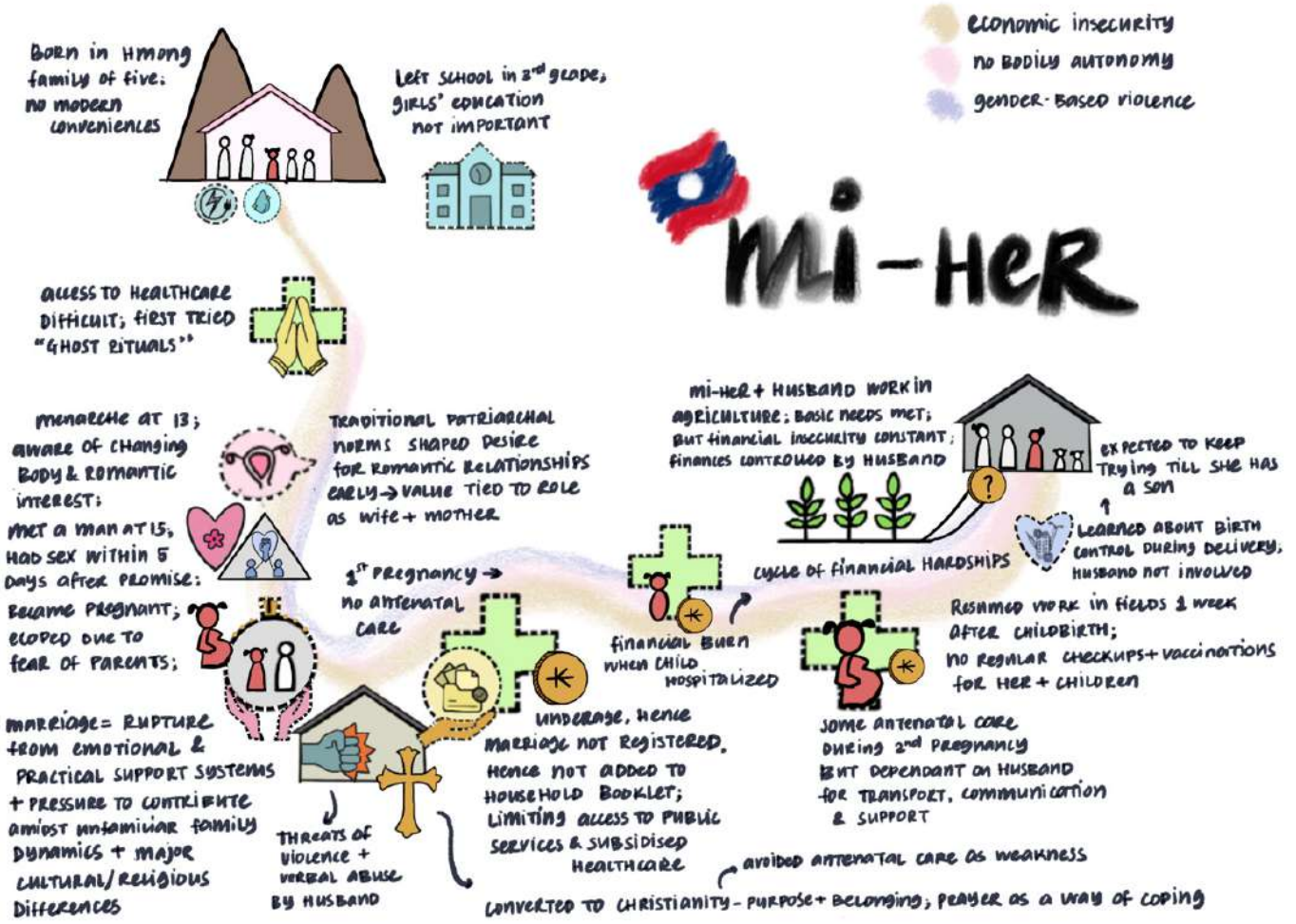
Mi-Her's periods began when she was 13. Soon after, she began to notice changes in her body and developed an interest in romantic relationships. Reflecting on her adolescence, she remembered:

> *"After I started menstruating, I noticed changes in my chest and hips. I started thinking about love and relationships differently. I really wanted to have a boyfriend, and I felt a different kind of excitement when talking to a man than I felt when I was younger and mingling with male friends. Seeing my friends with boyfriends made me wish for one as well."*

Like other Hmong girls, Mi-Her knew she would marry and have children early. However, she had no knowledge about safe sex, contraception, or pregnancy prevention, as these topics were never discussed at home, school, or amongst friends. As a result, she entered adolescence and navigated her first relationship largely unprepared, with little understanding of their reproductive consequences. She explained:

> *"I personally feel sex is very normal if a man loves us and promises to protect us in all situations. Growing up as a Hmong woman, I observed many of my sisters and friends contemplating marriage and starting families by the age of 12 or 13. Hmong women typically do not pursue higher education due to their traditional perception that women would ultimately move to their husband's household after marriage."*

These cultural norms stem from a patriarchal system that values sons for inheriting land, continuing the lineage, and honouring ancestors. Because daughters are expected to leave for their husband's home, Mi-Her was raised to view her worth through the lens of marriage and motherhood rather than



education, which guided her along the route of early marriage and childbearing.

RELATIONSHIP AND MARRIAGE

In January 2022, when Mi-Her was 15 years old, she met the man who is now her husband. They started by talking to each other over the phone. He told her he was in love with her and promised to take care of her. Mi-Her trusted him. Five days later, they had sex, and a month later, she discovered she was pregnant. The pregnancy was unintended and, fearing her parents' objection, she decided to elope with him. Only later did Mi-Her realise that she barely knew the man or his family.

Moving to her in-laws' village was far more difficult than she had anticipated. More than simply a geographical relocation, it was a sudden severance from her familiar emotional and practical support systems. Living amongst her husband's extended family, she struggled to adapt to unfamiliar dynamics while meeting heavy household demands. Although they shared a Hmong background, the social and cultural environment in this village was different since most residents had converted to Christianity. In this new setting, Mi-Her deeply missed her parents and siblings and felt increasingly isolated. As she explained:

> *"I'm not really married. Since I eloped and became pregnant, we didn't have a proper wedding. After we ran away, my husband's cousin met my parents and told them not to look for me because I was living with my husband's family. After a month, when we visited my parents, they blessed us on behalf of our family. However, they moved me out of our house ghost, and put the responsibility of taking care of my parents' house ghost on my two brothers. I can't go back home anymore. I haven't visited my parents in the last two years, and they haven't visited me either."*

PREGNANCY AND CHILDBIRTH

Neither of her two pregnancies was planned. During her first, Mi-Her only realised she was pregnant after missing her period and confirming the pregnancy with a test. She did not seek any antenatal care. Unaware of its importance, she only visited the hospital when it became absolutely necessary.

Throughout this period, Mi-Her's husband offered little sup-

port and rarely accompanied her to the doctor. Although the doctor emphasised the need for regular check-ups, she could not go to the hospital because he forbade her from travelling alone. Lacking driving skills and afraid to provoke his anger, she was completely dependent on him for transportation. Without a Hmong-speaking doctor, she relied on him for translation as well. Fearing that seeking help would be seen as a sign of weakness, Mi-Her pushed herself and kept working hard without any medical supervision until her amniotic fluid ruptured at seven months. Rushed to the provincial hospital by her husband, she gave birth prematurely to a fragile baby girl.

Because Mi-Her was still underage, her marriage could not be officially registered and was reported informally to the village head. Because of this, neither she nor her children could be registered in the Household Book, which restricted their access to public services and subsidised healthcare. Hence, the family had to pay out of pocket for all pregnancies, childbirths, and medical care. The financial consequences were significant. A substantial portion of the household's income had to be set aside for possible illnesses and medical emergencies, and when her child became seriously ill and required hospitalisation, the family's savings were wiped out. She recounted:

> *"We save most of our income for hospital visits when we are unwell. When my child had to be hospitalised last year, we spent all our money on treatment. If someone in the house is sick, no money is left for other expenses that year."*

This set off a cycle of financial hardship, since the illness not only depleted funds but also reduced their capacity to work and generate income. The family had to borrow money to cover treatment, transport, food, and other related costs, pushing them farther into financial difficulty.

Through her second pregnancy, Mi-Her sought antenatal check-ups around four times. Both her children were born at the Houaphanh Provincial Hospital, a large, well-equipped facility. It was easy to travel to the hospital, but without their names in the family booklet, they had to bear the delivery expenses, which came to almost two million Lao kip (USD 90), including transportation. Her mother-in-law covered these expenses.

A major turning point after marriage was her conversion to Christianity. When her first baby was born prematurely and suffered from postnatal complications, Mi-Her embraced the faith with the full consent of her husband and his family. The church became the cornerstone of her social world, and her faith in Jesus transformed her perspective, instilling a renewed sense of purpose and belonging. Mi-Her shared:

> *"… In a difficult situation, I sought advice from the village elders. They encouraged me to seek blessings from Jesus, even though my baby was too young to understand. Caught between fear and hope, I converted to Christianity and embraced the faith. My husband and his family shared that respect for Jesus, and they fully supported my decision."*

POSTPARTUM, SON PREFERENCE, AND CONTRACEPTION

Mi-Her remained true to her Hmong roots when it came to postpartum care. For the first month after each delivery, she adhered strictly to cultural customs, avoiding certain foods such as beef, red-tail fish, and specific fruits. Despite the physical toll, she returned to work in the fields barely a week after giving birth, carrying her babies along to breastfeed them for the first six months. Her husband supported her by sourcing special Hmong herbs to add to her diet, and her mother-in-law occasionally assisted with baby care. However, Mi-Her had to bear most of the household responsibilities, from cooking and laundry to full-time childcare.

The hospital also recommended she attend postnatal check-ups and a vaccination schedule for her babies. However, due to travel constraints, Mi-Her managed to attend only her first child's check-up. Her husband was dismissive about regular check-ups and vaccinations, since he thought both mother and child were in good health. He felt that regular visits to a doctor were necessary only when someone was visibly ill.

Mi-Her and her husband never discussed safe sex or contraception. It simply was not part of their conversations. She was unsure if he was even aware of family planning. It was only after the birth of her first child that a hospital doctor introduced her to options like pills and injections. But they have not used any of these, as her husband believes contraception should wait until after they have four or five children. These cultural expectations weigh heavily on her. Although she loves her daughters profoundly, she is unable to escape the pressure of these traditional values. Mi-Her shared:

> *"My husband wants four or five children and plans to have another child as soon as possible. Although he does not discriminate against our daughters, he wants me to continue hav-*

ing children until we have a son because, in Hmong culture, a son is important to continue the family lineage and honour the ancestors. This pressure affects our family dynamics."

As a mother of two daughters, Mi-Her feels a persistent pressure to fulfil this expectation. While her husband treats their daughters with love and does not discriminate against them, the cultural pressure to have a son remains palpable. This is not merely his personal desire but a deeply ingrained cultural expectation that influences their family dynamics and future. Mi-Her knows that as long as she has not had a son, she is expected to keep trying.

Her boyfriend, now her husband, and she never discussed safe sex or contraception. It simply was not part of their conversations, and she had no idea if he knew anything about preventing pregnancy. The first time she even heard about birth control was at the hospital, after giving birth to her first child. The doctor mentioned options like pills and injections, but they have not used any of these. Her husband believes they should have around four children before considering contraception. This cultural burden impacts her sense of responsibility, and although she loves her daughters profoundly, she cannot escape the pressure to adhere to these traditional values.

SOCIAL ISOLATION AND ABUSE

Although her husband has never physically assaulted her, she has faced frequent verbal abuse, threats of violence, and expulsion from home. As Mi-Her narrated:

"I've been living with my husband for two years. While there has never been physical violence like slapping, there have been instances of serious arguments when he threatened to hit me during serious arguments. He often scolds me and sometimes kicks me out of the house when he's angry. His temper worsens when he drinks too much."

The absence of direct physical assault did not mean safety or security. Instead, the threat of violence, verbal abuse, and being expelled from the home created a climate of fear and instability. This was compounded by her profound dependence on her husband for mobility, finances, and access to healthcare. She felt she had nowhere to go and no practical way to leave the relationship. In her words:

"I have no place to go. I haven't finished my education past the 3rd grade, my Lao language skills aren't strong, I don't know how to drive, and I've never lived away from home. I came here with my husband, without much money, and now have two children, so I can't afford to go anywhere. I am dependent on my husband even for dealing with illness or the children's health needs."

Her husband's family also criticised her as 'lazy' or too weak to manage childcare and agricultural work. With no local friends or family nearby to share her feelings with or confide in, Mi-Her feels totally alone.

Supporting two children with no independent employment, income, housing, or driving skills, leaving her husband seems virtually impossible. Returning to her natal family is also not a viable option, as she fears they would send her back to her husband. She believes that a married woman with children would face severe societal rejection and an uphill task to rebuild her life elsewhere.

Amid these uncertainties, the local church has become her sole refuge. Her Christian faith has provided Mi-Her a space for comfort and hope, with prayer as a primary mechanism for coping with loneliness and distress. Ultimately, Mi-Her's narrative reveals how non-physical abuse, when coupled with structural dependency and social isolation, can trap women as effectively as physical force.

LAE'S STORY

Lae is 30 years old and lives in rural Lao PDR, where she has spent 15 years with her husband. Together, they have seven living children: four daughters and three sons, with their youngest being a one-year-old daughter. Lae is currently eight months pregnant. The family's primary source of livelihood is agriculture. However, recurrent flooding in the area has severely affected their crop yield in recent years, leaving them struggling to meet their basic needs.

> *"My family's income is not enough due to the flooding problem. It floods almost every year. This year, we didn't have enough rice to eat because it was out of stock due to the disaster. We only eat vegetables that we manage to grow since we don't have money to buy them."*

Their annual income is around 500,000–1,000,000 LAK (USD 25–45), supplemented by selling chickens and pigs. Despite this, the family frequently experiences food shortages and occasionally borrows from relatives for rice. The family's financial limitations also affect their ability to hire labour for farming, leaving Lae and her husband to manage the agricultural work themselves. The couple would like a big family to have more hands to help with the farming; however, the children are still too young, and instead, the burden of caring for their many children, as well as their agricultural workload, is all borne by the couple.

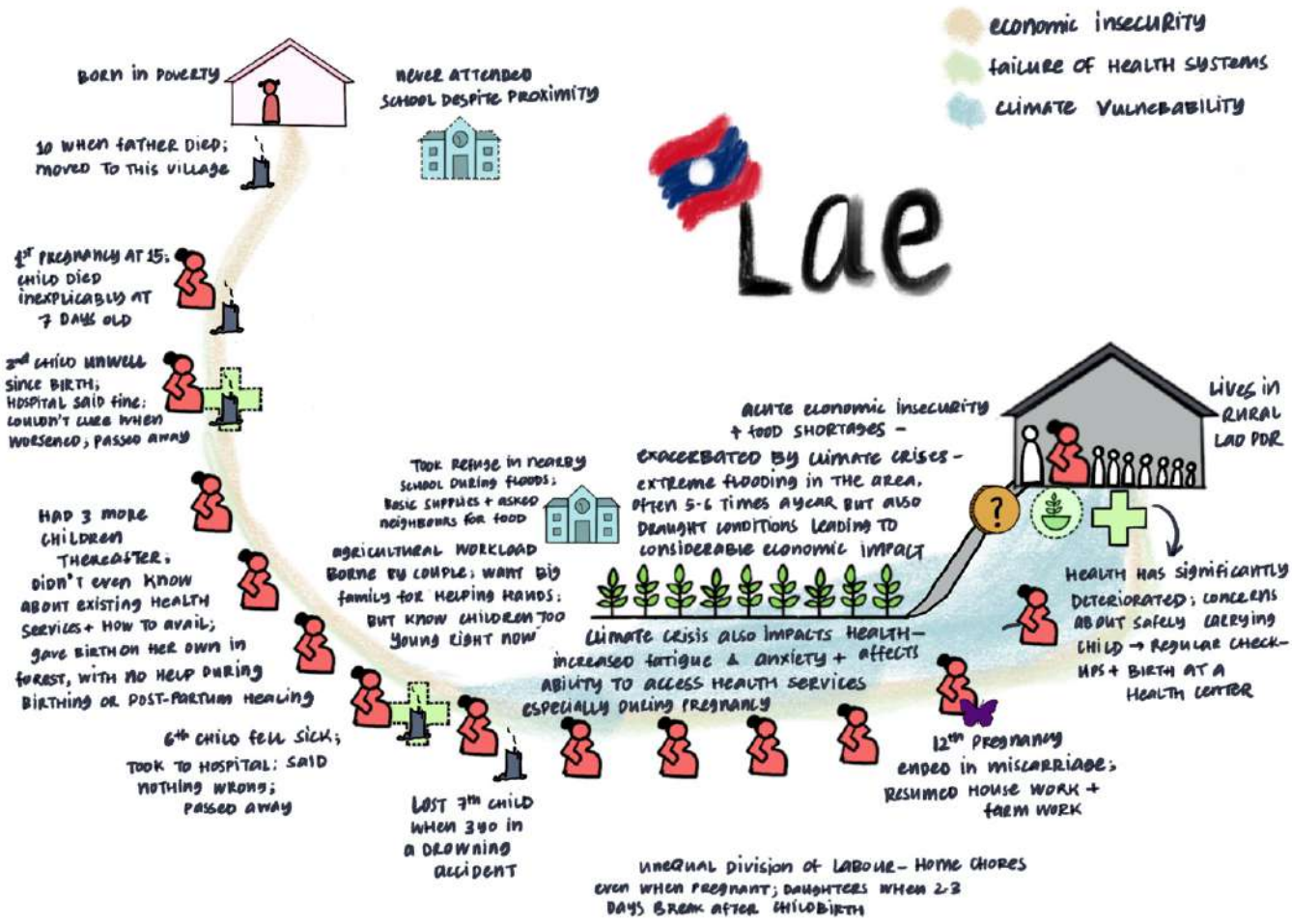
> *"Some years I have had to take my child to beg for food up to 10 times until December, which is the harvest season for rice, when we get some income. If I get any food, I will give it to my children first. A mother like me sometimes won't get anything to eat. I would eat only bamboo shoots and just add a little rice to it."*

CHILDHOOD

Lae's current hardships are rooted in a childhood shaped by poverty, where domestic responsibilities and financial constraints limited her access to education and autonomy. She was born in a village and lived there with her family until she was 10. When her father died, her mother moved with Lae and her siblings to the village where they currently live. Lae never attended school and does not know how to read or write. Her lack of formal education reflects the financial constraints her family faced, alongside the demands of domestic responsibilities. Growing up in poverty, Lae and most of her siblings did not attend school, despite a school being located nearby.

> *"My parents didn't have money. We were a poor family. And there was no one to help with the housework. So my siblings and I couldn't study. There was a primary school near our village, but I was lazy and didn't want to go to school."*

Like most girls in her community, Lae started working to support her family at a very young age. This included housework such as collecting and storing water, gathering food from the forests, and pounding rice, as well as helping out on the farms. She now expects the same from her children, despite wishing she could let them grow up a little more before asking them to labour as she had to.



"From my own experience, an eight-year-old can do everything, such as planting rice, collecting water, collecting food and farming. If you asked me if this is an appropriate age for an eight-year-old child to work, maybe not. But it is necessary. There is no labour force, so we need to start working at a young age. I really want the children to grow up a bit more before they have to do this kind of work. But because of poverty, if they don't do it, we would have nothing to eat."

In Lae's community, gender roles are clearly defined from a very young age, reflecting a traditional division of labour that reinforces gender inequality. Women are primarily responsible for domestic tasks, while men are expected to earn a livelihood through activities such as agricultural work. These roles are shaped by the belief that men are better suited to physically demanding work, while domestic tasks such as cooking and collecting water are considered women's responsibilities. This division of labour is so rigid that even when Lae is unwell or recovering after childbirth, her husband does not help with household chores or care for her. Instead, her daughters take on these responsibilities and care for her during the 2–3 days she needs to rest after childbirth. Even tasks such as collecting water are expected to be done by her daughters, while her husband and sons do not help.

MARRIAGE AND CHILDBIRTH

Lae has been married to her husband for 15 years and had her first pregnancy at the age of 15. She has since had 14 pregnancies, including one miscarriage and has lost five children—four boys and a girl—which could have been prevented with proper and timely medical care and intervention.

Lae has delivered all her children by herself, often in the forest without assistance during the birthing process or during the postpartum period. She considers hospitals too expensive and believes seeking care there is a waste of money. During her early pregnancies, she was unaware of the existing health services and how to access them.

"I gave birth myself. I didn't go to the hospital to give birth. I went to give birth in the forest.

I went to give birth alone. My husband didn't help me. I gave birth 13 times by myself and have had one miscarriage."

Lae's first child was seven days old when he died. The cause of his death remains unknown. Lae remembers that he had been unwell, and one day began crying and suddenly became quiet. She was doing her daily chores at that time, when she went to check on him, she found that his face and body had turned dark and he had stopped breathing.

Her second child had also been unwell since birth and was frequently sick. When he was three years old, he developed a high fever that lasted for 2–3 days. Lae took him to the hospital near their home, and the doctor examined him and told her that the child was fine. However, his condition worsened after she brought him home. He developed a higher fever and continued crying. When Lae took him back to the hospital, the doctors said they could not determine what was wrong or treat him. She took him home, where he died a few days later.

Lae had three more children soon after. Her sixth child was only two months old when he fell sick—he stopped eating and would vomit whatever he was fed for several days. Despite the lack of funds, Lae took him to the health centre, where, once again, the doctors told her there was nothing wrong with the infant. However, when she brought him home, he developed a fever and kept crying until he stopped breathing. Lae lost one more child, a girl, her eighth child, to similar symptoms at the age of two months.

She also lost a son (her seventh child) when he was about 3 years old. Lae was busy at work, and he was left unattended. There was an accident, and he drowned. Her twelfth pregnancy also ended in a miscarriage. She was working in the fields when she felt a sharp pain in her stomach. She was about two months pregnant at the time. By the time she came home, she had begun bleeding and knew she had lost the baby. As with all her pregnancies, she could take only a 2–3 day break after the miscarriage, after which she had to resume not only her household chores but also return to the farm with her husband.

Lae is now in her fourteenth pregnancy, but after her many previous pregnancies, her health has significantly deteriorated. She no longer feels as strong or healthy as she did in her previous pregnancies, raising concerns about her ability to safely carry and deliver another child. Concerned about her well-being, especially during pregnancy and childbirth, she has decided to seek medical care. Unlike her previous pregnancies, she has begun visiting the hospital for regular check-ups. Additionally, she plans to give birth at a health centre, fearing that her current health condition might result in complications during a home birth.

"I feel my health is not as strong as before. I get dizzy and I'm always so tired. With symptoms like this, if I give birth at home, I'm afraid my child and I might be in danger. So, I am going to the hospital. I have never had these symptoms before."

She is also worried about the timing of the birth of the baby and is hoping for a smooth delivery so that she can get back to work.

"For this pregnancy, if the baby is born next month, which is the rice-planting season, I must return to the fields very soon after delivery. I need to help my husband plant rice, as there are only two of us who can do it."

CLIMATE CRISES AND THEIR IMPACTS

Over the past 15 years, her village has experienced severe water-related disasters, with floodwaters reaching alarming levels. In one notable incident, around eight years ago, floodwaters inundated her home up to the roof. Lae recalls the traumatic experience of navigating four-metre-high water while carrying her infant to safety.

"There had been severe floods. One year, the floodwaters reached the roof. I was carrying this child and swimming across to the side of a hill. This happened about eight years ago when my fifth child was only one month old."

Frequent floods have repeatedly destroyed homes, livestock, and crops, causing significant economic losses for her family. During floods, Lae's family often takes refuge in a local primary school, where they lack basic necessities such as food and cooking facilities. These disasters have also destroyed household items, clothing, rice crops, and livestock, causing economic losses estimated in the millions of LAK.

"It's very difficult because we don't have a place to live. We sought refuge at the primary school, but there was no place to cook or even light a fire. We had to stay there because we

had no other option and didn't know what to do. We had nothing except the clothes we were wearing. We had no rice, no water, and no food, so we had to ask villagers for food because our rice fields were flooded and all the poultry left behind died. All our household items were swept away by the flood."

Lae continues to face significant hardships due to the unpredictable climate. The past year brought a respite from severe flooding, but the lack of rain has led to drought conditions that threaten her family's food supply and agricultural livelihood. The unpredictability of weather patterns leaves them uncertain about the future, as they struggle with the dual threats of floods and drought, leaving Lae with persistent anxiety.

"This year … if there is no rain by September (which is considered the end of the farming season), there will be no water for farming. I don't know where we will get rice to eat then. If it doesn't rain, we will surely die."

Lae's experiences also revealed the profound impact of extreme weather conditions on her health during pregnancy. She reported increased fatigue and discomfort during hot weather, as well as heightened anxiety during heavy rains and flooding.

Additionally, Lae highlighted that climate-related disasters, such as flooding, have significantly impacted her ability to access healthcare services.

"When it rains too much and causes flooding, it makes me feel very anxious and worried to the point of fainting. I am very afraid of the winds. My family don't dare sleep in this house; rather, we go down to sleep downstairs for our safety. I was so worried the trees would fall on us or that the roof might blow away."

The psychological and physical effects of these weather conditions, including fear of strong winds and falling debris, necessitate adjustments in her living conditions, such as seeking safer sleeping arrangements. Lae's story echoes similar fears expressed and experienced by communities residing in climate-affected areas across the country, as they wait for the State to implement policy measures to address the climate crisis that take into account the specific vulnerabilities of rural women like Lae.

her-stories

THE PHILIPPINES

THE PHILIPPINES

INTERSECTING MARGINS: DISABILITY, MIGRATION AND SRHR REALITIES

THE PHILIPPINES — Country Context Indicators	
A. ECONOMIC INDICATORS	
National poverty rate	5.32% extreme poverty (< USD 3/day); 15.5% below the national poverty line; Bangsamoro Autonomous Region of Muslim Mindanao (BARMM): 23.5%[102]
Gini coefficient	39.09, one of the highest in East Asia and the Pacific; inequality has not significantly decreased despite economic growth[103]
Women workforce participation rate	50.5% female labour force participation; 55.6% of Overseas Filipino Workers are women; [104]28.4% of seats in House of Representatives held by women[105]
B. KEY GENDER AND HEALTH INDICATORS	
Gender Gap Index	0.781, ranked 20/1468 countries;[106] Human Development Index: 0.742, ranked 113/193; Gender Inequality Index: 0.349, ranked 77/170[107]
Maternal mortality ratio (MMR)	84 per 100,000 live births; BARMM significantly higher; HIV-positive women face additional barriers to obstetric care[108]
Adolescent birth rate (ABR)	32 births per 1,000 women aged 15–19; adolescent pregnancy is the second-leading cause of maternal death; rates significantly higher among poor and rural adolescents[109]
Modern contraceptive prevalence	42%; unmet need is 12%[110]
Population with at least some secondary education	The Philippines ranks first globally in educational attainment gender parity;[111] however, the SDG Gender Index places the Philippines 70/139 on substantive gender equality outcomes[112]
C. LEGAL FRAMEWORK — SEXUAL AND REPRODUCTIVE HEALTH	
Abortion	Criminalised on all grounds under the Revised Penal Code (1930); no exceptions for rape, incest, foetal abnormality, or risk to health; an estimated 973,000 abortions annually, the vast majority unsafe; no national target to reduce unsafe abortion[113]
Gender-based violence (GBV)	17.5% of Filipino women aged 15–49 have experienced any form of physical, sexual, and emotional violence from their intimate partners; marital rape is criminalised; enforcement gaps persist for migrant workers, Indigenous women, and women with disabilities[114]
LGBTQI+ communities	Same-sex relations not criminalised, but no legal recognition of same-sex partnerships; SOGIESC Equality Bill reached House plenary discussion (2024) but not enacted as of early 2026; transgender women routinely misgendered in legal processes and denied appropriate healthcare.[115]
D. GEOGRAPHIC AND SOCIAL STRATIFICATION	
Regional inequality	National Capital Region GDP per capita is 4–5 times higher than BARMM; geographic isolation compounds service access gaps for women in Visayas and Mindanao[116]
HIV epidemic	One of the fastest-growing HIV epidemics globally; ~106,000 people living with HIV (2022); women living with HIV face profound stigma in health institutions[117]

Note: Regional disparities are significant: BARMM has poverty rates, maternal mortality, and child marriage rates far higher than national averages. HIV epidemic data and disability-disaggregated data are available for some indicators but are unevenly collected.

The socio-economic landscape of the Philippines continues to reflect deep structural inequalities that disproportionately affect women, particularly those from marginalised communities, including women with disabilities, rural and urban poor women, Indigenous women, and those engaged in migrant or informal labour. While national policies have made strides in recognising gender equality and reproductive health, structural inequalities continue to shape the lived realities of women, particularly those from marginalised communities, with persistent gaps in access, autonomy, and dignity. Poverty, gender norms, and unequal power relations intersect to limit opportunities in education, decent work, and health. For many Filipino women, basic survival takes precedence over bodily autonomy, resulting in early pregnancies, unsafe abortions, lack of contraception, and heightened exposure to violence and exploitation.

These inequities are even more acute for women with disabilities, who face additional layers of exclusion. They experience barriers not only due to gender and poverty but also due to ableism embedded in institutions, families, and public services. Many continue to be denied equal access to education, face restrictions on mobility, and encounter discriminatory attitudes within healthcare settings, where their decisions are routinely questioned or overridden. Their vulnerabilities are often misunderstood or ignored, even as they shoulder significant caregiving and economic responsibilities within their families. This exclusion perpetuates cycles of poverty and vulnerability, as limited access to education and employment opportunities further restricts their ability to live independently. Similarly, women from Indigenous and rural communities often face geographic and financial barriers to healthcare, compounded by cultural marginalisation.

Labour migration remains another defining feature of Filipino women's socio-economic journeys. Close to 2.1 million Filipinos were Overseas Filipino Workers (OFWs) in September 2023, an increase of 9.8% from the previous year's estimates.[118] Of these, 55.6% were Filipino women[119] who migrated abroad to serve as primary economic providers for their families. Many seek work abroad as domestic workers or low-wage employees in elementary occupations,[120] driven by poverty, marital instability, and lack of employment opportunities at home. While migration can provide income and temporary respite from violence or hardship, it also exposes women to abusive employers, exploitative recruitment practices, and limited legal protections. In the worst cases, migrant women are pushed into informal or coerced sex work as a means of survival, with little access to healthcare or mechanisms to report abuse. Women migrant workers encounter numerous barriers to accessing care, including language barriers, high costs, and restrictive labour or immigration policies in destination countries. These policies may require pregnancy or HIV testing, with a positive result often leading to deportation or contract termination.[121] Concurrently, on the domestic front, the Philippines has one of the fastest-rising HIV epidemics worldwide,[122] with sexual transmission being the leading mode. This epidemic disproportionately affects key populations, including women involved in sex work.

The intertwined issues of sex work, stigma, and HIV/AIDS further highlight the gaps in sexual and reproductive health and rights (SRHR) in the Philippines. Women who engage in sex work, whether by choice or due to economic necessity, are often denied access to non-judgemental healthcare, are subjected to police harassment, and blamed for their circumstances. HIV-positive women face profound stigma in society and within health institutions, where they may be denied services, humiliated, or forced to conceal their diagnosis.

The following case studies by Likhaan- Centre for Women's Health, provide a critical lens into these realities, illustrating how the struggle for socio-economic empowerment and SRHR in the Philippines is ultimately a fight for human rights, bodily autonomy, and justice for those pushed furthest to the margins. The case studies reflect the lived realities and experiences of migration, HIV, and other chronic illnesses and disabilities that, in turn, result in systemic violence at educational and health centres.

MARIAM'S STORY

Mariam is a 65-year-old HIV/AIDS activist in Manila, with four adult children who lead independent lives. She has been separated from her husband for almost 33 years. She does not interfere in her children's lives but is proud that she has empowered her daughters to negotiate their own sexual and reproductive lives, unlike her own youth and relationships, over which she had no control.

CHILDHOOD AND EARLY LIFE

Mariam was one of ten siblings, growing up in a large family steeped in poverty. Money was so scarce that she and her siblings fought over food and only wore hand-me-down clothes from relatives and friends. A bright student, Mariam wanted to continue her education but was discouraged by the belief that "women did not need to get higher education because they would just get married and take care of the family." Despite this, she completed elementary and high school by earning money through babysitting and washing clothes for neighbours. Although she graduated with honours, her family prioritised her brothers' education, reinforcing the gender inequality that shaped her early life.

MARRIAGE AND DOMESTIC VIOLENCE

After graduation, Mariam worked, doing laundry and mending garments and curtains. In 1977, at the age of 18, she married her husband, a security guard whom she had met while working in a canteen. They fell in love and eloped. Mariam's early years of marriage were a relentless cycle of poverty and closely spaced pregnancies. Her husband was irresponsible and often spent many nights away from home, drinking. She became pregnant soon after marriage and gave birth to her first child at 19, followed by two more children in successive years. Her husband refused to use condoms, leaving her with limited control over her fertility. Although she briefly tried oral contraceptive pills, severe headaches forced her to discontinue them.

Their home was not safe; it was a site of abuse, violence, and coercion. Arguments over her husband's drinking and irresponsibility often escalated into physical abuse. Mariam recounts the reality of being "beat up then forced to have sex," highlighting how intimate partner violence and sexual coercion were deeply intertwined. Despite working multiple jobs to support her family, she was routinely denied the freedom of control over her body and sex was treated as an obligation. Her husband would say, "Oh, you have to let me have my way first, before you go to sleep." This sustained violence had lasting consequences for her emotional well-being and her relationship with sexuality, causing her to eventually lose all desire for sex with him.

During this period, her husband lost his job and contracted tuberculosis (TB), leaving Mariam responsible for supporting their children and mother-in-law, as well as covering his medication and nutritional needs. Following her third pregnancy, the situation became increasingly difficult: her husband began bringing friends home to drink, and she discovered that he was involved with another woman. Complaining about the situation would result in fights, where he would beat and verbally abuse her. He also subjected her to physical and sexual violence and rape when she refused sex. Mariam later reflected that the trauma of intimate partner violence from someone she loved was ultimately more painful than her subsequent HIV diagnosis.

UNSAFE ABORTIONS

Faced with persistent financial hardship and a husband who had contracted TB, Mariam was resolute that she would



not have more children. Despite his refusal of family planning, her husband agreed to fund the costs of the abortions that followed. As a devout Catholic, Mariam was opposed to abortion, but knew that they could not support another child given their circumstances. She underwent three unsafe abortions, using herbal preparations, a bitter tea from leaves and bark and abdominal massage by a 'hilot' (traditional birth attendant). When these methods were unsuccessful, she would have tablets inserted into her vagina to induce abortion. During the second abortion, she had to rush to a hospital because of excessive bleeding. At the hospital, she was told, "Oh, ma'am, you must've done something. I'm sure you did something that's illegal. So now, you're bleeding, I won't...I can't write a prescription because it's prohibited." The doctor eventually provided medication to stop the bleeding but asked her to leave discreetly. The experience had lasting physical and psychological consequences. The final abortion remained particularly difficult for Mariam, as she had to see and bury the foetus herself:

> *"I saw it, and I was even the one to bury it myself. That has been imprinted in my mind forever. As a woman, as a mother, as a Catholic, my guilt was manifold. I was burying what was supposed to be my child. And yet I knew I had no choice. But the pain was mine alone; there was no one to help. The man who impregnated me was useless, and I couldn't lean on him."*

In 1981, following the birth of her fourth child, she underwent tubal ligation to prevent further pregnancies.

MIGRATION TO WEST ASIA

The same year, Mariam migrated to West Asia as an Overseas Filipino Worker.[123] She worked as a house tailor for a 'rich Arab family' until the Gulf War in 1990, when she was evacuated back to the Philippines. In 1992, she returned to Oman to work as a cutter[124]. While there, she learned that her son had run away after being beaten by her husband, while her daughter wrote to her about their father withholding food and spending the family's money on alcohol. Mariam returned to the Philippines and decided to separate from her husband.

In 1995, she moved to Dubai to work as a patternmaker. However, the shop closed down; she entered sex work through a Filipino pimp, who connected her with clients. Having undergone a tubal ligation, Mariam was not worried about getting pregnant. She was also paid handsomely for sex work, getting a minimum of 500 dirhams (equivalent to 8000 Philippine pesos today) for having sex without a condom. She met a wealthy client, who became her boyfriend. But the relationship soured when he pressured her to have non-consensual sexual acts in exchange for her visa fee. She eventually ran away when he asked her to have sex with his other employees.

Her work also exposed her to sexually transmitted infection (STI) risks. She developed symptoms: a foul odour and thick, viscous, cheese-like vaginal discharge. Living in fear of the authorities, she could not seek formal medical care as she was afraid of questioning, detention or deportation. Instead, she resorted to self-medication, relying on remedies from fellow Filipinas, seeking drugs (often at exorbitant rates) from her mamasang (pimp), and sometimes using a Bactidol-based douche as a makeshift solution.

HIV DIAGNOSIS AND STIGMA

Soon after, Mariam received the devastating news of her HIV diagnosis.

> *"My boss told me I had tested positive for HIV and would have to go back home. I'd be deported, and would have to find an institution which would look after me. I had no one to talk to about my status, I knew nothing. All I knew then was that AIDS is a killer disease and that I'd be deported the next month. That's when I tried to commit suicide."*

Back in the Philippines, Mariam was advised to consult at the government's Centre for the Research, Diagnosis, and Control of Infectious and Tropical Diseases, where she was told that no treatment was available and that she had 5–10 years to live. She quietly accepted this prognosis and decided to simply wait for her time. She also decided to tell her children, only to learn their father had already told them. By 2003, she was experiencing weight loss and irregular menstruation, and in 2007 she was hospitalised with opportunistic infections, including oral candidiasis, before finally beginning ARV treatment.

From 1996 to 2000, Mariam kept herself busy working in a boutique, again as a tailor, where she earned her employers' respect and affection. Her children were still studying and lived with her. Her youngest daughter was with her husband, but she too ran away and came to live with Mariam. Her children helped with her work whenever possible, but it was not easy to support them. Their education was frequently disrupted, as one of them often had to drop out of school so the others could continue studying.

STIGMA AND DISCRIMINATION IN HEALTHCARE

In 2005, she began losing weight and appetite and experienced irregular menstruation, accompanied by an abdominal mass that turned out to be a myoma. She returned to the Centre for HIV treatment and advice and was referred to a hospital for surgical removal of the myoma. She read the referral, which included terms like 'universal precaution' and 'immunocompromised'—terms she had encountered for the first time. However, she was told the record would read 'hepatitis,' as it was considered more acceptable in the medical community than HIV/AIDS.

After Mariam fulfilled all the requirements for her surgery, the referral hospital initially refused admission for various reasons, including uncertainty about which ward she would be in, lack of an available bed, and the hospital's lack of capacity and safety measures to operate on HIV-positive patients.

She was subsequently referred to another hospital by one of the doctors, where she underwent surgery. However, there too, she was subjected to discrimination by everyone, except for the doctors, who kept silent. She was yelled at and asked to strip and leave her clothes on the floor, which were then kicked into a trash can by the hospital staff. Cleaners refused to clean her bed and food servers avoided serving her directly, and staff blamed her for exposing them to HIV.

> *"'Oh, this is the one with AIDS,' they (hospital staff) would yell. Nobody wanted to touch me. When I had to change into the hospital gown for my surgery, they made me strip my clothes myself and asked me to leave the clothes on the floor. They then picked up the clothes with their toes and threw them in the trash. My child was there; they could have given them to her, but instead, they threw them. That's how scared they were…."*

It was in the healthcare system, the place meant to save her, that Mariam encountered the most blatant stigma and discrimination. She was severely humiliated and hurt by her

experience, but she steeled herself for the long, hard path to recovery and treatment. In 2020, she recalled, another member of her support group was publicly identified and directed to leave a hospital because of her HIV status:

> *"In 2020, just before the pandemic, one of our members was told (at a hospital), 'You are the one with AIDS, go there instead, you don't belong here.' They yelled out her complete name in public in the hospital where everyone could hear."*

On her own wellness journey, despite feeling weak and going through several infections, Mariam has persisted with her HIV medications. She has also returned to work, making intricately embroidered dresses and gowns for a growing clientele of wealthy women, including businesswomen and politicians.

ADVOCACY AND REPRODUCTIVE RIGHTS

This experience of being "denied the right to live with dignity" led Mariam to advocate for the rights of People Living with HIV (PLHIV). She started openly sharing her experience in various forums, including the Department of Foreign Affairs (DFA). Her impassioned 'elevator speech' to a senator about the critical importance of ARV treatment contributed significantly to her co-authorship of a bill. Mariam continues to speak out, not only about her own journey, but also highlighting other SRH abuses, such as the forced ligation experienced by other women living with HIV in her support group. Mariam also shares what she has learned with her children and grandchildren, encouraging them to openly discuss and claim their sexual and reproductive rights:

> *"I have been able to share all my learnings with my children. I keep thinking of how, if I were still with my husband, I would not be able to do that. I freely talk to my grandchildren about gender and sexuality. One of them recently told me that she likes another girl. I am happy I am there for them to discuss all these things openly with me."*

Mariam stands today as a formidable voice, turning personal trauma into a lifelong mission for health equity, dignity and sexual and reproductive rights.

EMILY'S STORY

Emily is 30 years old and lives with cerebral palsy in Quezon City. She resides with her family of 12: her 6-year-old son, her father, her sister and her 6 children, and her brother and his 3-year-old son. Emily is the only earning member of the family, and all the others are her dependents. Her father is an alcoholic and has not held a paid job for many years. She works with the government to improve its policies and programmes for women with disabilities, and also holds a senior role at a local organisation that advocates for and provides services to persons with disabilities in the city. She has also started her own organisation that works on disability rights, building on her past experiences with the W-DARE[125] Project where she played an active role. Emily takes on projects whenever funding is available. Her advocacy work has greatly empowered her.

CHILDHOOD AND EDUCATION

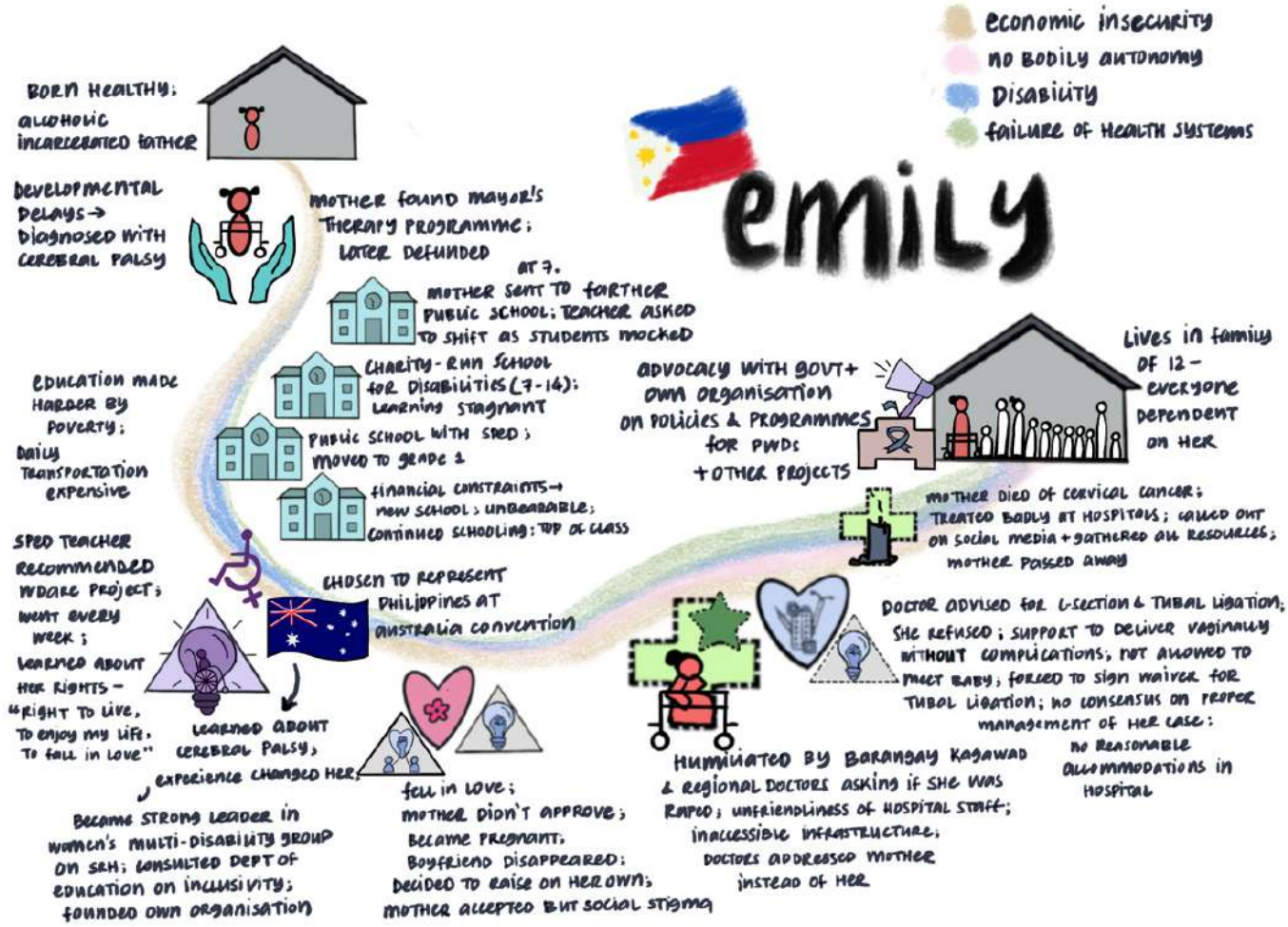
Emily was born in Bacolod City, "...a big, healthy baby three-point-something kilos, my mother used to say with pride." But things changed in the months that followed. At six months old, her family moved to Quezon City. As she was growing up, the family began to notice that something was wrong. She was unable to meet the developmental milestones on time and could not lift her head or crawl. While others around her thought these were just minor delays, her mother's intuition told her otherwise. After several visits to the hospital and many tests, Emily was diagnosed with cerebral palsy. There were few facilities for children with disabilities then, but her mother found a therapy programme run by the city mayor at the time. "My mama would always massage my bones," Emily remembers. "That's why my lower body wasn't too affected. I could walk. But my upper body, that was what was weak."

Therapy helped, but the programme was later defunded when the mayor changed. Still, her mother persisted. Emily began to walk at the age of three. Despite her early limitations, Emily grew up surrounded by people. "I wasn't hidden," she says proudly. "I grew up like a normal child. I had friends. The only thing was, people in the barangay called me 'Inday Lasing', because of my movements. They thought I looked like a drunk girl."

Those early years shaped her spirit: she was aware of her difference, yet determined not to let it define her. Emily entered formal schooling at seven, in a public school her mother had carefully chosen. Her mother would have preferred a private school, but they did not have the money for that. This public school was farther away, but she believed the kids there were better disciplined and would be kinder to Emily.

Emily was seven when she entered grade 1. However, within two months, the teacher called her mother to say that she found it difficult to handle her as the other children kept mocking her, and that Emily would be better off in a school for people with disabilities. Emily reflects that this was the first time she realised that she was 'different' and 'not normal'. Remembering that still makes her sad.

Her mother found a small charity-run school, which taught children with various disabilities. But it was a 'non-graded' school; the curriculum never advanced beyond teaching ABCs and numbers. Emily stayed there till she was 14. She feels she had stagnated in her learning and was not progressing. A compassionate teacher finally asked her mother why Emily was still there. "She said I was just caged," Emily recalls. The teacher helped her transition to another public school with a



SPED (Special Education) programme. But even then, progress was slow.

At 16, Emily was still in SPED. When she was finally assessed and moved to grade 1 at a regular public school, she was 17, studying with seven-year-olds. She looks back at that time with bitterness and says, "it's funny and annoying. But I don't want other young PWDs to go through what I went through."

On her first day at the new school, the children stared at her and asked her uncomfortable questions. But eventually she became friends with them. The family's poverty, though, made her education even harder. Daily transportation cost almost ₱100, a burden her mother, who worked at the Barangay office, could not sustain. Emily often walked over an hour to get home to save money, or hitched rides with the police. Her father was in prison at that time, and the family survived on her mother's meagre income and a ₱500 monthly allowance from a church sponsor. Finally, due to the financial constraints, Emily had to change schools. At the new school, the bullying was unbearable, and Emily felt she did not want to study further. However, her mother convinced her to try once more, and with her mother's support, she continued her schooling and did exceedingly well. She was always amongst the top two in her class, despite her frequent absences.

When she was 21 and in grade 4, her SPED teacher recommended that she participate in a six-month participatory action research project (the W-DARE Project), which assessed the SRHR of women with disabilities in urban and rural settings in the Philippines. She went to the centre every Saturday.

> *"It was the first time I learned about our rights. I was 21 years old. I didn't even know I had rights before! The right to live, to enjoy my life, to fall in love."*

Because of her performance, she was chosen to represent the Philippines at an international convention for women with intellectual disabilities in Australia, where she learned more about cerebral palsy. The experience transformed her. It was also her first trip abroad. "It was like I was enlivened."

On her return, she became a strong leader of the women's multi-disability group on SRH action, formed during the research. She also consulted with the Department of Education to enhance the inclusiveness of its basic education sector and

is currently working with the Quezon City government to improve its policies and programmes for women with disabilities. She also founded the organisation Persons with Disabilities in the barangay (village).

FALLING IN LOVE AND PREGNANCY

Emily's mother was always concerned about Emily and was not open to her falling in love. Emily had had romantic crushes in the past but did not know who to talk to. It was only after she joined the research programme and began attending training that she realised her feelings were normal. At 23, Emily fell in love. It was a relationship that brought both joy and pain. Her mother did not approve of the relationship as she was apprehensive.

Emily soon found herself pregnant, but her boyfriend had disappeared. She realised he was unreliable and convinced herself she was capable of having the child and raising it on her own. Her mother cried when she found out Emily was pregnant, but soon accepted it. Still, Emily withdrew from the world. "I didn't go out of the house," she recalls. "Instead of letting people gossip, I just stayed inside."

But gossip found her anyway. A barangay kagawad[126] handling health summoned her to the local centre. There he questioned her about her pregnancy and assumed she had been raped; "We'll have him jailed!" they said. Emily was humiliated. She had not asked for any help. All she wanted was to stay away from people and from gossip. Her emotional distress nearly caused her to have a miscarriage. The trauma eventually pushed her to leave home for the last few months of her pregnancy and stay elsewhere to clear her head. Through it all, she carried herself with quiet defiance. "I am an advocate for reproductive health!" she laughs bitterly. "I know what I'm doing with my body."

CHILDBIRTH AND OBSTETRIC VIOLENCE

She returned to the regional government medical centre near home for her antenatal check-ups. She gradually began to notice the hospital's and its personnel's unfriendliness. The hospital bed was too high for her to sit on, and the railings were too low to prevent her from falling. The doctors would discuss her case with her mother as if she were not there or could not understand.

Emily was admitted to a public hospital in the city in 2017 for her delivery. She was not allowed to have a companion despite the weakness of her right arm and constant upper body spasms that affected her mobility and articulation. When the doctor finally came to check on her, once again, he began to interrogate her rather than ask about her health and contractions.

> *"'Where's the father of your baby?' they asked. Then they said, 'Were you raped?' I said, 'If I was raped, I would've told you immediately. I wasn't raped. I wanted what happened.' But they didn't believe me."*

Her doctor advised her to have a caesarean delivery followed by a bilateral tubal ligation (surgical sterilisation). "They had decided what to do with my body without even asking me." She adamantly refused both. Her mother supported her; fortunately, another doctor also supported her choice to deliver vaginally, which turned out fine. Emily gave birth to a son without any complications. However, she was not allowed to hold her baby until the following day. One of the nurses dropped the baby while handling him post-delivery. The baby was fine, but Emily was very scared.

After her delivery, her doctor refused to move her back to the ward until she agreed to have the tubal ligation and sign a waiver (which excused the hospital from any liability for the surgery). She had refused this vehemently because she wanted to have more children. But the doctors were insistent, and the nurses were whispering amongst themselves, "She doesn't want ligation? She'll just be back here pregnant again!" Emily finally gave in and agreed to have the surgery the next day; she had refused them four times, was tired and hungry, and saw she was the only patient left in the hospital.

At the time of her surgery, Emily was shocked to find herself surrounded by medical interns assigned to discuss her case (the hospital being a teaching hospital), and dismayed that none of them had read up on her case and had to resort to a Google search when asked by their preceptor. So, Emily volunteered to explain her condition. During the discussion, she was further disheartened to find there was no consensus on the proper management of her case, when one of the doctors asked why she was being ligated when she was only 23 years old and had had only one child. "It was as if I were being punished for having a baby. The pain was double—the physical pain and the pain of being treated like I didn't matter."

Throughout her stay at the hospital, Emily felt she had been given neither the appropriate accommodation nor the assistance a person with disabilities needed. She struggled to eat, move around, and care for her baby by herself. Because it was a public hospital, she even had to share her bed with another mother until her discharge. She stayed in the hospital for three days, crowded into a bed with two other women. When she

was finally discharged, Emily carried her baby herself, running her own papers through the hospital bureaucracy.

PERSONAL LOSS AND RESILIENCE

In 2023, Emily went through what she considers the lowest point in her life: her mother fell ill and died of cervical cancer. Her mother had been bleeding for a month when Emily found out. At the first hospital she was taken to, they were treated very badly and kept getting referred from one department to another, without any doctor actually examining her. In a severe test of her will and resourcefulness, she got her mother admitted to a second hospital where she was eventually diagnosed and treated after Emily went on social media and called out the first hospital that had ignored and rejected them. She gathered all the resources for her mother's treatment – diapers, blood, chemotherapy, radiation, social health insurance, etc., and she alternately watched over her mother and worked double-time on other consultancies to manage the bills.

Today, Emily continues her advocacy work, raising her son, Dylan, as a single mother. Her experiences of exclusion and institutional violence fuel her fight for inclusion, dignity, and justice.

> *"Sometimes I still ask myself, 'Why didn't I speak louder that day in the hospital?' I know I'm educated. I know my rights. But when you're there—when they're in power—you feel small."*

Then she pauses. "But I also know this: they can't take away what I know now. I know I have rights. I know my worth. And I will keep fighting, so no other woman with a disability will go through what I went through."

her-stories

VIETNAM

VIETNAM

NAVIGATING DISABILITY, RIGHTS AND REPRODUCTIVE JUSTICE IN THE CONTEXT OF RAPID CHANGE

VIETNAM — Country Context Indicators	
A. ECONOMIC INDICATORS	
National poverty rate	1.6% in extreme poverty (< USD 3/day); about 4.2% of the population remains below the national poverty line, with vulnerabilities to shocks still present, particularly in the Midlands, Northern Mountains, and Central Highlands.[127]
Gini coefficient	36.09; rising absolute inequality[128]
Women workforce participation rate	68.6% female labour force participation; vulnerable employment amongst women is 57.1%;[129] 30.6% of seats in parliament held by women [130]
B. KEY GENDER AND HEALTH INDICATORS	
Gender Gap Index	0.712, ranked 72/148 countries;[131] Human Development Index: 0.726, ranked 107/193; Gender Inequality Index: 0.296, ranked 91/170[132]
Maternal mortality ratio (MMR)	48 per 100,000 live births nationally, a 42% decline since 2000; significantly higher in remote mountainous and ethnic minority areas[133]
Adolescent birth rate (ABR)	34 per 1,000 nationally;[134] 115 per 1,000 in Northern Midlands and mountainous regions.[135] Child marriage: 14.6% of women aged 20–24 are married before 18.[136]
Modern contraceptive	72.1% of demand satisfied with modern methods[137]
Population with at least some secondary education	Female literacy ~95% (urban); significant gaps in remote ethnic minority areas[138]
C. LEGAL FRAMEWORK — SEXUAL AND REPRODUCTIVE HEALTH	
Abortion	Legal on request under the Law on Protection of People's Health (1989); one of the highest abortion rates in the world (~40% of pregnancies); sex-selective abortion technically prohibited but weakly enforced; no criminal penalties for providers or pregnant persons[139]
Gender-based violence (GBV)	23% of ever-married women in the 15–49 age group have experienced intimate partner violence. Marital rape not explicitly criminalised; cultural norms of 'mediation' and family privacy suppress reporting[140]
LGBTQI+ communities	Same-sex activity never criminalised; Civil Code (2015) recognised the right to gender reassignment; 2024 Law on Citizen Identification permits transgender citizens to update documents upon transition, pending a Gender Affirmation Law (proposed for 2025 National Assembly vote); conversion therapy banned by Ministry of Health (2022); no anti-discrimination law on sexual orientation or gender identity
D. GEOGRAPHIC AND SOCIAL STRATIFICATION3	
Disability and marginalisation	Approximately 7% of the population (~6.7 million people) live with a disability, acknowledged as an undercount. Women with disabilities face cultural stigma rooted in Confucian norms framing disability as shame; encounter ableism in healthcare settings; and are more likely than non-disabled women to experience gender-based violence. Reproductive rights routinely undermined by provider attitudes and inaccessible facilities.[141]
Climate vulnerability	Vietnam ranks 13th on the Climate Risk Index. The Mekong Delta (sea level rise, salinity intrusion) and Central coastal regions (typhoons, flooding) are highly exposed. Climate events disproportionately displace ethnic minority and rural communities and disrupt access to health services.[142]

Note: Vietnam's national averages mask profound disparities between the Kinh majority and the 53 recognised ethnic minority groups, who constitute approximately 15% of the population but account for a disproportionate share of poverty, maternal mortality, and reproductive health inequity. Disability-disaggregated reproductive health data are largely absent from national statistics.[143]

Vietnam's economic transformation since Đoi moi[144] has led to significant poverty reduction and notable improvements in maternal health at the national level. Yet these aggregate gains have not been evenly distributed, and profound disparities persist. These disparities are particularly stark between the Kinh majority and the country's 53 recognised ethnic minority groups, between urban centres and remote mountainous regions, and between those with access to formal healthcare systems and those who continue to face institutional exclusion. For women and girls with disabilities, reproductive justice remains a particular site of failure: access to reproductive health services, the right to make informed decisions about their own bodies, and the expectation of dignified care are frequently denied, not because the law prohibits them, but because provider attitudes, accessible facilities, and appropriate support systems have not kept pace with formal commitments.

Disability in Vietnam is significantly undercounted, with the official figure of approximately 7% of the population widely considered an underestimate. Women with disabilities are disproportionately affected by poverty, restricted mobility, and exclusion from education and employment, and are substantially more likely than non-disabled women to experience gender-based violence.[145] Cultural norms have historically framed disability as a family shame or moral failing. These norms continue to shape how women with disabilities are treated in healthcare settings.[146] The assumption that reproductive life is incompatible with disability, that a woman with a disability should not expect to bear children, or that her reproductive decisions require external validation, is documented across multiple healthcare contexts in the country. Sexual and reproductive health education is not adapted for students with disabilities.[147] The healthcare system's response to pregnancy and childbirth for women with physical disabilities has been ad hoc, dependent on the knowledge and openness of individual providers rather than any systemic protocol or training.[148]

Formal policy gains have outpaced implementation. Free health insurance covering 100% of costs for persons with severe disabilities,[149] legal recognition of the right to gender reassignment under the 2015 Civil Code, and a 2022 Ministry of Health directive requiring non-discriminatory treatment of LGBT+ patients are genuine advances. Yet the absence of disability-sensitive reproductive health protocols, near-total dependence on civil society and personal networks for support during pregnancy and the postpartum period, and the ongoing documentation of procedures performed without informed consent illustrate that the gap between entitlement and experience remains wide.[150] Civil society organisations, particularly those led by and for persons with disabilities, have been central to producing shadow reports, disseminating reproductive health information, running pilot personal assistance programmes, and pushing for legal reform. The onus of that work has fallen disproportionately on the women who have navigated these gaps themselves.[151]

The case story documented by the Centre for Creative Initiatives in Health and Population (CCIHP) in Vietnam traces the life-course experience of one such woman as she navigates disability, reproductive health, and the disability rights movement across decades of significant national change. Her story illuminates both what was absent when she needed it most and what it takes to build, through personal determination and collective advocacy, the conditions for a reproductive life lived with dignity.

LINH'S STORY

Linh is a 46-year-old woman living with osteogenesis imperfecta (brittle-bone disease), who uses a wheelchair. She holds degrees in foreign languages and information technology. She married at 30, has a 17-year-old son, and is the founder and director of a Centre for the Rights of Persons with Disabilities in Vietnam.

Linh grew up in the mountains of northern Vietnam. Her family experienced both hardship and relative comfort over the course of her childhood. Her father was an engineer and her mother was an accountant at a state-owned factory during the subsidised era of the centrally planned economy. When Vietnam underwent an economic transformation in the late 1980s, her parents took early retirement, opened their own businesses in rice trading and car accessories, and became, for a time, one of the wealthiest families in their town. In the early 2000s, however, they invested in a pharmaceutical factory that produced antimalarial drugs. An accident at the factory, combined with her father's ill health, drove the family into bankruptcy at a time when Linh had just finished her studies.

CHILDHOOD AND EDUCATION

Linh started school three years later than her peers, as she had recurring fractures in her legs. Each hospitalisation meant weeks of absence from school. The local health station near their home could offer only basic first aid; every serious fracture required a long journey to a hospital far away, with transport arranged through her parents' factory. There were no subsidies for the costs involved, or if there were, her parents still had to pay a great deal each time. Her condition was finally diagnosed when she was around six years old, at the National Children's Hospital in Hanoi, where a visiting team of Swedish doctors was able to identify her condition as osteogenesis imperfecta, or brittle-bone disease.

People in the neighbourhood were superstitious, and her parents were sometimes accused of being immoral, as though having a child with a disability was a sign of a moral failing.

> *"Whenever there was a conflict between households, they would blame my parents. Later on, they realised their mistake and apologised. But by then it was too late; the damage was done. We were already hurt."*

Around 1996, the community's attitudes and perceptions changed when Linh won public recognition of her abilities. When Linh was 18 years old, three years older than her classmates, she received an award from a charity and was given a new wheelchair.

Her academic performance had been exceptional, and the recognition brought her to public attention in a way that shifted how people perceived her.

Linh faced problems getting to school; it was never straightforward. As a child, she was either carried by her grandmother, her parents, or her teachers, or was transported on the back of a bicycle. When she was in junior high school, her parents hired someone to take her; at the university, she relied on friends, motorbike taxis, or her younger sister.

Linh attended Hanoi University of Foreign Studies, and the teacher who accompanied her there in the early days later became her sister-in-law. There were no policies in place to support students with disabilities at that time. She was exempted from military studies only after applying individually, because no formal provision existed. In her telling, the contrast with the present day is stark.



> *"Nowadays, it's like living a fairy tale. If you have severe disabilities, you are exempt from exams, promoted to the next grade, and provided with language support. In the past, you had to apply to be exempt from some subjects. It wasn't automatic like it is now."*

University life opened up another world and exposed her to new experiences. When Linh first arrived there, her class had just over 20 students and her homeroom teacher quickly came to know her, seeing her arrive early each morning, waiting for whoever was bringing her that day, and sometimes sharing her breakfast with Linh while they waited together. Her peers eventually noticed that she was dependent on others for transport. Some days she arrived very early; other days she waited long after class for a motorbike taxi to appear. When her friends offered to take her, she simply accepted.

Where the wheelchair could not go, her friends carried her. Her classrooms and the school's bathrooms were on floors where the chair could not reach; her friends would carry her from the entrance to her seat and back again. On days when she needed to use the bathroom, she would hold it rather than ask them to carry her again. She would quietly opt out of class outings, too embarrassed to ask for help, too proud to make herself a burden. Her friends eventually worked this out and began to trick her into coming. Twenty students in her class each carried her for part of the journey to the Hung Temple festival, which she had initially refused to attend.

She was too afraid to tell her mother at first. While pursuing her foreign languages degree, she was also simultaneously enrolled at a second institution, studying information technology. In the mornings, it was one school; in the afternoons it was another. In the evenings and on weekends, she taught English.

INFORMATION ON MENSTRUAL AND REPRODUCTIVE HEALTH

On days when she had her period, Linh managed by herself, just as she had learned to handle most things in life. She could not always change or wash at school. At that time, there were no specific provisions, no accessible facilities, and no guidance about menstrual health for young women with disabilities. She found her own way, as she had learned to do in most things.

"There was no guidance back then. I just had to find the information on my own, which was very difficult. There wasn't any information, and I didn't know which information was correct. Later, when the internet became available, it was easier to search for information. Until then, I would ask my friends to buy me sanitary pads. Later, when my sister came to stay with me, I would ask her."

WORK, INDEPENDENCE, AND PROVING HERSELF

When Linh was finishing her studies, a friend from the Disabled Student Club told her about an internship at a printing and design company. The director had studied abroad and was open-minded about hiring her. She started as a receptionist, became assistant to the CEO, and eventually moved into sales. At one point, she was selected as a photo model, a well-known competition at the time.

Initially, her colleagues were not warm, but over time, the scepticism receded. When the director travelled, he left her in charge of operations. Gradually, people realised that she could deliver, that the boss trusted her, and that she had earned her place through her capabilities rather than through concession. Later, she took a position as a communications officer for an international NGO working on disability rights in Vietnam, at a salary lower than her previous one.

LOVE, FAMILY RESISTANCE, AND MARRIAGE

Linh had boyfriends while studying. She was, by her own account, pretty and well-regarded, and came from a prosperous family; the only thing that set her apart was the wheelchair. Her relationship with her first serious boyfriend ended because of his mother. A visit by the boyfriend's mother to Linh's family left Linh's mother in tears. His mother had said that Linh would not be able to have children, would not be able to be a wife, and was not pretty enough for her son. Linh did not hesitate; she broke up with the boyfriend the very next day. He suggested moving away from his parents and going to the south to marry, but Linh refused. She did not want to leave her parents and her job. She was hurt by what his mother had said, and even more so to see her mother cry.

After that, Linh kept men at a distance. She eventually met her husband, Tran, while working for a disability organisation. He was a friend's colleague, and they met at an event. He began courting her. But she was not interested in marriage. She had a busy life, working for an international NGO, leading a community, and travelling constantly. She had not been thinking about marriage.

She changed her mind when Tran rescued her during a typhoon despite losing his own house and business investment. When she met Tran's family, all his neighbours came to see her, crowding around a window in his house. His family asked her to stay for dinner.

After Linh left, Tran's family held a meeting. She found out months later what they had discussed: that if Tran married her, he would have to care for her for the rest of his life. His siblings questioned whether she could be a wife or a mother. Only his father, a revolutionary veteran, accepted her.

PRE-WEDDING QUALMS

A month before the wedding, Linh went alone for a premarital appointment with a specialist who was visiting Vietnam. She wanted to know whether osteogenesis imperfecta was hereditary. The doctor confirmed that it was, but told her he had met people with the same condition who had had children without passing it on and advised her not to worry. This month was, by her account, the most stressful of her life. Instead of the joy that she should have felt before her wedding, she was beset by people trying to stop it. Colleagues from the disability community and other long-time associates questioned her decision, expressed concerns that she was being exploited, and worried that marriage would pull her away from the movement.

PREGNANCY AND CHILDBIRTH

Linh and Tran had not planned on children, letting things happen naturally. Because her menstrual cycle was irregular, she did not realise she was pregnant until she took a test on an impulse. When it came back positive, she cried—not from joy, at least not at first, but from an overwhelming surge of emotions that she could not immediately identify. She had just received a scholarship to study for a master's degree in Ireland and thought she had lost the chance to go. She decided to stay in Vietnam.

Finding appropriate antenatal care was not easy. Linh needed a facility that could both manage her specific condition and accommodate a wheelchair user. A friend recommended a doctor at the Vietnam-Japan unit within Bach Mai Hospital in Hanoi. The doctor provided good care, but she was not always available. Unfortunately, the other doctor who attended to Linh did not share the same attitude. She asked Linh to rethink

her pregnancy, then retreated, claiming she had only been expressing concern about possible difficulties. There were other absurdities: when Linh arrived at the hospital for her antenatal appointments, the staff would sometimes refer her to the rehabilitation department when they saw her in a wheelchair, unable to understand why a wheelchair user might be there for obstetric care.

Her doctor planned a caesarean section because of the risks of bone fracture during strong contractions. The surgery proceeded without complication and Linh delivered a healthy boy. The same doctor later delivered her sister's children, and Linh has recommended her to other women with disabilities in her network. She is grateful for the doctor's competence and care, as she is aware that a great deal depends on finding the right person.

POSTPARTUM DEPRESSION AND MOTHERHOOD

The weeks after the birth were harder than Linh had anticipated. Her work responsibilities had been so demanding that it took three people to cover for her during her maternity leave. Now Linh was confined at home, breastfeeding every two hours, receiving a constant stream of advice from everyone around her about how to eat, rest, and hold the baby. Everyone's attention was on the child. Even her husband was absorbed entirely in the newborn. No one attended to her. She became irritable and distressed, was unable to sleep, and was overwhelmed by emotions she did not understand. Only her mother noticed something was wrong.

Her workplace began calling just 25 days after the baby's birth, asking her to check emails, and this ultimately pulled her back. The office policy allowed six months of maternity leave for people with disabilities, but in practice, she was recalled to part-time work after four months. Returning to work reminded her of who she had been before the baby's birth, and this helped her. She was never told that what she was experiencing was postpartum depression; healthcare professionals did not raise the issue. It was her own social network, her mother's observations, a friend's directness, and colleagues' emails that pulled her back into living with purpose and carried her through this difficult time. "If I hadn't received that support, I don't think I'd be who I am today."

When Linh's son was young, childcare support came first from her younger sister and then from a caregiver she found through a pilot programme run by an Independent Living Centre in Hanoi, supported by a Japanese foundation. A woman came to assist her for several hours a day, helping with childcare and housework, and the Centre funded her services. When the programme ended, Linh continued to employ the woman at her own expense, acknowledging that this was a privilege denied to most people in her situation.

KNOWLEDGE, ADVOCACY, AND THE COLLECTIVE

Linh largely attributes her marital compatibility and easy relationship with Tran to having access to information on sexuality and reproductive health, which most disabled people in Vietnam in the 1990s and early 2000s did not have. While working for an international NGO engaged in disability issues, she was given an English-language book on reproductive and sexual health for people with disabilities, produced by a US organisation, to translate into Vietnamese. While translating it, she was learning. It covered everything: contraception, infection, sexual positions for those with limited lower-body mobility or paralysis, and care across a range of conditions. It was the most complete resource she had ever encountered on the subject.

The knowledge she gained through that translation, she shared with others. She went on to teach short courses on reproductive and sexual health, specifically for people with disabilities and primarily for those with mobility impairments, and also once taught a group of hearing-impaired people. She also became acutely aware of violations experienced by people for whom reproductive decisions were made without their knowledge or consent. In a shadow report produced by her organisation, she documented cases in which individuals with intellectual and hearing disabilities underwent procedures without understanding what was being done to them.

One case in Ho Chi Minh City stood out: a deaf couple went for what they believed was a routine antenatal check-up, and only realised something was wrong when they saw the doctor preparing surgical instruments. They had not understood that the recommendation was to terminate the pregnancy. They protested, writing on paper, and the procedure was halted. The case, for Linh, encapsulated everything about what was missing from reproductive healthcare for people with disabilities. It was not just accessible facilities, but also meaningful communication, genuine consent, and clinicians trained to provide both.

Linh continued to advocate for services that she herself was not provided. She and her colleagues successfully pushed for the inclusion of a sign language service provision in Vietnam's amended Healthcare Law, which required significant effort to ensure its acceptance by the health sector. She has been part of efforts to update legislation, to create resource guides for disabled people on where to find knowledgeable healthcare providers, and to integrate support services for disabled women into the public health system.

"Vietnam doesn't have the kind of state-funded personal assistance that exists in Japan, South Korea, and Thailand. Projects like the one from the Independent Living Centre are very much needed, but are only available for a few years."

WHAT SHE HAS BUILT

Linh decided not to have more children, not because she could not, but because she was too busy, and because having one child had been, in itself, what she calls proof: proof that she could do it, proof that the women who had questioned her right to bear children were wrong. She has raised her son, now 17, with the same openness that she believes she owed herself. She talks to him about gender and sexuality as a matter of course.

"Having this knowledge made things very comfortable between my husband and me. Our married life went smoothly. If I didn't have this knowledge, it would have been difficult for us, but since I knew about it, I could discuss everything openly with my husband, and he was very understanding. I even educated my child about these issues, so he has a good understanding."

Linh lists the biggest achievements of her life: a happy family, stable work, the ability to enjoy life. She places family above the organisation she has built, which is, by any measure, successful.

CHAPTER 3

PATTERNS OF EXCLUSION AND SITES OF RESISTANCE: CROSS-CUTTING FINDINGS FROM REPRODUCTIVE HER-STORIES

CROSS-CUTTING PATTERNS ACROSS DIVERSE CONTEXTS

Despite the considerable diversity of communities, countries, circumstances, and lived experiences represented in the stories, a set of cross-cutting patterns emerged with notable consistency. The 15 stories documented in this publication span six countries and encompass a wide spectrum of structural marginalisations: caste discrimination, ethnic minority status, disability, conflict-affected displacement, climate vulnerability, migration, HIV status, and gender identity. Yet the analysis of each account reveals that beneath this diversity, certain systemic conditions operate in strikingly similar ways across national and community boundaries, producing comparable constraints on reproductive autonomy, failures of health and social systems, and reliance on informal networks of solidarity and resistance. These patterns are not coincidental; they are the expression of a shared underlying architecture of patriarchy, economic inequality, institutional discrimination, and climate precarity that manifests differently in different contexts but carries the same ethos of exclusion. Identifying them is not an exercise in homogenising these key factors, but an essential methodological step in developing an indicator framework that captures what the most-marginalised have in common, alongside what is specific to each group and context. These patterns provide the empirical grounding for the reproductive justice indicator domains that have been drawn up and presented in the next chapter.

Lack of bodily integrity and autonomy: The stories show bodily integrity and bodily autonomy to be distinct but inseparable. Integrity was breached not only within marriage, but by institutions and authorities. Autonomy was curtailed at every stage of the life course. Across the stories, women entered sexual life, pregnancy, and menopause without information, and the norms that withheld it were inherited rather than chosen. Menstruation brought seclusion and restrictions on movement in most of the stories. Contraception was withheld or controlled by husbands and family and community member and often, overrode the woman's own decisions. Information was itself a condition of autonomy. For instance, Fathima, who received none before marriage, later kept the same silence with her own daughters, reproducing across generations the limits on informed decision-making. Where women did exercise choice, it was often covert and carried a cost, often in the form of violence. Information reached these women through chance rather than entitlement, which is why the framework treats sexuality education and accessible information as preconditions for informed reproductive decision-making.

Economic security: The most pervasive pattern is the foundational relationship between economic deprivation and restricted bodily autonomy and reproductive freedom. Across every story, poverty operated not merely as a condition of economic scarcity but as a constraint on decision-making, on the capacity to refuse or negotiate, and on the ability to seek care or redress. Whether in the context of child marriage, multiple pregnancies, inability to access health services, or inability to leave a violent relationship, the absence of economic security consistently narrowed the space for reproductive agency. This finding corroborates and extends the evidence base for the argument advanced in the introduction that reproductive justice cannot be achieved through health sector interventions alone; it requires structural conditions, including economic reforms, that make genuine choice possible. Further, household-level measures also obscure who commands resources within the household. Mi-Her's husband controlled the household finances and Fathima's withheld money for household needs, while Rama's access to treatment for post-menopausal bleeding turned, over two years, on whether her husband would agree to spend. Earning did not reliably convert into control: Radha, a trained nurse, was repeatedly made to resign from work by her husband, and Seema's earnings sustained her household while decisions on contraception and mobility remained his. Food was similarly unequally distributed, with mothers such as Lae eating last and least. Poverty lines and household asset classifications alone cannot tell us whether the women and girls within a household are economically secure, which is why we make a case for indicators need to be measured at the level of the individual woman or girl as well as the household.

Gender-based violence, in its domestic, institutional, and systemic forms, was also present across all the stories, not as an exceptional event but as a structuring condition of women's reproductive lives across the life course. Intimate partner violence intersected with coerced pregnancy, denial of contraception, and reproductive coercion in many of the stories. Another common thread was 'institutional violence', experienced as discrimination, humiliation, and denial of care within health systems, as well as in educational institutions and workplaces. The stories also illuminate the ways in which GBV operates across the life course, from child marriage and early sexual initiation to obstetric violence and the manipulation of contraceptive decisions in adult relationships. Critically, GBV was never encountered in isolation: it intersected with caste discrimination, disability stigma, HIV-related stigma, displacement, and poverty to produce forms of harm that no single-sector response can adequately address. Mathuja's story also depicts how experiences of GBV can cause generational trauma and perpetuate cyclical and generational forms of violence. The stories show that violence enforces the denial of choice, and that choice cannot exist where integrity is not protected. Yet the two are measured very differently. Prevalence of violence is comparatively well tracked, while consent, coercion, and decision-making power over marriage, contraception, and one's own body remain largely unmeasured, which is why the framework needs indicators for both.

The failure of health systems to serve structurally excluded communities was a consistent theme and took two distinct forms, often within a single life. The first was a failure of presence: facilities, trained providers, transport, and services in local languages were absent in remote and poorer areas, as in Paromita's first pregnancy in Bangladesh, Mi-Her's reliance on her husband to interpret at the hospital in Lao PDR, and the long journeys that marked Linh's childhood fractures in Vietnam. The second was a failure of inclusion: services were available but organised in ways that stigmatised, overrode, or turned away the very women they were meant to serve. Often manifesting in multiple forms: geographic inaccessibility, unaffordable costs, absence of services in local languages, medical paternalism and patriarchy, active discrimination against women from Dalit communities, transgender persons, women living with HIV, and women with disabilities, and the routine absence of services that fall outside the narrow reproductive-age framework, such as psychosocial support, mental health services, and information on menopause. Formal entitlements seldom translated into effective protection. Insurance, maternity benefits, and welfare schemes appear across the stories, yet women still met the cost of care through savings, loans, and the goodwill of individual providers. Rama's insurance cover of Rs 1 lakh met only Rs 25,000 of her hysterectomy, leaving her to pledge her gold and negotiate instalments with the surgeon. Eligibility, in these accounts, was mediated by documents, spousal permission, timing, and provider discretion, none of which is visible in indicators that record only whether a scheme exists. Measuring effective coverage and out-of-pocket burden is therefore central to any framework that seeks to hold states accountable. The stories highlight the gap between the formal availability of health services and their effective accessibility and rights-respecting character for the most marginalised, a key consideration when designing indicators.

The intersection of climate vulnerability and reproductive vulnerability was documented with particular clarity in the Bangladesh and Lao PDR stories. Climate crises such as cyclones, floods, and droughts disrupt livelihoods, destroy housing, contaminate water sources, and sever access to health services, with disproportionate impacts on already vulnerable populations, such as pregnant and postpartum women. For women in Bangladesh and Lao PDR, childbirth and climate catastrophe were not sequential but simultaneous, underscoring the need for indicators that capture the reproductive health dimensions of climate vulnerability rather than treating them as separate analytical domains. The stories show how gender shapes each of these crises, and that climate was not the only one. The gendered division of labour left women responsible for water, food, and shelter as conditions deteriorated, with no time to recover. Consistent with the polycrisis framing of the first chapter, indicators need to capture the continuity of SRH care, protection, and dignity in crisis, disaggregated by gender and group, rather than treating climate, conflict, and economic shocks.

Yet the stories gathered here also offer evidence of what makes a material difference. Laws and policies, where they existed and were implemented, changed lived realities in concrete ways, demonstrating that structural entitlements are not merely symbolic but can translate into tangible protection and redress. Finally, despite the weight of structural barriers documented in each story, the evidence consistently points to the transformative role of collective organising, peer networks, and civil society engagement in advancing reproductive justice. Mariam's co-authorship of HIV-related legislation, Vinura's founding of transgender rights networks, Emily's disability rights advocacy, and NGO-facilitated health worker networks that connected her to antenatal care during her second pregnancy all demonstrate that access to rights is not simply a function of individual entitlement but depends on the capacity for collective action and the existence of enabling civil society infrastructure. It is often through collective feminist and community mobilisation, not individual claim-making alone, that structural entitlements are converted into lived rights. Both

the failures documented, costs of invisibility and the enablers, the power of collective action are essential inputs into the indicator framework that follows.

THE IMPORTANCE OF SPECIFICITY: FOREGROUNDING THE MOST VULNERABLE

While the cross-cutting patterns described above reflect shared structural architectures of exclusion, the stories collected/documented also resist any singular or comparative reading of vulnerability. An intersectional feminist lens insists that experiences of marginalisation cannot be ranked against one another, nor can they be abstracted into a generalised account of "vulnerability". Each is shaped by the specific convergence of gender, caste, disability, sexuality, health status, geography, and conflict that produces it. What connects these distinct experiences is not their comparability, but their shared grounding in violations of bodily autonomy and reproductive justice.

The reproductive justice concerns of a transgender man navigating a discriminatory health system are not the same as those of a Dalit woman living in a settlement without sanitation. Each is shaped by distinct structures of stigma, access, and state neglect. The vulnerabilities of an indigenous adolescent girl who has never encountered the concept of reproductive rights cannot be equated with those of a woman living with HIV negotiating mandatory employment-related testing. The former is shaped by epistemic exclusion, the latter by surveillance and stigma.

Similarly, the challenges of a conflict-affected woman living with war-related disabilities differ fundamentally from those of an older woman navigating menopause in an informal settlement (as in Rama's and Seema's stories), one is shaped by the violence of conflict and displacement, the other by the invisibility of ageing women's health within biomedical systems. These examples are not offered as a hierarchy of suffering, but as evidence that redressal, whether legal, medical, or social, must be equally specific. A framework of reproductive and sexual justice that fails to account for this specificity risks reproducing the very exclusions it seeks to address, flattening distinct experiences into a single, generalisable category of "vulnerable woman" that erases the particular conditions each person must navigate.

Unless the particular conditions and vulnerabilities of the most-marginalised groups are actively foregrounded within indicator frameworks, they remain structurally invisible; and this invisibility is never neutral. In data systems built without an intersectional feminist lens, invisibility has concrete policy consequences: it perpetuates structural exclusion, misallocates resources away from those who need them most, and allows states to claim progress on indicators that leave the most disadvantaged untouched. What gets counted shapes what gets addressed; and what remains uncounted is, disproportionately, the experience of those already pushed to the margins by intersecting structures of gender, caste, race, disability, sexuality, ethnicity and location.

The stories also show what makes a real difference. Where laws and policies existed and were properly implemented, they changed lives showing that legal entitlements are not just words on paper, but can lead to real protection and justice. Equally significant is the pivotal role of collective organising: collective feminist and community mobilisation, not individual claim-making alone, often converts structural entitlements into lived rights. Both the failures documented here, the costs of invisibility, and the enablers, the power of law and collective action, are essential inputs into the indicator framework that follows.

The domains presented in the next chapter should be read in this light. They are comparable in the rights they name, not in the experiences from which they are drawn. Each illustrative issue is a starting point that must be disaggregated by caste, ethnicity, disability, HIV status, gender identity, and location and, where the groups concerned are not counted at all, generated with the communities themselves.

CHAPTER 4

THE REPRODUCTIVE JUSTICE INDICATOR DOMAINS: DEVELOPMENT AND CONTENT

METHODOLOGY FOR DOMAIN DEVELOPMENT

The process of developing the reproductive justice indicator domains proceeded in two stages. In the first stage, all rights and entitlements whose absence or violation contributed to reproductive justice violations were identified for each of the case studies. This produced a comprehensive, story-level catalogue of rights deficits, spanning conditions of material life, health system failures, legal and policy gaps, gender-based violence, and structural discrimination. In the second stage, these rights deficits were grouped thematically, drawing on both the internal logic of the stories and the conceptual architecture of the reproductive justice framework, to produce a set of domains that collectively map the conditions necessary for reproductive justice. Within each domain, the specific issues identified across the case studies were retained as 'illustrative issues' not an exhaustive list, but a grounded and evidence-based set of reference points for indicator development.

OVERVIEW OF THE REPRODUCTIVE JUSTICE DOMAINS

The first two domains on bodily integrity and autonomy, and sexual and reproductive rights, address the core terrain of SRHR, but the stories reveal dimensions of these domains that conventional frameworks do not adequately capture. Domain 1 encompasses not only freedom from physical and sexual violence but the right to sexual pleasure, to privacy, and to protection from the health impacts of climate events and overwork, conditions whose relevance to reproductive wellbeing is well-established in the evidence but rarely reflected in mainstream indicator sets. Domain 2 extends the conventional framing of sexual and reproductive health (SRH) services to include comprehensive sexuality education as a precondition for informed reproductive decision-making, gender-affirming care as an SRH entitlement, and the quality and rights-respecting character of service provision as distinct from mere availability. Domain 3, a safe environment for children, reflects the reproductive justice insistence that the right to parent safely is a reproductive right, and that children's wellbeing is inseparable from their parents' reproductive justice. Domains 4 and 5, conditions of living and access to basic resources, and conditions of working, address the material foundations of reproductive wellbeing, encompassing economic security, food, housing, safe water and sanitation, legal identity documentation, decent work, and labour protections including for migrant workers. Domain 6, availability of social support and social security mechanisms beyond the governmental, acknowledges the critical role played by peer networks, community groups, faith-based organisations, and civil society in filling the gaps left by inadequate state provision. The stories repeatedly document the significance of these informal and non-governmental support systems, particularly in crisis contexts and in sustaining reproductive wellbeing where state systems have failed.

Domains 7, 8, and 9 address the three areas identified as requiring separate treatment. Domain 7, mental health and psychosocial wellbeing, recognises that the psychological dimensions of reproductive experience, including the trauma of forced or coerced reproductive decisions, obstetric violence, the cumulative psychosocial burden of structural discrimination, and the mental health impacts of conflict and climate displacement are integral to justice and cannot be addressed through SRH services alone. Domain 8, access to justice and accountability mechanisms, addresses the consistent finding across the stories that rights violations occur within a context of impunity, and that the absence of functional legal and institutional accountability mechanisms is itself a structural determinant of reproductive injustice. Domain 9, menstrual health and rights, reflects the evidence that menstruation is a site of stigma, restriction, and institutional neglect across most country contexts, and that this neglect extends from menarche to the systematic absence of recognition of menopause as a phase of the reproductive health continuum warranting information, support, and clinical care. Domain 10, participation in collective organising for rights, reflects the consistent empirical finding across the stories that individual rights awareness is insufficient without the structural conditions for collective action. While, Domains 11, and 12 address the legal and policy architecture of reproductive justice: non-discrimination in

all its dimensions; laws and policies that actively enable RJ, including through social protection, anti-GBV legislation, and legal identity frameworks; and specific protections for structurally excluded groups, including persons with disabilities, those affected by conflict, and those displaced by climate crises. The domains are designed to outlast any single monitoring cycle: the indicator frameworks mapped here, including those anchored in the Sustainable Development Goals, are treated as existing sources of data rather than as the organising logic of the framework, keeping open avenues for advocacy beyond 2030.

TABLE 1: REPRODUCTIVE JUSTICE INDICATOR DOMAINS AND ILLUSTRATIVE ISSUES IDENTIFIED FROM THE CASE STORIES

RJ INDICATOR DOMAIN	ILLUSTRATIVE ISSUES IDENTIFIED FROM THE CASE STORIES
Bodily Integrity and Autonomy	• Right to privacy • Freedom from physical, emotional, and sexual violence and abuse, including non-consensual sex • Freedom from sexual harassment • Freedom of movement without harassment and assault • Protection from sexual assault in times of conflict and climate crisis • Freedom from child, early and forced marriage, FGM/C and other harmful practices • Right to choose one's sexual and marriage partner • Right to sexual pleasure • Right to make informed decisions about one's body, sexuality, and reproduction • Right to enjoy a respectful relationship with one's partner or husband • Protection from the health impacts of climate crises (extreme rainfall, floods, extreme heat, fires) • Protection from overwork and its impacts on health and reproductive wellbeing • Freedom from non-consensual medical procedures, including sterilisation, IUD insertion, termination, and surgery, and the right to give or withhold free and informed consent • Freedom from reproductive coercion, including denial of contraception, forced pregnancy or abortion, and pressure to bear sons • Right to choose whether, when, and whom to marry, including where marriage is compelled by kin, community, or armed or political authorities
Right to Sexual and Reproductive Health Services	• Access to information on sexual and reproductive health in multiple dialects and forms (written, audio, visual) to prevent exclusion • Access to comprehensive sexuality education, including for adolescents, persons with disabilities, and those in remote or conflict-affected areas • Access to the full range of SRH services as defined by the Guttmacher-Lancet Commission (2018), including gender-affirming care, with particular attention to adolescents, young people, and persons from structurally excluded groups • Availability of SRH services at the last-mile level • SRH services that are free at the point of care, especially for structurally excluded communities • SRH services that are technically sound, respectful, non-discriminatory, and uphold the human rights of all persons, free from medical paternalism and medical patriarchy • Free and informed consent to contraception, sterilisation, abortion, and other procedures, with recourse where consent is not obtained

	• Effective coverage and financial protection: insurance and entitlement schemes that cover SRH care in practice, without catastrophic out-of-pocket expenditure or borrowing • Continuity of care and referral, including postpartum, post-surgical, and chronic care • Contraceptive services free of both coercion and gatekeeping, whether imposed by providers or blocked by partners and families
Safe Environment for Children	• Safe and secure environment for children, including a newborn's right to be born safely with skilled attendance • Protection from discrimination on grounds of gender, ability, caste, or ethnicity • Adequate food and nutrition • Safe housing and protection from risks of accidents and injury • Safe childcare and schooling environments • Access to timely and appropriate healthcare • Safety from neglect and physical, emotional, or sexual violence and abuse • Protection from child labour and child marriage • Protection from displacement due to climate crises or civil strife • Protection from war- and civil strife-related violence, including recruitment as child soldiers • Right to receive citizenship from mother • Right to custody of children and to receive alimony
Conditions of Living and Access to Basic Resources that Enable Sexual and Reproductive Well-being	• Food security and freedom from hunger • Economic security and the ability to meet basic needs on an everyday basis • Right to universal education and skill attainment • Adequate and secure housing • Access to potable drinking water and sanitation facilities • Legal identity and civil documentation (birth registration, national identification, household registration) that enables access to public services, healthcare, social protection, and legal entitlements • Freedom from the psychosocial burden of poverty, insecurity, and overwork • Women's and girls' control over income, food, land, and housing within the household, irrespective of household poverty classification
Conditions of Working that Enable Sexual and Reproductive Wellbeing	• Right to decent work • Right to a living wage • Safe working conditions that do not compromise health and reproductive wellbeing • Protection from sexual and gender-based harassment, abuse, and discrimination, including for structurally excluded groups • Fair and equal wages

Conditions of Working that Enable Sexual and Reproductive Wellbeing	• Paid medical leave and maternity leave • Childcare facilities for workers • Protection of the rights of migrant workers, including access to SRH services and freedom from mandatory HIV or pregnancy testing as conditions of employment • Right to social protection for disability, disease and death due to working conditions
Availability of Social Support and Social Security Mechanisms (Beyond Governmental)	• Access to peer support networks • Presence of support services for care work, and support groups for caregivers • Availability of family and community support during economic and social crises • Access to economic support in times of a crisis • Access to civil society organisations, faith-based organisations, and community groups that provide social security in times of a crisis, including food supply, shelter, skills training, and SRH education
Mental Health and Psychosocial Wellbeing	• Access to mental health and psychosocial support services, including for survivors of gender-based violence (GBV), conflict, and climate-related trauma • Integration of mental health care within SRH services, recognising the psychological dimensions of reproductive experiences including pregnancy loss, forced abortion, coerced sterilisation, and sexual violence • Freedom from stigma and discrimination associated with mental health conditions • Access to non-judgemental psychosocial support for persons from structurally excluded groups, including transgender persons, people living with HIV, and women in conflict-affected settings • Recognition of chronic poverty, overwork, and cumulative discrimination as structural determinants of mental health and reproductive wellbeing
Access to Justice and Accountability Mechanisms	• Access to functional, affordable, and non-discriminatory legal and justice systems for survivors of gender-based and intimate partner violence • Effective enforcement of laws against GBV, including police responsiveness and prosecution • Access to legal aid and support services for women and gender-diverse persons seeking legal redress • Accountability mechanisms for healthcare providers who violate patients' rights through discrimination, coercion, or denial of services • Access to grievance and redress mechanisms within health systems and public institutions for persons from structurally excluded groups • Protection of complainants from retaliation and secondary victimisation
Menstrual Health and Rights	• Access to safe, affordable, and culturally acceptable menstrual hygiene materials • Access to clean water, sanitation, and private facilities for menstrual hygiene management at home, in schools, workplaces, and health facilities

Menstrual Health and Rights	• Freedom from menstrual stigma, seclusion practices, and restrictions on mobility, food intake, or participation during menstruation • Access to accurate information about menstruation across the life course, including menarche, menstrual irregularities, and menopause • Recognition of menopause as a phase of the reproductive health continuum, with appropriate information, psychosocial support, and clinical services available to older women • Integration of menstrual health across the life course into school curricula, health systems, and workplace policies • Menstrual health supports that account for disability, including accessible sanitation and the additional costs faced by menstruators with disabilities
Participation in Collective Organising for Rights	• Opportunities to participate in empowering collective activities, especially for structurally excluded groups • Opportunities to engage in the public domain through civil society organisations • Opportunities for leadership training, rights education, and the articulation of collective demands
Laws and Policies that Enable Reproductive Justice	• Food security policies and programmes, including nutritional supplementation for pregnant women and children • Poverty-mitigation and social security policies • Laws and policies against gender-based discrimination in all spheres • Legal safeguards against gender-based and intimate partner violence, including publicly funded health and social services for survivors and measures that enable economic freedom and independent living • Legal and policy frameworks guaranteeing universal civil registration and legal identity documentation, including for stateless persons, undocumented migrants, and those excluded from household registration systems • Right to non-discrimination in educational and health facilities and in employment opportunities, including on grounds of gender identity and expression, language, ethnicity, disability status, HIV status, sex work, displacement, or caste • Access to effective recourse for challenging discrimination • Equity-oriented health and public service systems that proactively address structural barriers to access
Laws and Policies that Protect the Rights of Structurally Excluded and Other Vulnerable Groups	• Laws and policies protecting the rights of persons with disabilities, including access to education and SRH services, such as specialised maternity care and state-sponsored childcare support • Laws and policies protecting those affected by climate crises and civil strife from risks to life, health, housing, and livelihoods • Mechanisms to protect vulnerable groups from war-time rights violations and threats to life and health

Laws and Policies that Protect the Rights of Structurally Excluded and Other Vulnerable Groups	• Pregnancy, perinatal, and postnatal support to women in disaster-prone or conflict-affected areas • Adequate health, social, and economic support to internally displaced persons, including the right to resettlement and compensation • Integration of SRH services within humanitarian aid frameworks

MAPPING POTENTIAL INDICATORS: METHODOLOGY AND FINDINGS

Building on the justice indicator domains, the research team undertook a systematic review of existing indicator frameworks and data sources to identify potential indicators for each domain and to assess the availability of cross-country comparable data. Sources reviewed included the SDG indicator system and associated monitoring frameworks; ILO labour and occupational health standards; UNICEF child protection indicators; OHCHR human rights indicators across multiple thematic areas; UN Women gender data resources; UNAIDS Global AIDS Monitoring frameworks; the WHO Mental Health Atlas and related frameworks; the Trans Rights Indicator Project; the UNDP LGBTI Inclusion Index; and specialised indicator frameworks developed by civil society organisations and research institutions, including the Global Network of Sex Work Projects (NSWP) Monitoring and Evaluation Framework for sex workers' rights, the International Community of Women Living with HIV (ICW)'s Confronting Coercion data set, and the UNICEF/WHO Joint Monitoring Programme for WASH.

The review revealed significant variation in indicator availability across the domains. For domains related to conditions of living, conditions of working, bodily integrity, and aspects of sexual and reproductive rights, existing indicator frameworks are relatively well-developed, with cross-country comparable data available through the SDG monitoring system, the ILO, and the World Bank, albeit often with limited disaggregation by caste, ethnicity, disability status, HIV status, or gender identity. For several other domains, notably social support and social security mechanisms beyond governmental structures, participation in collective organising, menstrual health and rights, and access to justice, no macro-level indicators with cross-country comparability were identified. This finding is analytically significant: it suggests that the domains most consistently neglected by mainstream indicator frameworks are precisely those that the case studies identify as among the most important enablers and barriers of reproductive justice for the most marginalised.

Amongst the other domains, including non-discrimination, the rights of structurally excluded groups and mental health, rich indicator frameworks developed by human rights bodies and civil society organisations exist but have not been integrated into national or global monitoring systems. The OHCHR Article 5 equality and non-discrimination indicators, the Trans Rights Indicator Project's cross-country dataset, the NSWP Monitoring and Evaluation Framework, and the UNDP LGBTI Inclusion Index are examples of resources that represent a significant investment in indicator development but whose adoption by states and international monitoring bodies remains limited. Bridging this gap between available indicator frameworks and their systematic use in monitoring and accountability processes is one of the key implementation challenges identified by this process.

TABLE 2: EXISTING INDICATORS FOR THE REPRODUCTIVE JUSTICE INDICATOR DOMAINS IDENTIFIED FROM THE CASE STUDIES

RJ Indicator Domain	Potential Indicators or Sources for Indicators	DATA AVAILABLE?
Bodily Integrity and Autonomy	• SDG 5 indicators (UN Women gender SDG indicator list) • Matrix of Early Warning Indicators of Conflict-Related Sexual Violence (StopRapeNow/UNFPA) • MARA (Monitoring and Reporting Arrangements) Provisional Guidance Notes on CRSV (Office of the Special Representative of the Secretary-General on Sexual Violence in Conflict)	Yes
Right to Sexual and Reproductive Health Services	• SRHR indicators for humanitarian settings (systematic review: PubMed/NCBI) • Environmental Justice and Reproductive Rights Policy Framework (Center for Reproductive Rights) • Global AIDS Monitoring indicators: 4.1 Discriminatory attitudes towards people with HIV; 4.4 HIV-related discrimination experienced in healthcare settings (UNAIDS) • People Living with HIV Stigma Index: country and global reports (2020–2024) • Confronting Coercion: data on abuse experienced by women living with HIV when seeking SRH services (Women's HIV Research International Network) • SRH and HIV Linkages Compendium (UNFPA): indicator list for SRH services for women living with HIV	Partial – indicator lists and HR standards available; cross-country comparable data limited and, in some cases, dated
Safe Environment for Children	• UNICEF Child Protection Outcome Indicators (UNICEF Strategic Plan Goal Area 3 Indicator Manual)	Yes
Conditions of Living and Access to Basic Resources that Enable Sexual and Reproductive Wellbeing	• Gender-related SDG indicators (UN Women) • Gender Inequality Index (UNDP Human Development Reports) • World Bank Gender Data Portal (multi-sectoral gender indicators) • Multiple Indicator Cluster Surveys (MICS) — UNICEF: national-level data on education, water, sanitation, and child protection	Yes
Conditions of Working that Enable Sexual and Reproductive Wellbeing	• SDG 8 Targets 8.5, 8.7, and 8.8 (ILO Statistics / ILOSTAT) • ILO Safety and Health at Work indicators • Maternity protection data (World Bank Gender Data Portal) • Women, Business and the Law indicators: childcare, workplace safety, and pay equity (World Bank)	Yes

Availability of Social Support and Social Security Mechanisms (Beyond Governmental)	• No macro-level comparable indicators identified • Several indices used in small-scale community studies exist but are not standardised for cross-country comparison	No
Mental Health and Psychosocial Wellbeing	• WHO Mental Health Atlas: country-level data on mental health service availability and policy • SDG 3.4.2: Suicide mortality rate (disaggregated by sex where available) • WHO/UNHCR Mental Health and Psychosocial Support (MHPSS) toolkit indicators for humanitarian settings • WHO Mental Health Action Plan 2013–2030: proposed indicators for integration of mental health within primary and SRH services • Trauma and Injury Intelligence Group frameworks for conflict- and disaster-affected populations	Partial – national-level data available for some indicators; disaggregated, community-level, and SRH-integrated data largely absent
Access to Justice and Accountability Mechanisms	• SDG 16.3.1: Proportion of victims of (interpersonal) violence who reported their victimisation to competent authorities • SDG 5.2.1 and 5.2.2: Prevalence of intimate partner violence and non-partner sexual violence • CEDAW reporting indicators on legal frameworks and access to justice for women • OHCHR indicators on access to effective remedy for human rights violations • WHO/UN Women data on health sector response to GBV survivors (health system response indicators)	Partial – SDG indicators available; enforcement, implementation, and intersectional data are weak or absent
Menstrual Health and Rights	• WASH in Schools and Health Facilities indicators: menstrual hygiene management facilities (UNICEF/WHO Joint Monitoring Programme for Water Supply, Sanitation and Hygiene) • SDG 6.2.1: Population using safely managed sanitation services, including handwashing facilities (partial proxy) • UNICEF MICS: includes menstrual hygiene management questions in selected country surveys • Menstrual health indicators proposed by the Global Menstrual Collective and HRP (UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme on Human Reproduction) • National survey data on menstrual seclusion and restriction practices (available in selected South and Southeast Asian country surveys)	Partial — WASH proxy indicators available; dedicated menstrual health and menopause indicators at macro level largely absent

Participation in Collective Organising for Rights	• No macro-level comparable indicators identified • Community participation indicators developed by NGOs exist (e.g., Shirley Ryan Ability Lab Community Participation Indicators), but are not standardised for national or cross-country monitoring • Academic literature proposes various measures; none have achieved broad adoption	No
Laws and Policies that Enable RJ	• SDG 5 indicators, including 5.1.1 (legal frameworks for gender equality), 5.6.2 (laws and regulations on reproductive rights), and 5.c.1 (systems to track gender equality budgets) • CEDAW State Party reporting indicators Illustrative indicators on equality and non-discrimination • OHCHR Article 5 framework indicators (cross-referenced to SDG indicators) • Preventing discrimination in healthcare: OHCHR/UN Women guidance note with HR indicators • Sex workers' human rights indicators: NSWP Monitoring and Evaluation Framework 2022–2025 • Trans Rights Indicator Project (TRIP): cross-country dataset on transgender rights (Cambridge University Press) • LGBTI Inclusion Index (UNDP, 2019)	Partial -- indicator lists available; standardised cross-country data limited to select frameworks
Laws and Policies that Protect the Rights of Structurally Excluded and Other Vulnerable Groups	• Inclusive SDG indicators for persons with disabilities: OHCHR CRPD-SDG resource (SDG 3 and SDG 5 policy guidelines) • UN Disability Inclusion Strategy (UNDIS) reporting indicators (OHCHR)	Illustrative set of inclusive indicators; not yet standardised for cross-country comparison

APPLICATIONS OF THE FRAMEWORK: GUIDANCE FOR USE

The reproductive justice indicator framework presented in this publication, comprising 12 domains, their illustrative issues, and a mapping of potential indicators and data sources, is intended as a practical resource for multiple audiences and purposes. It is not offered as a finalised or definitive system; it is explicitly designed to be adapted, extended, and contextualised. The following sections outline six specific applications.

DEVELOPING LOCALLY RELEVANT INDICATORS FOR SPECIFIC POPULATION GROUPS

The domains and their illustrative issues can serve as a structured starting point for the development of locally relevant, population-specific indicators. Each domain identifies a set of issues drawn from the case studies documented in this publication; in other contexts, and with other population groups, these issues can be augmented or adapted to reflect specific structural conditions, legal frameworks, and forms of marginalisation that are not represented in the current case studies. For example, a team working with Indigenous women in a context defined by land dispossession might add issues under Domain 4 relating to customary land rights and territorial security as conditions for reproductive wellbeing. A team working with migrant domestic workers might develop additional indicators under Domain 5 that address the specific vulnerabilities of live-in workers, including employer control over reproductive decisions, restricted mobility, and exclusion from national labour protections.

Critically, the process of developing locally relevant indicators should be participatory and community-driven. The methodology employed in this publication, of in-depth interviews in safe, participant-chosen settings, transformed through a re-storying process that preserves the participant's own voice, provides one model. The vulnerability maps developed for each story offer a further participatory tool. They can be used in community discussions to identify which domains are most relevant to participants' lives, which issues within those domains are most acute, and which enabling conditions have been most significant. Positioning community members as co-producers of the indicators that will be used to measure progress in their lives, rather than as subjects of externally designed data collection, is both an ethical imperative and a methodological requirement for producing indicators that are genuinely grounded in lived experience. Because the stories and vulnerability maps draw on highly sensitive material, including experiences of violence, HIV status, and other diagnoses, their reuse in community discussions, monitoring, and training should have continued anonymisation, and data protection safeguards that go beyond those applied at the time of the original interviews.

INFORMING THE DEVELOPMENT OF CROSS-COUNTRY COMPARABLE RJ INDICATORS

The potential indicators identified in Table 2 are intended as inputs for the elaboration of reproductive justice indicators comparable across countries. This is a longer-term and more complex undertaking than the development of locally relevant indicators, requiring engagement with national statistical systems, international monitoring bodies, and the political processes through which indicator frameworks are adopted and institutionalised. The indicator sources mapped in Table 2 represent a starting point: several existing frameworks could, with appropriate adaptation and investment, contribute to filling the cross-country data gaps identified above.

The most significant gaps in social support mechanisms, collective organising, menstrual health across the life course, and access to justice, will require not only the development of new indicators but advocacy for their adoption within national survey instruments and international monitoring frameworks. Civil society organisations have a critical role in making the case for these additions, drawing on community-generated evidence of the kind assembled in this publication to demonstrate the materiality of these domains to the reproductive lives of the most marginalised. The framing of this advocacy should be explicit: the absence of indicators for these domains is not a neutral technical gap; it is a reflection of the same structural biases that render certain lives invisible in mainstream policy and data frameworks.

ADVOCACY AND ACCOUNTABILITY AT NATIONAL AND INTERNATIONAL LEVELS

The domain framework provides a structured resource for civil society organisations engaged in advocacy and accountability processes at multiple levels. At the national level, the domains can be used to construct monitoring reports that assess government performance across a broader and more rights-based set of dimensions than those captured by standard sectoral reporting. At the international level, the framework can inform the preparation of shadow reports to treaty bodies, including the Committee on the Elimination of Discrimination Against Women (CEDAW), the Committee on the Rights of Persons with Disabilities (CRPD), and the Universal Periodic Review (UPR), as well as contribute to civil society inputs into the ICPD and SDG review processes. The framework's strength for these purposes lies in its integration of narrative evidence and structured domains: community testimony can be organised and presented through the lens of the 12 domains, making visible the specific areas of rights deficit that official reporting fails to capture.

The framework is also well-suited to monitoring the implementation gap, the distance between formal legal commitments and their realisation in the lives of the most-marginalised which is a consistent concern in the accountability literature and a persistent finding of ARROW's monitoring work over more than two decades. Laws and policies that exist on paper but are not enforced, funded, or accessible to those who most need them, are a recurring feature of the case studies documented in this publication, and the domains framework provides a systematic approach to documenting and presenting this evidence.

BUDGET-TRACKING AND RESOURCE ALLOCATION ANALYSIS

The domains collectively map the range of sectors and policy areas including, health, social protection, labour, housing, legal identity, justice, mental health, and civil society, that must be adequately resourced if reproductive justice is to be realised for the most marginalised. This makes the framework a practical tool for budget-tracking and public expenditure analysis. Advocates and researchers can use the domains to interrogate whether allocations across relevant budget lines are sufficient and whether they reach the communities most in need: whether health budgets fund last-mile SRH services for structurally excluded populations; whether social protection schemes include the undocumented and stateless, whether humanitarian response budgets integrate SRH services rather

than treating them as a secondary consideration; and whether mental health services are funded within or alongside SRH programmes.

Budget analysis framed through the domains can also identify chronic under-investment that corresponds to the indicator gaps documented in Table 2. The absence of macro-level indicators for social support mechanisms, collective organising, and menstrual health is, in part, a function of the fact that these areas receive limited systematic public funding and therefore generate limited official data. Making the relationship between funding gaps and data gaps explicit is an important contribution of the framework to the evidence base for resource mobilisation advocacy.

COMMUNITY-LED MONITORING AND SELF-ASSESSMENT

The framework has significant potential as a tool for community-led monitoring, that is, for communities themselves to assess and document their own conditions, track changes over time, and generate evidence from the ground up. The vulnerability maps developed as part of the re-storying methodology in this publication point to this possibility. Adapted as participatory self-assessment instruments, the domains can structure periodic community reviews that identify which areas of reproductive justice are most deficient, document specific rights violations or enabling conditions, and build a longitudinal record of community-level change. This community-generated evidence can in turn be used for local advocacy, engagement with government service providers, and input into civil society monitoring processes.

Community-led monitoring is not a substitute for robust national data systems; it is a complementary approach that generates the granular, contextually grounded evidence that aggregate indicators cannot provide. It also constitutes, in itself, a process of rights awareness and collective capacity-building: the act of communities analysing their own conditions through a rights framework, identifying gaps, and formulating demands is precisely the kind of empowering collective activity that Domain 10 identifies as a structural enabler of SRJ.

TRAINING AND CAPACITY-BUILDING

The domains framework and its illustrative issues provide a structured resource for training and capacity-building across multiple audiences. For researchers and data collectors, the framework offers a comprehensive guide to the life conditions relevant to SRJ that standard reproductive health surveys routinely omit, and the illustrative issues can serve as prompts for qualitative interview guides and survey instrument design. For community health workers and frontline civil society staff, the framework supports training in rights-based approaches that recognise the structural determinants of reproductive wellbeing, including economic conditions, working conditions, legal documentation, mental health, and justice access, and can identify intersectoral referral pathways accordingly. For national statistical office personnel and policy analysts, the framework provides a structured guide to the indicator gaps that most require attention and a mapped set of existing frameworks from which to begin filling them. Training programmes that draw on the case studies in this publication as teaching materials can ground these analytical frameworks in the textured reality of actual lives, making the connection between structural conditions and reproductive outcomes concrete and legible.

CHAPTER 5

CONCLUSION

This publication has sought to demonstrate, through a combination of life-course narrative research and systematic indicator mapping, that the conditions enabling or obstructing reproductive justice are structural, intersectional, and multi-domain in character and that their measurement requires indicator frameworks that are correspondingly comprehensive, disaggregated, and grounded in the lived realities of the most marginalised. The 12 reproductive justice domains identified through this process extend considerably beyond the conventional scope of SRHR monitoring, encompassing material conditions of life, working conditions, legal identity, social support, mental health, justice, menstrual health, anti-discrimination, and collective organising alongside the more familiar terrain of SRH services and rights.

The indicator-mapping exercise confirms that significant gaps exist in the current landscape of cross-country comparable indicators, particularly for domains that are central to the reproductive lives of the most-marginalised, but have attracted limited investment from national statistical systems and international monitoring bodies. Addressing these gaps requires both technical work that includes the development and standardisation of new indicator frameworks as well as political work which focuses on advocacy necessary to persuade states and international bodies that data on the most- excluded populations is a governance priority, not a peripheral concern.

As the global community approaches the end of the SDG framework in 2030 and begins to define the terms of the next generation of development commitments, the argument for a fundamental reorientation of reproductive health monitoring is both timely and urgent. The polycrisis of climate change, economic volatility, and democratic regression, and the resurgence of anti-rights movements are all documented as present-tense conditions in the lives of the women and gender-diverse persons whose stories constitute this publication. They demand accountability frameworks that can capture the specific, compounded vulnerabilities of those living at the intersections of multiple structural disadvantages.

ARROW and her partners present this framework as a contribution to that reorientation. The 12 domains, the illustrative issues, the mapped indicators, and the six proposed applications are offered as practical resources for a range of stakeholders including researchers, civil society organisations, community groups, policymakers, national statistics offices, and others, who share the commitment to ensuring that the measurement of reproductive justice progress reflects the realities of the most- marginalised rather than the convenience of the easily counted. Indicators are not neutral instruments. What is measured determines what is funded, and what is funded is what gets acted upon. Any genuine commitment to reproductive justice that acts on the premise of leaving no one behind, requires that the tools of measurement be extensive, intersectional, and grounded in lived experiences. The life stories documented in this publication, and the many thousands of similar stories that remain undocumented, constitute both the empirical foundation and the moral mandate for this work.

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