

Feminist Alliance for Rights (FAR)*

Contribution to the UN Working Group on
Discrimination against Women and Girls:

**“Women and Girls’ Sexual and Reproductive Health and Rights
in Situations of Crisis”**

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I. Introduction

In response to the call for submissions by the UN Working Group on Discrimination against Women and Girls (WGDAGW) on Women and girls' Sexual and Reproductive Health and Rights (SRHR) in contexts of crisis, the Feminist Alliance for Rights (FAR) has prepared the present document for your consideration.

FAR is a global alliance whose purpose is to amplify the voices and leadership of women from the Global South and from marginalized communities in the Global North in order to advance human rights and strengthen national and international accountability. FAR is comprised of a wide range of women's and human rights activists who work in various areas of women's rights. It is guided by a Steering Committee,¹ and its work plan is operationalized by the Center for Women's Global Leadership (CWGL) in the capacity of Global Coordinator.

The thematic focus of our alliance since 2018 has been the elimination of gender-based violence (GBV) against women and girls. In our 2019 annual meeting, the FAR Steering Committee agreed to prioritize GBV and SRHR in situations of crisis for the period 2019-2021, aiming to contribute to the development of human rights standards in this area and to facilitate feminist collective action to influence global norms and processes to improve the implementation of women's human rights. The Steering Committee requested FAR's Global Coordinator to lead a global consultation process to gather inputs which ultimately became the basis of FAR's contribution.

Methodology

This document reflects the challenges, main concerns, and recommendations that activist experts in the field of SRHR² from four regions—Africa, Asia, Latin America, and the Middle East and North Africa (MENA)—identified during a global consultation process that started on November 2019. This process was led by FAR and supported by regional partners.³ This process included four consultations,⁴ two follow-up

¹ The FAR Steering Committee includes: Abiola Akiyode-Afolabi (Africa); Priyanthi Fernando (Asia); Rosalee Gonzalez (North America); Alicia Wallace (Caribbean); Margarita Guillé (Latin America); Fatima Outaleb (MENA); Magdalena Szarota (Europe); and Krishanti Dharmaraj (Executive Director, Center for Women's Global Leadership).

² Including women's rights defenders and advocates with experience using human rights mechanisms to advance GBV and SRHR globally, but also members of grassroots local, national, and regional organizations who have little experience using those mechanisms.

³ Forum for Women, Law and Development (FWLD), Women's Human Rights Education Institute (WHRI), and Arab Institute for Women (AIW).

⁴ Nairobi, Kenya in November 2019; Kathmandu, Nepal in January 2020; Latin American and Caribbean region in July 2020 (online); and MENA region in August 2020 (online). The names of the activists consulted are listed under each chapter.

sessions,⁵ interviews⁶ or email communication with activists, and secondary research to supplement their contributions conducted by FAR's Global Coordinator.

FAR used a feminist, human rights, and intersectional approach while gathering information to understand the root causes and multiple and compound impacts of crisis situations on SRHR in each region.

Key Findings

Crisis situations are multifaceted and can affect people physically, mentally, emotionally, and socially. Crises can lead to death, injuries, illness, and disabilities. It can forcibly displace individuals and communities, contribute to family and social network disintegration, destroy livelihoods and homes, and take away jobs and educational opportunities. In most instances, women and girls⁷ lives and wellbeing are impacted far more by any crisis because of the impact crises have on their SRHR. These are some of the main findings FAR identified throughout the global consultation and research process:

1. **Gender-based discrimination:** Structural gender-based discrimination against women and girls exacerbates the negative impact of crises on SRHR. Biological and physiological differences are not the reasons why crises affect women differently.⁸ The differentiated effects of crises on women and girls are linked to gender inequalities, which are rooted in cultural norms and stereotypes around women, girls, and sexual/gender minorities. Often they have lower socio-economic conditions and lack of decision-making roles. Furthermore, during and after a crisis, women continue to be the main caregivers in traditional communities and in societies with weak social security systems there are additional consequences for women's health as women have limited time to seek SRHR services. All these factors reduce the effectiveness of mitigation measures and crisis recovery plans.
2. **Gender-based violence:** Structural gender inequality is also the most significant risk factor for GBV in crisis contexts. In places where GBV is widespread and insufficiently addressed, when a crisis arises, existing violence is exacerbated and new forms of GBV arise, including reproductive

⁵ Latin American and Caribbean region in August 2020 (o-line) and African region in September 2020 (online).

⁶ FAR also conducted follow-up interviews with activists in MENA and Africa.

⁷ The phrase "women and girls" includes all people who either publicly or privately identify as women, regardless of assigned sex or genitalia. The term "sexual/gender minorities" is inclusive of transgender and cisgender women and girls, transgender men, gender non-conforming/non-binary people, and lesbian, gay, bisexual, etc. people. Though the experiences of these groups, and those whose identities overlap, are not a monolith (as no experience or group is), it is understood that all these identities are legitimate and share oppressions that are linked to one another (i.e. misogyny is linked to homophobia and is linked to transphobia) and in some cases are the same source of oppression (i.e. misogyny and transphobia). It is understood that many of the topics in this report relating to sexual and reproductive health rights are not just limited to cisgender identities, heterosexual identities, or women-identifying people.

⁸ A few exceptions include the case of elderly or sick women, women with disabilities, and pregnant women due to increased vulnerabilities and decreased mobility which makes them less able to self-protect or self-rescue.

violence. It was found that traditional definitions of crisis do not necessarily include particular situations that have devastating impacts on women and girls' human rights. During FAR's consultations, some activists expressed that there is a "gender inequality crisis" and called for states to adopt transformative structural measures to address it.

3. **Health systems:** The state of the health system before a crisis is an important indicator of what can be expected in times of crisis. Evidence suggests that when a health system is ill-prepared, its reproductive health services and supplies will not be delivered during a crisis despite their being critical to women and girls. In places where gender inequalities are pervasive, SRHR services are immediately deprioritized and funds are diverted to areas considered "more important" without a proper assessment of the long-term impact of these measures. An overarching problem identified by the activists consulted is the failure to include affected communities—especially women, girls, and minority groups—in planning, managing, and leading policies and programs to prepare and respond to crises.
4. **Marginalized communities:** Women and girls who belong to marginalized communities endure intersecting grounds of discrimination which further increases their vulnerability and affects their access to sexual and reproductive health (SRH) services during crisis. This document refers to the situation of some of these sectors, for example, indigenous women with disabilities in Nepal who face both physical and language barriers to access SRHR; internally displaced African-descendent women in Colombia who have suffered disproportionate levels of sexual violence; migrant domestic workers in Lebanon whose legal status has exposed them to abuse and affected their SRH; impoverished women belonging to religious minorities in Sri Lanka where government, religious authorities, and husbands make decisions concerning their bodies; young girls in the context of armed conflict in Yemen and Syria who are married for economic reasons; and adolescent women whose pregnancy rates spiked during the Ebola epidemic in Sierra Leone. In all these cases, women and girls' autonomy is very limited given the multiple layers of discrimination they would have to overcome.
5. **Gender stereotypes:** FAR's contribution includes several examples of how cultural norms and gender stereotypes surrounding social roles, sexuality issues, and SRH hinder women's access to essential healthcare and contribute to gender inequality. Stereotyping in healthcare services impedes women's access to safe abortion, sexuality education, contraceptives, and other SRHR services. This document also addresses a concerning trend in various regions where religious actors and anti-rights groups have been effective in influencing laws, policies, or measures that address women and girls' SRH needs.
6. **Agents of change:** Despite structural gender-based discrimination and violence, women and girls are also powerful agents of positive change during and after crises. They have played an active role in crisis recovery to ensure other people—especially women and girls—have access to SRHR services, supported and empowered victims of sexual violence, and implemented initiatives to advance the recognition and protection of women and girls' SRHR before, during, and after crises. Women's organizations also implement advocacy actions to hold states accountable for their response to crisis.

7. **Sexual and reproductive health and rights in contexts of crisis in different regions:** This document is focused on three main crisis situations: 1. natural disasters, 2. political crises/armed conflicts, and 3. health crises (especially COVID-19) as well as concerning trends in each region. Findings from all regions indicate exacerbated effects on women and girls' SRHR due to crises. Relevant examples are presented below:

8. **Natural disasters**

- a. In Africa, access to safe water was reported as one of the biggest challenges due to climate change. Safe drinking water is a major determinant for safer pregnancy and for children's health. Additionally, it was noted that women were the ones who carried heavy vessels, sometimes even during pregnancy, across long distances.
- b. In Asia, many countries face the brunt of natural disasters which has direct impact on women and girls' SRHR. Most governments in the region have failed to establish strong disaster management guidelines that use a gender-sensitive approach or address the needs of women and girls. In Sri Lanka, men tend to lead controlled relief efforts which makes it more difficult for women to access to their SRH needs because of the stigmas and taboos associated with the subject. In Nepal, after the 2015 earthquake, the government established birthing centers but deprioritized abortion. In India, it was reported that there were limited water, sanitation, hygiene (WASH) facilities and safe spaces for women in relief camps.
- c. Latin America and the Caribbean are prone to hurricanes and other natural disasters. In Puerto Rico, preparedness and disaster risk reduction programs are not tailored to women's needs, especially pregnant women. In the past, interpersonal violence increased in the aftermath of hurricanes but the state deprioritized domestic violence shelters and failed to adopt protocols to prevent GBV in shelters.

9. **Political crises and armed conflicts**

- a. In Africa, it was reported that areas of armed conflicts are often the site for violence against women and girls. The insurgency group in Uganda increasingly threatens GBV, including rape, murder, and sexual slavery. Boko Haram in Nigeria blocked hospitals to reduce access to services, particularly those pertaining to SRH. Even in the refugee camps, higher rates of maternal mortality were reported. The Anglophone crisis in Cameroon has especially affected the livelihoods of women and girls in the country. This led to an increase in sexual violence, forced prostitution, and lack of access to medical assistance which forced women to give birth in the bush.
- b. In Asia, Burmese security forces have committed widespread killings, arrests, sexual violence, and mass arson as part of a campaign of ethnic cleansing against Rohingya Muslims in Rakhine State. Access to SRH care at refugee camps in Bangladesh is limited. In Sri Lanka, the government has administered forced, cohesive, and involuntary birth control programs that have uniquely targeted Tamil women in the north and east.
- c. In the MENA region there have been decades of war and economic sanctions. As a result, in Iraq there is a shortage of drugs, medical staff, and trained midwives. Additionally,

women in rural regions face hardships when accessing SRH services because there are limited medical facilities. Food insecurity in Yemen has impacted pregnant women, leading to pregnancy loss, complications, maternal mortality, or child malnourishment. The armed conflict in Sudan has restricted access to information, contraception, natal care, and birthing environments. Limited health services have resulted in still-births, miscarriages, death during childbirth, and other labor complications. In Palestine, women face movement and travel restrictions, no access to health systems for women with irregular migration status, increased cases of domestic violence, among other issues.

- d. In Latin America, women living in territories controlled by powerful gangs in Honduras, El Salvador, and Guatemala have been killed, raped, and gang raped by gang members. Young women, especially, are forced to have sexual relationships with gang leaders. In the war against drug cartels in Mexico, women are being detained and sexually tortured by security forces. In Colombia, protracted armed conflict has resulted in forced displacement, widespread sexual violence, and reproductive violence, including forced abortions, sterilization, forced contraceptives, and forced pregnancies.

10. Health crises (COVID-19)

- a. In Africa, it was found that crises linked to endemic violence have deprioritized SRHR in many countries' political agendas. Government lockdowns to slow the spread of the virus led to limited or no access to healthcare services. This created additional challenges for pregnant and lactating women who need access to healthcare services for regular check-ups, vaccinations, antenatal care, abortions, and deliveries. It also impacted women who wish to access free services or products from health systems such as contraception or menstrual products. In many countries, there are reports of increased cases of domestic violence and interpersonal violence.
- b. In Asia, countries like Cambodia and Bangladesh reported that medical facilities were converted into COVID-19 response centers, limiting access to SRH services. Women also expressed fear of contracting the virus upon seeking healthcare services. In Nepal, there was a nearly 200 percent increase in the maternal mortality rate. Transgender people living with HIV also faced challenges in accessing healthcare. In the Philippines, pregnant women were denied access to facilities for deliveries, leading to maternal mortalities.
- c. In the MENA region, COVID-19 has led to the reinforcement of gender stereotypes, the de-prioritization of women's issues, increased domestic and interpersonal violence, restriction in mobility and access to healthcare, limited availability of data on SRH issues, anti-mask and vaccination campaigns, and limited access to contraception and menstrual products. Lack of access to menstrual products is especially concerning in the case of women deprived of liberty in Egypt.
- d. In Latin America, governments have deprioritized SRH care. There are no comprehensive plans to respond to the pandemic and the measures that have been taken are disarticulated and lack a gender-sensitive approach. Contraceptive supply and HIV-treatment has been interrupted and health facilities have been converted to COVID-19

hospitals without providing alternatives for SRHR services such as maternal care.

Domestic and interpersonal violence has also increased as a result of lockdowns.

11. Recommendations: During FAR's global consultation process, participants identified key recommendations for states in each region which are presented after each section. The following compilation reflects common concerns and recommendations across regions. FAR recommends that states:

- a. Allocate adequate budgets that strengthen and expand countries' healthcare and social systems, SRHR services in particular.
- b. Prioritize SRHR in situations of crisis and ensure SRHR services and supplies are classified as essential, including pre- and post-natal care, access to safe abortion, access to modern contraceptives, HIV services, and access to menstrual products and ensure these services and supplies are free and not suspended during a crisis.
- c. Adapt GBV and SRHR policies and responses to specific crisis situations and women and girls' needs and vulnerabilities.
- d. Ensure victims of GBV, including sexual violence and reproductive violence, have access to victims' centers and/or shelters where they will receive SRHR and social services.
- e. Adopt measures to ensure accountability for GBV and SRHR violations in crisis contexts and provide reparations using a transformational approach.
- f. Repeal laws that criminalize the interruption of pregnancy.
- g. Use a human rights, gender, and intersectional approach to develop and implement SRHR policies and to ensure SRHR services are accessible and available during crises.
- h. Adopt the necessary measures to ensure SRHR services are adequate and accessible to women with disabilities, indigenous women, sexual and gender minorities, women refugees and migrants, women informal workers, and other marginalized groups; it is important that states ensure their responses are comprehensive and tailored to multiple coexisting dimensions of discrimination.
- i. Adopt measures focused on transforming gender roles to respond to the global crisis of gender inequality and invest in comprehensive long-term plans on sexual education.
- j. Ensure women take part in the decision-making process for policies, programs, and plans regulating the provision of SRHR during normal times and times of crises.
- k. Consult women and girls, sexual and gender minorities, and other marginalized communities during the planning and implementation of SRHR policies and services.

II. Sexual and Reproductive Health and Rights in Situations of Crisis: Regional Findings

I'm from Mozambique. On 18 September 2020, I had a spontaneous abortion. My miscarriage was not the only trauma I had to go through that day. I left my home bleeding to the emergency health services of the Central Hospital of my hometown city... I went there in hopes that they would alleviate my pain by giving me adequate care. But to my total horror, dismay, and disbelief what I went through took me from the 21st century to the medieval era. I was subjected to a vacuum aspiration with no sedatives, I felt the most excruciating pain of my life, I screamed but I was told to stop. My body was in shock, my mind was in shock, I knew I had to get still or I could be injured but the pain was unbearable... After what seemed as an eternity they stopped the procedure. They left me in the surgical table and told me to breathe and said that the nurse would help me walk out of there. The nurse let me breathe for two minutes and asked me if I could walk. I didn't know if I could walk because I was not feeling my body at all, it was all pain but I nodded 'yes'... I wanted to leave that hospital by all means. My story gets darker because I had to go for a second vacuum aspiration because the first was not well done. I still don't know if I am ok I am still in treatment. The reason why I am sharing my story is because abortion is a taboo topic in Mozambique and I want to break the silence... Corruption is the main problem. Because for many years abortion was a crime and it is still a taboo topic, women's access to the information about their rights is limited creating opportunities for abuse of all sorts. Illiteracy also plays a big role, norms and regulations are written in the official country language but more than 50 percent of the total population are alphabet and the most affected are women that are the majority of the population but the least educated. The legal commitments about women's health and reproductive rights are not translated from paper to the ground. Sadly my story is the story of many and also the story of woman who are not in this place today. I want to bring awareness to how pain plays a big role in the safety of an abortion.

D.M. (33 years old)

I. Africa

This chapter is based on information provided by activists who are experts in the field of SRHR in the African region. These experts participated in an in person summit on November 11, 2019⁹ organized by FAR in partnership with CWGL and in a follow-up online consultation on September 21, 2020¹⁰ convened by FAR. This report supplements their inputs with desk research, individual interviews,¹¹ and email

⁹ Jane Anyango, Odongo Polycom Development Project (Kenya); Catherine Nyambura, Dandelion (Kenya); Hauwa Shekarau, International Federation of Women Lawyers (FIDA) (Nigeria); Modupe Asama, Women Advocates Research and Documentation Centre (WARDC) (Nigeria); Bless-me Ajani, Family Planning 2020 (Nigeria); Osai Ojigbo, Amnesty International (Nigeria); Mulumba Mathias Ssuuna, researcher on climate change, GBV, and humanitarian aid (Uganda); Marian Pleasant Kargbo, Pleasant Children's Foundation (Sierra Leone); Dinah Musindarwezo, Womenkind Worldwide (Rwanda); Pauline Kahuubire, Akina Mama Waafrika (Uganda); Beatrice Odallo, Center for Reproductive Rights (Global/Africa Region); Nancy Moloantoa, Ford Foundation (South Africa); and Abiola Akiyode-Afolabi, FAR Steering Committee member (Nigeria).

¹⁰ Annhkay (Zambia); Awungnija Tetchoukwi (Cameroon); Caroline Peters (South Africa); Pooja Mahendra Karia (Tanzania); Emmanuela Azu (Nigeria); Mandy Asagba (Nigeria); Abiola Akiyode-Afolabu, FAR Steering Committee member (Nigeria).

¹¹ Nyaradzo Mashayamombe (Zimbabwe).

exchanges with activists.¹² While it is not exhaustive, this section aims to give examples of how different types of crisis situations have had an impact on women and girls' SRHR and rights in Africa.

This chapter is focused on three types of crisis: armed conflict/political violence, natural disasters, and health crises. It also includes promising practices and recommendations that were elaborated by the participants in the consultation on November 11, 2019.

Crisis Situations

A. Armed Conflict

1. Many armed conflicts in the region have emerged as a response to limited resources and are exacerbated by climate change which further limits access to life-saving resources such as water and food. Transcending national borders, participants from Nigeria, Uganda, and Kenya during FAR's consultation process highlighted the extreme poverty in areas of conflict as a result of which discussions of SRHR are often seen as non-essential by government officials, even if armed conflict zones are central sites of violence against women and girls. Such responses do not consider the adverse effects of armed conflict on women and girls who bear the brunt of the violence in this region.¹³
2. **Uganda:** Today, a powerful insurgency group still maintains control of some Ugandan villages and threatens an increase in sexual and GBV, including rape, murder, and sexual slavery.¹⁴ Activists proclaim that issues of SRHR have worsened in these areas of conflict as people flee or are restricted from accessing safe services. These conflicts have led to extreme rates of poverty, especially in island districts, coupled with budgeting gaps which have resulted in very limited SRH care services. Lack of literacy and access to accurate information often lead victims to be uninformed and unaware of where to seek help.¹⁵
3. **Nigeria:** The extremist group Boko Haram, connected to ISIS, continues to cause widespread terror in the communities it controls. In territories occupied by Boko Haram, restrictions have caused mass refugee crises, sparked additional community conflicts, and disproportionately affected the safety of women and girls by way of sexual violence and limiting SRH access. The ongoing Boko Haram crisis combined with climate change droughts has resulted in a change of movement for nomadic herders from northern Nigeria into the south which is dominated by more settled farmers. As such, herders and farmers have begun to compete for resources resulting in

¹² D.M. (Mozambique). The person requested FAR to use her initials in.

¹³ Activist (Kenya), consultation in Nairobi co-organized by the Feminist Alliance for Rights (FAR) and the Center for Women's Global Leadership (CWGL), November 2019.

¹⁴ Sophie Neiman, "The enduring harm inflicted by the Lord's Resistance Army," *The New Humanitarian*, August 11, 2020, <https://www.thenewhumanitarian.org/news-feature/2020/08/11/Kony-LRA-Uganda-Congo-CAR>.

¹⁵ Activist (Uganda), consultation organized by FAR and CWGL, November 2019.

violent conflict and people being attacked, murdered, and/or raped.¹⁶ These conflicts have resulted in hospitals being blocked off, restricting access particularly for women and girls in need of SRHR services. As a result, the region has seen an increase in maternal mortality rates and preventable deaths.¹⁷ One activist noted, “In those war-torn areas ... when a woman is sick, some of them die before they even get to the hospital... When a woman is in labor, transporting her from the IDP camp to the hospital is another issue entirely.”¹⁸ The situation was further explained by a Nigerian activist in these terms, “During the crisis, most of the hospitals were affected and most of the women, especially women in the IDPs camps, were not well provided for, the women were not well taken care of sick. There are no health facilities in the IDP camps and they do not actually provide for essential needs, like family planning needs, sanitary products, etc. There are also high rates of maternal mortality [and starvation] in that region as well.”¹⁹

4. **Cameroon:** The current Anglophone crisis stems from the historical separation and union of Anglophone and Francophone Cameroon. In 2016, the conflict between the two cultural groups reached a boiling point of an armed conflict over the secession of Anglophone Cameroon, resulting in a civil war between these groups. The Anglophone crisis has particularly affected the livelihoods of women and girls in the country, leading to an increase in sexual violence, forced prostitution, lack of access to medical assistance, and giving birth in the bush.²⁰ The latter has been normalized, even for the international agencies and non-governmental organizations who are trying to help.²¹ “The Anglophone crisis had left many women from the Hinterlands as internally displaced people because they had left their homes and were living in camps. Some of them had even crossed over to Nigeria and they were refugees there. The situation worsened due to COVID-19. We have very horrible hospital conditions, most of the IDP camps don’t even have doctors or nurses to attend to them.”²² There are concerns over the issue of sexual exploitation and abuse as those in positions of power were demanding sexual favors in exchange for commodities, even from younger girls.²³

¹⁶ Siobhán O’Grady, “This little-known conflict in Nigeria is no deadlier than Boko Haram,” *The Washington Post*, July 26, 2018, <https://www.washingtonpost.com/news/worldviews/wp/2018/07/26/this-little-known-conflict-in-nigeria-is-now-deadlier-than-boko-haram/>.

¹⁷ Activist (Kenya), consultation organized by FAR and CWGL, November 2019.

¹⁸ Mandy Asagba (Nigeria), consultation organized by FAR and CWGL, September 2020.

¹⁹ Emmanuela Azu (Nigeria), consultation organized by FAR and CWGL, September 2020.

²⁰ Laura Angela Bagnetto, “Women bear the brunt of violence in Cameroon’s Anglophone crisis,” *RFI*, 2020, <https://www.rfi.fr/en/international/20200303-women-bearing-brunt-ongoing-violence-cameroon-s-anglophone-crisis>.

²¹ UNFPA has provided rape kits, caesarean birth kits, and even bush kits for those who need them. Each bush kit contains the essential items for women who are giving birth in the bush: a clean plastic sheet to give birth on, gloves, scissors to cut the cord, as well as diapers for the newborn.

²² Awungija Tetchoukwi (Cameroon), consultation organized by FAR and CWGL, September 2020.

²³ Women’s Commission for Refugees Women and Children, “Reproductive Health Coordination Gap, Services Ad hoc: Minimum Initial Service Package (MISP) Assessment in Kenya,” *Women’s Refugee Commission*, 2008, <https://www.yumpu.com/en/document/read/5389468/reproductive-health-coordination-gap-services-ad-hoc-misp>.

B. Climate Change and Natural Disasters

1. In various countries the climate crisis, including flooding, fluctuating weather patterns, desertification, and drought, has caused scarcity of resources making it difficult for families to sustain themselves. Due to cultural gender roles and norms, in rural communities across the globe, women and girls overwhelmingly undertake the labor of gathering water, food, and household energy resources.²⁴ For example, droughts along the border of Kenya and Ethiopia have spawned conflict in the region, spreading water access precarity.²⁵ With clean water access increasingly scarce, the burden of securing a daily water supply has become a daunting task for women and young children who often spend hours a day carrying water for their families from remote locations.²⁶
2. Lack of access to safe water is particularly critical to the health of women and their children during pregnancy and after. Walking to collect water and carrying heavy vessels of water prove dangerous for a pregnant woman. Further, the consumption of unsafe water can be harmful to the health of both mother and her child. From maintaining a healthy pregnancy to nourishing a newborn child, women need access to safe water at home.²⁷ A study conducted in sub-Saharan Africa highlights that across all countries of study where women and girls have to travel long distances to collect water, they face risk of sexual violence and associated stress.²⁸

C. Health Crisis

Ebola Virus Epidemic

1. The Western African Ebola virus epidemic from 2013-2016 was the most widespread outbreak of Ebola virus in the region. Studies have revealed the detrimental effect of the outbreak on public health and health systems in West Africa, where even prior to the outbreak countries faced weak health delivery systems and a severe shortage of qualified health workers. The effect of the Ebola outbreak was particularly detrimental to women and girls' reproductive health services. In a study conducted in Guinea, it was found that Ebola affected all services assessed during and after the

²⁴Joe McCarthy, "Why Climate Change Disproportionately Affects Women," *Global Citizen*, 2020, <https://www.globalcitizen.org/en/content/how-climate-change-affects-women/>.

²⁵Codi Kozacek, "Water Conflict: Violence Erupts Along Ethiopia-Kenya Water-stressed Border," *Circle of Blue*, 2011, <https://www.circleofblue.org/2011/world/water-conflict-violence-erupts-along-ethiopias-and-kenyas-water-stressed-border/>.

²⁶Sarah Stuteville, Alex Stonehill, Jessica Partnow, and Ernest Waititu, "Water Wars: Ethiopia and Kenya," *Pulitzer Center*, 2008, <https://pulitzercenter.org/projects/africa/water-wars-ethiopia-and-kenya>.

²⁷"A women's crisis," Water.Org, accessed April 27, 2021, <https://water.org/our-impact/water-crisis/womens-crisis/>.

²⁸Jay P. Graham, Mitsuaki Hirai, and Seung-Sup Kim, "An Analysis of Water Collection Labor among Women and Children in 24 Sub-Saharan African Countries," *PloS One* 11, no.6 (2016), doi: [10.1371/journal.pone.0155981](https://doi.org/10.1371/journal.pone.0155981).

outbreak. Thus, while family planning recovered post-Ebola, shortfalls were observed in recovery of antenatal care and institutional deliveries.²⁹

2. The Ebola epidemic in Sierra Leone resulted in wide scale shutdowns of school and workplaces, increasing the number of pregnancies, particularly among teenagers. Unplanned pregnancy causes its own set of issues around family planning, where many of the services including abortion are outlawed, culturally taboo, and/or restricted to private practices, resulting in child abandonment, unsafe abortions, and class-based segregated access to SRHR. According to a study by the United Nations Population Fund (UNFPA), after the outbreak, more than 14,000 teenage girls became pregnant, of whom 11,000 were in school before the outbreak.³⁰ According to a Lancet study, most maternal and child health indicators saw a decline during the outbreak of the virus in Guinea. The trends during the epidemic showed fewer institutional deliveries, fewer antenatal care visits for pregnant women and lower vaccination deliveries for children less than a year old.³¹

COVID-19 Pandemic

1. The COVID-19 pandemic and the lockdowns that followed have further restricted and limited access that women, girls, and sexual/gender minorities have to contraception, HIV care, abortion, pre- and post-natal care, birthing environments, and menstrual hygiene products. During FAR's consultation, activists shared the following challenges:
 - a. **Sexual and reproductive rights have been deprioritized.** "Zimbabwe's economic crisis has been further exacerbated by the COVID-19 pandemic. The sexual and reproductive rights and health of women and girls has been deprioritized to focus instead on the pandemic, but not on how the pandemic necessarily affects sexual and reproductive rights and health. This further harms women and girls in low-income financial situations struggling with economic accessibility to sexual and reproductive services."³²
 - b. **Access to hospitals where women and girls can get sexual and reproductive healthcare is limited.** For example, the lockdown in Zambia "has influenced people to only seek hospital care when they are sick, meaning that minor and major medical emergencies are going untreated, children are being born at home, and prescriptions are left unfilled. Zambia has also seen an increase of doctors travelling to treat COVID-19 patients, limiting

²⁹ Bienvenu S. Camara et al., "Effect of the 2014/2015 Ebola outbreak on reproductive health services in a rural district of Guinea: an ecological study," *Transactions of the Royal Society of Tropical Medicine and Hygiene* 111, no. 1 (2017): 22-29, doi: <https://doi.org/10.1093/trstmh/trx009>.

³⁰ "Spotlight on Adolescent Girls in Sierra Leone," UNFPA Sierra Leone, 2017.

<https://sierraleone.unfpa.org/en/publications/spotlight-adolescent-girls-sierra-leone>.

³¹ Alexandre Delamou, Alison Ayadi, Sidikiba Sidibe et al., "Effect of Ebola virus disease on maternal and child services in Guinea: a retrospective observational cohort study," *The Lancet Global Health*, 5, no. 4 (2017): E448-457.

³² Nyaradzo Mashayamombe (Zimbabwe), interview by FAR and CWGL, September 2020.

access to healthcare professionals when people do venture out to hospitals. Even cervical cancer screening has been at risk.”³³ In Zimbabwe “the COVID-19 pandemic has closed down several clinics, further restricting pre- and post-natal care, particularly for low-income individuals. Due to clinic closures, pregnant women are forced to find open clinics in other communities and sometimes even bribe clinic workers to assist them.”³⁴ Also “the Zimbabwe government’s COVID-19 lockdowns prohibited people from leaving a three-mile radius from their homes without a letter from an employer or healthcare provider granting them permission to leave. Approximately 95 percent of the population did not have access to employers who were able to grant them these letters and healthcare providers, being overworked due to the pandemic, were often inaccessible to citizens. This has further prohibited the physical access that women and girls had to clinics, pharmacies, and hospitals for SRHR services and to medical stores for menstrual products. This is particularly an issue for rural communities that are located several miles away from health facilities and necessitate home births.”³⁵

- c. **Access to abortion.** The health crisis due to COVID-19 “has also affected women who are in need of abortions, as the law is very strict on the requirements needed for one to get an abortion procedure.”³⁶ The Kenyan SRHR information and tele-counseling service, Auntie Jane Hotline, has noted that since the start of the pandemic, women have increasingly called to discuss the lack of access to the drug misoprostol,³⁷ commonly used to induce labor, manage miscarriages, treat postpartum hemorrhaging, and for safe abortions.³⁸ The hotline published that women who were able to access misoprostol noted price gouging at pharmacies, with drug prices rising from 30 USD pre-pandemic to 90 to 250 USD during the pandemic.³⁹
- d. **Access to contraceptives.** Due to COVID-19 restrictions, people were only allowed to visit hospitals when critically ill. This prevented thousands of women who depend on the free contraceptives offered in government hospitals from accessing contraception and family planning services. Zambia is a very patriarchal country where most married women are not allowed to take contraceptives without their husbands’ consent. Most husbands only allow their wives three months of contraceptives; anything longer often leads to dispute. With restrictions on mobility and the high price of store bought contraceptives this has been a huge issue for women.⁴⁰

³³ Ann Holland (Zambia), email communication with FAR and CWGL, September 2020.

³⁴ Nyaradzo Mashayamombe (Zimbabwe), interview by FAR and CWGL, September 2020.

³⁵ Ibid.

³⁶ Ann Holland (Zambia), email communication with FAR and CWGL, September 2020.

³⁷ MAMA Network, “Accessing Safe Abortion during Lockdown in Africa,” *Girls Globe*, 2020, <https://www.girlsglobe.org/2020/06/23/accessing-safe-abortion-during-lockdown-in-africa/>.

³⁸ Rebecca Allen and Barbara M. O’Brien, “Uses of Misoprostol in Obstetrics and Gynecology,” *Reviews in Obstetrics & Gynecology* 2, no. 3 (2019): 159-168, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2760893/>.

³⁹ MAMA Network, “Accessing Safe Abortion during Lockdown in Africa,” *Girls Globe*, 2020.

⁴⁰ Ann Holland (Zambia), email communication with FAR and CWGL, September 2020.

- e. **Access to menstrual products.** “COVID-19 has negatively impacted women’s ability to earn money, this in turn has affected their access to sexual and reproductive health and rights. Women can barely afford to buy menstrual products, this has added to the dire case of period poverty in the country. With high taxes and an increase in commodity prices, pads have simply become an expensive commodity.”⁴¹ Lockdowns and lack of menstrual resources in Zambia have also forced women and girls to find alternatives to menstrual hygiene including the use of cloth (sanitary or not) and charcoal, which could lead to infections and long-term ailments.⁴²
- f. **Impact of COVID-19 on displaced women and girls.** “Ongoing Nigerian communal resource altercations due to climate change and Boko Haram activity have left people displaced, particularly impacting women and girls’ access to healthcare and sexual and reproductive care. Displacement due to conflict has also put displaced people at higher risk of contracting COVID-19, especially for migrant and refugee women and girls who are at higher risk of sexual violence.”⁴³
- g. **Increased intimate-partner violence.** Lockdowns and quarantines across the globe have disproportionately impacted women and girls, many of whom are stuck at home with their abusers. This has resulted in an increase in domestic violence and GBV in many countries, including Nigeria and Cameroon. Increased sexual violence, particularly among girls, has increased the number of unplanned, unwanted, and emotionally and physically harmful pregnancies. Particularly in countries with restrictions on contraception and abortion access, this has caused a severe crisis for women and girls in finding alternative termination methods and is a general harm to their mental health which impacts their SRHR.⁴⁴ “Gender-based violence has spiked tremendously in the last six months. With a new report showing that every three hours [and] seventeen minutes, a Zambian girl gets raped. Femicide has risen. Women have very few places to escape to for help and in a country where rape culture is rampant, this does not seem like it will end any time soon.”⁴⁵
- h. **Lack of policies using a gender perspective.** Many countries, including some of those outlined above and those not noted, lack a gender-based COVID-19 analysis or plan, resulting in women and girls bearing the brunt of the pandemic’s effects. Lacking a gender-based plan makes it difficult to hold governments accountable for women, girls, and gender/sexual minorities facing COVID-19 related challenges.

⁴¹ Ibid.

⁴² Ibid.

⁴³ Mandy Asagba (Nigeria), consultation with FAR and CWGL, September 2020.

⁴⁴ Ibid.

⁴⁵ Ann Holland (Zambia), email communication with FAR and CWGL, September 2020.

D. Other Concerning Trends

Unwanted Pregnancy, Abortion Access, and Family Planning

1. Women and girls have limited access to the full spectrum of high-quality SRHR care throughout the region. Poor access to contraception and safe abortion are also indicators of profound gender-based discrimination affecting women and girls' rights. This is also concerning considering the high rates of sexual violence in the region including intimate-partner violence, community violence, armed conflict, political violence, terrorism, and increased violence during forced displacement.
2. In 2017, 93 percent of women of reproductive age in Africa lived in states with restrictive abortion laws.⁴⁶ Only Cape Verde, South Africa, and Tunisia allowed unrestricted⁴⁷ abortion access.⁴⁸ During 2010-2014, an average of about one in four abortions in Africa were safe.⁴⁹ Even in countries where the law allows abortion under limited circumstances, it is likely that few women were able to obtain a safe legal procedure. Lack of information around SRH services resulted in carrying pregnancies to term despite negative complications or seeking dangerous abortion alternatives.
3. Globally, countries with restrictive abortion policies have much higher levels of maternal mortality. The very restrictive abortion laws in Africa have resulted in the highest number of abortion-related deaths in the world. The vast majority of abortions result from unintended pregnancies. Current rates are the highest only after Latin America and the Caribbean region.⁵⁰ According to the World Health Organization (WHO), 20 percent of global maternal deaths happen in Nigeria. As of 2015, a woman in Nigeria has a 1 in 22 lifetime risk of dying during pregnancy, childbirth, or postpartum/post-abortion.⁵¹
4. To better control the number and timing of births, women need improved access to modern contraceptives. However, cultural norms around SRH tend to be one of the major barriers cited by activists. Governments' dedication to upholding culturally conservative sexual norms are a widespread concern across the region. In Uganda, laws which close spaces for civil society organizations affects their efforts to advance a SRHR agenda.⁵² In Zimbabwe there exists a deep

⁴⁶ Abortion is not permitted for any reason in 10 out of 54 African countries.

⁴⁷ In any of these countries women need to prove a reason for having an abortion. However they have gestational time period restrictions on abortion access.

⁴⁸ "Abortion in Africa: Fact Sheet," Guttmacher Institute, 2018, https://www.guttmacher.org/sites/default/files/factsheet/ib_awafrica.pdf.

⁴⁹ Ibid.

⁵⁰ Susheela Singh, Lisa Remez, Gilda Sedgh et al., "Abortion Worldwide 2017: Uneven Progress and Unequal Access," Guttmacher Institute, 2018, <https://www.guttmacher.org/report/abortion-worldwide-2017#>.

⁵¹ WHO, "Maternal health in Nigeria: Generating information for action," Sexual and Reproductive Health Programme, 2019, <https://www.who.int/reproductivehealth/maternal-health-nigeria/en/>.

⁵² Activist (Uganda), consultation with FAR, November 2019.

seated stigma against contraception access. Thus judgmental nurses and doctors dissuade young people from searching for safe sex options such as contraceptives and condoms.⁵³

5. Marginalized sectors of the population also have limited access to contraceptives including women with disabilities, forcibly displaced people, those in rural communities, those belonging to the LGBTQ+ community, and women who face economic hardship which contributes to a lack of SRHR care. Zambian activists noted that, “While contraception is freely available in the country, it is virtually only available in urban areas, leaving rural women and girls unable to access affordable contraception.”⁵⁴ In Nigeria, the government operates a family planning program centered on married heterosexual people. As such, no government assistance is allotted for non-heterosexual families, split families, or displaced women and girls who are often the most at risk for sexual violence and lack financial resources to search out alternative family planning methods.⁵⁵
6. Activists highlight that, despite some efforts from political figures and grassroots activists, religious and cultural norms still prevent the provision of access to SRH care. Thus, organizations and political figures searching for grants to help provide these services are forced to leave out health issues from the conversations, further spreading misinformation around what qualifies as SRHR.⁵⁶
7. Cameroonian women and girls, due to many of the outlined reasons above, have seen an increase in teenage pregnancy which can cause severe complications, emotional, physical, and economic distress. Teenage pregnancy contributes to increased maternal and infant mortality rates and access to menstrual products also remains limited. An activist explained the situation in these terms: “We’ve had a lot of rape cases during this period, from [Anglophone] crisis going up to the COVID-19 period which has led to a lot of teenage pregnancy. It has left many women, many young girls, with complications because many have very few people to attend to them. We have a problem of very high infant mortality rates now because of lack of basic medications. The response of the government has been very, very deplorable. The government has done little to nothing for the needs of women. They think more about the national dialogue and how to bring an end to the [Anglophone] crisis rather than thinking about what women are going through [due to the crisis] in particular.”⁵⁷

Discriminatory Gender Stereotypes and Sexuality Education

1. Access to reliable, evidence-based sexuality education in the region is also lacking. In Sierra Leone, activists shared that there is a stigma attached to any discussions around SRHR, due to its culturally taboo construction, and that contraceptives are associated with “prostitutes,” leading

⁵³ Nyaradzo Mashayamombe (Zimbabwe), interview with FAR and CWGL, September 2020.

⁵⁴ Activist (Zambia), consultation organized by FAR and CWGL, November 2019.

⁵⁵ Activist (Nigeria), consultation organized by FAR and CWGL, November 2019.

⁵⁶ Activist (Kenya), consultation organized by FAR and CWGL, November 2019.

⁵⁷ Awungija Tetchoukwi (Cameroon), consultation with FAR and CWGL, September 2020.

to people being less likely to use/demand them. This is harmful in many ways, further restricting access to reproductive agency and contributing to the demonization of sex workers.⁵⁸

2. In Zambia, “the government’s program, which is being funded by UNESCO and the Swedish Embassy, is basically a sex education program for young girls in schools where they not only teach them about sexuality education but they also give out free contraceptives to try and reduce the number of teenage pregnancies and STIs. It recently came out that hundreds, if not thousands of girls, are getting on contraceptives and reducing the number of teenage pregnancies. However, the government doesn’t like it because we are a very Christian nation and very hypocritical in the sense that they are now against all these young girls having contraceptives. [...] The government is trying to have the sex education removed.”⁵⁹
3. Cultural taboos surrounding SRHR are also reflected in the Ugandan education system. The government adopted a policy on “comprehensive sexuality education” but still limits its focus to abstinence only, closing off the possibilities for other forms of safe sex. Abstinence only education has been proven time and again to be ineffective and has actually increased the number of unwanted and teenage pregnancies, often resulting in pregnancy and birth-related complications or the pursuit of dangerous measures for termination.⁶⁰
4. In Zimbabwe, a majority of children who attend school are from middle and upper class families. A majority of children do not have access to education due to economic issues. As such, many girls are married at young ages and/or become pregnant. Lack of access to education is also known to limit a girl’s empowerment and knowledge on how to access health services, continuing the cycle of GBV such as child marriage, rape, and sexual assault and lack of access to SRHR.⁶¹

Discriminatory Practices: Female Genital Mutilation (FGM)

1. Female Genital Mutilation (FGM) continues to be a widespread practice in countries all over the world, though it largely occurs in Africa. The global trend of FGM has increased by approximately by half a million between 1994 and 2019. Taking into consideration the upward trend, an estimated 50 million girls in Africa alone will be at risk of FGM by 2030.⁶²
2. FGM can cause severe emotional and physical distress and complications. Aside from the psychological issues associated with FGM, labor and pregnancy complications are common with the most severe of FGM methods and reports of death from blood loss due to FGM occur regularly. FGM also contributes to long-term health problems including serious infections, pain during sex, mental health issues, painful urination and menstruation, infections caused by

⁵⁸ Activist (Kenya), consultation organized by FAR and CWGL, November 2019.

⁵⁹ Ann Holland (Zambia), email communication with FAR and CWGL, September 2020.

⁶⁰ Activist (Uganda), consultation organized by FAR and CWGL, November 2019.

⁶¹ Nyaradzo Mashayamombe (Zimbabwe), interview with FAR, September 2020.

⁶² First African Summit on FGM and Child Marriage, “Final Report,” Dakar, Senegal, 2019.

urination and menstruation, increased maternal mortality, and increased risk of death for newborns.⁶³

3. Approximately 98 percent of women and girls between the ages of 15 to 49 have experienced FGM in Somalia,⁶⁴ the highest percentage in the world,⁶⁵ and approximately 90 percent of women and girls in Sierra Leone have undergone this practice.⁶⁶

Promising Practices

1. Civil society organizations in the region have engaged with different actors to raise awareness and change attitudes regarding SRHR. In various countries, civil society organizations operate safe spaces and form programs which are dedicated to addressing women and girls' access to SRH and sexuality education. Organizations also implement leadership development programs to tackle power imbalance and gender inequality.
2. During FAR's consultation in November 2019, activists from Sierra Leone shared that they have been in meetings with religious leaders, youth groups, and women lawyers who have educated both the leaders and youth on SRHR and culture which has helped to disseminate information and change harmful ideas about sex.⁶⁷ Activists from Uganda shared that introducing the concept of SRHR and sexuality education to young boys and girls in Uganda has helped to start the educational process at a young age and change the negative culture around sexuality. Organizations have also led litigation strategies with positive results, overturning the criminalization of homosexuality.⁶⁸

A. Rainbo Initiative in Sierra Leone⁶⁹

1. "Sierra Leone is a deeply gendered society, where the socio-cultural norms that govern attitudes, behaviors, practices, and expectations results in gender inequality. Gender inequality coupled with staunchly held restrictive gender norms that manifest in high levels of GBV due to the weakened social structures in Sierra Leone leave survivors vulnerable and unable to seek redress."⁷⁰

⁶³ "Zero Tolerance for Female Genital Mutilation: FGM Factsheet," Ifrah Foundation, 2019, https://37f4e620-94cb-43cc-a3f9-b74a3542b63d.filesusr.com/ugd/74d910_1407f5e7adfc4e269b58c4560e4e37a2.pdf.

⁶⁴ European Asylum Support Office, "COI Query Response," 2019, https://www.ecoi.net/en/file/local/2013242/2019_07_23_EASO_COI_QUERY_Somalia_FGM_Q19.pdf.

⁶⁵ "Zero Tolerance for Female Genital Mutilation: FGM Factsheet," Ifrah Foundation, 2019, https://37f4e620-94cb-43cc-a3f9-b74a3542b63d.filesusr.com/ugd/74d910_1407f5e7adfc4e269b58c4560e4e37a2.pdf.

⁶⁶ Liliane Bitong, "Fighting genital mutilation in Sierra Leone," *Bulletin World Health Organization* 83, no. 11 (2005): 801-880, <https://www.who.int/bulletin/volumes/83/11/news21105/en/>.

⁶⁷ Activist (Sierra Leone), consultation organized by FAR and CWGL, November 2019.

⁶⁸ Activist (Uganda), consultation organized by FAR and CWGL, November 2019.

⁶⁹ Awungija Tetchoukwi (Cameroon), consultation with FAR, September 2020.

⁷⁰ "Welcome to Rainbo," Rainbo Initiatives, accessed April 27, 2021, <http://www.rainboinitiativesl.org>.

2. In this context, the grassroots organization Rainbo Initiative is relevant as it provides free rescue, treatment, and psychosocial services to victims of rape and sexual and GBV. The Rainbo Initiative has five centers which they operate in Freetown, Bo, Kanema, Kono, and Makeni. Collaboration between the Rainbo Initiative and public hospitals/health facilities has reduced negative attitudes concerning teenage pregnancy and seeking reproductive health services when one is not married.

B. MAMA Network and Telehealth/Tele-Counseling Services during COVID-19⁷¹

1. The MAMA Network is a regional movement, founded by the organizations Trust for Indigenous Culture and Health and Women Help Women. The Network opened three hotlines in May 2020 which focus on women and girls' SRH in Cameroon, the Democratic Republic of the Congo, and Zambia, in addition to their preexisting hotlines in Nigeria, Kenya, Tanzania, Malawi, and Uganda. The MAMA Network and telehealth/tele-counseling hotlines provide crucial and accurate information about how women and girls' SRHR can and has been affected by the pandemic, while also helping callers find safe and healthy ways of working through their SRHR issues.

C. TaLI: Every Child in School in Zimbabwe⁷²

1. The organization Friends of Tag a Life International (TaLI) has engaged in advocacy to change policies and laws that promote and affect girls and young women's rights, such as the initiative "Every Child in School Campaign" which TaLI has been leading in partnership with more than 250 local and international NGOs demanding for the government of Zimbabwe to provide for state funded basic education for all children. In response, the Zimbabwean government has released the Education Bill which provides for state funded basic education.
2. The initiative is promising because it promotes comprehensive education including sexuality education and encourages girls who become pregnant to return to their education. Current challenges center on holding the government, schools, and families accountable and finding funding to maintain access to education for all children which has become increasingly difficult during the current health crisis.⁷³

D. Community Health Workers in Kenya⁷⁴

1. In Kenya, services related to SRH are often thought to be the work of "traditional workers." Referred to now as Community Health Workers, they were officially integrated into the health system and their services were upgraded from being traditional birth attendants. The services

⁷¹ MAMA Network, "Accessing Safe Abortion during Lockdown in Africa," *Girls Globe*, 2020.

⁷² Nyaradzo Mashayamombe (Zimbabwe), interview with FAR and CWGL, September 2020.

⁷³ Ibid.

⁷⁴ Activist (Kenya), consultation organized by FAR and CWGL, November 2019.

they offer range from promotive, preventive, and partly curative services, including maternal and child health, HIV care, and treatment of malaria.⁷⁵ This initiative is relevant because Community Health Workers add value to addressing SRHR issues in communities, although continued efforts are necessary to provide better training, availability of necessary resources and equipment, and reporting and welfare infrastructure.

Recommendations

1. The activists who attended the consultation on November 11, 2019 discussed and agreed on a number of recommendations that states must take into account for an effective response to SRHR in crisis contexts.
 - a. Classify menstrual products as essential, making them accessible and free.
 - b. Remove taxes on menstrual products to increase affordability.
 - c. Establish safe spaces for victims and provide properly trained respondents for survivors of sexual violence and rape centered on healing and safety.
 - d. Establish centers which provide good quality healthcare, social services, and information on SRHR standards in a proactive manner.
 - e. Provide emergency packages including condoms and contraceptives for women.
 - f. Fund grassroots organizations and civil society organizations that are raising awareness about SRHR.
 - g. Adopt measures to ensure accountability for GBV and SRHR violations in contexts of crisis.
 - h. Engage members of the parliament in discussions around the need to ensure access to SRHR and to increase awareness that addressing gender issues in humanitarian action is lifesaving and planning and budgeting needs to reflect this fact.
 - i. Decriminalize abortion and ensure availability of contraception.
 - j. Ensure access to abortion for victims of sexual violence within a framework of reparations.
 - k. Call for national emergencies concerning the rise of GBV and rape culture.
 - l. Provide comprehensive sex education and comprehensive sexuality education that includes LGBTQ+ information and implement programs throughout the country.
 - m. Implement nation-wide campaigns that focus on ending rape culture in every home and work place.
 - n. Launch campaigns which focus on destigmatizing LGBTQ+ people and providing resources to them.

⁷⁵ Herman Ormel et al., "Salaried and voluntary community health workers: exploring how incentives and expectation gaps influence motivation," *Human Resources for Health* 17, no. 59 (2019), doi: <https://doi.org/10.1186/s12960-019-0387-z>.

- o. Ensure sexual reproductive health clinics are established throughout the country and widespread education about reproductive health rights including access to abortion and contraception is available.
- p. Increase funding to help women attain SRHR.
- q. Provide online, radio, television, and social media support for women and girls struggling due to COVID-19.
- r. Provide safety and permanent residences for refugees and displaced people, particularly women and girls.
- s. Provide incentives for families to keep their children in school.

II. Asia⁷⁶

The current chapter is based on information provided by activists, who are experts on the field of SRHR in South Asia, East Asia, and Asia Pacific and participated in an in person consultation on January 14, 2020⁷⁷ organized by FAR along with the Forum for Women, Law and Development (FWLD) and FAR's Global Coordinator, the Center for Women's Global Leadership (CWGL). FAR conducted desk research in August and September 2020 to supplement the information gathered during the consultation and received additional inputs from a few activists via email. To contribute to FAR's submission, ARROW drafted the section focused on the impact of COVID-19 on SRHR. This is based on secondary sources and inputs provided by ARROW's partners in various countries in the region.

The following chapter is focused on three types of crisis in this sub-region and their impact on women and girls' SRHR: 1. Natural Disasters; 2. Armed conflict/political violence; and 3. COVID-19. These sections are followed by promising practices in the region. The last section includes a few recommendations that were elaborated by the participants in the consultation on January 14, 2020.

Crisis situations

A. Natural Disasters

Impact of Natural Disasters on SRHR

1. Every year, millions of people in Asia are affected by changing weather patterns and climate-related disasters.⁷⁸ In 2015, Asia reported the greatest number of natural disasters globally.⁷⁹

⁷⁶ This chapter mainly focuses on South Asia, East Asia, and Asia Pacific.

⁷⁷ Sabin Sir, Forum for Women in Law and Development (FWLD) (Nepal); Neha Gurung, FWLD (Nepal); Deepesh Shrestha, FWLD (Nepal); Roshana Pradhan, FWLD (Nepal); Prabhakar Shrestha, Center for Reproductive Rights (Nepal); Laxmi Nepal, Blind Women Association in Nepal (Nepal); Salina Kafle, Trial International (Nepal); Madhavi Bajracharya, Ipas Nepal (Nepal); Kamal Gautam, Arrow (Nepal); Yasso Kanti Bjattachan, National Indigenous Women's Forum (Nepal); Bimala Puri, Care (Nepal); Palita Thapa, National Women Commission (Nepal); Pratima Gurung, National Indigenous Disabled Women (Nepal); Shireen Huq Naripokkho (Bangladesh); Leonora Evriani, Perkumpulan Keluarga Berencana Indonesia (PKBI)/Family Planning Association (IPPA) (Indonesia); Shreen Abdul Saroor, NorthEast Women's Action Network (Sri Lanka); Emmanuella Kania Mamonto, Asia Justice and Rights AJAR (Indonesia); Flora Bawi Nei Mawi, Latsi Nu Women Agency (Myanmar).

⁷⁸ A 2019 World Bank study found that "[i]n Asia, nearly 700 million people—half of the region's population—were affected by one or more climate-related disasters and changing weather patterns are expected to impact directly over 800 million people by 2050." Ditte Fallesen, Haris Khan, Ahsan Tehsin, and Atishay Abbhi, "South Asia needs to act as one to fight climate change," *World Bank Blogs*, November 11, 2019, <https://blogs.worldbank.org/endpovertyinsouthasia/south-asia-needs-act-one-fight-climate-change>.

⁷⁹ Bhavya Joshi, "Sexual and Reproductive Health in Crisis Situations- India's Case Study," *WomenSARRA*, 2020, 1 (submission to the Working Group).

Research has found that East Asia and South Asia, a region prone to seismic hazards, registered the highest exposure to cyclones, droughts, and floods in the last twenty years.⁸⁰

2. Disasters have a particularly negative impact on agriculture which is the primary source of income for most households in South Asia.⁸¹ Experts estimate that climate change could push 62 million South Asians below the extreme poverty line by 2030.⁸² Thus, the situation will affect vulnerable groups disproportionately due to pre-existing social and economic inequalities including women, girls, and sexual/gender minorities. For example, the Disaster Risk Management Report of Indonesia found that in the 2015 post-tsunami scenario, women suffered economically and socially more than men and that female-headed households remained more vulnerable to shocks and instability than male-headed households. The study noted that “strong patriarchal traditions and many years of conflict made it difficult for tsunami affected women to assert their rights and raise their voices.”⁸³
3. Social norms constrain women’s mobility, hindering self-rescue during and in the aftermath of an emergency.⁸⁴ In some cases, women cannot leave their homes without male permission. Also, linked to the imposition of gendered social norms, “many women’s workload in terms of caring for children, the infirm, the elderly and those with functional limitations or disabilities, rise at exactly the same time when traditional support networks may have been damaged.”⁸⁵ This has an effect on their physical and mental health and leaves them with little time to seek healthcare for themselves.
4. Empirical data points to the difficulty of raising awareness about prevention plans among women. “Given their role as housewives, women spend most of their time working at home and they do not have access to information regarding safety measures needed during a natural disaster.”⁸⁶ In some places, superstitious beliefs among women and the population at large prevail over scientific-based prevention policies. “Disaster prevention plans are confronted by superstitious

⁸⁰ E. Christenson, M. Elliott, O. Banerjee, L. Hamrick, and J. Bartram, “Climate-related hazards: a method for global assessment of urban and rural population exposure to cyclones, droughts, and floods,” *International journal of environmental research and public health* 11, no. 2 (2014): 2169-2192, <https://doi.org/10.3390/ijerph110202169>.

⁸¹ J.P. Aryal, T.B. Sapkota, R. Khurana et al., “Climate change and agriculture in South Asia: adaptation options in smallholder production systems,” *Environ Dev Sustain* 22 (2020): 5045-5075, <https://doi.org/10.1007/s10668-019-00414-4>.

⁸² Stephane Hallegatte, Mook Bangalore, Laura Bonzanigo, Marianne Fay et al., “Shock waves: Managing the impacts of climate change on poverty,” World Bank Group, 2016, <https://openknowledge.worldbank.org/bitstream/handle/10986/22787/9781464806735.pdf>.

⁸³ “Indonesia’s Disaster Risk Management Baseline Status Report 2015,” National Disaster Management Authority, 2015, 24, https://www.preventionweb.net/files/50832_5083220161031indobaselinereportfina.pdf.

⁸⁴ Sneha Gangwar, “Integrating Gender Issues in Mitigation and Management of Disaster in India,” *International Journal of Environmental Engineering and Management* 4, no. 6 (2013): 615, https://www.ripublication.com/ijeem_spl/ijeemv4n6_15.pdf.

⁸⁵ “A Practical Guide to Gender-sensitive Approaches for Disaster management,” International Federation of Red Cross and Red Crescent Societies (IFRC), 7-9, <https://www.ifrc.org/PageFiles/96532/A%20Guide%20for%20Gender-sensitive%20approach%20to%20DM.pdf>.

⁸⁶ Leonora Evriani (Indonesia), consultation with FAR, FWLD, and CWGL, January 2020.

beliefs, for example that natural disasters are the result of sins and are God's way of punishment.” These ideas are engrained among not only the general public but also government representatives.⁸⁷

State Response and Access to SRHR Services and Supplies

1. Women and girls’ access to essential SRHR services and supplies could be extremely limited in the aftermath of a disaster. This was the case after the tsunami in India, Indonesia, Thailand, and Sri Lanka in December 2004. As a regional organization reported, “Many [women] complained that they had no access to contraception until six months had passed. The damage to hospitals included destruction of drug stores and many hospitals did not have stocks of contraceptives – pills, injectables, loops, condoms – until several weeks after the tsunami.”⁸⁸
2. Women and girls have specific needs that should be considered when distributing emergency relief kits. In relation to their SRHR, these should include sanitary pads or other menstrual products that are appropriate in the community where they are being distributed, underwear, and soap among other essential items.⁸⁹ However, very often women and girls did not have access to essential products for menstrual hygiene management and that there have been associated problems linked to the absence of gender-sensitive measures like ensuring adequate distribution and designated spaces to utilize menstrual products in a dignified and safe manner.
3. In Sri Lanka, in the aftermath of the 2014 tsunami, distribution of sanitary products in camps was under the control of male officials who handed them out one at a time, so women had to go back and ask repeatedly.⁹⁰ This was problematic because women could be reluctant to approach men regarding their personal hygiene requirements. A study in India reported the negative impact of floods on women’s access to SRHR services, health, and other aspects of their lives. With regards to menstrual hygiene management, “women often felt ashamed to ask for Sanitary Napkins if men were leading the relief efforts. Apart from this there was a feeling that menstrual health or sexual reproductive health are not survival issues such as food, water and shelter, therefore any deeper discussion on these topics was not encouraged.”⁹¹

⁸⁷ Ibid.

⁸⁸ C.H. Akmatova and Chiang Mai, “Guidelines for Gender Sensitive Disaster Management: Practical Steps to Ensure Women’s Needs Are Met and Women’s Human Rights Are Respected and Protected during Disasters,” *APWLD*, 2006, 24.

⁸⁹ “UNFPA Dignity Kits: Nepal Earthquake,” UNFPA, 2015, <https://www.unfpa.org/resources/dignity-kit-nepal-earthquake>.

⁹⁰ C.H. Akmatova and Chiang Mai, “Guidelines for Gender Sensitive Disaster Management: Practical Steps to Ensure Women’s Needs Are Met and Women’s Human Rights Are Respected and Protected during Disasters,” *APWLD*, 2006, 12.

⁹¹ Bhavya Joshi, “Sexual and Reproductive Health in Crisis Situations- India’s Case Study,” *WomenSARRA*, 2020, 6.

4. In a number of countries, there are disaster management laws that include women and children among the vulnerable groups that should be prioritized.⁹² However, there are challenges when male soldiers implement them as their existing perceptions constrain their ability to address the issues of women's and children's health adequately.⁹³ During an emergency situation in Myanmar, the military was given the responsibility to manage the crisis. On this action, an activist commented, "While it might have been important in the first phase, currently, in the rehabilitation and recovering process, it is tricky to witness how it added to the violation of women and children rights in villages during the process taken up by the military."⁹⁴ In Indonesia, an additional problem occurred when for political reasons the national level government did not make proper use of the aid that came to Indonesia.⁹⁵
5. Obstacles that women have faced while accessing SRHR services in the aftermath of an emergency includes the lack of female medical personnel. This is particularly important when cultural norms may not allow women to be examined by male physicians. In Pakistan, after the tsunami, a majority of expectant mothers in the camps delivered their babies in tents despite the availability of medical aid. The reason reported by women was that the medical doctors present were mostly men and they and their families were very hesitant to bring the doctors either to the tents or to take women to the medical units.⁹⁶
6. In Nepal after the massive earthquake in 2015, there was a lack of distribution or availability of sanitary pads and public toilets, and a limited number of health facilities in general, which made it more challenging for women to access SRH services soon after the disaster.⁹⁷ Hospitals were understaffed, health care providers did not have adequate training,⁹⁸ and health facilities in different localities reported shortages of SRHR supplies immediately after the earthquake.⁹⁹ Moreover, "the government set up birthing centers but deprioritized abortion services."¹⁰⁰ When

⁹² For example, the law concerning disaster management in Indonesia refers to the protection and priority of vulnerable groups which only includes infants, preschoolers, children, pregnant women or nursing mothers, the disabled, and the elderly.

⁹³ Leonora Evriani (Indonesia), consultation with FAR, FWLD, and CWGL, January 2020.

⁹⁴ Flora Bawi Nei Mawi (Myanmar), consultation FAR, FWLD, and CWGL, January 2020.

⁹⁵ Examples of this are seen in the aftermath of natural disasters, such as the 2004 tsunami in Aceh Indonesia. In the Collaborative Listening Project, Aceh citizens welcomed international aid to help rebuild their communities but expressed concern for how those resources were redistributed. As the report states, "People regularly used such words as 'corruption' and 'nepotism' to describe their sense of how the distribution of aid occurs." "Collaborative Listening Project: Field Visit Report in Aceh, Indonesia," Collaborative Learning Project, November 2005, <https://www.cdacollaborative.org/wp-content/uploads/2016/02/Field-Visit-Report-Aceh-Indonesia.pdf>.

⁹⁶ C.H. Akmatova and Chiang Mai, "Guidelines for Gender Sensitive Disaster Management: Practical Steps to Ensure Women's Needs Are Met and Women's Human Rights Are Respected and Protected during Disasters," *APWLD*, 2006, 22.

⁹⁷ Kamal Gautam (Nepal), consultation with FAR, FWLD, and CWGL, January 2020.

⁹⁸ Ibid.

⁹⁹ A. Myers, S. Sami, M.A. Onyango et al., "Facilitators and barriers in implementing the Minimum Initial Services Package (MISP) for reproductive health in Nepal post-earthquake," *Conflict Health* 12 (2018): 35, <https://doi.org/10.1186/s13031-018-0170-0>.

¹⁰⁰ Sabin Shrestha (Nepal), consultation FAR, FWLD, and CWGL, January 2020.

abortion services were provided, women raised concerns related to the lack of confidentiality and privacy.¹⁰¹ Finally the Nepali government requested an organization to supply medical abortion drugs to the affected districts and to conduct training of abortion service providers.¹⁰²

7. Another example that shows how the Nepali government failed to address women's SRHR during a natural disaster involves a case represented by Forum for Women, Law and Development (FWLD). In this case, while the government provided free treatment to the injured during the earthquake, it denied free treatment to a woman who had a miscarriage saying that it "was not an immediate impact of earthquake [but a] merely a consequence." She was forced to pay for all of her medical expenses.¹⁰³

Safe Shelter and water, sanitation, hygiene (WASH)

1. Access to appropriate safe shelter, water, and sanitation is particularly important to ensure people's wellbeing and reduce threats of GBV, including sexual violence, in the aftermath of an emergency.¹⁰⁴ An activist from Indonesia noted that the state's negligence regarding the needs of women and children in disaster planning and management was reflected in the use of gender-neutral language and the lack of protection measures which has resulted in increased sexual violence after natural disasters.¹⁰⁵
2. Spacing and design of shelters and camps is important for ensuring safety and adequate privacy for women and girls. After the 2015 earthquake in Nepal, many women and girls who were staying in camps and temporary shelters did not have access to separate toilets and spaces.¹⁰⁶ Women and girls with disabilities reported psychological, physical, and sexual violence at an increased rate in shelters and were often assaulted by relatives, family members, or strangers,¹⁰⁷ which is evidence of the increased vulnerability of this group in contexts of crisis. Unfortunately, redress measures for victims of GBV were not accessible in the aftermath of the earthquake.¹⁰⁸

¹⁰¹ Madhavi Bajracharya (Nepal), consultation with FAR, FWLD, and CWGL, January 2020.

¹⁰² Ibid.

¹⁰³ Sabin Shrestha noted there is also the social perception that if any woman delivers a baby during the time of an earthquake then the child will be born with physical incapacities which played a role in harmful practices. Sabin Shrestha (Nepal), consultation with FAR, FWLD, and CWGL, January 2020.

¹⁰⁴ P. Chaudhary, G. Vallese, M. Thapa, V. Alvarez, L. Pradhan, K. Bajracharya, S. Goyet et al., "Humanitarian response to reproductive and sexual health needs in a disaster: The Nepal Earthquake 2015 case study," *Reproductive Health Matters*, 25, no. 51 (2017): 25-39, <https://www.jstor.org/stable/26495949?seq=1>.

¹⁰⁵ Emmanuella Kania Mamonto (Indonesia), consultation FAR, FWLD, and CWGL, January 2020.

¹⁰⁶ "Gender Equality and Social Inclusion in Post-Earthquake Reconstruction," Forum for Women, Law and Development, 2017, <http://fwld.org/wp-content/uploads/2018/11/Gender-Equality-and-Social-Inclusion.pdf>.

¹⁰⁷ Sapana Basnet Bista and Shaurabh Sharma, "Violence Against Women and Girls with Disabilities During and after the 2015 Nepal Earthquake: Thematic Analysis of Qualitative Data," *The Lancet Global Health* 7 (March, 2019): S45-S45, [https://doi.org/10.1016/S2214-109X\(19\)30130-5](https://doi.org/10.1016/S2214-109X(19)30130-5).

¹⁰⁸ "Gender Equality and Social Inclusion in Post-Earthquake Reconstruction," Forum for Women, Law and Development, 2017, <http://fwld.org/wp-content/uploads/2018/11/Gender-Equality-and-Social-Inclusion.pdf>.

3. A research in India highlighted that given the lack of space, facilities, and basic necessities in the aftermaths of floods, women were unable to manage monthly menstruation in a safe, private, and dignified manner. The lack of separate toilets or spaces shelters aggravated the problem.¹⁰⁹
4. Failure to provide safe spaces within the camps, where women and girls can be examined in privacy, is essential to ensure proper access to SRH services. As an organization documented, women's SRHR in Lampuuk village which was affected by the 2004 tsunami became a grave concern: "health examinations were normally conducted in open tents without proper examination beds or in unenclosed areas. Therefore, women were reluctant to examine their reproductive organs when they had any pain or ailments."¹¹⁰

Impact on Women and Girls Belonging to Marginalized Communities

1. Women belonging to marginalized communities face additional barriers to access SRHR services, supplies, and information. During the consultation, an activist referred to the situation of indigenous women in Nepal. She shared, "In very remote areas, there is a lack of transportation and communication. So, there are no proper health services which addresses the reproductive health and needs of women in that area. Sadly, not only in the mountain region, but also in the remote and rural areas, most of the specialized doctors do not wish to work there. In case there is any doctor then it is usually a male. Thus, it creates an awkward situation for women in such areas to receive health services from male practitioners. Language is another barrier for women while trying to access health services."¹¹¹ Likewise Dalit communities, which are the lowest of the 125 caste groups in Nepal, live in remote, disaster-prone areas. According to the Feminist Dalit Organization (FEDO), when the earthquake struck, government disaster relief support failed Dalit communities. Dalit women in particular found it difficult to access government resources because of their lower caste status and marginalization.¹¹²
2. Women with disabilities neither receive help for accessing distribution locations and nor is relief aid delivered to them. The situation is compounded for indigenous women with disabilities, as they need to overcome multiple obstacles including physical and language barriers.¹¹³ It is important to note that the Safe Motherhood and Reproductive Health Right Act enacted in Nepal in 2019 requires that services be implemented considering the needs of adolescents and persons with disabilities and that this law should be utilized to supplement Nepal's Disaster Management

¹⁰⁹ Bhavya Joshi, "Sexual and Reproductive Health in Crisis Situations- India's Case Study," *WomenSARRA*, 2020, 3-6.

¹¹⁰ C.H. Akmatova and Chiang Mai, "Guidelines for Gender Sensitive Disaster Management: Practical Steps to Ensure Women's Needs Are Met and Women's Human Rights Are Respected and Protected during Disasters," *APWLD*, 2006, 24.

¹¹¹ Yasso Kanti Bhattachan (Nepal), consultation with FAR, FWLD, and CWGL, January 2020.

¹¹² "Life after the earthquake for Dalit communities in Nepal," Minority rights Group International, December 29, 2015, <https://minorityrights.org/2015/12/29/life-after-the-earthquake-for-dalit-communities-in-nepal/>.

¹¹³ Pratima Gurung (Nepal), consultation with FAR, FWLD, and CWGL, January 2020.

Act from 2018. However, activists have highlighted these promising laws are not being adequately implemented.¹¹⁴

3. As noted by the Committee on the Rights of Persons with Disabilities regarding the situation in Myanmar, “the rights and the specific requirements of women with disabilities in situations of humanitarian emergencies are not sufficiently considered in the Natural Disaster Management Law or the Action Plan on Disaster Risk Reduction, and there is a lack of protocols, plans and measures with respect to persons with disabilities in these situations. Persons with disabilities, especially women and girls with disabilities and those belonging to ethnic and religious minorities, face heightened risks in areas affected by conflict and humanitarian emergencies, including where stateless, internally displaced and returnee populations are resident or hosted in northern Rakhine, Shan and Kachin States.”¹¹⁵
4. On the issue of discrimination against the Muslim population, an activist noted, “While Muslims have been facing multiple violence and suffering as a result of disasters, and many funds come in their name, these have not been utilized properly and their situation remains the same. In the Rakhine state of Myanmar, the intersecting systems of power makes indigenous women and other discriminated groups more vulnerable to violence.”¹¹⁶

Participatory Risk Assessment and Women’s Organizations’ Participation

1. Participatory risk assessments before and after designing and implementing SRHR services are key to understanding the needs of the population and in particular the very specific needs of women and girls which vary throughout their life cycle. An evaluation of a cyclone response in 2007-2008 in Bangladesh found that focus groups and household interviews conducted as part of the shelter needs assessment involved almost twice many men as women because, as the assessment report acknowledged, only male enumerators were hired, questions did not explicitly consider gender issues, and responses by female-headed households were not disaggregated in the report.¹¹⁷
2. According to an activist, “when it comes to responding to natural disasters in Myanmar, the state action followed a top down approach that did not include the participation of people at the local level. The rural community and local groups were not consulted and their needs were not addressed. Especially with regards to women and girls' right to health and protection. The language barrier made it worse.”¹¹⁸

¹¹⁴ Sabin Shrestha (Nepal), consultation with FAR, FWLD, and CWGL, January 2020.

¹¹⁵ “Concluding observations on the initial report of Myanmar,” Committee on the Rights of Persons with Disabilities, October 2019, 4, https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD/C/MMR/CO/1&Lang=En.

¹¹⁶ Flora Bawi Nei Mawi (Myanmar), consultation with FAR, FWLD, and CWGL, January 2020.

¹¹⁷ Sara Davidson, “A Review of the IFRC- led Shelter Coordination Group Bangladesh Cyclone Sidr Response,” July 2008, 29.

¹¹⁸ Flora Bawi Nei Mawi (Myanmar), consultation with FAR, FWLD, and CWGL, January 2020.

3. Information regarding women's rights organizations' involvement in the development, implementation, or monitoring of the strategy/plan/policy on disaster and risk management remains limited. In Nepal, the Disaster Risk Reduction and Management Act of 2017 included different committees at the province, district, and local level. However, the government did not make it compulsory to appoint women members in the committees.¹¹⁹

B. Conflict and Institutional Violence

1. GBV against women and girls is a major societal problem across Asia which increases in contexts of conflict and political violence. An official report from the WHO shows a 40.2 percent of lifetime prevalence of intimate partner violence and non-partner sexual violence in the region.¹²⁰ However, comprehensive and reliable records of GBV during conflicts are not available. Data on GBV is especially scarce in Asia where demographic and health surveys are comparatively infrequent and national reporting systems are relatively underdeveloped.¹²¹
2. GBV in the context of conflict/political crisis has particularly negative impacts on women and girls' SRHR in the region. As the examples below show, GBV includes rape, sexual slavery, trafficking, child and forced marriages, forced pregnancies, and involuntary contraceptive implants. There are forms of violence that violate SRHR and that are not specific to the context of conflict. For example, in many cultures and religions, child marriage, early, and forced marriages are accepted, but it is further exacerbated during conflict, perhaps due to shrinking economic resources within the family or using marriage as a safety net to protect girls from sexual violence and abduction or as a way to avoid conscription of girls into the military.¹²²
3. As noted by ARROW barriers for women and girls' access to SRHR services in contexts of conflict include: 1. inaccessible or non-universally available contraceptive information and services, including emergency contraception, post-exposure prophylaxis, safe abortion, and post-abortion care, 2. emergency obstetric care, 3. fear of further violence and stigmatization (if violence is reported), 4. prohibitive costs of services, 5. language barriers, 6. lack of transportation, and 7. fear of sexual violence during travel.¹²³
4. Access to medical and psychological services for women and girls who are victims of conflict and political violence is challenging in most countries. A participatory action research project developed by Asian Justice for Rights (AJAR) found that women in Timor-Leste, Indonesia, and Myanmar had little to no reproductive health services and education before, during, and after

¹¹⁹ Sabin Shrestha (Nepal), consultation with FAR, FWLD, and CWGL, January 2020.

¹²⁰ "Global and regional estimates of violence against women," WHO, 201, <https://www.who.int/reproductivehealth/publications/violence/9789241564625/en/>.

¹²¹ Jacqui True, "The State of Conflict and Violence in Asia," *The Asia Foundation*, 2017, https://asiafoundation.org/wp-content/uploads/2017/10/The_State_of_Conflict_and_Violence_in_Asia-12.29.17.pdf.

¹²² Biplabi Shrestha, "Redefining Peace: Interlinkages of Conflict, Gender, and Sexual and Reproductive Health and Rights," Arrow, 2018, 11.

¹²³ Ibid., 15.

sexual assault. Adequate healthcare was inaccessible or unaffordable in rural communities in each region and sometimes non-existent. In each region, “victims remain[ed] invisible to healthcare providers. They are unable to access basic health services, and need specialized programmes to deal with trauma, reproductive health and aging.”¹²⁴

5. An activist from Indonesia noted that the Papua region of Indonesia is facing an ongoing crisis. A research project her organization conducted in 2013 found that women were victims of systemic sexual violence and that today they struggle to survive. She stated that it is very difficult for her organization to counsel victims due to the severe violence and injuries they suffered. Today women in the conflict area of the Papua region are living with HIV/AIDS and the next generation is more vulnerable as they face the risk of infection and rejection from society. She noted that “the vicious cycle of gender-blind policies, narrow provisions of reproductive health by government, and the trend of criminalization of the victim along with difficulty in accessing health services and ad hoc approaches are the major challenges faced by the women in Indonesia.”¹²⁵

Examples of Conflict and Institutional Violence with a Negative Impact on SRHR

Sexual Violence during the Armed Conflict in Nepal¹²⁶

1. While there is no official data on sexual violence, evidence suggests that there was a high prevalence of such crimes. Organizations have been able to document that women were detained, tortured, raped, and killed for suspected association with the Maoists and for belonging to the families of security forces personnel.¹²⁷ Survivors of conflict-era sexual violence did not register complaints, mostly due to fear of repercussions or stigmatization, and, in general, the existing legal framework did not allow them to have access to compensation and other forms of reparations.¹²⁸
2. During the consultation, an activist shared her experience working with victims of sexual violence to seek justice and reparations: “It was a difficult task to reach out to those women as they barely open up due to stigmatization. There is a lot to be done to understand their needs and prioritize them and work accordingly. When we went to collect the cases for documentation, the women in the community were happy to share their suffering as they felt heard, but when the team told that these cases would also be taken to the legal mechanism to be heard, the survivors did not

¹²⁴ Galuh Wandita, Agustina Amtaran, Ah Hkam, Angela et al., “Enduring Impunity: women surviving atrocities in the absence of justice,” Asia Justice and Rights, 2015, <https://asia-ajar.org/2015/11/enduring-impunity-women-surviving-atrocities-in-the-absence-of-justice/>.

¹²⁵ Emmanuella Kania Mamonto (Indonesia), consultation with FAR and FWLD, January 2020.

¹²⁶ This refers to Nepal’s Civil War, 1996-2006.

¹²⁷ “Nepal’s grand debt to its victims of sexual violence,” Trial International, 2019, <https://trialinternational.org/latest-post/nepals-grand-debt-with-its-victims-of-sexual-violence/>.

¹²⁸ “Submission for the Thematic Report of the Special Rapporteur on Violence Against Women on a grave and systematic human rights violation and gender-based violence against women,” Trial International, 2020, https://trialinternational.org/wp-content/uploads/2020/05/Reports-and-publications_Nepal_submission-to-SRSV_202004.pdf.

agree. At the start there were altogether 18 women who shared the incidents of violence but at the end only 3 women gave them the power of attorney to take the case to the legal mechanism. The women did not want to pursue legal action because their names would be known by large and that would elicit further stigmatization. It was devastating to see that their needs were not addressed at all. Despite the efforts from the government, it did not recognize the torture and sexual violence during the conflict, which is why they are also excluded from the Interim Relief Program and are not under the group to receive reparations. Most of them have not even shared their problems to their husbands or family members and are bound to live with them. Many women still experience serious physical and psychological problems so we urge further proper assessment as to the sexual and reproductive health needs of those women.”¹²⁹

Sexual Violence and Ethnic Cleansing against Rohingya Women and Challenges to Ensure SRHR at Cox’s Bazar Camp

1. Since August 2017, Burmese security forces have committed widespread killings, arrests, sexual violence, and mass arson as part of a campaign of ethnic cleansing against Rohingya Muslims in Rakhine State in Myanmar. Women and girls were raped, gang-raped by multiple soldiers, forced to public nudity and humiliation, and suffered sexual slavery in military captivity. Many had to witness family members, friends, and neighbors being slaughtered in front of them.¹³⁰ As a result, more than 600,000 Rohingya fled to neighboring Bangladesh.¹³¹ To reach their destination, people had to walk up and down hills for days. This was especially harsh for vulnerable people including elderly people, injured and sick people, and those who had limited physical mobility. An international human rights organization documented the difficulties for women who had severe injuries after being gang raped and for those in advanced stages of pregnancy who endured pain during the long walk.¹³²
2. Today Rohingya refugees live in cramped conditions in makeshift shelters and the monsoon rains have worsened the already dire conditions in Cox’s Bazar camp in Bangladesh.¹³³ The Inter-Agency Working Group on Reproductive Health in Crisis found that post-rape care, including access to

¹²⁹ Salina Kafle (Nepal), consultation with FAR, FWLD, and CWGL, January 2020.

¹³⁰ Statement by the Special Representative of the Secretary-General on Sexual Violence in Conflict Pramila Patten, Security Council Briefing on Myanmar, December 12, 2017.

¹³¹ “Since August 2017, 707,000 new Rohingya refugees have come to Bangladesh. Bangladesh has hosted Rohingya refugees for three decades; there are a total 918,936 Rohingya refugees in Cox’s Bazar (as of 21 June, 2018). Among them, 52 per cent are women and girls and 16 per cent are single mothers.” “Crisis Update: Nearly one million Rohingya Refugees are in Bangladesh now,” UN Women, 2018, <https://www.unwomen.org/en/news/stories/2018/8/feature-rohingya-humanitarian-update>.

¹³² “All of my body was pain,” Human Rights Watch, 2017, <https://www.hrw.org/report/2017/11/16/all-my-body-was-pain/sexual-violence-against-rohingya-women-and-girls-burma>.

¹³³ COVID-19 has brought new concerns given the living conditions of the population. “Testimony: an update on the Rohingya Crisis,” Refugees International, 2020, <https://www.refugeesinternational.org/reports/2020/8/3/an-update-on-the-rohingya-crisis>.

safe abortion and emergency contraception, was inadequate in the camps, and that services were rarely comprehensive, of inconsistent quality, and unavailable 24/7 in all locations.¹³⁴ Lack of access to adequate materials and facilities for managing menstruation posed further problems for women and girls in the Rohingya camps.¹³⁵

3. Because of the shortage of medical personnel to work in the camps in Bangladesh, the focus has been much more on mortality issues rather than access to SRHR services. “The government has to deal with the infant mortality and maternal mortality challenges alongside environmental issues, such as water sanitation or access to nutritious food; the overcrowded camps have worsened the situation. Despite the government’s effort, the sexual and reproductive health rights of women and girls in this community are in extremely poor condition. But in comparison to Myanmar, Bangladesh has gained a wide progress in terms of providing services to the Rohingya people.”¹³⁶
4. Emergency obstetric and new-born care is not available 24/7 and therefore deliveries take place at home.¹³⁷ As an activist noted, “Both in Myanmar and Bangladesh, the deliveries in the Rohingya community are handled by traditional birth attendants. This has become an issue because the international agencies have put pressure on the government of Bangladesh to stop training the traditional birth attendants and only employ medically trained birth attendants. This situation has caused tension between the local and regional human rights practitioners who are prepared to work with the traditional birth attendants and the international agencies and their protocols, which require the existence of certain conditions. The problem is that international standards and protocols are not based on the realities of our countries.”¹³⁸
5. The crisis in Myanmar and the displacement into Bangladesh has further exacerbated already existing gender inequalities in Rohingya communities and increased the incidence of domestic and other violence against women and girls, especially sexual violence. There are accounts of forced prostitution, trafficking, and sexual violence within the camps, including child marriage, intimate partner violence, and sexual exploitation and abuse.¹³⁹

¹³⁴ “Women and Girls critically underserved in the Rohingya Humanitarian Response,” Inter-Agency Working Group on Reproductive Health in Crisis, 2018, <https://reliefweb.int/sites/reliefweb.int/files/resources/IAWG%20Statement%20on%20Rohingya%20Humanitarian%20Response.pdf>.

¹³⁵ “One Year On: time to put women and girls at the heart of the Rohingya Response,” Oxfam, 2018, <https://s3.amazonaws.com/oxfam-us/www/static/media/files/bp-one-year-on-rohingya-refugee-women-girls-110918-en.pdf>.

¹³⁶ Shireen Huq (Bangladesh), consultation with FAR, FWLD, and CWGL, January 2020.

¹³⁷ “Women and Girls critically underserved in the Rohingya Humanitarian Response,” IAWG, 2018.

¹³⁸ Shireen Huq (Bangladesh), consultation with FAR, FWLD, and CWGL, January 2020.

¹³⁹ “Women and Girls critically underserved in the Rohingya Humanitarian Response,” IAWG, 2018.

Forced Pregnancies and Involuntary Contraceptive Implants in Sri Lanka

1. Sri Lanka experienced an armed conflict that lasted 13 years and ended in 2009. During that period, violence by the state military and police against Tamil women in northern and southern Sri Lanka was rampant.¹⁴⁰ However, political violence has taken a different form affecting women and girls' SRHR in a particular way.
2. As an organization noted, the end of the Sri Lankan civil war sparked a new era of Sinhala Buddhist ethno-nationalism and therefore Sinhala women are viewed as the "biological producers of the nation." Thus "drastic measures have been taken to promote population growth within the Sinhala community, including closure of all abortion clinics, banning irreversible family planning methods and prohibiting non-governmental organizations from providing family planning services."¹⁴¹
3. The Sri Lankan government, who has administered forced or involuntary birth control programs have uniquely targeted Tamil women in the north and east of Sri Lanka.¹⁴² An activist explained that in order "to control the Muslim population, the government is inserting an intrauterine device after women's delivery without their or their husband's permission. The doctors are instructed to do so by the government itself, so that the women will not be able to reproduce further. When the Muslim population discovered the birth control strategy of the government, women started to deliver the babies at home. This brought more complications as the men themselves started to assist women during the delivery. As they did not have experience in delivering babies, this resulted in a number of cases where the wives lost their lives. When this was brought to the attention of Muslim politicians, the Mullahs decided to teach the husbands how to deliver a child. Thus, by large the reproductive rights of women in the Muslim community is hugely violated and women are reluctant to go for simple regular check-ups in the hospital. Tamil women's SRHR have been completely taken away as the State, the nationalist, the Mullahs and women's husbands decide how women can reproduce and where the delivery should be done."¹⁴³

¹⁴⁰ Biplabi Shrestha, "Redefining Peace: Interlinkages of Conflict, Gender, and Sexual and Reproductive Health and Rights," Arrow, 2018, 11.

¹⁴¹ "Written Statement of the Pasumai Thaayagam Foundation, a non-governmental organization in special consultative status (A/HRC/28/NGO/94)," United National General Assembly Human Rights Council, 2015, https://www.ecoi.net/en/file/local/1192764/1930_1425549459_g1503364.pdf.

¹⁴² Ibid.

¹⁴³ Shreen Abdul Saroor (Sri Lanka), consultation with FAR, FWLD, and CWGL, January 2020.

C. Health crisis: COVID-19¹⁴⁴

1. The WHO declared coronavirus a global pandemic on March 11, 2020 and called for government action to flatten the curve. The pandemic has affected countries all across the globe, including countries in the Asia-Pacific region.¹⁴⁵
2. Past humanitarian crises have had a devastating impact, especially on women and girls' SRHR. The COVID-19 pandemic has impacted the region's healthcare systems and there is a risk that SRHR will move even further from the reach of women and girls. Most of the Asia-Pacific countries have reverted their resources for SRHR, which were already low, away from vital SRHR services to COVID-19 response.
3. With lockdown and movement restriction, women, girls, adolescents, and other marginalized group in the Asia-Pacific region are facing significant barriers in accessing essential SRH information and services. There has been reduced access to contraceptives, increases in sexual and GBV, increases in harmful and traditional practices like early and forced child marriage and FGM, and increases in teenage pregnancy and maternal mortality.

Country Context

1. The country context is heavily drawn from the Submission to the Special Rapporteur on violence against women, its causes and consequences for the thematic report on COVID-19 and the increase of domestic violence against women prepared by ARROW and its partners. In order to submit this report, ARROW conducted secondary desk research and collected information/experience from its national partners to understand the country context of Bangladesh, India, Indonesia, Nepal, Pakistan, and the Philippines.

Bangladesh

1. The on-going pandemic has overburdened an already strained health system affecting access to and availability of essential services and information, which affects women and girls in particular. The number of trained doctors and medics¹⁴⁶ who are equipped with the knowledge on how to address the SRHR-related concerns of women and girls in the face of a global crisis is inadequate. Moreover, the high number of infection rates and COVID-19 related deaths¹⁴⁷ among health and

¹⁴⁴ This section was drafted by ARROW.

¹⁴⁵ The most updated data is available in the website: "Impact of the Crisis," United Nations Office for the Coordination of Humanitarian Affairs, 2020, <https://interactive.unocha.org/data/ap-covid19-portal/impact-crisis.html>.

¹⁴⁶ "Chinese medical expert team arrives in Bangladesh to help fight COVID-19," Xinhua, 2020, http://www.xinhuanet.com/english/2020-06/08/c_139124099.html.

¹⁴⁷ "Covid-19: Bangladesh's death toll surpasses 800 mark," AA, 2020, <https://www.aa.com.tr/en/asia-pacific/covid-19-bangladeshs-death-toll-surpasses-800-mark/1866622>.

medical practitioners¹⁴⁸ means that the general public is avoiding hospitals and clinics unless absolutely necessary. UNICEF estimates that 2.4 million babies will be born under the shadow of the COVID-19 pandemic in Bangladesh.¹⁴⁹

2. Sources from a NGOs working on disability rights have reported that at least 50 girls and women with disabilities have faced different types of violence from March to June 2020 and certainly the degree of violence has increased due to the outbreak of COVID-19. This information was collected from daily newspapers (*Prothom Alo*), electronic media (DIPTO Television), and phone calls from the Disabled People's Organization (DPO) and colleagues working on disability rights on the national level. Transgender individuals have been subjected to physical violence during the lockdown period in different parts of the country.

India

1. Abortion and maternal care are time-sensitive interventions. Recognizing this, a public interest litigation (PIL) petition was filed in the Delhi High Court for directions to the central government to ensure access to medical services for pregnant women. As a relief measure, the high court directed the Delhi government to ensure a helpline service is made available for pregnant women and is publicized through newspapers and social media.¹⁵⁰
2. There has been a steep rise in violence perpetrated against women across the country amid restrictions imposed due to the COVID- 19 outbreak. According to ARROW, the highest numbers of complaints were related to domestic violence.

Indonesia

1. After the Indonesian government labelled COVID-19 a national disaster, public health facilities were prioritized for COVID-19 response and medical emergencies. This situation created additional barriers for women and girls to access reproductive health services, especially unintended pregnancy services. The mapping carried out in 10 provinces by Aliansi Satu Visi (ASV) members showed changing patterns of services for reproductive health. Some community health services (Puskesmas) limit reproductive health services except for cases considered emergencies. As a result, other cases, including family planning were limited to certain days and hours or must be by appointment or online consultation. Some health facilities have temporarily closed due to insufficient supply of personal protective equipment (PPE).

¹⁴⁸ Faisal Mahmud, "Hundreds of Doctors in Bangladesh infected with Coronavirus," *Aljazeera*, April 24, 2020, <https://www.aljazeera.com/news/2020/04/24/hundreds-of-doctors-in-bangladesh-infected-with-coronavirus/>.

¹⁴⁹ "Pregnant mothers and babies born during COVID-19 pandemic threatened by strained health systems and disruptions in services," UNICEF Bangladesh, May 7, 2020, <https://www.unicef.org/bangladesh/en/press-releases/pregnant-mothers-and-babies-born-during-covid-19-pandemic-threatened-strained-health>

¹⁵⁰ Rupavardhini B.R. and Vrinda Agarwal, "Our Pandemic can't be an excuse to overlook women's reproductive rights," *The Wire*, May 18, 2020, <https://thewire.in/health/covid-19-pandemic-women-reproductive-rights-abortion-access>.

2. With health systems overwhelmed due to COVID-19, clinics are no longer the safe places they used to be. Pregnant women fear that they increase their risk of catching COVID-19 if they go to the clinic for their check-ups. The Indonesian Midwives Association has hundreds of thousands of members and they are doing their best to collect information from across the country. Many midwives are afraid to provide services because they do not have optimal protective equipment and that the pregnant women they work with are also avoiding seeking care.¹⁵¹
3. The Legal Aid Foundation of the Indonesian Women's Association for Justice (LBH APIK) and the Women's Empowerment and Child Protection Ministry reported a significant increase in reports of violence against women and children in Indonesia.¹⁵² The Coalition of Care for Vulnerable Victims of COVID-19 (PEKAD) also reported an increasing burden on women due to their continued household tasks including daily shopping at the market which increases their risk of exposure to the virus.¹⁵³ As well as exacerbating the frequency and seriousness of violence in already abusive relationships, the large scale social restriction measures may also aggravate tensions in families because of extended periods of confinement, leading to the deterioration of previously healthy relationships and instances of violence where none had previously occurred.¹⁵⁴

Nepal

1. At least 32 women died due to birth complications in the first two months of lockdown in March 2020. This is an almost 200 percent increase in the maternal mortality rate since the lockdown began, compared to 80 cases in the previous fiscal year. Antenatal and postnatal visits by pregnant women have been halted due to the lack of public transportation. The postnatal home visitation program performed by a trained nurse has also stopped. Many health facilities have ceased providing maternal care services due to the ongoing fear of COVID-19 transmission. More women are compelled to give birth at home, risking their lives.¹⁵⁵ Women and girls are facing barriers to accessing safe abortion services and other reproductive health services due to lockdown. Women and girls are reluctant to access health facilities due to the fear of transmission of COVID-19 and

¹⁵¹ "Locked Down and Pregnant: clinics are no longer the safe places they used to be, so what can be done?" UNFPA, 2020, <https://reliefweb.int/report/indonesia/locked-down-and-pregnant-clinics-are-no-longer-safe-places-they-used-be-so-what-can>.

¹⁵² Moch Fiqih Prawira Adjie, "Psychological Consultation Hotline launched in virus stricken Indonesia," *Jakarta Post*, April 24, 2020, <https://www.thejakartapost.com/life/2020/04/29/psychological-consultation-hotline-launched-in-virus-stricken-indonesia.html>.

¹⁵³ Maya Dania, "Pandemic, National Disaster and Domestic Violence," *Jakarta Post*, May 3, 2020, <https://www.thejakartapost.com/academia/2020/05/03/pandemic-national-disaster-and-domestic-violence.html>.

¹⁵⁴ Balawyn Jones, "Home is not safe: domestic violence increases as COVID 19 pandemic takes toll," University of Melbourne, May 4, 2020, <https://indonesiaatmelbourne.unimelb.edu.au/home-is-not-safe-domestic-violence-increases-as-covid-19-pandemic-takes-hold/>.

¹⁵⁵ Arjun Poudel, "A 200 percent increase in maternal mortality since the lockdown began," *Kathmandu Post*, May 27, 2020, <https://kathmandupost.com/national/2020/05/27/a-200-percent-increase-in-maternal-mortality-since-the-lockdown-began>.

lack of information regarding the continuation of all safe motherhood and reproductive health services.

2. Transgender people living with HIV and AIDS have been affected as they do not have access to their regular health check-ups and Antiretroviral Therapy ARTs. Though ARTs have been delivered at homes by some organizations, full body check-ups for CD4 counts and viral load are not available which has affected the course of treatment.
3. In regards to general health check-ups, sexual and gender minorities already faced stigma and discrimination prior COVID-19. This stigma has doubled as normal fevers have also become highly stigmatized. Stigma and discrimination have led to a decrease in health-seeking behavior among sexual and gender minorities.
4. Transgender women are uniquely affected by the lockdown. There is a shortage of hormone medications and, due to the unavailability of hormones, side effects such as withdrawal symptoms are becoming common among transgender women.
5. Ever since the lockdown was implemented, 1145, the national helpline operated by the National Women Commission, has reported that GBV is on the rise. In the roughly 30 days since the lockdown began in March, the helpline received 521 calls, of which 119 have been specifically about domestic violence.¹⁵⁶ Within the first two months of lockdown, statistics show that violence against women, particularly domestic violence, has intensified as many at-risk women find themselves locked in with their abusers. According to the Women's Rehabilitation Centre (WOREC Nepal),¹⁵⁷ 336 cases of violence against women and girls from 33 districts of Nepal were reported from March 24 to May 15, 2020. Among the reported cases, 198 cases were of domestic violence, 48 cases were of rape, 10 were attempted rape, 29 were related to social violence, 12 were cases of sexual abuse, and so on. The perpetrators of violence against women are mainly husbands (155 cases), family members (67), and neighbors (66). Women and girls aged 17-25 were the most affected (108), followed by the age group 26-35 (103).¹⁵⁸
6. The risk of intimate partner violence has also increased among transgender people who frequently have no source of income and have to depend on their partner financially. With activities shifting to digital platforms, online violence has also been exacerbated due to COVID-19.

¹⁵⁶ Aditi Aryal, "Fears of a rise in cases of domestic violence due to the lockdown may have come to pass." *Kathmandu Post*, April 27, 2020, <https://kathmandupost.com/national/2020/04/27/fears-of-a-rise-in-cases-of-domestic-violence-due-to-the-lockdown-may-have-come-to-pass>.

¹⁵⁷ WOREC Nepal is a movement-based organization that functions with the premise of women's rights and social justice as a prerequisite for peace, social justice, and sustainable development. See <https://www.worecnepal.org/>.

¹⁵⁸ "Violence against women and girls during lockdown," WOREC, May 20, 2020, <https://worecnepal.org/content/131/2020-05-20>.

Pakistan

1. For women, access to health care services, including reproductive health services, has become a challenge, especially for pregnant women, women who need post-abortion care services and contraception counselling and services. In addition, access to health care services for young and newlywed women has also been affected.
2. Though the Department of Health and Population, Government of Sindh developed Standardized Operation Procedures (SOPs) for family planning and reproductive health on March 21, the implementation of the SOP has been a challenge and, at the same time, people have been unable to access the services.
3. COVID-19 and lockdowns exacerbated the risk of violence against women and girls, including domestic violence across the world, including in Pakistan. Prior to COVID-19, according to the Pakistan Demographic Health Survey 2017-2018, almost one-third of women aged between 15 and 40 reported having experienced physical violence since age 15.¹⁵⁹ The percentage was higher among younger women and women from rural areas while women with higher educational backgrounds reported lower incidents of physical violence.¹⁶⁰ Domestic violence, in particular, has occurred at an alarming rate across the country. 90 percent of women in Pakistan have experienced some form of domestic violence at the hands of their husbands or families.¹⁶¹

Philippines

1. Public health centers continued to offer family planning services, devices, and advice during the quarantine period.¹⁶² However, during this period, there were reported cases of pregnant women who died in labor after being denied services by several hospitals and medical facilities.¹⁶³
2. The city of Luzon saw a total of 804 reported GBV and violence against women and children cases since the beginning of lockdown on March 15 to April 30, according to data collected by the Philippine Commission on Women (PCW) from the Philippine National Police's Women Children Protection Center (PNP-WCPC).¹⁶⁴ A report to Congress found that since the implementation of

¹⁵⁹ "Pakistan Demographic and Health Survey 2017-18," National Institute of Population Studies, 2020, <https://www.dhsprogram.com/pubs/pdf/FR354/FR354.pdf>.

¹⁶⁰ Ibid.

¹⁶¹ "Gender and Pandemic: Urgent Call for Action," United Nations Office on Drugs and Crime, 2020, https://www.unodc.org/documents/pakistan//Advocacy_Brief_4_Gender_COVID-19-Punjab.pdf.

¹⁶² Aliyya Sawadjaan, "COVID-19 and Sexual and Reproductive Health," *Business World*, June 1, 2020, <https://www.bworldonline.com/covid-19-and-sexual-and-reproductive-health/>.

¹⁶³ Franco Luna, "Government urged to keep women's health a priority amid COVID-19 pandemic," *Philstar*, May 17, 2020, <https://www.philstar.com/headlines/2020/05/17/2014620/government-urged-keep-womens-health-priority-amid-covid-19-pandemic>.

¹⁶⁴ Pia Ranada, "During Coronavirus lockdown Abused women, children move vulnerable," *Rappler*, May 9, 2020, <https://www.rappler.com/newsbreak/in-depth/during-coronavirus-lockdown-abused-women-children-more-vulnerable>.

the enhanced community quarantine, 763 cases of crimes against women and 521 cases of crimes against children were reported.¹⁶⁵

3. It has been found that many victims have not been able to report abuse, partly due to the quarantine measures themselves. The Philippine Commission on Women (PCW) said they could be discouraged by "limited mobility and the absence of public transportation" in areas where this has been suspended to curb the spread of the coronavirus.¹⁶⁶

Promising Practices

A. Disaster Risk Reduction and Management Act Nepal¹⁶⁷

1. The 2015 earthquake in Nepal demonstrated that the government was not prepared, resulting in peoples' increased suffering and violations of human rights. Women's SRHR needs were overlooked as the government did not have the capacity to deal with the crisis. The natural disaster that Nepal faced provided essential learning and promising practices. After the earthquake, the government promulgated a new constitution and adopted new legislation to supplement positive provisions of the constitution in the area of SRHR, including the Disaster Risk Reduction and Management Act which was enacted in 2017. The Disaster Risk Reduction and Management Act includes a wide range of issues regarding prevention, protection, and immediate measures to be taken during a natural disaster. It also covers the right to protection and services for women and children. The act includes provisions such as additional punishment for cases of sexual and gender-based violence in times of disaster. Previously the government's only mechanism to deal with disaster was the Ministry of Home Affairs. However, now the act provides three separate mechanisms: "preparedness" which is led by the Ministry of Federalism and Local Development; "rescue" which is led by the Ministry of Home Affairs; and "reconstruction" led by the Ministry of Physical Infrastructure. Despite a robust act, the new legal framework does not include women within these committees.
2. The Disaster Risk Reduction and Management Act is complemented with the recently enacted Safe Motherhood and Reproductive Health Right Act in 2018 which acknowledges the right to receive SRHR care and services including access to safe abortion and emergency obstetric and newborn care, including family planning information and contraceptives. It also states that the denial of reproductive health services is a crime and orders the implementation of services considering the needs of adolescents and persons with disabilities. It also prohibits discrimination on the ground of one's origin, religion, color, caste, ethnicity, sex, community, occupation, business, sexual and gender identity, physical or health condition, disability, marital status,

¹⁶⁵ "Report to the Joint Congressional Oversight Committee," Official Gazette, Philippines, May 5, 2020, <https://www.officialgazette.gov.ph/downloads/2020/05may/20200504-Report-to-the-Joint-Congressional-Oversight-Committee.pdf>.

¹⁶⁶ Ibid.

¹⁶⁷ Sabin Shrestha (Nepal), consultation with FAR and FWLD, January 2020.

pregnancy, ideology, state of being infected with or vulnerable to any disease or germ, state of morbidity, personal relationship, or any other similar ground. This law cannot be suspended during disaster situations.

B. Lady Health Worker Program in Pakistan¹⁶⁸

1. In Pakistan, the national Lady Health Worker program hires local women to deliver treatment for minor ailments, immunization, and reproductive health services in their communities. The main recipients of this program are female members of households given their important role in educating young children and looking after the household. After the 2005 earthquake, over 8,000 community and Lady Health Workers were mobilized along with mobile health teams to serve more distant areas. The lower mortality and morbidity rates after the disaster have been attributed to this program. The IFRC and German Red Cross, in partnership with the Pakistan Red Crescent Society, implemented a number of emergency health and hygiene activities in Banian Union Council through this network. This practice allows the active participation and leadership of women in the implementation of humanitarian response. Women are being trained to deliver an important humanitarian service and they also contribute to empowering other women.

C. All-Acehnese Women's Congress in Indonesia¹⁶⁹

1. Evidence indicates that women play an active role in disaster recovery and reconstruction. The collective will of the All-Acehnese Women's Congress got women into driver's seat in a traditionally orthodox and male dominated society in Indonesia for the planning and implementation of one of the most successful post-disaster recovery and reconstruction programs. This provided significant lessons about how the capacities and strength of women can be utilized for rebuilding a community ravaged by disaster. The skills and capacities that women display in coping with and managing regular disasters such as seasonal floods, droughts, landslides, etc. in South Asian countries points to the utmost importance of factoring in such capacities for effective disaster risk reduction.

Recommendations

¹⁶⁸ "A Practical Guide to Gender-sensitive Approaches for Disaster Management," International Federation of Red Cross and Red Crescent Societies (IFRC), 18, <https://www.ifrc.org/PageFiles/96532/A%20Guide%20for%20Gender-sensitive%20approach%20to%20DM.pdf>.

¹⁶⁹ "Issues of Vulnerability with Specific Reference to Gender in the Asia Pacific Post-2015 framework for disaster risk reduction consultations," United Nations Office for Disaster Risk Reduction, 4.

1. The activists that attended the consultation taking place on January 14, 2020 discussed and agreed on a number of recommendations that states must consider for an effective response to SRHR in contexts of crisis.
 - a. Implement human rights based policies to address women and girl's SRHR in contexts of crisis.
 - b. Develop short-term and long-term plans to aid survivors of crisis situations;
 - c. Increase the number of medical professionals to address the consequences of crisis and ensure they act in a sensitive manner.
 - d. Increase the number of counsellors, mental health care professionals, and social services to accommodate victims of sexual or GBV in conflict and peaceful areas.
 - e. Ensure SRHR services are accessible, available, and inclusive during contexts of crisis.
 - f. Adopt special measures to ensure that services are accessible to women with disabilities, indigenous women, the LGBTQ+ community, women refugees, and other marginalized groups.
 - g. Consider that multiple factors of discrimination can affect women and girls at the same time and design state responses to be comprehensive and tailored to these multiple dimensions.
 - h. Increase awareness programs about SRHR services.
 - i. Adopt measures to end the stigmatization of women who are raped and the criminalization of women who have abortions.
 - j. Ensure women are consulted during the planning and implementation of aid plans and health services.
 - k. Integrate local and regional childbirth practices by ensuring traditional birth attendants are provided with the necessary training to ensure proper services are being delivered.

III. Middle East and North Africa (MENA)

This chapter is based on information provided by activists who are experts in the field of SRHR and/or GBV issues in countries in the MENA region. They participated in an online consultation that took place on August 21, 2020¹⁷⁰ organized by FAR and the Arab Institute for Women (AIW). A separate interview was conducted on September 3, 2020.¹⁷¹ FAR supplemented their inputs with desk research. While it is not an exhaustive section, it aims to provide examples of how different types of crisis situations have had an impact on women and girls' SRHR in MENA, followed by promising practices and recommendations.

Crisis Situations

Over the past years, the MENA region has seen consistent shifts in state power, civil wars, regional power struggles, occupation, abuses of government power, and the increasing presence of insurgency groups. Ongoing crisis situations disproportionately affect the lives and rights of women, girls, and sexual/gender minorities due to gender-based inequality and violence. Systemic discrimination of women is per se a crisis in the MENA region and globally. It is rooted in gender stereotypes, traditional gender norms, and discriminatory laws and social institutions which historically restrict women's rights and freedoms. Such crises have had devastating effects on women's rights up to the highest level of health. The following includes specific examples to illustrate the impact of conflict on women and girls' SRHR.

A. Armed Conflict

1. **Arab Republic of Syria:** The ongoing conflict in Syria has disproportionately affected women and girls. From food insecurity, loss of educational opportunities, lack of health services, and high rates of GBV, women and girls continue to face the brunt of ongoing crises. Various international and national NGOs have documented crimes of sexual violence committed by all parties during the Syrian conflict. In its January 2013 report, the International Rescue Committee described "rape as a significant and disturbing feature of the Syrian civil war. It further highlighted child and forced marriages in the camps resulted in early/teenage pregnancies."¹⁷² In pre-war Syria, an estimated 13 percent of girls under the age of 18 and 12 percent of Syrian refugees in Jordan were married.

¹⁷⁰ Randa Siniora, Women's Center for Legal Aid and Counseling (Palestine); Olfat Mahmoud, Palestinian Women's Humanitarian Organization (Palestine); Paola Daher, Center for Reproductive Rights (Lebanon); Ghida Anani, Abaad (Lebanon); Roula Seghaier, International Domestic Workers Federations (Lebanon); Ahlem Belhadj, Association Démocratique des Femmes Tunisiennes (Tunisia); Mervat Rishmawi, independent consultant (Palestine); Hana Hamood, Public Aid Organization (Iraq); Bahar Ali, Emma Organization for Human Development (Iraq); Fatima Outaleb, Steering Committee member Feminist Alliance for Rights (Morocco).

¹⁷¹ Researcher from Egypt who requested anonymity for security concerns.

¹⁷² "Violence against women in Syria: Breaking the Silence," International Federation for Human Rights, April 2013, 8, https://www.fidh.org/IMG/pdf/syria_sexual_violence-web.pdf.

By 2013, a reported 25 percent of girls under the age of 18 were married.¹⁷³ The traditional understanding of sexual violence as taboo and a source of stigma as well as honor killing and domestic violence as a private matter has inhibited many survivors from coming forward with their stories to authorities or loved ones for reasons including guilt, shame, fear of further physical, psychological, or sexual violence, or being outed into unsupportive home lives.¹⁷⁴

2. **Iraq:** The health status of the Iraqi population has suffered major setbacks due to decades of war and economic sanctions.¹⁷⁵ Corruption, prioritization of other areas like security,¹⁷⁶ and the lack of financial allocations for health from the state's general budget have contributed to Iraq's health system crisis. There is a shortage of drugs, medical staff to administer them, and a lack of qualified midwives.¹⁷⁷ Other contributing factors include: a lack of health institutions at the national, state and local levels, which is not commensurate with population increase; a shortage of diagnostic and therapeutic medical devices; instability for medical staff which affects good follow-up care; the immigration of qualified doctors due to poor security conditions; poor distribution of medical staff according to need; and a lack of health awareness in large sectors of society.¹⁷⁸ The health system crisis has direct effects on women and girls' access to SRHR services: "In Iraq, there are 32 specialized hospitals of pediatric, gynecology and obstetrics, all of them are in the governorate centers, which means that rural and remote areas lack the services provided by these hospitals, so there [are] a lot of difficulties to transfer of emergency births to a hospital, and this situation leads to the use of the unauthorized midwives who work in rudimentary ways, which leads to serious problems, and sometimes causes the death of the mother, her newborn... Maternal mortality is very high, reaching 31 percent during 2017."¹⁷⁹
3. **Yemen:** In Yemen, five years of a bloody civil war have resulted in an intractable military and political stalemate between the parties to the conflict and their international sponsors, imposing a heavy death toll and a major humanitarian crisis for the population. The conflict has brought food insecurity and UNFPA found that approximately one million pregnant women were malnourished in 2018 which resulted in pregnancy loss, complications, and death. If the food

¹⁷³ "Too Young to Wed: The growing problem of child marriage among Syrian girls in Jordan," Save the Children Fund, 2014. <https://www.savethechildren.org.uk/content/dam/global/reports/education-and-child-protection/too-young-to-wed.pdf>.

¹⁷⁴ K. Alsaba and A. Kapilashrami, "Understanding women's experience of violence and the political economy of gender in conflict: the case of Syria," *Reproductive Health Matters*, May 2016.

¹⁷⁵ Hannah Hamood (Iraq), consultation with FAR, Arab Institute for Women (AIW), and CWGL, August 2020.

¹⁷⁶ According to an article published in *Reuters*, in 2019, a year of relative peace, the government allocated just 2.5 percent of the state's 106.5 billion USD budget to its health ministry, a fraction of spending elsewhere in the Middle East. By comparison, security forces received 18 percent and the oil ministry 13.5 percent. Ahmed Aboulenein and Reade Levinson, "Special Report: The medical crisis that's aggravating Iraq's unrest," *Reuters*, 2020, <https://cn.reuters.com/article/us-iraq-health-specialreport/broken-health-the-medical-crisis-thats-aggravating-iraqs-unrest-idUSKBN20P1QB>.

¹⁷⁷ Hannah Hamood (Iraq), consultation organized by FAR, AIW, and CWGL, August 2020.

¹⁷⁸ Ibid.

¹⁷⁹ Ibid.

security situation worsens, the effects may double, impacting two million women.¹⁸⁰ Pregnant women in Yemen have also reported fears about going to the hospital when they are in labor out of concern for being caught between Yemeni military and rebel group violence.¹⁸¹ Ongoing armed conflict further restricts access to SRH care. As of 2019, approximately half of the UN-run health clinics were closed which resulted in the untreated malnourishment of pregnant women, restricted access to proper pre- and post-natal care, and an increase of preventable pregnancy related deaths.¹⁸² Another effect of the crisis is the increase of child marriage. In Yemen, “families marry off their daughters earlier to get money to pay for basic food items and at the same time to reduce the daily cost of feeding the family.”¹⁸³ In other places where women and girls are at risk of being raped, families choose marriage as a method to protect girls from rape and having children out of wedlock. This practice, however, increases sexual violence and risks of maternal mortality.

4. **Sudan:** Limited access to sexual and reproductive health services is a consequence of years of armed conflict between Sudanese government forces and the armed wing of the rebel Sudan People’s Liberation Movement/Army-North (SPLM/A-North), a spin-off of the former southern Sudanese liberation movement and now ruling party of independent South Sudan.¹⁸⁴ Women and girls living in rebel-held areas of the Nuba mountains of Southern Kordofan have been disproportionately affected: they have little or no access to contraception, adequate antenatal care, or emergency obstetric care.¹⁸⁵ This has resulted in stillbirths, miscarriages, death during childbirth, and other labor complications.¹⁸⁶

B. Impact of the Occupation of Palestinian Territories on SRHR

1. Palestinian women and girl’s lack of access to SRHR is directly connected to Israel’s continued institutionalized discrimination and occupation of Palestinian Territories. An activist elaborated on the situation in these terms: “[t]he root problem is the prolonged military occupation that has impacted every aspect of the Palestinian life. The social, economic, political – everything – the water we drink, the infrastructures, our right to movement, our right to enjoy our rights as

¹⁸⁰ Kelly Ashton, “Looming famine threatens the lives of 2 million pregnant women and new mothers in Yemen,” UNFPA, 2018, <https://www.unfpa.org/news/looming-famine-threatens-lives-2-million-pregnant-women-yemen>

¹⁸¹ Ibid.

¹⁸² Lena Masri, “U.N. says women and babies at risk in Yemen as funds crunch forces clinics to shut,” *Reuters*, September 5, 2019, <https://www.reuters.com/article/us-yemen-women-health/u-n-says-women-and-babies-at-risk-in-yemen-as-funds-crunch-forces-clinics-to-shut-idUSKCN1VQ2B1>.

¹⁸³ Taha Yaseen and Debbie Hillier, “Yemen’s Shattered Food Economy and Its Desperate Toll on Women,” Oxfam, 2019, <https://www.oxfam.org/en/research/yemens-shattered-food-economy-and-its-desperate-toll-women>.

¹⁸⁴ Skye Wheeler, “‘No Control, No Choice’: Lack of Access to Reproductive Healthcare in Sudan’s Rebel-Held Southern Kordofan,” Human Rights Watch, 2017, <https://www.hrw.org/report/2017/05/22/no-control-no-choice/lack-access-reproductive-healthcare-sudans-rebel-held>.

¹⁸⁵ Ibid.

¹⁸⁶ Ibid.

Palestinians has been all the time disrupted. It has further affected us as women and girls because of the patriarchal structures under which we live, which further exacerbates our sufferings and make these sufferings even disproportionate compared to others. We are much more relegated over the traditional rules as housewives and mothers and [have increased] economic hardships because we are not employed in the labor force.”¹⁸⁷ Thus, the occupation of Palestine Territories combined with patriarchy is considered the root of the infringement on the human rights of women.

2. In particular, Israeli checkpoints required for traveling, for example, in the Gaza Strip, West Bank, and entrance into Jerusalem have isolated and separated Palestinians from their families and from the necessary medical care.¹⁸⁸ In addition to travel checkpoints, the Israeli permit system, which identifies the permanent or primary location of Palestinians, has created issues of “legal” Israeli citizenship for Palestinians, further restricting their movement in and out of Palestinian Settlements and Israeli Occupied Palestine, particularly in the Gaza Strip. Both the issues of checkpoints of and permits present challenges for Palestinians’ rights to movement and freedom. The situation is compounded with COVID-19 as the lack of freedom of movement “has further intensified during COVID-19 because women’s ability to move became much more difficult with a lot of constraints on that because of the health situation, but further because of the social norms that made it even more restrictive.”¹⁸⁹
3. During FAR’s consultation,¹⁹⁰ activists identified a number of connected obstacles in ensuring women and girls’ SRHR: 1. restrictions on movement and travel for Palestinian women have resulted in dangerous health issues, including reports of women giving birth at checkpoints after being delayed or prohibited entrance; 2. Palestinian women residing in Jerusalem with an irregular migration status do not have access to the Israeli health system or health care in Palestine; 3. traditionally, Palestinian women are in charge of taking care of the wellbeing and health of others in society at the expense of their own health, wellbeing, and safety. Therefore, they do not seek services related to their reproductive rights even if available; 4. domestic violence has increased and there is no legal system in place that could provide protection;¹⁹¹ 5. there are a lot of constraints due to the personal status laws and criminal laws that are being enforced which include cases of criminalizing, for example, safe abortions or a woman’s right to control her own life and her own body.

¹⁸⁷ Randa Siniora (Palestine), consultation organized by FAR, AIW, and CWGL, August 2020.

¹⁸⁸ Ibid.

¹⁸⁹ Ibid.

¹⁹⁰ Ibid.

¹⁹¹ On this issue, an activist noted: “With the existence of different legal systems made it even further complicated with a lot of constraints by some of the fundamentalist groups in the adoption of the Family Protection Law and meeting of the obligations of the state of Palestine after the accession to the CEDAW Convention without reservations.” Randa Siniora (Palestine), consultation with FAR, August 2020.

4. The Israeli military occupation and armed conflicts have caused thousands of Palestinians to seek refuge in surrounding countries such as Lebanon and Egypt which are undergoing their own political conflicts.

C. Political Crisis

Sectarianism in Lebanon

1. Sectarianism, a mode of governance which amalgamates diverse religious communities within a constitutional and political order, is at the center of other crises in Lebanon. Sectarianism also “plays a pivotal role in oppressing women and discriminating against women and girls keeping them as second class citizens where they cannot take decisions regarding divorce, inheritance also their own body autonomy.”¹⁹² Personal status issues continue to be governed by 15 separate religious laws, all of which discriminate against women and none of which guarantee basic rights.¹⁹³
2. Gender stereotypes are at the center of religious, social, and legal norms in Lebanon. Thus, women and girls’ SRHR are provided through maternal health services and are directly linked to expectations around women and girls’ roles in society. As an activist noted: “sexual and reproductive health and rights are not apprehended through the lens of women and girls’ rights to bodily autonomy but rather around women and girls being mothers and their ultimate role of motherhood and that creates issues because it creates a hierarchy of services that women should be able to access. And these stereotypes are being instrumentalized and women’s bodies are being instrumentalized by the sectarian regime and religious leaders in Lebanon who really use women as political pawns in their little war for power. [Therefore,] women and girls are kept as second-class citizens.”¹⁹⁴
3. In this context, the sectarian government silences sexual health activists when they bring up issues of women’s rights and LGBTQ+ rights. “Even within progressive circles, SRHR are being deprioritized due to their political divisiveness in the country, leaving particularly vulnerable women and other sexual/gender minorities without access to life saving health care.”¹⁹⁵
4. While the Lebanese government has laws in place to end GBV, including protections for survivors and shelters,¹⁹⁶ the enactment of said laws is limited and/or has written a more subversive form of discrimination against women into it.¹⁹⁷ By doing so, “the laws meant to protect women from

¹⁹² Paola Daher (Lebanon), consultation organized by FAR, AIW, and CWGL, August 2020.

¹⁹³ “Lebanon: Failure to Address Economic, Political Crisis,” Human Rights Watch, August 3, 2020, <https://www.hrw.org/news/2020/08/03/lebanon-failure-address-economic-political-crisis#>.

¹⁹⁴ Paola Daher (Lebanon), consultation organized by FAR, AIW, and CWGL, August 2020.

¹⁹⁵ Ibid.

¹⁹⁶ “Shelters for Women Survivors of Violence: Availability and Accessibility in the Arab Region,” United Nations Economic and Social Commission for Western Africa, 2020, <https://www.unescwa.org/publications/shelters-arab-region-availability-accessibility>.

¹⁹⁷ Ibid.

gender-based violence become nothing more than symbolic while still enacting the same harm caused by the cultural stereotypes of reproduction and women's gender roles."¹⁹⁸

5. The power-sharing sectarian system has failed to provide even basic public services. As a result, health services in Lebanon are privatized. While access to legal and health services for victims of sexual assault and access to Post-exposure prophylaxis (PEP) services should be free of charge for any women in Lebanese territory, organizations found that "everything related to clinical management of rape was really missing and women had to secure forensic doctors and pay 200 USD to be able to obtain only the report and this is without even talking about other services needed under that package."¹⁹⁹ Another activist noted, "So for the limitations also, I would point to one limitation. Some services exist and are accessible, but the problem is the only services [that] are accessible are those [that] these institutions deem as necessary, so if they don't see they fit under SRHR, they are not seen as a priority they are not there."²⁰⁰
6. The explosion on August 4, 2020 created a situation where SRHR and rights have been completely deprioritized and the health system is not able to cope.²⁰¹

Effects of the Arab Spring

1. The Arab Spring began in Tunisia in 2010 and spread to other Arab nations and resulted in regime changes in Tunisia, Libya, Egypt, and Yemen and repression and/or violence in Syria, Bahrain, Sudan, and elsewhere. In the last decade, women's human rights have been impacted in very unique ways.
2. The Tunisian Revolution, also called the Jasmine Revolution, began as civil resistance to an authoritarian regime that changed the political system. Due to the mobilization of the women's rights movement, women's rights granted prior to the revolution were preserved and, in some cases, expanded including the Parliament's adoption of the new comprehensive law against gender-based violence (Law 58), which forbids all forms of GBV, redefined sexual harassment in the workplace and the streets, made GBV more easily punishable by law, introduced harsher penalties for domestic violence, and made it difficult for rapists to escape prosecution.²⁰² Despite this and other important achievements, the current government has control over women's access to sexual health care. One activist pointed out that "after the Jasmine Revolution, we had the democratic transition and now we speak about political crisis... With this crisis we see that sexual

¹⁹⁸ Guida Anani, (Lebanon), consultation organized by FAR, AIW, and CWGL, August 2020.

¹⁹⁹ Ibid.

²⁰⁰ Roula Seghaier (Lebanon), consultation organized by FAR, AIW, and CWGL, August 2020.

²⁰¹ Paola Daher (Lebanon), consultation organized by FAR, AIW, and CWGL, August 2020.

²⁰² Hind Ahmed Zaki, "Why Did Women's Rights Expand in Post-Revolutionary Tunisia?" Brandeis University Crown Center for Middle East Studies, 2019, <https://www.brandeis.edu/crown/publications/middle-east-briefs/pdfs/101-200/meb131.pdf>.

and reproductive health services are not available [the same way they were] before. It began before the revolution and continued decreasing until these days.”²⁰³

3. The Arab Spring in Egypt terminated a long-term dictatorial regime in 2011 and was followed by the election of a conservative leader through a series of popular elections in 2012. In 2013, there was a coup d'état led by the minister of defense, General Abdel Fattah El-Sisi, and in 2014, presidential elections confirmed El-Sisi's role in power. Since then, the Egyptian regime has escalated a campaign of intimidation, violence, and arrests against political opponents, civil society activists, and many others who have voiced any criticism of the government.²⁰⁴ In this context of crisis, women and girls continue to experience systemic discrimination, including in their access to SRHR. The government has failed to protect women and has not implemented human rights-centered measures to ensure women and girls' access to rights.
4. The Arab Spring revolution in Egypt has led to an increase in accountability and documentation of sexual health access and sexual violence responsiveness for women, girls, and sexual/gender minorities, however, the consultation with activists revealed that publicized data concerning these issues is still sparse.²⁰⁵ Sexual violence cases against women, girls, and LGBTQ+ people and indictments of sexual violence are often still halted in court as evidence and witnesses are either dismissed or impossible to verify.²⁰⁶ In some cases, individuals' sexual history and sexuality is used to discredit allegations of sexual violence.²⁰⁷ Consequently, victims of sexual violence are discouraged from reporting the violence they experience and their limited access to SRH services.

D. Forced Displacement

Palestinian Women Refugees in Lebanon

1. With large amounts of political and military disagreements in MENA in recent decades, millions of people from Syria, Yemen, Iraq, Palestine, Libya, and Afghanistan have been forced to seek safer places to live throughout the region and beyond. Millions of people found themselves seeking refuge in places where they face a new set of challenges, discrimination, and violence.

²⁰³ Consultation organized by FAR, AIW, and CWGL, August 2020.

²⁰⁴ “Egypt – Events of 2018,” Human Rights Watch, 2019, <https://www.hrw.org/world-report/2019/country-chapters/egypt#>.

²⁰⁵ Researcher from Egypt. Interviewed by FAR and CWGL, August 2020.

²⁰⁶ Ibid.

²⁰⁷ In a 2014 rape case (referred to as the Fairmont Hotel case) an 18-year-old girl was raped by a group of men. The survivor was repeatedly ignored despite evidence against the perpetrators. When a group of people came forward with evidence to support the survivor, their phones were confiscated and it was discovered that at least one of the witnesses was gay. They were publicly out and their sexuality was used to undermine the evidence that they had brought forward, slowing the investigation and any justice for the survivor. This case is just one example of state abuses of power discriminating against sexual assault survivors and sexual/gender minorities in the country.

Gender-based discrimination and violence disproportionately affects women and girls in these contexts and has a particularly negative effect on SRHR.

2. During a consultation organized by FAR in August 2020, an activist who is a refugee herself shared some of the main challenges she and other Palestinian women and girls face in Lebanon.²⁰⁸ Her account illustrates the experiences of female refugees in similar contexts. "I'm a refugee myself and I work in refugee camps. We have many crises, not just one, but the main one is being refugees and that's because of the long occupation. So being refugees means you [are] considered stateless. We don't have access to any government, we don't have structure, we don't have ministries, government, anything like that. People got stuck to their culture and people have to prove their identity. So they believe in different kinds of norms. And you know, most of these norms are against women. As my colleague said, [there is a] uncertain political situation due to [COVID-19], the political situation in Lebanon, the revolution [in October 2019], the very bad economic situation in Lebanon, and the drop of Lebanese lira that makes life very difficult in general. So, for the refugees, it is more because we don't have the right to work in Lebanon. Refugees do daily paid jobs and because of the revolution and all of this, these people lost their jobs and they don't have income and all of this affects women and their sexual and reproductive rights. First of all, this topic is taboo. Secondly, they actually don't put their sexual and reproductive rights on the top of the priorities. It's the opposite. So for women, instead of saying 'I'm going to see the doctor' they say 'I need to feed my children' and this is very common. So, because of the bad economy situation, men lost their power. They were the breadwinners but not anymore. They feel they lost their power and they want to show their power so they show it in a very aggressive way. And this is why during wars and conflicts we have many cases of unwanted pregnancies. And because of abortion is considered illegal, women get pregnant even if they don't want this pregnancy. There are not many services in the camps. The UN provides good health services for pre- and post-natal care, but after that there is nothing. This leaves refugees in a very difficult situation. As a non-governmental organization, my organization - Palestinian Women's Humanitarian Organization - we do our best to raise awareness and to educate; we try to look at the problem deeply and also we have support from Lebanese NGOs, for example, Abaad. We have a project together to raise awareness. One of the components is sexual and reproductive health care. My message is to take into consideration refugees and highlight their situation."²⁰⁹

Iraqi Internally Displaced Women

1. Because of the terrorist acts of ISIS in Iraqi governorates that led to displacement and internal migration there are still 1.7 million displaced persons according to 2019 estimates from the

²⁰⁸ "Humanitarian Advocates Program," Women Deliver, accessed April 27, 2021, <https://womendeliver.org/humanitarianadvocates/>.

²⁰⁹ Olfat Mahmoud (Palestine), consultation organized by FAR, AIW, and CWGL, August 2020.

International Organization of Migration. Displaced persons are living in camps that lack health conditions and, due to overcrowding and the deteriorating environmental situation, the health situation has decreased among them. The efforts of the Ministry of Health are not integrated in this circumstance. Numbers of displaced women, especially those whose family members are suspected of belonging to ISIS, have been subjected to assault, sexual abuse, rape, exploitation, and sexual harassment in displacement camps, as well as bargaining over their bodies in exchange for foods and basic needs.²¹⁰

2. Violence against women and girls not only serves as a cause for flight for women and girls, but also manifests in different ways in humanitarian settings, especially in contexts where women and girls comprise the majority of the displaced. A study found that refugee women in Jordan, Lebanon, and Iraq cited violence against women and girls as an increasing problem.²¹¹
3. The gendered segregation of refugee camps across the MENA region prompts issues for LGBTQ+ individuals like sexual assault, physical safety concerns, mental health issues, and access to menstrual products. Broadly speaking, LGBTQ+ migrants and refugees tend to be ignored by states and people alike.²¹²

E. Other Concerning Trends and Systems

Unwanted Pregnancy and Abortion

1. The actual health impact of unsafe abortions in the MENA region is not well known due to a lack of data. Access to abortion is limited due to criminalization and government and cultural restrictions.
2. All countries in the MENA region, except Tunisia, explicitly criminalize abortion.²¹³ Research shows that all countries in the MENA region permit abortion if the pregnant woman's life is in danger. Some MENA countries also permit abortion in cases of a risk to the pregnant woman's physical health (Bahrain, Iraq, Jordan, Kuwait, Libya, Morocco, Oman, Occupied Palestinian Territories, Qatar, Saudi Arabia, and Yemen), a risk to the pregnant woman's mental health (Algeria, Bahrain, Jordan, Lebanon, Morocco, Qatar, and Saudi Arabia), fetal impairment (Iran,

²¹⁰ Hannah Hamood (Iraq), consultation organized by FAR, AIW, and CWGL, August 2020.

²¹¹ "Shelters for Women Survivors of Violence: Availability and Accessibility in the Arab Region," United Nations Economic and Social Commission for Western Africa, 2020, <https://www.unescwa.org/publications/shelters-arab-region-availability-accessibility>.

²¹² Fatima Outaleb and researcher from Egypt. Consultation and interview respectively, organized by FAR and CWGL, August 2020.

²¹³ Jocelyn DeJong and Hyam Bashour, "Regional Report: Sexual and Reproductive Health Laws and Policies in Selected Arab Countries," UNFPA, 2016, <https://arabstates.unfpa.org/sites/default/files/pub-pdf/Sexual.pdf>.

Kuwait, Morocco, Qatar, Saudi Arabia, Tunisia, and UAE), or rape (Morocco, Saudi Arabia, and Sudan).²¹⁴

3. In several countries in the MENA region, cuts in government health expenditures and the emergence of conservative religiously-oriented parties have contributed to the restriction of publicly provided abortion services.²¹⁵ There is a trend in the region that shows the growing role that social class, marital status, income, age, and education play in shaping the possibility of accessing abortion care or determining the type of facility women can go to (where abortion is legal) and, consequently, the kinds of experience they have.²¹⁶
4. In some countries like Egypt and Tunisia, despite the official position on abortion (illegal and legal, respectively), safe abortion practices are affected by private versus public healthcare, cultural norms surrounding the practices, and doctors' individual feelings regarding abortion and contraception access.²¹⁷ An activist in Tunisia highlighted that "contraception and abortion [have been] legal since the 60s: contraception was available since [1960] and limited abortion since 1965. In 1973, the right to abortion was introduced in the penal code. [I]t, [however,] was not for women's right but for limiting births. But when the demographic situation changed, the priority also changed. Services now are not available as before. There are many kinds of crises, for Tunisia: the first, when there was a political revolution in 2011 and the second, during the COVID-19 crisis. In both crises, SRHR became even less accessible."²¹⁸
5. In other countries, criminalization does not appear to be an unbeatable obstacle for women who want to terminate a pregnancy under medical supervision if they have the information and resources to pay for the service. In Morocco, women who can afford it can easily get abortion care, but unmarried and marginalized women may find it impossible to find a doctor willing to perform an abortion.²¹⁹ One activist referred to the state's failure to comply with international obligations given the restrictive abortion laws and the lack of access to health services. "While it is really difficult to have to access to health services, it is more difficult to access to SRHR services and information because, for instance, services like abortion are criminalized. Women who want an abortion should have money to pay for this service creating inequalities in society. That restrictions plus the privatized nature of the health system really creates and deepens socio-

²¹⁴ Irene Maffi and Liv Tonnessen, "Editorial: The Limits of the Law: Abortion in the Middle East and North Africa," *Health and Human Rights Journal*, 2019, <https://www.hhrjournal.org/2019/12/editorial-the-limits-of-the-law-abortion-in-the-middle-east-and-north-africa/>.

²¹⁵ Ibid.

²¹⁶ Activist (Egypt), interview with FAR and CWGL, September 2020.

²¹⁷ Ahlem Belhadj and researcher from Egypt. Consultation and interview organized by FAR and CWGL, August 2020.

²¹⁸ Ibid.

²¹⁹ Irene Maffi and Liv Tonnessen, "Editorial: The Limits of the Law: Abortion in the Middle East and North Africa," *Health and Human Rights Journal*, 2019, <https://www.hhrjournal.org/2019/12/editorial-the-limits-of-the-law-abortion-in-the-middle-east-and-north-africa/>.

economic inequalities and inequalities in terms of accessing services to start with. This is exacerbated for women and girls who face intersectional discrimination.”²²⁰

6. In Palestine, abortion is illegal so services are not provided in refugee camps. As one activist explained, “there are a lot of constraints with the personal status laws that are being enforced and the criminal laws that are being enforced are really an obstacle, which include cases of criminalizing, for example, safe abortions or the right of the woman to control her own life and her own body.”²²¹ Accessing abortion in other places is extremely difficult under occupation given the lack of freedom to travel.
7. There are also countries where abortion is illegal and doctors still provide the service. As an activist noted, “one result of sexual violence by ISIS [is that] women get pregnant. Despite abortion [being] illegal in Kurdistan Iraq, some doctors got permission to conduct abortions.”²²² In most countries, post-abortion care is inadequate.²²³

Lack of Access to Contraception

1. In most countries, married youth typically do not use family planning and utilization rates are low in other segments of communities where stigma and religious reasons prevail.²²⁴ Full access to contraception for women and girls with disabilities is limited.
2. As of January 2019, the Egyptian government has instituted a program to limit the birthrate in the country. This policy denies welfare aid to families with three or more children²²⁵ and considers the rising birth rate to be a “national security threat.”²²⁶ Concerns around this policy are about who has access to family planning and health services. Outside of the financial distress that this policy places on low-income women, girls, and sexual/gender minorities, it also raises concerns around general bodily autonomy and personal family planning decisions.²²⁷
3. SRH in Egypt is still primarily seen as a necessity for married women due to cultural standards for sexual relationships. In practice, this results in the barring of necessary health care access for unmarried and younger women and girls as well as for sexual/gender minorities whose relationships are not recognized by the state. As such, sexual/gender minorities and unmarried women are forced to seek either unsafe SRH alternatives or attend a privatized pharmacy/hospital

²²⁰ Paola Daher (Lebanon), consultation organized by FAR, AIW, and CWGL, August 2020.

²²¹ Randa Siniora (Palestine), consultation organized by FAR, AIW, and CWGL, August 2020.

²²² A. Behar (Iraq), consultation organized by FAR, AIW, and CWGL, August 2020.

²²³ Jocelyn DeJong and Hyam Bashour, “Regional Report: Sexual and Reproductive Health Laws and Policies in Selected Arab Countries,” UNFPA, 2016, <https://arabstates.unfpa.org/sites/default/files/pub-pdf/Sexual.pdf>.

²²⁴ Ibid.

²²⁵ Jonathan Abbamonte, “Egyptian Government Pushes for Population Control,” Population Research Institute, 2018, <https://www.pop.org/egyptian-government-pushes-for-population-control/>.

²²⁶ Researcher from Egypt, interview with FAR, August 2020.

²²⁷ Nana Abuelsoud, “More than numbers!” Egyptian Initiative For Personal Rights, August 4, 2020, <https://eipr.org/en/blog/nana-abuelsoud/2020/08/more-numbers>.

which are significantly more expensive and limits who has access to these services.²²⁸ A survey conducted about pharmacists' attitudes towards prescribing emergency contraception to unmarried Egyptian women found that while 62 percent of women said that they would "buy from pharmacies regardless of their marital status," several felt intimidated and judged for asserting their sexual and reproductive needs.²²⁹ In Saudi Arabia family planning remains very controversial, though some contraceptives can be purchased directly from pharmacies.²³⁰

4. In Lebanon, outside of labor laws, refugee and undocumented women and girls face further restrictions in access SRH care and family planning programs due to their lack of citizenship and are, therefore, unable to benefit from public social services.²³¹

Discriminatory Systems and Their Impact on SRHR

5. **Abusive male guardianship system:** The male guardianship system in Saudi Arabia allows for women's movement and autonomy to fall under the jurisdiction of their husbands or male family member, regardless of age.²³² Under the male guardianship system, a woman's entire life and health is under the control of a man. It exposes women to intimate partner violence and domestic violence and hinders their right to autonomy, including their right to move freely, travel, work, and access healthcare. Under this system, a woman's guardian may deny access to SRH care or restrict who may provide any sort of treatment based on the provider's gender which causes preventable or treatable health issues to escalate.²³³ In addition, health laws forces women to obtain consent of their husbands for life saving abortion, against the state-issued religious edict permitting this procedure without a guardian's permission, when deemed medically necessary by three medical experts.²³⁴
6. Guardianship restrictions of movement and healthcare access becomes solely the jurisdiction of the guardian and is subjected to his beliefs of what is right and necessary, which completely ignores the autonomy of the woman and their needs. Women under guardianship lack the ability to participate in family planning without the consent of their husbands, nullifying their sexual and reproductive decisions, including the number of children they have.

²²⁸ Researcher from Egypt, interview with FAR, August 2020.

²²⁹ Doaa Abdelaal and Nana Abuelsoud, "Women's Access to Emergency Contraceptives in Egypt: A Pilot Study in Greater Cairo Governate," *Mawanie*, 2017, <https://static1.squarespace.com/static/582b16bbbe65945f3876bca6/t/593d5c9abf629a6afedf77e6/1497193647017/Women%27s+Access+to+Emergency+Contraceptives+in+Egypt+%28Mawanie%29.pdf>.

²³⁰ Jocelyn DeJong and Hyam Bashour, "Regional Report: Sexual and Reproductive Health Laws and Policies in Selected Arab Countries," UNFPA, 2016, <https://arabstates.unfpa.org/sites/default/files/pub-pdf/Sexual.pdf>.

²³¹ Roula Seghaier (Lebanon), consultation organized by FAR, AIW, and CWGL, August 2020.

²³² This includes reports of women's male children assuming guardianship over their mothers.

²³³ Musawah, "Thematic Report on Muslim Family Law and Muslim Women's Rights in Saudi Arabia" Malaysia 2018, 10, <https://www.musawah.org/wp-content/uploads/2019/02/Saudi-Arabia-Thematic-Report-2018-CEDAW69.pdf>.

²³⁴ Ibid.

7. **Kafala, or sponsorship, system:** The *kafala* system permits workers to have an in-country sponsor, usually their employer, who is responsible for their visa and legal status. Workers are unable to change jobs without their employer's permission which allows employers to exploit their workers. This system has a unique impact on the human rights of migrant women and domestic workers throughout the region, including their SRHR.
8. An expert who participated in FAR's consultation explained that in Lebanon, women workers are monitored and scrutinized by their employers and the state in efforts to restrict or deny their emotional, personal, and romantic relationships with citizens and other refugees in efforts to solely exploit them as employees.²³⁵ Women workers under this system face increased risks of SRH problems such as cervical cancer, maternal health issues, and obstetrical emergencies like neonatal deaths and mental issues, for example, higher risks of postpartum depression, in part due to the lack of access/limited access to health services. According to the expert, the *kafala* system also restricts women's bodily autonomy as their "status of their existence in this country is that of a worker, not of a mother, not of a lover not of anything else."²³⁶

F. COVID-19 Impacts on SRHR

1. The COVID-19 pandemic entirely changed the world and will have lasting effects on women and girls' access to SRHR. The pandemic has and continues to exacerbate healthcare issues, sexual and bodily autonomy, reproductive rights, and domestic and sexual violence. Its more specific impact is connected to people's identities and conditions. When referring to the differentiated impact of COVID-19, an activist highlighted that "coronavirus has impacted people differently according to their gender, sex, social, economic status, and their geographical region. People living in urban areas have more access to some services than those living in remote rural areas, who are really left behind [and] are being excluded from the spectrum of services."²³⁷
2. Activists participating in FAR's consultation identified the following challenges to women and girls' human rights and, in particular, their right to bodily integrity and SRHR:
 - a. **Reinforcement of gender stereotypes:** In lockdown, women have to perform even more reproductive labor which has made their situation increasingly difficult. Women are expected to take care of others at their own expense.
 - b. **Women's issues are deprioritized:** SRHR are not only deprioritized by the government but also by progressive circles. An associated problem is donor dynamics and how donors dictate the agenda regardless of the priorities that feminist movements want to highlight. This creates a division between different organizations which form the fabric of the feminist movement.

²³⁵ Roula Seghaier (Lebanon), consultation organized by FAR, AIW, and CWGL, August 2020.

²³⁶ Ibid.

²³⁷ Fatima Outaleb (Morocco), consultation organized by FAR, AIW, and CWGL, August 2020.

- c. **Increase of domestic violence:** In countries in the MENA region, there has been an increase of domestic and sexual violence, particularly against women, girls, and sexual/gender minorities due to COVID-19 lockdown orders. Financial instability weakens opportunities for women, girls, and sexual/gender minorities to become self-sufficient to escape from abusive situations and to access sexual health care, such as menstrual products and contraception. Activists also reported anxieties around the physical, sexual, and mental safety of women, girls, and sexual minority groups who are quarantined with their abusers or violently unsupportive families.
- d. **Transformation of hospitals into COVID-19 centers:** In Morocco, “pregnant women suddenly found themselves with fewer options for care, delivering at home in very primitive unsafe conditions. The issues of abortion, which is criminalized in Morocco, has also reinforced the risks that women are facing and the absence of choices they have.”²³⁸
- e. **Restriction of mobility:** Women and girls have limited mobility for seeking care for medical emergencies and anxieties surrounding the unknown effects of COVID-19 which has resulted in medical malpractice, especially for those who are pregnant or living with HIV (who are already at higher risk for COVID-19 complications). Women’s access to contraceptives also decreases as women fear contagion.
- f. **Lack of planning/strategy using a gender approach:** As noted by several activists representing different areas in the MENA region, one of the major issues is a lack of strategy. Many countries, including Morocco, Lebanon, and Egypt, lack any gender-based COVID-19 health plans. A Lebanese activist said, “We need a very clear policy framework strategy with dedicated budget that will reflect a real political will. Sometimes we say [that] there is collaboration with the government because they are not stopping our work, but we need to translate that into concrete documents and concrete budgeting and mechanisms. That's the most important, not only giving a space for civil society to do what they want, which is basically doing things on their behalf, so that they don't have to worry about resources because civil society is doing everything out there.”²³⁹ Another activist stated, “To summarize, I can say that all the challenge, or most of the challenges, are closely related to the absence of gender-based COVID-19 policies and measures. It means the management of the crisis was not made under gendered lenses.”²⁴⁰
- g. **Lack of information and data:** Information related to the spread of COVID-19 for women, girls, and sexual/gender minorities is limited or withheld. In Egypt, “any information that is shared by the state government is solely through telecommunication (online, television, radio, etc.) which limits the information that is disseminated only to those who have access to those forms of communication, severely affecting low-income populations and

²³⁸ Ibid.

²³⁹ Guida Anani (Lebanon), consultation organized by FAR, AIW, and CWGL, August 2020.

²⁴⁰ Fatima Outaleb (Morocco), consultation organized by FAR, AIW, and CWGL, August 2020.

women, girls, and sexual/gender minorities.”²⁴¹ In addition to the lack of COVID-19 planning, international organizations, such as the WHO, have had delayed translations into Arabic of COVID-19 information which restricts who is able to read and access this information on SRHR.

- h. **Compounded situation of women refugees:** Many refugees in Lebanon, including Palestinians and Syrians, have been further affected by lockdowns which restrict or end their ability to work. This has resulted in a sharp decrease in financial stability which reduces access to the already limited healthcare and social services refugees have at their disposal.²⁴² COVID-19 has further exacerbated movement issues in Palestine from the mandatory Israeli lockdown. The lockdown provides further reason for permit and checkpoint denials, particularly for ill Palestinians.²⁴³
- i. **COVID-19's worsening impact on other crisis situations:** Hospitals and clinics across the region have seen an influx of people since the onset of the COVID-19 pandemic. The increase in patients has only been aggravated by disasters, such as the Beirut explosion, armed conflict in Palestine, and survivors of domestic/sexual violence in need of medical care. With hospitals and clinics overwhelmed with patients and some hospitals even being shut down, like in Morocco,²⁴⁴ SRHR issues often fall by the wayside. Moroccan women have reported having to give birth at home without access to proper pre- and post-natal care.²⁴⁵ Egyptians with HIV face discrimination and physical assault at public hospitals which, until very recently, was the only place to get antiretroviral medications.²⁴⁶ The Egyptian government also released statements that those at high risk for COVID-19 complications, including those with HIV and pregnant women, should only attend hospitals that followed COVID-19 safety protocols. This corresponds with financial status, putting low-income women, girls, sexual/gender minorities, and HIV+ people at higher risk of COVID-19 and financial danger. It also begs the question as to why all hospitals, private or public, are not being assisted by the government to ensure a safe environment.²⁴⁷
- j. **Anti-mask and anti-vaccination campaigns:** Ongoing anti-mask and anti-vaccination campaigns pose further threats to marginalized communities by increasing the spread of COVID-19 which continues lockdowns and shelter-in-place orders. As shown above, this excessively impacts the safety and health care access of women, girls, and sexual/gender minorities. In Morocco, “women have high exposure to the virus by their male partners and relatives’ [opposition] to social distancing and health measure driven by religious or

²⁴¹ Researcher from Egypt, consultation organized by FAR, AIW, and CWGL, August 2020.

²⁴² Olfat Mahmoud (Palestine), consultation organized by FAR, AIW, and CWGL, August 2020.

²⁴³ Randa Siniara (Palestine), consultation organized by FAR, AIW, and CWGL, August 2020.

²⁴⁴ Fatima Outaleb (Morocco), consultation organized by FAR, AIW, and CWGL, August 2020.

²⁴⁵ Ibid.

²⁴⁶ Researcher from Egypt, consultation organized by FAR, AIW, and CWGL, August 2020.

²⁴⁷ Ibid.

political motivations and enhanced by the ambiguous position of the conservative government... The pushback against [COVID-19] [by conservative religious and government leaders] really reflects the pushback of women's rights."²⁴⁸

- k. **Access to contraceptives:** Governments, such as in Egypt, failed to actively prioritize the need for safe and affordable contraception. It was reported that the Egyptian government had only saved enough contraception to be publicly dispersed for three months. As was noted in the above section, contraception is only considered a necessity for married women which leaves unmarried, sexually active women, and sexual/gender minorities to have to find alternative forms of contraception at already crowded hospitals, pharmacies, and clinics, further exposing them to COVID-19.²⁴⁹ Particularly in locations like Egypt, where campaigns to curb the birth rate are present, the COVID-19 pandemic is being used as an excuse to limit sexual and bodily autonomy around family planning.²⁵⁰
- l. **Price gouging and medical malpractice related to birth:** In some countries, price gouging and medical malpractice related to birth has seen an increase. Despite multiple medical resources, including the WHO, claiming that pregnant women and gender minorities need not have a cesarean delivery (C-section) if they have been exposed to COVID-19, a report showed that most births in Egypt have been by C-section which can cause their own complications and have denied birthing options to women.
- m. **Access to menstrual products:** In the current circumstances, menstrual products are viewed as luxury items which makes them restricted to people based on their income. Access to menstrual hygiene products for low-income women and girls is limited.
- n. **Women deprived of liberty:** In most places, due to COVID-19 lockdowns, prisoners have been cut off from their families/visitors. Many of these incarcerated women rely on their families for sexual health services and/or money to purchase those products that are limited by the prison. Access to menstrual products and sexual health is further limited to imprisoned women, girls, and sexual/gender minorities who are forced to purchase menstrual pads and products.²⁵¹ For those who cannot afford to purchase menstrual necessities, they are often forced to find unhealthy and unsafe alternatives to address their needs, including using cloths that are not disinfected as makeshift menstrual pads.
- o. **Marginalized groups:** Those in rural areas, particularly women and girls, lack quality COVID-19 related care and resources, including sexual health and sexual/domestic violence assistance, which is worsened by lockdown protocols that restrict travel to urban areas which can provide those resources. In Morocco, "The situation of migrant women has worsened with the pandemic and some migrant women are left to the mercy of

²⁴⁸ Fatima Outaleb (Morocco), consultation organized by FAR, AIW, and CWGL, August 2020.

²⁴⁹ Researcher from Egypt, consultation organized by FAR, AIW, and CWGL, August 2020.

²⁵⁰ Ibid.

²⁵¹ "'Periods in Prison' a campaign calls on the prison authorities to provide cotton-based sanitary pads to female prisoners free of charge," Egyptian Initiative for Personal Rights, March 8, 2019, <https://eipr.org/en/press/2019/03/international-womens-day-periods-prison>.

pimps. Women with disabilities were also left behind and their needs and rights are not taken into consideration. Amazigh women living in rural areas are survivors of the bad management of the crisis, increasing risks of death among them. And the LGBT community is not part of the spectrum at all.”²⁵²

Promising Practices

A. Bourj el Barajnh Palestinian and Syrian Refugee Camp in Lebanon

1. In 2019 the Women’s Humanitarian Organization (PWHO) started a project in the Bourj el Barajnh Palestinian and Syrian refugee camp in Beirut to increase the autonomy of women in the camp through sexual and reproductive education, leadership roles, advocating for self-autonomy through “advocacy workshops,” sport and aerobic classes, female health clinics, psychosocial support and counselling, peer support groups, informal discussion groups, trips, literacy training, English training, self-relaxation, and wellbeing awareness raising sessions, and raising awareness about how to deal with children and adolescents.²⁵³ The project both directly and indirectly impacted 798 women and girls and 112 men and boys.²⁵⁴
2. According to the Narrative Report released by the PWHO and Kvinna Till Kvinna, the program increased women’s knowledge and access to reproductive and sexual health services, awareness of women’s rights and history, feelings of self-worth and ability to assert autonomy, educational skills, and awareness of the importance of education. Additionally, the program set out to educate men on the harms of early marriage and GBV, citing an increase of awareness among men and boys in the camp.²⁵⁵

B. Campaign #LockdownNotLockup in Lebanon

1. The Lebanese organization Abaad launched the campaign #LockdownNotLockup that spreads awareness through a helpline number that is dedicated to women enduring violence at home during the lockdown. The goal of the campaign is to provide GBV survivors with information about services and how to access them. People are encouraged to share helpline numbers – from Abaad, other women’s organizations, and the police – on a sheet and hang it on their balconies during the day. The campaign conveyed the message, also disseminated through social media, that women are not alone and there is someone who can help. In collaboration with community centers and municipalities, Abaad reached women and girls who might face domestic violence including sexual violence and incest by taking food door-to-door. They also embedded messages

²⁵² Fatima Outaleb (Morocco), consultation with FAR, August 2020.

²⁵³ “Kvinna Till Kvinna Narrative Annual Report,” Women’s Humanitarian Organisation, 2020 (unpublished).

²⁵⁴ Ibid.

²⁵⁵ Ibid.

in cereal boxes and milk knowing that in most cases women are the ones who would use those items. This is a promising practice because the initiative facilitates the reception of essential information regarding women and girls' rights and a shares helpline number without increased risks of retaliation.²⁵⁶

C. Reinsertion of Women Victims of Sexual Violence in Yazidi Communities

1. When ISIS controlled part of Iraq, they attacked minorities, including Yazidi people, capturing more than 3,000 women and girls and using them as sex slaves. In Yazidi society, when a woman is raped the community or her family can kill her, blaming the victim for what happened as she is considered to having made a mistake. In 2014, two women ran away from ISIS. The Emma Organization engaged in advocacy actions with the Yazidi community, religious leaders, and the government and was able to convince them that capture and rape are not the fault of women and girls. In 2015, the Committee of Yazidi approved a statement to accept all the women and girls who were sexually enslaved by ISIS. While women must convert to Islam, this is a promising practice in the context of a very traditional community which otherwise would reject or even kill them.²⁵⁷
2. As a result of sexual violence by ISIS, some women get pregnant. The Emma Organization established a shelter for women and their children and have conducted advocacy for reparations.

Key Messages to States

1. During FAR's consultation, participants came up with specific messages that the Working Group could consider including within its thematic report:
 - a. Governments are not taking seriously SRHR and they are leaving women to fight this battle alone, disregarding their international obligations. SRHR are human rights and we should accept no less.
 - b. During all crises, SRHR will be the first rights to be attacked so we as women's organizations have to do much more to protect them.
 - c. Civil society organizations – the feminist movement, the LGBTQ+ movement, and other social movements – must work together to protect these rights.
 - d. Regarding Palestine, it has to be acknowledged that occupation maintains a system of laws, policies, and measures that affect women and girls' SRHR – “unless occupation ends, women and girls' sexual and reproductive health and rights cannot be guaranteed.”²⁵⁸

²⁵⁶ Guida Anani (Lebanon), consultation with FAR, August 2020.

²⁵⁷ Bahar Ali (Iraq), consultation with FAR, August 2020.

²⁵⁸ Mervat Rishmawi (Palestine), consultation with FAR, August 2020.

Recommendations

1. Participants in FAR's consultation discussed and outlined the following priority recommendations for states in MENA:
 - a. Make gender equality a priority and allocate budgets for plans and policies that address SRHR and GBV.
 - b. Be more proactive in adopting legislation to eliminate discrimination against women, including sexual violence against women.
 - c. Increase and provide women and LGBTQ+ affirmative medical practitioners, counselors, and social workers to address gender-based and sexual violence; increase social services that provide safe and affirming spaces for women and LGBTQ+ people.
 - d. Standardize high quality public health resources (including hospitals, pharmacies, and clinics), centering issues of maternity and HIV.
 - e. Ensure safe abortions are guaranteed in the region, especially for victims of sexual violence.
 - f. Adopt measures to protect domestic workers, refugee women, and stateless people who are in vulnerable situations.
 - g. Ensure that budgets not only provide access to health services, but specifically prioritize SRHR in situations of crisis.
 - h. Use an intersectional approach when developing and implementing policies.
 - i. Ensure quality education on SRHR.
 - j. Provide economic welfare, legal protections, and SRHR resources for refugees, day laborers, and undocumented people.
 - k. Fund grassroots local organizations providing SRHR health care.

IV. Latin America and the Caribbean

This chapter²⁵⁹ is based on information provided by expert activists in the field of SRHR in Latin America and the Caribbean who participated in an online consultation on July 24, 2020 organized by FAR, CWGL, and the Institute of Women's Human Rights Education (WHRI).²⁶⁰ The same group of activists participated in a second consultation on August 6, 2020. FAR's team conducted supplementary desk research and received additional information from some activists by email.

Crisis Situations

Virtually every country in Latin America and the Caribbean has laws or policies to address gender-based discrimination and violence against women,²⁶¹ putting the region at the forefront of recognizing this problem. However, the current legal framework does not ensure that women and girls will have access to essential sexual and reproductive health services especially in crisis contexts where GBV and discrimination are exacerbated. As illustrated through the following examples, gender-based discrimination and violence are constant in women's lives and this is exacerbated during crisis situations.

A. Endemic Violence

1. GBV and discrimination against women and girls, especially sexual violence and femicide, has been exacerbated in the context of post-conflict countries occurring in Central America region. During the 1970s and 1980s, civil wars in this region gave rise to hundreds of extrajudicial executions and arrests, disappearances, massacres, and torture. Women in particular experienced rape, slavery and sexual slavery, and forced abortions. Especially in Guatemala, Indigenous women were the main recipients of violence perpetrated by both state forces and paramilitary and guerrilla groups. Such violence affected the social fabric and had serious

²⁵⁹ This chapter focuses on Latin America and the Spanish-speaking Caribbean.

²⁶⁰ Soledad Deza, president of Fundación Mujeres x Mujeres (Argentina); Paula Estenssoro, Catholics for Choice (Bolivia); Beatriz Galli, National Rapporteur on the Right to Sexual Reproductive Health at Plataforma de Direitos Humanos Dhesca Brasil (Brazil); Camila Maturana, attorney at Humanas (Chile); Cristina Rosero, attorney at the Center for Reproductive Rights (Colombia); Rocío Rosero, member of Coalición Nacional de Mujeres del Ecuador (Ecuador); Karen Molina, director of INCIDEJOVEN (Guatemala); Sara García, advocacy coordinator at Agrupación Ciudadana por la Despenalización del Aborto (El Salvador); Norma Carías, member of Somos Muchas (Honduras); Oriana López Uribe, director of Balance México (Mexico); Mayte Ochoa, regional consultant at IPAS Central America and Mexico (Nicaragua); Rossina Guerrero, programs director of Promsex (Peru); Lourdes Inoa Monegro, programs associate at Mujer y Salud at Taller Salud (Puerto Rico); Cinthya Amanecer, director of intercultural connection at La Ceiba (Dominican Republic); Estefanía Mendoza, coordinator at Mullier (Venezuela); Marcia Aguiluz, attorney at Women's Link Worldwide (regional); Lisette Alas, co-coordinator at La Sombrilla Centroamericana (regional).

²⁶¹ Follow-up Mechanism of the Convention of Belém do Pará (MESECVI), "Tercer Informe Hemisférico sobre la Implementación de la Convención de Belém do Pará," OEA, 2017, 36-58, <http://www.oas.org/es/mesecvi/docs/TercerInformeHemisferico.pdf>.

consequences up to the present.²⁶² Today, women are subjected to increasing GBV, including sexual violence, perpetrated by gang groups.²⁶³ In recent years Guatemala, El Salvador, and Honduras ranked among the five countries worldwide with the highest rates of femicide perpetrated both in the private and public spheres.²⁶⁴

2. In Latin America, “the escalation of lethal violence against women... may be the result of increased militarization of the state and society in response to drug wars, which directly affect or even target women, the persistent machismo culture”.²⁶⁵ In Mexico, a militarized public security strategy to combat organized crime cartels was launched in 2006. The study “The Two Wars: The Impact of Armed Forces Clashes on Women's Murders in Mexico (2007-2018)” concludes that the “war on drugs” influenced the increase in homicides against women in the short term in places where there were clashes between military and organized crime organizations.²⁶⁶ Such killings were committed both at home and in public space.²⁶⁷ On the other hand, women who are deprived of liberty linked to the “war on drugs” have experienced in a regular basis sexual torture by armed forces.²⁶⁸
3. On top of high levels of GBV and discrimination against women and girls in this sub-region is the impunity, the lack of judicial redress and the weakness of public health sectors, including sexual and reproductive health services, factors that perpetuate the cycle and the effects of gender-based violence. As an activist explained, “There are high rates of corruption in the region that have an impact on the protection of women's rights, and sexual and reproductive rights. There is no rule of law and justice institutions are weak leaving women -who face more and more violence- unprotected.”²⁶⁹
4. As discussed below, restrictive abortion regulations in many countries in the region have devastating consequences on women considering the state’s inability to protect women from

²⁶² “The fact that a good part of the population witnessed, experienced or participated in these atrocities has generated a generalized psychosocial trauma.” “Crime and Development in Central America,” UN Office on Drugs and Crime, 2007, 14, <https://www.unodc.org/documents/data-and-analysis/Central-america-study-es.pdf>.

²⁶³ “El salario del miedo: maras, violencia y extorsión en Centroamérica,” Crisis Group 62, April 6, 2017, 19. <https://www.refworld.org/cgi-bin/texis/vtx/rwmain/opensslpdf.pdf?reldoc=y&docid=58e74ee34>.

²⁶⁴ Geneva Declaration Secretariat, “Global Burdens of Armed Violence,” (Cambridge: Cambridge University Press, 2015), 94. http://www.genevadeclaration.org/fileadmin/docs/GBAV3/GBAV3_Ch3_pp87-120.pdf.

²⁶⁵ Ibid.

²⁶⁶ The same study documented that the majority of homicides were registered inside houses and, as of 2009, deaths in public spaces exceeded those committed in the victims’ home. Furthermore, the murder of women with firearms increased exponentially after 2007. The study found that confrontations are associated with an increase in homicides of women committed both at home and on the street, with firearms and no firearm. Laura H. Tuesta and Estefanía Vela, “Las dos guerras: el impacto de los enfrentamientos de las fuerzas armadas en los asesinatos de mujeres en México (2007-2018),” *Intersecta*, 2020, 11-15. <http://www.intersecta.org/lasdosguerras/>.

²⁶⁷ Ibid.

²⁶⁸ “Mujeres con la frente en alto, Informe sobre la tortura sexual en México y la respuesta del Estado,” Centro Prodh Miguel Agustín Juárez, 2018, 24-29.

²⁶⁹ Margarita Guillé, consultation with FAR, FWLD, and CWGL, January 2020.

violence. The situation is particularly serious for women in the most marginalized sectors including adolescent girls, informal workers, indigenous women, migrants, and refugees.

B. Armed Conflict

1. **Colombia:** The armed conflict in Colombia that began in 1960 and, albeit with less intensity, extends to this day, has involved illegal and legal armed actors who have engaged in various forms of sexual and reproductive violence on girls, adolescents, women, and LGBTQ+ people as a “habitual, widespread, systematic and invisible practice.”²⁷⁰ Such violence has had a disproportionate impact on rural, Afro-Colombians, and indigenous women “which has aggravated the discrimination, inequalities, and poverty they have suffered historically.”²⁷¹ It also “continues, reinforcing and amplifying the violence that is present in the lives of Colombian women outside the armed conflict.”²⁷²
2. Although there has been progress in the recognition of forms of GBV in the context of conflict including abortion, sterilization, contraception, and forced pregnancies, these crimes “remain under documented or seen as impacts arising from sexual violence, without sufficient analysis of the incidence they have had, their own physical impacts, mental and social as well as its consequences against the project of life of its victims.”²⁷³ The Centre for Reproductive Rights conducted a research project that found that reproductive violence in the context of conflict responds to a structural context of gender discrimination that affects women, girls, and LGBTQ+ people and that was perpetrated by all actors in the conflict against combatants and civilians.²⁷⁴
3. In Colombia, as part of the peace agreement signed by the Colombian government with the Revolutionary Armed Forces of Colombia, measures were promised to ensure the safety of human rights defenders, including social leaders. However, this part of the agreement has not been properly implemented. Between March 2018 and May 2019 alone, 482 attacks were reported against women human rights defenders and 19 female leaders were killed in 2019.²⁷⁵

²⁷⁰ “Violencia Reproductiva en el Conflicto Armado colombiano,” Center for Reproductive Rights, 2020, 3. https://reproductiverights.org/wp-content/uploads/2020/12/Violencia-reproductiva-en-el-conflicto-armado-colombiano_Reporte-1.pdf.

²⁷¹ “Situación de las mujeres afrocolombianas e indígenas. Colombia 2011-2014,” Corporación Humanas, 2015, 52-54. <https://www.yumpu.com/en/document/view/53351653/situacion-de-las-mujeres-afrocolombianas-e-indigenas-colombia-2011-2014>

²⁷² “This violence in all areas and throughout their lives has to do with harassment, abuse, mistreatment and rape present in the relationships of coexistence at home, at work, in the town or community.” Comisión de Verdad y Memoria de Mujeres Colombianas, “La verdad de las mujeres victimas del conflicto armado en Colombia,” Ruta Pacífica de Mujeres, 2013, 32, <https://www.rutapacifica.org.co/descargue-los-libros/79-tomo-i-tomo-ii-y-resumen-ejecutivo>.

²⁷³ Cristina Rosero (Colombia), consultation organized by FAR, Women’s Human Rights Education Institute (WHRI), and CWGL, July 2020.

²⁷⁴ Ibid.

²⁷⁵ Ibid. “In Colombia, the situation of human rights defenders is critical, especially in the midst of a scenario of increased risk, where the pandemic has made a direct institutional response difficult. For this reason, it is necessary that immediate measures be taken to protect social leaders with a gender perspective.”

C. Political crisis

1. **Bolivia:** Bolivia has one of the highest rates of adolescent pregnancies and maternal mortality in the region,²⁷⁶ which itself creates a crisis for thousands of adolescents each year. This is not only a problem of lack of information, sexuality education for adolescents, or limited access to contraception, but GBV against women that is exercised structurally and that affects Indigenous girls and adolescents more intensely.²⁷⁷ This situation was aggravated in a context of Bolivia's recent political, social and institutional crisis that resulted in a lack of political will to guarantee sexual and reproductive health.²⁷⁸
2. **Nicaragua:** Nicaragua has one of the highest adolescent fertility rates in Central America.²⁷⁹ The situation is particularly serious in a country where, according to a survey conducted by the Nicaraguan Ministry of the Family, 50 percent of pregnancies in girls and adolescents are the product of sexual violence and where access to abortion is criminalized in all cases.²⁸⁰ This situation takes place in the context of a political and social crisis that began in April 2018 and is characterized by serious violations of human rights and freedom of expression aggravated by the absence of a regulatory system that guarantees free, fair, transparent, and legitimate elections, a situation that has led to the alteration of the constitutional and democratic order of the country.²⁸¹ In this context, "the persecution of human rights defenders reached alarming levels. It included attacks, such as intimidation, psychological harassment, smear campaigns, unlawful detention, torture and ill-treatment, and even sexual violence."²⁸²
3. **Venezuela:** Since 2016 Venezuela has been in the midst of a serious humanitarian crisis caused by political instability that severely compromises the guarantee of human rights for the entire population. One of the effects of the country's political and financial crisis is the collapse of the public health system.²⁸³ However, as an activists noted, "this humanitarian emergency has a differentiated impact on women and girls, this results in serious violations of their rights to sexual and reproductive health, the right to live a life free from violence, the right of women not to die from causes related to their pregnancy, having reproductive autonomy and the right to food,

²⁷⁶ "Estudio sobre el embarazo en la adolescencia en 14 municipios de Bolivia," UNFPA, 2016, 4, https://bolivia.unfpa.org/sites/default/files/pub-pdf/Cartilla_Embarazo_Adolescencia_14_mun.pdf; Arthur Erken, "Estado de la Población Mundial," UNFPA, 2019, 153, https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2019_ES_Estado_de_la_Poblacion_Mundial.pdf.

²⁷⁷ Paula Estenssoro (Bolivia), consultation organized by FAR, WHRI, and CWGL, July 2020.

²⁷⁸ Ibid. "In Bolivia there have been four changes of health ministers in November 2019 but to date, none of them has given any guidelines or attention in the field of sexual and reproductive health."

²⁷⁹ "Acelerar el progreso hacia la reducción del embarazo en la adolescencia en América Latina y el Caribe," UNFPA, 2016, 22, 24, https://lac.unfpa.org/sites/default/files/pub-pdf/ESP-EMBARAZO-ADOLESC-14febrero%20FINAL_5.PDF.

²⁸⁰ "Nicaragua debe atender el embarazo precoz y la violencia sexual, según Unicef," *El Nuevo Herald*, March 29, 2019, <https://www.elnuevoherald.com/noticias/mundo/america-latina/article228618049.html>.

²⁸¹ Mayte Ochoa (Nicaragua), consultation organized by FAR, WHRI, and CWGL, July 2020.

²⁸² Ibid.

²⁸³ Estefanía Mendoza (Venezuela), consultation organized by FAR, WHRI, and CWGL, July 2020.

among others.”²⁸⁴ The collapse of the health system has resulted in a shortage of contraception and family planning, increased maternal mortality, teenage pregnancies, sexually transmitted infections, including HIV, and the increase in unsafe and unwanted abortions.²⁸⁵ Access to basic services and goods is even more limited for women in vulnerable sectors, such as refugee women and especially migrants when they have an irregular migration situation. On the other hand, women who are being held in institutions where there is no external monitoring face a high risk of sexual violence and lack of health and reproductive care. The fact finding mission in Venezuela found that in detention centers where women are detained for political reasons they do not have sufficient provision of safe water or access to menstrual hygiene products.²⁸⁶ Likewise, the mission reported that officials of the Bolivarian National Intelligence Service (SEBIN) are involved in perpetrating sexual violence against detained women.²⁸⁷

D. Natural Disasters

1. Natural disasters affecting Latin America and the Caribbean such as volcanic eruptions, earthquakes, floods, and landslides caused by persistent rains, tropical storms, hurricanes, forest fires, and droughts are on the rise and have differentiated impacts on women because they relate directly to pre-existing roles, responsibilities, opportunities, and gender difficulties.²⁸⁸ Women, particularly young women and adolescents, are vulnerable to the various manifestations of violence during humanitarian emergencies including sexual violence, harassment, sexual exploitation and abuse, human trafficking, or even femicide.²⁸⁹
2. **Puerto Rico:** After Hurricane Maria activists documented a crisis of GBV which was the result of a lack of prioritization in the preparation phase and during the implementation of a response to the emergency. In this regard, one activist noted, “Neither the state nor the federal government had protocols for handling cases of harassment, sexual assault or domestic violence in refugee centers. As a result, no scrutiny was carried out on sexual offenders in admission to government shelters, even though state agencies have an official list identifying these people.”²⁹⁰
3. The perception of activists is that domestic violence shelters were not prioritized nor were protocols adapted to address GBV in ongoing cases of violence.²⁹¹ In addition, “risk preparedness

²⁸⁴ Ibid.

²⁸⁵ Ibid.

²⁸⁶ Independent International Fact-Finding Mission on the Bolivarian Republic of Venezuela, A/HRC/45/CRP.11, September 15, 2020, paragraphs 302, 946, 1924 and 1925.

²⁸⁷ Ibid., paragraphs 303 and 1926.

²⁸⁸ “Violencia de Género y los Desastres Naturales en América Latina y el Caribe,” UNFPA, January 2012, 17-20, <https://lac.unfpa.org/es/publicaciones/violencia-de-g%C3%A9nero-y-los-desastres-naturales-en-am%C3%A9rica-latina-y-el-caribe>.

²⁸⁹ Ibid.

²⁹⁰ Francisca Vigaud-Walsh, “Sobrevivientes del Huracán María: ‘La Seguridad de las Mujeres No Fue Prioridad,’” Refugees International, 2018, 5. <https://static1.squarespace.com/static/506c8ea1e4b01d9450dd53f5/t/5bb63e95652dead3ba8a12b9/1538670229/989/Puerto+Rico+Women+and+Girls+Issue+Brief+-+September+2018+-+Spanish.pdf>.

²⁹¹ Ibid., 4.

and mitigation plans for health and/or environmental emergencies are not tailored to the needs of women, especially pregnant women.”²⁹²

E. Other Concerning Trends in Sexual and Reproductive Rights

Influence of Religious and Anti-Rights Groups

1. Over the past two decades, a self-proclaimed pro-life and pro-family movement, led by the Catholic church, evangelist churches, and related groups, has strengthened throughout Latin America. These actors have managed to penetrate different levels of government structures. Today, “conservative movements have an important, sometimes dominant, presence in the legislature of their respective countries, which explains the regressive role that Latin American parliaments play in all sexual and reproductive rights and minority rights.”²⁹³ In different countries, public servants, parliamentarians, judges, and health providers in public hospitals, influenced by religious ideas and actors, have denied women and girls health services undermining their right to health and integrity, autonomy over their bodies, their privacy, and their lives.
2. Activists in the region noted during FAR’s consultative sessions in 2020 that this situation has exacerbated the various crises addressed in this document, including the current health crisis related to COVID-19 discussed in depth in the last section. In El Salvador, “in addition to the crisis, anti-rights groups continue to attack women who have faced obstetric emergencies and sexual and reproductive rights defenders, causing stigmatization, misinformation and virtual attacks.” In other countries, “fundamentalist groups are attacking democracy and women’s rights.”²⁹⁴ In Bolivia “in this critical context, which has been aggravated by the pandemic, conservative religious, fundamentalist, anti-rights positions called pro-life have joined the government and the Ministry of Health... this risks a backlash on women and girls’ sexual and reproductive rights. In addition, the electoral [crisis] context has not yet been resolved.”²⁹⁵
3. Today, the conservative and anti-rights movement that has permeated different levels of state and society has successfully advanced the idea of a so-called “gender ideology” that rejects sexuality education plans and even any reference to gender-based discrimination or violence. According to one article, between 2015 and 2017, the Ministers of Education of Brazil, Colombia, Uruguay, and Peru have faced strong opposition from conservative groups.²⁹⁶ In Peru, conservative organizations won a case against the inclusion of a gender-sensitive approach to the academic curriculum. After this first decision, the judiciary overruled this decision, granting legal protection to gender-sensitive approaches to the school curriculum.²⁹⁷ In Colombia, gender

²⁹² Lourdes Inoa Monegro (Puerto Rico), consultation organized by FAR, WHRI, and CWGL, July 2020.

²⁹³ Camila Gianella, Marta Rodriguez de Assis Machado, and Angelica Peñas Defago, “What causes Latin America’s high incidence of adolescent pregnancy?” Chr. Michelsen Institute, CMI brief 16, no. 9, 2017, <https://www.cmi.no/publications/6380-what-causes-latin-americas-high-incidence-of>.

²⁹⁴ Sara García (El Salvador), consultation organized by FAR, WHRI, and CWGL, July 2020.

²⁹⁵ Paula Estenssoro (Bolivia), consultation organized by FAR, WHRI, and CWGL, July 2020.

²⁹⁶ Camila Gianella, Marta Rodriguez de Assis Machado, and Angelica Peñas Defago, “What causes Latin America’s high incidence of adolescent pregnancy?” Chr. Michelsen Institute, CMI brief 16, no. 9, 2017, <https://www.cmi.no/publications/6380-what-causes-latin-americas-high-incidence-of>.

²⁹⁷ Rossina Guerrero (Peru), consultation organized by FAR, WHRI, and CWGL, July 2020.

ideology was used by conservative actors to reject the peace agreement which referred to “the elimination of all forms of discrimination,” affecting women’s standing as political subjects. It diminished the efforts to combat discrimination based on gender, sexual orientation, and diverse gender identity and to understand the impact of conflict and GBV on children and adolescents. In Guatemala, the weakening of institutions that promote women's rights, including the dismantling of the Secretariat of the Presidency of Women (SEPREM), is also linked to the influence of fundamentalist groups.²⁹⁸ In Argentina, religious fundamentalists are a constant threat to the women’s human rights movement’s gains. As women achieve rights, these groups become more sophisticated in their efforts to roll back women’s human rights.²⁹⁹

Deficit in Access to and Implementation of Sexual and Reproductive Health Services

1. Low investment in health systems and, in particular, sexual and reproductive health services predicts any government’s inability to deal with a crisis. An activist from Nicaragua explained this situation in her country in these terms: “health for the general population, and in particular for women, has not been a state priority, which is evident in the low budget allocated to public health... Today the health system is collapsed and unable to meet the reproductive needs of women and girls.”³⁰⁰
2. During the FAR consultation, activists highlighted the lack of information and sexuality education, the lack of protocols and regulations to ensure the implementation of sexual and reproductive services, even when they are legal, and the inappropriate use of conscientious objection that allows medical personnel to impose their moral and religious criteria and deny sexual and reproductive health services. For example, in Colombia, administrative barriers that prevent women from effective access to services are linked to lack of information, prejudices of officials, and unavailability of sexual and reproductive health services.³⁰¹ In Puerto Rico the main problem is that services are privatized, have a high cost, and are inaccessible, in addition to the lack of universal health services. While access to abortion is legal, there is an outreach problem for women in rural areas.³⁰²

Unplanned Pregnancy and Access to Legal Pregnancy Termination Services

1. **High rates of unplanned pregnancies:** Latin America and the Caribbean is the region with the highest unplanned pregnancy rate — 96 per 1,000 women of reproductive age.³⁰³ This problem is

²⁹⁸ Karen Molina (Guatemala), consultation organized by FAR, WHRI, and CWGL, July 2020. “The main challenge in Guatemala is not to lose everything that has been gained in the area of women’s human rights to the actions of the state that are contrary to women’s human rights. In particular, the institution that guarantees the implementation of women’s human rights, which has been achieved thanks to the efforts made by civil society.”

²⁹⁹ Soledad Deza (Argentina), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁰⁰ Mayte Ochoa (Nicaragua), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁰¹ Cristina Rosero (Ecuador), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁰² Lourdes Inoa Monegro (Puerto Rico), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁰³ Susheela Singh, Lisa Remez, Gilda Sedgh, Lorraine Kwok, and Tsuyoshi Onda, “Abortion Worldwide 2017: Uneven Progress and Unequal Access,” Guttmacher Institute 2017, 34-40, https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf.

directly related to the high rates of sexual violence, lack of access to sexuality education, and lack of information and contraceptives, including oral emergency contraceptives. A main challenge identified is the provision of contraceptives according to gender biases, where women are viewed as main responsible for reproduction and heterosexual sexual intercourse and reproduction are seen as the norm.³⁰⁴

2. **Limited access to abortion services:** Although a high percentage of pregnancies are unplanned, access to pregnancy termination services is uneven in Latin America. In contexts where abortion is penalized, abortion is practiced underground, risking the health and life of women and girls. According to a 2017 study, Latin America and the Caribbean has the highest annual abortion rate in all regions, 44 per 1,000 women of reproductive age compared to 36 in Asia, 34 in Africa, 29 in Europe, and 17 in North America (all per 1,000 women).³⁰⁵
3. The absence of counseling in reproductive health services, barriers to access to legal abortions, the limited availability of adequate technology for the treatment of incomplete abortion, the threat of legal proceedings, stigma and social sanction reinforce the clandestinity and insecurity of abortion.³⁰⁶
4. **Criminalization of abortion:** The Latin American region has some of the most restrictive laws concerning access to abortion services. With the exception of Cuba, Puerto Rico, Uruguay, and two states in Mexico (Mexico City and Oaxaca) where women have the right to terminate their pregnancy, the remaining countries range from prohibitive, restrictive, and moderately restrictive laws. El Salvador, Haiti, Honduras, Nicaragua, Suriname, and the Dominican Republic penalize abortion without any exception. El Salvador has used the law to criminalize both women who have had miscarriages and obstetric emergencies. "Currently, 18 women are deprived of their liberty for a crime they did not commit, imprisoned from hospital to prison, their fundamental rights violated."³⁰⁷
5. In Peru and Ecuador there are regulatory frameworks that are in tension with human rights. In this regard, one activist noted, "In Ecuador, criminal reform in rape abortion causality has not been approved in the National Assembly, the executive evades accountability and the Constitutional Court has not resolved on these issues. Added to this is the anti-women's rights pressure in the National Assembly and the disregard for the implementation of Recommendations of six Human Rights Committees on decriminalization in cases of rape abortion. The Code on Conscientious Objection and the Code of Children and Adolescents that do not provide for the insertion of standards of violence."³⁰⁸
6. The implementation of laws that prevent women and girls from making decisions about their own bodies have resulted in serious violations of their right to health, physical and psychological integrity, and autonomy. The suffering caused, aggravated by age, health, specific context, and other conditions, constitutes forms of violence that in themselves can be considered torture and

³⁰⁴ Jane T. Bertrand, Tara M. Sullivan, Ellen A. Knowles, Muhammad F. Zeeshan, and James D. Shelton, "Sesgo en los métodos anticonceptivos y cambios en la mezcla de métodos en países de bajos y medianos ingresos," Guttmacher Institute, 2015, 20-30, https://www.guttmacher.org/sites/default/files/article_files/4102015s.pdf.

³⁰⁵ Susheela Singh, Lisa Remez, Gilda Sedgh, Lorraine Kwok, and Tsuyoshi Onda, "Abortion Worldwide 2017: Uneven Progress and Unequal Access," Guttmacher Institute, 2017, 8, https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf.

³⁰⁶ Ibid., 18.

³⁰⁷ Sara García (El Salvador), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁰⁸ Rocío Rosero (Ecuador), consultation organized by FAR, WHRI, and CWGL, July 2020.

cruel, inhuman, and degrading treatment. During the consultation organized by FAR, activists agreed that the criminalization of abortion in their countries has not had the effect of decreasing the number of abortions and instead has caused increased maternal mortality and morbidity because it pushes women and girls underground and exposes them to unsafe, life-threatening services.

Teen Pregnancy and Obstetric Emergency

1. One of the most critical situations in the region is the high rates of adolescent fertility, 73.2 per 1,000 which is very high compared to the global rate of 48.9 and the rate of developing countries of 52.7.³⁰⁹ The pregnancy of girls and adolescents is in the vast majority of cases a product of rape or *stupro* where there is an unequal balance of power. Adolescent pregnancies particularly affect girls from families living in poverty and rural and Indigenous people and represents a failure of state protection.³¹⁰ The situation is particularly serious in countries where rape is not recognized to allow and ensure access to legal termination of pregnancy such as in Nicaragua, El Salvador, Peru, and Ecuador, among others.
2. Pregnancy in children under the age of 15 has been increasing in the region. In Peru, most child pregnancies are the result of rape. Peru's Comprehensive Health Insurance has reported that every day five girls under the age of 15 become mothers.³¹¹ In Nicaragua, annually more than 35,000 girls and adolescents carry out their pregnancy, representing 25.2 percent of all births.³¹² In Ecuador, between 2009 and 2016, 17,448 girls under the age of 14 gave birth according to the Database of Vital Statistics and Births of the National Institute of Statistics Census (INEC) and, on average, every year 2,181 girls under the age of 14 have a delivery in Ecuador, all victims of sexual violence.³¹³ In the same country, according to census data, teenage pregnancy increased by 74 percent over the past decade.³¹⁴
3. Given the restrictive legislation in several countries and the institutional practices that do not guarantee access to sexual and reproductive health services, in many cases girls and adolescents are forced to continue unplanned pregnancies. It is therefore no coincidence that, as an activist

³⁰⁹ Camila Gianella, Marta Rodríguez de Assis Machado, and Angelica Peñas Defago, "What causes Latin America's high incidence of adolescent pregnancy?" Chr. Michelsen Institute, CMI brief 16, no. 9, 2017, <https://www.cmi.no/publications/6380-what-causes-latin-americas-high-incidence-of>.

³¹⁰ "El Estado como 'aparato reproductor' de violencia contra las mujeres: Violencia contra las mujeres y tortura u otros malos tratos en ámbitos de salud sexual y reproductiva en América Latina y el Caribe," Amnesty International, 2016, 37, <https://www.amnesty.org/download/Documents/AMR0133882016SPANISH.PDF>.

³¹¹ Rossina Guerrero (Peru), consultation organized by FAR, WHRI, and CWGL, July 2020. "Más de 5 mil niñas obligadas a ser madres en los últimos cuatro años," *Wayka.pe*, May 29, 2019, <https://wayka.pe/mas-de-5-mil-ninas-obligadas-a-ser-madres-en-los-ultimos-cuatro-anos/>.

³¹² Mayte Ochoa (Nicaragua), consultation organized by FAR, WHRI, and CWGL, July 2020.

³¹³ "Las niñas invisibles de Ecuador," Wambra, March 2018, <https://wambra.ec/las-ninas-invisibles-ecuador/#:~:text=En%20promedio%2C%20cada%20a%C3%B1o%202.181,de%20catorce%20a%C3%B1os%20es%20violaci%C3%B3n>.

³¹⁴ Ximena Casas Isaza, Oscar Cabrera, Rebecca Reingold, and Daniel Grossman, "'Vidas Robadas,' Un estudio multipais sobre los efectos en la salud de las maternidades forzadas en niñas de 9–14 años," Planned Parenthood, 2016, <https://clacaidigital.info/bitstream/handle/123456789/977/Unestudio.multipa%C3%ads.pdf?sequence=5&isAllowed=y>.

from El Salvador pointed out, “suicide is the first cause of indirect maternal death in the case of adolescent pregnancy according to the Ministry of Health of El Salvador (MINSAL).”³¹⁵

4. Because their bodies are not fully developed, a number of girls’ pregnancies lead to obstetric emergencies. According to data from the INEC of Ecuador, in 2019, 226 girls between the ages of 10 and 14 went to a hospital for an obstetric emergency and nearly half of them had a miscarriage. In addition, 3,809 adolescents between the ages of 15 and 19 attended the hospital for obstetric emergencies.³¹⁶ Maternal mortality is one of the leading causes of death in adolescents and 15- to 24-year-olds in the region as a result of health problems during pregnancy, childbirth, or early postpartum.³¹⁷
5. A study notes that the discourse on the importance of adolescent comprehensive health has not resulted in budget priorities or investment in infrastructure dedicated to this group, or in the relevant incorporation of this group in the design, planning, implementation, and evaluation of actions for the development of services.³¹⁸

F. Health Crisis

Sexual and Reproductive Rights during COVID-19

1. Latin America and the Caribbean has become one of the regions most impacted by the COVID-19 pandemic, exacerbated by weak social protection structures, fragmented health systems, and deep inequalities where states were not sufficiently prepared to manage a health and human crisis of this magnitude.³¹⁹ Most states in the region face significant challenges in ensuring the right to health of their population, and consequently, their sexual and reproductive health.
2. Women and girls in Latin America have been disproportionately affected by the pandemic due to structural inequalities. They work mostly in the informal sector where they do not have access to protection systems, are poorer, have more care responsibilities, and face a high degree of GBV.

Impact on Health Systems: Fragmentation of Health Response and Disarticulation

1. During the FAR consultation, it was found that in several countries in the region, especially the poorest, health systems have collapsed and the various crisis contexts they encountered have exacerbated the impact of the health crisis on marginalized groups. For example, in Nicaragua “no

³¹⁵ Sara García (El Salvador), consultation organized by FAR, WHRI, and CWGL, July 2020.

³¹⁶ “Las niñas invisibles de Ecuador,” Wambra, March 2018, <https://wambra.ec/las-ninas-invisibles-ecuador/#:~:text=En%20promedio%2C%20cada%20a%C3%B1o%202.181,de%20catorce%20a%C3%B1os%20es%20violaci%C3%B3n>.

³¹⁷ “Acelerar el progreso hacia la reducción del embarazo en la adolescencia en América Latina y el Caribe,” UNFPA, 2016, 24, https://lac.unfpa.org/sites/default/files/pub-pdf/ESP-EMBARAZO-ADOLE-14febrero%20FINAL_5.PDF.

³¹⁸ Agustina Ramón Michel and Mariana Romero, “Seguimiento de la CIPD en América Latina y el Caribe después de 2014: Articulación de Organizaciones de la Sociedad Civil de América Latina y el Caribe,” 2004, 8 and 9. https://www.researchgate.net/publication/319433688_Seguimiento_de_la_CIPD_en_America_Latina_y_el_Caribe_despues_de_2014_Resumen_Ejecutivo.

³¹⁹ “Informe: El impacto del COVID-19 en América Latina y el Caribe, 9 Jul 2020,” ONU, 2020, <https://reliefweb.int/report/world/informe-el-impacto-del-covid-19-en-am-rica-latina-y-el-caribe-July-2020>.

measures were taken to prevent and contain COVID-19. The health system has collapsed and health personnel have been dismissed.”³²⁰

2. The situation in Peru illustrates what has also taken place in other countries in the region. As an activist noted, “[in this country] there is a fragmentation of the health system and insufficient investment to implement a primary health model, a structural weakness that has led to a total health collapse in the health system, with insufficient capacity to care for COVID-19 patients. This has had an impact on sexual and reproductive health and the response to violence against women.”³²¹ The activist also highlighted that as a result of this situation:
 - a. External medical appointments were suspended at the first level of sexual and reproductive health care without offering alternative services such as home visits, “telehealth services,” or by scheduling appointments since the state of emergency was decreed;
 - b. For a month and a half, no protocols were issued to address aspects of sexual and reproductive health. In April, a decree to ensure the health of pregnant women, continuity of care in family planning, and the care of victims of [gender-based] violence was issued. So far, its implementation has not been guaranteed;
 - c. Hospitals that attended births were earmarked for Covid-19 care;
 - d. Prenatal care in establishments was also suspended and thus the ability to detect high-risk complications;
 - e. Access to abortion has been limited to when women's lives are at risk, leaving out cases of health risk recognized by national law;
 - f. Access to modern contraception has been made difficult which will have an impact on the increase in the number of unwanted or unplanned pregnancies. This is due to high prices, lack of purchasing power, loss of sources of work, closure of first level services that provide access to modern contraceptive methods.
3. To be able to respond to the pandemic, Ecuador limited people's access to sexual and reproductive services. The government has diverted medical equipment and personnel to other areas and restricted the contraceptive supply chain to address the COVID-19 emergency.³²² In the whole region, people have faced multiple challenges to accessing to contraceptives. As UNFPA points out, if countries in Latin America and the Caribbean do not implement corrective measures, the result will be 1.7 million unplanned pregnancies, nearly 800,000 abortions, 2,900 maternal deaths, and nearly 39,000 child deaths.³²³

³²⁰ Mayte Ochoa (Nicaragua), consultation organized by FAR, WHRI, and CWGL, July 2020.

³²¹ Rossina Guerrero (Peru), consultation organized by FAR, WHRI, and CWGL, July 2020.

³²² Rocío Rosero (Ecuador), consultation organized by FAR, WHRI, and CWGL, July 2020.

³²³ Federico Tobar, Lucas Godoy Garraza, and José Ventura Pinedo, “Impacto de COVID-19 en el acceso a los anticonceptivos en América Latina y el Caribe,” UNFPA Latin America and the Caribbean, September 2020, 6-11, <https://lac.unfpa.org/es/publications/el-impacto-de-covid-19-en-el-acceso-los-anticonceptivos-en-am%C3%A9rica-latina-y-el-caribe#:~:text=El%20informe%20t%C3%A9cnico%20Impacto%20del,de%20la%20disminuci%C3%B3n%20de%20los>

Impact of the Health Crisis on Health Workers

1. In the region, half of the medical staff and more than 80 percent of nursing staff are women,³²⁴ the highest percentage in the world. However, overall, women remain a minority in decision-making positions and experience a 28 percent pay gap.³²⁵ In Chile, health workers “are mostly women who do not have the adequate personal protective equipment for taking care of their own lives; the ones that have caregiving responsibilities—towards their children and other people—neither receive support.”³²⁶ The Gender Observatory and COVID-19 in Mexico reported that as of June 16, 2020, women working in the health sector accounted for 57 percent of virus-positive cases and 29 percent of deaths. The most affected by contagion are nurses, who are mostly women.³²⁷

Increased Gender-Based Violence

1. A concerning trend in the region has been the increase in reports of domestic violence following the adoption by authorities of measures of lockdown and social distancing for the containment of the COVID-19 virus. In Mexico, the Gender Observatory and COVID-19 reported that in two months of COVID-19 confinement, calls and messages for support for GBV increased by more than 80 percent. In addition, more than 300 women, girls, and adolescents cohabiting with their aggressor were killed.³²⁸ In El Salvador, as an activist noted, between March 11 and May 20, the Prosecutor’s Office recorded 2,318 assaults on women. Out of these, 481 were cases of sexual violence and 28 were femicides.³²⁹ In Colombia, during lockdown until August 2020, there had been a 103 percent increase in reports of violence against women compared to the same previous period. In Bogota alone the increase was 230 percent.³³⁰
2. In Guatemala, “cases of violence against women have increased in the context of lockdowns. The Government has been concerned about the increase in these rates of violence, but the discourse does not correspond with reality because although there are efforts to adopt campaigns, this cannot materialize because the Justice System does not allow full access to justice for women and girls.”³³¹
3. In response to a domestic violence surge, information and telephone guidance campaigns have been carried out in Chile and new channels have been created for filing reports to enhance the protection of women. “However, the specificity and severity of sexual violence and the increased

³²⁴ Claudia Piras, “Las mujeres en América Latina y el Caribe enfrentan mayores riesgos ante el Coronavirus,” BID, 2020, <https://blogs.iadb.org/igualdad/es/mujeres-enfrentan-mayores-riesgos-ante-coronavirus/>.

³²⁵ “Gender equity in the health workforce: Analysis of 104 countries,” WHO, 2019, <https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf?sequence=1&isAllowed=y>.

³²⁶ Camila Maturana (Chile), consultation organized by FAR, WHRI, and CWGL, July 2020.

³²⁷ “Informe semanal de notificación inmediata de muerte materna,” Dirección General de Epidemiología (DGE), Secretaría de Salud de México, 2020, https://www.gob.mx/cms/uploads/attachment/file/564480/MM_2020_SE29.pdf.

³²⁸ “Observatorio Género y COVID-19 de México,” GIRE, 2020, <https://genero-covid19.gire.org.mx/tema/personal-de-salud/>.

³²⁹ Sara García (El Salvador), consultation organized by FAR, WHRI, and CWGL, July 2020.

³³⁰ Cristina Rosero (Colombia), consultation organized by FAR, WHRI, and CWGL, July 2020.

³³¹ Karen Molina (Guatemala), consultation organized by FAR, WHRI, and CWGL, July 2020.

vulnerability of girls and adolescents have not been addressed even though reports of sexual offences have increased.”³³² In this sense, it is emphasized that “in the face of this there is no reorientation of public policies in the campaign and attention to cases of sexual violence. The State does not guarantee information on the right to access abortion and hasn’t adopted clear guidelines for contraceptive supplies in general.”³³³

4. By the end of July, 500 sexual assaults had been reported against women and girls in Peru where there is a serious child pregnancy problem that is most often the result of rapes. During the consultation organized by FAR, it was noted that Seguro Integral de Salud reports that every day five girls under the age of 15 become mothers and so far this year the Ministry of Health issued 399 certificates of live births to mothers under the age of 15. In addition, locations which provide therapeutic abortion services were reduced from 10 to a single site. Accordingly, therapeutic abortion services have been eliminated as an essential service for girls and adolescents.³³⁴

State Response to the COVID-19 Crisis

1. During the FAR consultation, a number of challenges were identified in the state response to the health crisis that hinder women and girls’ access to sexual and reproductive services.
2. **Pre-existing crises hampered the formulation of adequate plans to address the pandemic:** In Guatemala, “the crisis response to the health crisis has been poor. The state has been weakened for a long time and we are now suffering the consequences, with the state’s limited ability to respond to the needs of the population. COVID-19 cases are increasing, and there is no capacity to respond effectively.”³³⁵ In Bolivia, “the legal framework allows the state to manage crisis situations. The executive branch can adopt declarations of state of emergency and emergency declarations and activate mechanisms for the extraordinary allocation of resources and contingency measures through the executive body. These measures must be approved by the legislative body. However, because of the political and institutional crisis, a transitional government has addressed the pandemic with improvisation, limiting risk management and recovery strategies. While bonds and economic plans have been issued, their improvised nature have generated implementation failures.”³³⁶ In Ecuador, political instability and institutional weakness as well as corruption and diversion of funds for particular purposes have amplified and aggravated the current health crisis.³³⁷
3. **Sexual and reproductive health services have been de-prioritized:** In El Salvador “the crisis has led to a shift in sexual and reproductive health needs, which have not been central to the state but in this context, they are thrown to the bottom of the priorities.”³³⁸ In Guatemala, “in general, women’s access to sexual and reproductive health services is minimal and in the context of the COVID-19 pandemic, this problem is exacerbated. Currently the priority are the COVID-19 cases thereby reproductive health, like other health issues, have been set aside.”³³⁹ In Peru, “a protocol

³³² Camila Maturana (Chile), consultation organized by FAR, WHRI, and CWGL, July 2020.

³³³ Ibid.

³³⁴ Rossina Guerrero (Peru), consultation organized by FAR, WHRI, and CWGL, July 2020.

³³⁵ Karen Molina (Guatemala), consultation organized by FAR, WHRI, and CWGL, July 2020.

³³⁶ Paula Estenssoro (Bolivia), consultation organized by FAR, WHRI, and CWGL, July 2020.

³³⁷ Rocío Rosero (Ecuador), consultation organized by FAR, WHRI, and CWGL, July 2020.

³³⁸ Sara García (El Salvador), consultation organized by FAR, WHRI, and CWGL, July 2020.

³³⁹ Karen Molina (Guatemala), consultation organized by FAR, WHRI, and CWGL, July 2020.

was developed for the care of pregnant women in times of COVID-19. However, it does not include an effective contingency plan and many specialized health facilities have had to be closed or directed solely to COVID-19 care.”³⁴⁰

4. **There are no comprehensive plans to address the contingency of the pandemic which has resulted in the adoption of disarticulated or delayed measures or measures lacking adequate funding:** In this regard, a Chilean activist noted that “the government publicized guidelines for the care of pregnancies and childbirth four months after the pandemic was declared... there are also no clear guidelines to address other sexual and reproductive health services. In particular, to ensure the continuity of fertility services, the prevention and diagnosis of cervical and breast cancer that in Chile are a major cause of mortality.”³⁴¹ In Peru, “minimum contingency measures have been taken ... No strategies have been developed, nor funds have been allocated.”³⁴² In Brazil it is perceived that “many factors have contributed to the failure of the effective response to the pandemic; these include; the absence of an authority [in charge of the strategy to combat COVID-19] from the Ministry of Health and the lack of a multisectoral articulation of policies to address the pandemic.”³⁴³
5. **Appropriate measures have been adopted but poorly implemented:** In Chile, “neglect of sexual and reproductive health is related to the absence of guidelines that take into account absenteeism among health staff because of illness or the conversion of health centers to provide care to COVID-19 cases.”³⁴⁴ In Colombia, the Ministry of Health has issued a series of guidelines where it has recognized that sexual and reproductive health services are essential, however, they have not taken sufficient steps to ensure compliance.³⁴⁵
6. **Lack of information on available services has affected access to sexual and reproductive health services:** Lack of information in simple and accessible formats on sexual and reproductive health services and the medical units that provide them, coupled with fears of the risk of contagion, affects women and girls’ access. In Brazil, “a factor that has contributed to the failure of the effective response to the pandemic has been the lack of reliable information.”³⁴⁶ In Mexico, although obstetric care services have been declared essential during the pandemic, there is no public information from the health services of federal entities on which units continue to provide maternal and child care specifically for obstetric emergencies.³⁴⁷ This situation is particularly serious when, according to official information issued by the Ministry of Health, the estimated maternal mortality is 44.2 deaths per 100,000 estimated births, representing an increase of 33.2 percent compared to the same epidemiological week of the previous year. In addition, COVID-19 is the leading cause of maternal death, with 21.7 percent of confirmed deaths.³⁴⁸

³⁴⁰ Ibid.

³⁴¹ Camila Maturana (Chile), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁴² Rossina Guerrero (Peru), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁴³ Beatriz Galli (Brazil), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁴⁴ Camila Maturana (Chile), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁴⁵ Cristina Rosero (Colombia), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁴⁶ Beatriz Galli (Brazil), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁴⁷ “Muerte Materna y Violencia Obstétrica,” GIRE, 2020, <https://genero-covid19.gire.org.mx/tema/acceso-a-anticonceptivos/>.

³⁴⁸ “Informe semanal de notificación inmediata de muerte materna,” Secretaría de Salud de México, 2020, 1,

SRHR Measures Lack a Gender and a Human Rights Approach

1. During FAR's consultation process it was noted that Brazil's regressive measures in the field of sexual and reproductive health and rights had been adopted before and during the pandemic. These measures infringe the political constitution and international standards. There is concern over a plan of the Ministry of Health to disappear the Directorate-General for Sexual and Reproductive Health.³⁴⁹ The absence of adequate policy frameworks has led to the adoption of measures without a human rights and gender approach that have resulted in human rights abuses or increased risk for some sectors, including women and girls. In El Salvador, "the COVID-19 pandemic has been addressed by the state from an authoritarian perspective; where militarization and censorship are crucial elements, health measures become militarized measures. In addition, the measures promoted are homogeneous in nature, for example the campaign 'Stay at Home' to the promotion of washing of hands. The former does not consider that 'staying at home' means for many women and girls staying at home with the aggressor; the latter does not consider that many households in El Salvador do not have drinking water."³⁵⁰ In Ecuador, the government cut staff in charge of the implementation of the Intersectoral Policy of Prevention of Pregnancy in Girls and Adolescents.³⁵¹ This was particularly severe given the high pregnancy rates among this sector, the consequences of the interruption in the supply of contraceptives, and the fact that lockdown orders could contribute to an upsurge in adolescent pregnancy as has happened in other countries."
2. **Absence of measures focused on marginalized or vulnerable sectors:** Lack of access to health care and quality health information is particularly serious in rural and remote areas and particularly affects Indigenous peoples.³⁵² In Colombia, "in the context of the pandemic barriers have deepened and new barriers are being presented. For example, mobility restrictions have affected many women, especially in rural areas, who have faced difficulties to access reproductive health services, services have been denied because they are not considered an essential service, and have faced delays in the provision of services."³⁵³ During the consultation organized by FAR, several activists indicated that no additional efforts have been made to counter the impact of the pandemic on lesbians, trans women, non-gender-conforming people, and in general the LGBTQ+ community. Activists from Chile and Bolivia noted that prevention and care programs for sexually transmitted diseases, including HIV AIDS, are not being guaranteed which mainly affects young

https://www.gob.mx/cms/uploads/attachment/file/576803/MM_2020_SE36.pdf.

³⁴⁹ Beatriz Galli (Brazil), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁵⁰ Sara García (El Salvador), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁵¹ Rocío Rosero (Ecuador), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁵² "Informe: El impacto del COVID-19 en América Latina y el Caribe," ONU, 2020,

<https://reliefweb.int/report/world/informe-el-impacto-del-covid-19-en-am-rica-latina-y-el-caribe-july-2020>.

³⁵³ Cristina Rosero (Colombia), consultation organized by FAR, WHRI, and CWGL, July 2020. "The organization recommends emphasizing how reproductive health services should be understood as essential services in crisis situations. This implies establishing clear care protocols for the comprehensive care of sexual and reproductive health needs, which include measures such as the use of telemedicine with sufficient information so that women can make decisions with full consent."

people who do not have effective access to retroviral treatment.³⁵⁴ In Colombia, difficulties seriously deepened in the case of migrant women and adolescents who already faced almost insurmountable obstacles to accessing these services before the pandemic.³⁵⁵ In Brazil, “the state has not only ignored, but has acted with the deliberate intention of putting into action a political plan of extermination of the most vulnerable populations subjecting it to conditions that can be regarded as genocide and other crimes against humanity. There is a clear intention of the government to subject certain vulnerable groups to deplorable conditions that are life-threatening.”³⁵⁶

Promising Practices

A. Good Practices, Promising Practices, and Lessons Learned from Civil Society

1. Dominican Republic National Alliance to Accelerate the Reduction of Maternal and Child Mortality³⁵⁷

The Dominican Republic is the country with the second highest maternal death rates in the region, behind Haiti, which is directly related to the quality of medical services that women receive. The percentage of hospital deliveries in the Dominican Republic is 99 percent and women are theoretically assisted by trained personnel and with at least four follow-up appointments during pregnancy. Despite this, in 75 percent of the cases, the main direct causes of death are hypertensive disorders during pregnancy, childbirth and postpartum, bleeding, and abortion. In May 2019, through ministerial resolution No. 00004, the government implemented the Framework Document: National Alliance to Accelerate the Reduction of Maternal and Child Mortality which is a proposal aimed at strengthening actions to reduce the maternal mortality rate of 70 per 1,000 live births. This resolution includes an increase in the budget allocated for training and recruitment of more health personnel who can provide adequate services to pregnant women during pregnancy, childbirth, and postpartum as well as empowerment measures to demand their health rights. The results could be seen almost immediately. By June 2018 there were 54 maternal deaths, while for the same period in 2019 the data show 46 deaths, indicating a 7 percent reduction in this period.

B. Good Practices, Promising Practices, and Lessons Learned from Civil Society

1. Central America:³⁵⁸ A good civil society practices in Central America is the alliance of 25 feminist organizations and independent women fighting for the decriminalization of abortion, Sombrilla Centroamericana [Central America Umbrella]. Sombrilla Centroamericana have formed an important space for learning and discussing population and development issues with an emphasis on the Montevideo Consensus. This alliance includes organizations in capital cities and other regions, Indigenous

³⁵⁴ Camila Maturana (Chile) and Paula Estenssoro (Bolivia), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁵⁵ Cristina Rosero (Colombia), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁵⁶ Beatriz Galli (Brazil), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁵⁷ Cinthya Amanecer Velasco Botello (Dominican Republic), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁵⁸ Norma Carías (Honduras), consultation organized by FAR, WHRI, and CWGL, July 2020.

women's organizations, Afro-descendants, trans women, rural women, etc. They articulate research actions, communications campaigns, and political advocacy and develop reporting and strategic litigation among other actions.

2. Mexico:³⁵⁹ In recent years, Mexican feminist organizations have formed accompanying networks to provide safe self-management of medical abortions. During the pandemic, this network helped to avoid overloading the health system when it had already collapsed. This feminist outlook and practice, which was designed to ensure access to abortion, also addresses the current crisis.

3. Argentina:³⁶⁰ In 2018, Argentina ended the year with a historic parliamentary debate where the lower house approved abortion but the Senate did not pass the bill, it contributed to strengthening the women's movement that gave birth to the "unstoppable" Marea Verde [Green Wave]. An important lesson learned from the Marea Verde is the need for women's organizations to ally with diverse social and human rights movements to consolidate their impact. This is important considering the ability of the religious fundamentalist actors to rapidly reorganize to respond to the women's movement's achievements. Another lesson learned highlighted during the FAR consultation was the effects of "judicializing" public policies such as protocols to regulate access to legal abortion. As an activist highlighted, protocols become a double-edged sword: they help standardizing good clinical practices, while at the same time protocols as treated as law which becomes an additional obstacle to overcome.³⁶¹

Issues for the consideration of the WGDAWG

The activists who participated in the consultative sessions organized by FAR in July and August 2020 mentioned a few aspects that could be considered in the Working Group's thematic report:

- a. Sexual and reproductive rights are at risk due to cultural and structural barriers in contexts of normality and crisis.
- b. The crisis of sexual and reproductive rights has a disproportionate impact in contexts of armed conflict, extractivism, displacement, climate crisis, militarism, and crisis caused by anti-rights groups. Often states' responses are absent or weak.
- c. The harming of women, girls, and adolescents' rights during the time elapsed since the non-implementation of the commitments made by states should be mentioned.
- d. The criminalization of abortion does not persuade women to not have an abortion. Instead, it leads to an increase in maternal mortality and morbidity because it pushes women and girls to underground options.

Key Messages to States

The activists who participated in the FAR consultation identified the following key messages for States:

- a. While it is true that gender-based discrimination and violence against women and girls in countries in the region is aggravated in contexts of crisis and human insecurity, states should be

³⁵⁹ Oriana López Uribe (Mexico), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁶⁰ Soledad Deza (Argentina), consultation organized by FAR, WHRI, and CWGL, July 2020.

³⁶¹ Ibid.

called upon to recognize that high levels of discrimination and violence against women in many of the countries in the region constitute a crisis per se. The gender inequality crisis must be addressed through transformative and long-term measures.

- b. Feminist and women's organizations call on states for the recognition of the existence of a pandemic of violence against women in public and private space. As such, urgent and comprehensive measures are needed to address the structural causes of the problem.³⁶²
- c. There is a crisis of sexual and reproductive rights that must be addressed with the highest commitment of states, both in the contexts of normality and in those crises where they are disproportionately affected.
- d. Stronger states are needed to ensure sexual rights, reproductive rights, and women's rights in general. Only secular states are able to effectively ensure access to essential public policies for sexual and reproductive rights.
- e. There is a huge disparity among countries regarding the advancement reproductive decisions can be made and the three grounds for having an abortion are available and guaranteed: to protect a woman's life and health, when pregnancy is the result of rape or incest or where there is fetal impairment.
- f. States must ensure a minimum floor that includes access to suitable facilities where women are served, access to family planning methods, and services.
- g. The implementation of a transformative sexuality education model is urgently needed to address discrimination against women, change gender stereotypes, reduce GBV, build autonomy, and normalize sexual diversity.

Recommendations

The activists that participated in the FAR consultative session made the following recommendations:

States

- a. Center the legally binding nature of sexual and reproductive rights which are human rights.
- b. Accelerate compliance with international standards.
- c. Strengthen the principles of non-regression and progressiveness of rights.
- d. Acknowledge the essential character of sexual and reproductive rights and make them accessible to women and girls. Adopt guarantees that make them a reality in their lives.
- e. Adopt an independent category of reproductive violence as it is sometimes not encompassed by the definition of sexual violence.
- f. Strengthen health and administrative measures aimed at ensuring sexual self-determination for women, lesbians, trans, and non-binary people and de-pathologizing intersex.
- g. Ensure access to justice and provide training to officials that assist victims or people who file complaints to avoid revictimization.
- h. Invest in measures focused on transforming gender roles to address the gender inequality crisis and invest in long-term comprehensive sexuality education.

³⁶² As a Salvadorean activist explained, "the pandemic of femicides, sexual violence, imposed pregnancies already placed women in a situation of systematic violation of human rights. The crisis was already in El Salvador, and for a long time there has been a struggle to transform this reality." Sara García (El Salvador), consultation organized by FAR, WHRI, and CWGL, July 2020.

- i. Mainstream a gender perspective into all government bodies, politics, and programs.
- j. Adopt measures to transform culture beyond classrooms. Campaigns and other measures must be addressed at public servants and citizens in general.
- k. Take immediate action to reform structural problems.
- l. Adopt an intersectional approach and specific measures to ensure access to sexual and reproductive health services for women and girls with disabilities, Indigenous, migrant, trans and gender non-compliant, etc.

Transitional Justice Mechanisms

- a. Sexual violence committed in the context of armed conflict should be considered in sufficient depth to understand its physical, emotional, and social impacts, as well as to adopt forms of comprehensive reparation, including transformative reparations such as public policies or measures that improve access to sexual and reproductive health services in rural areas and areas historically affected by armed conflict. This would include guarantees of non-repetition in the face of the persistence of sexual violence against Indigenous girls and adolescents by public security officers.