

## Feminist Alliance for Rights (FAR)\*

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

**“Women’s 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's and Girls' Sexual and Reproductive Health and Rights (SRHR) in contexts of crisis, FAR has prepared the present document for your consideration.

The Feminist Alliance for Rights (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 that work in various areas of women's rights. It is guided by a Steering Committee<sup>1</sup>, 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 is the elimination of gender-based violence (GBV) against women and girls. In the 2019 annual meeting, 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 later became the basis of FAR's contribution.

### Methodology

This document reflects the challenges, main concerns and recommendations that activist experts in the field of SRHR<sup>2</sup>, from four regions -Africa, Asia, Latin America and MENA- identified during a global consultation process that started on November 2019. This process was led by FAR and supported by regional partners.<sup>3</sup> This process included four consultations<sup>4</sup>, two follow-up sessions<sup>5</sup>, interviews<sup>6</sup> or email

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<sup>1</sup> 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).

<sup>2</sup> 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.

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

<sup>4</sup> Nairobi, Kenya on November 2019; Kathmandu, Nepal on January 2020; Latin American and Caribbean region, on July 2020 (on-line); MENA region on August 2020 (on-line). The names of the activists consulted are listed under each chapter.

<sup>5</sup> Latin American and Caribbean region, on August 2020 (on-line) and African region, in September 2020 (on-line).

<sup>6</sup> FAR also conducted follow-up interviews with activists in MENA and Africa.

communication with activists and secondary research to supplement their contributions conducted by FAR's Global Coordinator.

FAR used a feminist, human rights and an 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 multi-faceted and have 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 networks disintegration, destroy livelihoods and homes and take away jobs and educational opportunities. In most instances, women's and girls'<sup>7</sup> lives and wellbeing are impacted far more by any crisis because of the impact these crises will have on their SRHR. These are some of the main findings FAR identified throughout the global consultation process and research:

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.<sup>8</sup> The differentiated effects of crises on women and girls are linked to gender inequalities, which are rooted in cultural norms and stereotypes around women and girls, and sexual/gender minorities. It is often reflected by females' lower socio-economic conditions and lack of decision-making roles. Furthermore, during and after the crisis, women continue to be the main caregivers in traditional communities and in societies with weak social security systems, there are additional consequences on women's own health and women have limited time to seek SRHR services. All these factors reduce the effectiveness of mitigation measures and recovery crisis plans.
2. **Gender-based violence-** Structural gender inequality is also the most significant risk factor for GBV in contexts of crisis. In places where GBV was widespread and insufficiently addressed, when a crisis arises, existing violence is exacerbated and there is also the rise of new forms of GBV, including reproductive violence. It was found that traditional definitions of crisis do not necessarily include particular situations that have devastating impacts on women's and girls'

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<sup>7</sup> 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 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.

<sup>8</sup> A few exceptions include the case of elderly or sick women, women with disabilities and pregnant women due to increase vulnerabilities and decreased mobility which makes them less able to self-protection or self-rescue.

human rights. During FAR's consultations, some activists expressed that there is a "gender inequality crisis" and called for states to adopt transforming structural measures to address it.

3. The state of the health system before a crisis is an important indicator of what can be expected at 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 them being critical to women and girls. In places where gender inequalities are pervasive, SRHR services are immediately deprioritized and the 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 that 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 have exposed them to abuse and affected their SRH; impoverished women belonging to religious minorities in Sri Lanka where government, religious authorities and husbands take decisions over their bodies; young girls in the context of armed conflict in Yemen and Syria who are married for economic reasons and adolescent women for whose pregnant rates spiked during the Ebola epidemic in Sierra Leone. In all these cases, women's 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 persons' 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's 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 -and especially women and girls- have access to SRHR services; have supported and empowered victims of sexual violence, and have implemented initiatives to advance the recognition and protection of women's 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 focused on COVID-19) as well as concerning trends in each region. Findings from all regions have indicated exacerbated effects on women's and girls' SRHR due to crises.

#### **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's 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 disaster, the government established birthing centers, but deprioritized abortion. In India, it was reported that there were limited WASH facilities and safe spaces for women in the 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 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, the 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 Burma's Rakhine State in Myanmar. Access to SRH care at refugees camp 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 Northern and Eastern Sri Lanka.
- 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. The food security issue in Yemen has impacted pregnant

women, leading to pregnancy loss, complications, maternal mortality, or child malnourishment. The armed conflict in South Sudan has restricted access to information, contraception, natal care, and labor environments. Limited health services have resulted in still-births, miscarriages, death during childbirth, and other labor complications. In Palestine, women face restrictions in movement and travel, no access to health systems for women with irregular migration status, increased cases of domestic violence, etc.

- 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, the 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 the political agenda for many countries. 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 service or products from health systems like 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 the medical facilities were converted into COVID response centers, limiting access to SRH services. Women also expressed fear of contracting the virus upon seeking healthcare services. In Nepal, there was almost a 200 percent increase in maternal mortality ratio. 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 MENA region, COVID has led to the reinforcement of gender stereotypes, the deprioritization of women issues, increased domestic and interpersonal violence, restriction in mobility and access to healthcare, limited availability of data on SRH issues, anti-masks and vaccinations campaigns, limited access to contraception and menstrual products. The latter is especially concerning in the case of women deprived of liberty.
- d. In Latin America, governments have deprioritized SRH healthcare. 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 in more than two regions. FAR recommends states:

- a. to allocate adequate budgets that strengthen and expand countries' healthcare and social systems, and SRHR services in particular;
- b. to prioritize SRHR in situations of crisis and to 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 to ensure these services and supplies are free and are not suspended during a crisis;
- c. to adapt GBV and SRHR policies and responses to the specific crisis situation and women's and girls' needs and vulnerabilities;
- d. to 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. to adopt measures to ensure accountability for GBV and SRHR violations in contexts of crisis and to provide reparations using a transformational approach;
- f. to repeal laws that criminalize the interruption of pregnancy;
- g. to use a human rights, gender and intersectional approach to develop and implement SRHR policies and to ensure SRHR services are accessible and available during crisis;
- h. to 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 comprehensive responses which are tailored to multiple dimensions of discrimination that can coexist,
- i. to adopt measures focused on transforming gender roles to respond to the global crisis of gender inequality and to invest on comprehensive long-term plans on sexuality education;
- j. to ensure women take part in the decision-making process of policies, programs and plans regulating the provision of SRHR during normal times and during times of crises; and
- k. to effectively 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

*My name is Dione, 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 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 is alphabet and the most affected are women that are the majority of the population but the least educated. The legal commitments about women 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 the information provided by activists, who are experts in the field of SRHR in the African region. The experts participated in an in-person summit on November 11<sup>th</sup> 2019<sup>9</sup> organized by FAR in partnership with CWGL and in a follow-up on-line consultation on September 21<sup>st</sup> 2020<sup>10</sup>, convened by FAR. This report has supplemented the inputs with desk research, individual interviews<sup>11</sup> and email exchanges with activists.<sup>12</sup> While it is not exhaustive, this section aims to bring examples on how different

<sup>9</sup> 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, humanitarian (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); Abiola Akiyode-Afolabu, FAR Steering Committee member (Nigeria).

<sup>10</sup> 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).

<sup>11</sup> Nyaradzo Mashayamombe (Zimbabwe).

<sup>12</sup> D.M. (Mozambique).

types of crisis situations have had an impact on women's and girls' SRHR and rights in Africa, followed by promising practices and a few recommendations.

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

## Crisis situations

### A. Armed Conflict

1. Many armed conflicts in the region have emerged as a response to limited resources, exacerbated by climate change which further limits access to life saving resources such as water and food which are critical to people's health. Transcending national borders, participants from Nigeria, Uganda and Kenya during FAR's consultation 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.<sup>13</sup>
2. **Uganda.** Today, a powerful insurgency group still maintains control of some Ugandan villages and threatens increase in sexual and GBV including rape, murder, and sexual slavery.<sup>14</sup> Activists denounce that issues of SRHR have worsened in these areas of conflict, as people flee or are restricted from access to 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 being uninformed and unaware of where to seek help.<sup>15</sup>
3. **Nigeria.** The extremist group Boko Haram, connected to ISIS, continues to cause widespread terror in the communities it controls. Territories occupied by Boko Haram have restricted caused mass refugee crises, sparked additional community conflicts, and has disproportionately affected the safety of women and girls by way of sexual violence and restricting 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 violent

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<sup>13</sup> 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.

<sup>14</sup> Neiman, Sophie. "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>.

<sup>15</sup> Activist, Uganda. Consultation organized by FAR and CWGL. November 2019.

conflict and people being attacked, murdered, and/or raped.<sup>16</sup> 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 of maternal mortality rates and preventable deaths.<sup>17</sup> An 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.”<sup>18</sup> 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.”<sup>19</sup>

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 for 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.<sup>20</sup> The latter has been normalized, even for the international agencies and non-governmental organizations who are trying to help.<sup>21</sup> “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.”<sup>22</sup> There are concern 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.<sup>23</sup>

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<sup>16</sup> O’Grady, Siobhán “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/>.

<sup>17</sup> Activist, Kenya. Consultation organized by FAR and CWGL. November 2019.

<sup>18</sup> Mandy Asagba, Nigeria. Consultation organized by FAR and CWGL. *Zoom*, September 2020.

<sup>19</sup> Emmanuela Azu, Nigeria. Consultation organized by FAR and CWGL. *Zoom*, September 2020.

<sup>20</sup> 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>.

<sup>21</sup> 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 new-born.

<sup>22</sup> Awungija Tetchoukwi, Cameroon. Consultation organized by FAR and CWGL. *Zoom*, September 2020.

<sup>23</sup> 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

5. 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 in those conditions. 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.<sup>24</sup> For example, droughts along the border of Kenya and Ethiopia have spawned conflict between the people in the region, spreading water access precarity.<sup>25</sup> 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.<sup>26</sup>
6. 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.<sup>27</sup> 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.<sup>28</sup>

## C. Health Crisis

### Ebola Virus Epidemic

7. The Western African Ebola virus epidemic taking place 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 system delivery 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

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

<sup>25</sup> Codi 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-ethiopia-and-kenyas-water-stressed-border/>.

<sup>26</sup> Sarah 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>.

<sup>27</sup> WaterOrg. "A women's crisis." <https://water.org/our-impact/water-crisis/womens-crisis/>.

<sup>28</sup> Jay 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*, vol 11(6) e0155981. 2016. doi: [10.1371/journal.pone.0155981](https://doi.org/10.1371/journal.pone.0155981).

during and after the outbreak. Thus, while family planning recovered post-Ebola, shortfalls were observed in recovery of antenatal care and institutional deliveries.<sup>29</sup>

8. 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. Sierra Leone Demographic and Health Survey (SLDHS) showed that 34 percent of all pregnancies of teenagers and 40 percent of maternal deaths were a result of complication from teenage pregnancy. According to a study by UNFPA, after the outbreak, more than 14,000 teenage girls became pregnant, of whom 11,000 were in school before the outbreak.<sup>30</sup> According to a Lancet study, most maternal and child health indicators saw a decline in during the outbreak of the virus in Guinea. The trends during the epidemic showed fewer institutional deliveries, fewer ante-natal care visits for pregnant women and lower vaccination deliveries for children less than a year.<sup>31</sup>

## COVID-19 Pandemic

9. 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."<sup>32</sup>
  - b. *Access to hospital 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 going left unfilled.

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<sup>29</sup> Camara, Bienvenu S 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* vol. 111,1 (2017): 22-29. doi:10.1093/trstmh/trx009.

<sup>30</sup> UNFPA Sierra Leone. "Spotlight on Adolescent Girls in Sierra Leone." UNFPA, 2017. <https://sierraleone.unfpa.org/en/publications/spotlight-adolescent-girls-sierra-leone>.

<sup>31</sup> Dr. 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*, Vol 5. Issue 4, E448-%457. 2017.

<sup>32</sup> Nyaradzo Mashayamombe, Zimbabwe. Interview by FAR and CWGL. Zoom, September 2020.

Zambia has also seen an increase of doctors travelling to treat COVID-19 patients, limiting access to healthcare professionals when people do venture out to hospitals.” For example, cervical cancer screening has also been at risk [in Zambia].<sup>33</sup> 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.”<sup>34</sup> 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 live several miles away from health facilities and had to necessitate domiciliary deliveries.<sup>35</sup>

- c. *Access to abortion.* “It 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.”<sup>36</sup> The Kenyan SRHR information and tele-counseling service, Aunty Jane Hotline, has noted that since the start of the pandemic, women have of increasingly called to discuss lack of access to the drug misoprostol,<sup>37</sup> commonly used to induce labor, manage miscarriages, treat postpartum hemorrhaging, and for is a safe abortion medication.<sup>38</sup> The hotline published that women who were able to access misoprostol, noted price gouging at pharmacies, where pre-pandemic the rise was approximately around 30 USD as compared to 90 to 250 USD.<sup>39</sup>
- 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 aren't allowed to take contraceptives without their husbands’ consent. Most husbands only allow their wives three months contraceptives; anything longer often leads to dispute.

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<sup>33</sup> Ann Holland, Zambia. Email Communication with FAR and CWGL. September 2020.

<sup>34</sup> Nyaradzo Mashayamombe, Zimbabwe. Interview by FAR and CWGL. Zoom, September 2020.

<sup>35</sup> Nyaradzo Mashayamombe, Zimbabwe. Interview by FAR and CWGL. Zoom, September 2020.

<sup>36</sup> Ann Holland, Zambia. Email Communication with FAR and CWGL. September 2020.

<sup>37</sup> 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/>.

<sup>38</sup> Allen, Rebecca and O’Brien, Barbara M. “Uses of Misoprostol in Obstetrics and Gynecology.” *Reviews in Obstetrics & Gynecology*, 2019 2(3): 159-168. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2760893/>.

<sup>39</sup> MAMA Network. “Accessing Safe Abortion during Lockdown in Africa.” 2020.

With restrictions on mobility and expensive store bought contraceptives this has been a huge issue for women.<sup>40</sup>

- 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...”<sup>41</sup> 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.<sup>42</sup>
- 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.”<sup>43</sup>
- g. *Increased intimate-partner violence.* Lockdowns and quarantines across the globe have disproportionately impacted women and girls, many of whom are stuck at homes with 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 finding alternative termination methods and is a general harm to their mental health, which impacts their SRHR.<sup>44</sup> “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.”<sup>45</sup>
- 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.

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<sup>40</sup> Ann Holland. Email Communication with FAR and CWGL. September 2020.

<sup>41</sup> Ann Holland, Zambia. Email Communication with FAR and CWGL. 2020.

<sup>42</sup> Ann Holland, Zambia. Consultation with FAR and CWGL. *Zoom*, 2020.

<sup>43</sup> Mandy Asagba, Nigeria. Consultation with FAR and CWGL. *Zoom*, 2020.

<sup>44</sup> Mandy Asagba, Nigeria. Consultation with FAR and CWGL. *Zoom*, 2020.

<sup>45</sup> Ann Holland, Zambia. Email Communication with FAR and CWGL. 2020.

## D. Other Concerning Trends

### Unwanted Pregnancy, Abortion Access and Family Planning

10. 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.
11. In 2017, 93 percent of women of reproductive age in Africa lived in states with restrictive abortion laws.<sup>46</sup> Only Cape Verde, South Africa, and Tunisia allowed unrestricted<sup>47</sup> abortion access.<sup>48</sup> During 2010–2014, an average of about one in four abortions in Africa were safe.<sup>49</sup> Even in countries where the law allowed abortion under limited circumstances, it was likely that few women were able to obtain a safe legal procedure. Lack of information around SRH services resulted in carrying to term despite negative complications or the seeking of dangerous abortion alternatives.
12. 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.<sup>50</sup> According to WHO, 20 percent of the 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.<sup>51</sup>
13. 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 issues cited by activists. Government's dedications to upholding culturally conservative sexual norms are a widespread concern across the region. In Uganda, laws closing spaces for civil society organizations, through laws that restrict their activities, affects their efforts to advance the SRHR agenda in which alternative educational modes are erased completely from the public.<sup>52</sup> In

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

<sup>47</sup> Unrestricted here is defined as reasoning, each of the listed countries do have gestational time period restrictions on abortion access.

<sup>48</sup> Guttmacher Institute. "Abortion in Africa: Fact Sheet." *Guttmacher Institute*. 2018. [https://www.guttmacher.org/sites/default/files/factsheet/ib\\_aww-africa.pdf](https://www.guttmacher.org/sites/default/files/factsheet/ib_aww-africa.pdf).

<sup>49</sup> Ibid.

<sup>50</sup> 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#>.

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

<sup>52</sup> Activist, Uganda. Consultation with FAR. November 2019.



Zimbabwe there exists a deep seeded stigma against contraceptive access, thus judgmental nurses and doctors which dissuade young people for searching for safe sex options such as contraceptives and condoms.<sup>53</sup>

14. Marginalized sectors of the population also have limited access to contraceptives including women with disabilities, forcibly displaced, in rural communities, those belonging to the LGBTQ+ movement and also women who face economic hardship which contributes to 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.”<sup>54</sup> In Nigeria, the government operates a family planning program centered on married heterosexual people. As such, no government assistance is allotted for non-heterosexual family, 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.<sup>55</sup>
15. Activists highlight that, despite some efforts from political figures and grassroots activists, religious and cultural norms still prevent the ability to provide access to SRH care. Thus, organization and political figures searching for grants to help provide these services are forced to divorce the issues of health from the conversations, further spreading misinformation around what qualifies as SRHR.<sup>56</sup>
16. 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 increase maternal and infant mortality rates and access to menstrual products also remain 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.”<sup>57</sup>

### **Discriminatory Gender Stereotypes and Sexuality Education**

17. 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

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<sup>53</sup> Nyaradzo Mashayamombe, Zimbabwe. Interview by FAR and CWGL. *Zoom*, September 2020.

<sup>54</sup> Activist, Zambia. Consultation organized by FAR and CWGL. November 2019.

<sup>55</sup> Activist, Nigeria. Consultation organized by FAR and CWGL. November 2019.

<sup>56</sup> Activist, Kenya. Consultation organized by FAR and CWGL. November 2019.

<sup>57</sup> Awungija Tetchoukwi. Consultation with FAR and CWGL. *Zoom*, 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.<sup>58</sup>

18. 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.”<sup>59</sup>
19. Cultural taboos surrounding SRHR are also reflected in the Ugandan education system. The government adopted a policy on “comprehensive sexuality education” but limits education still to abstinence-only education, 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 increase the number of unwanted and teenage pregnancy, often resulting in pregnancy and birth-related complications or the pursuit of dangerous measures for termination.<sup>60</sup>
20. In Zimbabwe, a majority of children who attend school are from middle-class 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, sexual assault- and lack of access to SRHR.<sup>61</sup>

### **Discriminatory Practices: Female Genital Mutilation (FGM)**

21. Female Genital Mutilation (FGM) continues to be a widespread practice in countries all over the world with a majority occurring in Africa. The global trend of FGM has increased by approximately by half a million between 1994-2019. Taking into consideration the upward trend, an estimated 50 million girls in Africa alone are at risk of FGM by 2030.<sup>62</sup>
22. 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, too, occur regularly. FGM’s also contribute to long-term health problems including serious infections, pain during sex, mental health issues, painful urination and menstruation, infections caused by

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<sup>58</sup> Activist, Kenya. Consultation organized by FAR and CWGL. November 2019.

<sup>59</sup> Ann Holland. Email Communication with FAR and CWGL. 2020.

<sup>60</sup> Activist, Uganda. Consultation organized by FAR and CWGL. November 2019.

<sup>61</sup> Nyaradzo Mashayamombe. Interview by FAR. *Zoom*, 2020.

<sup>62</sup> 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.<sup>63</sup>

23. Approximately 98 percent of women and girls between the ages of 15 to 49 have experienced FGM in Somalia,<sup>64</sup> the highest percentage in the world,<sup>65</sup> and approximately 90 percent of women and girls in Sierra Leone have been cut.<sup>66</sup>

## Promising Practices

24. 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.
25. 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, that has helped to disseminate information and change harmful ideas about sex.<sup>67</sup> 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.<sup>68</sup>

### A. Rainbo Initiative in Sierra Leone<sup>69</sup>

26. "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

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<sup>63</sup> Ifrah Foundation. "Zero Tolerance for Female Genital Mutilation: FGM Factsheet." *Ifrah Foundation*, 2019. [https://37f4e620-94cb-43cc-a3f9-b74a3542b63d.filesusr.com/ugd/74d910\\_1407f5e7adfc4e269b58c4560e4e37a2.pdf](https://37f4e620-94cb-43cc-a3f9-b74a3542b63d.filesusr.com/ugd/74d910_1407f5e7adfc4e269b58c4560e4e37a2.pdf).

<sup>64</sup> 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](https://www.ecoi.net/en/file/local/2013242/2019_07_23_EASO_COI_QUERY_Somalia_FGM_Q19.pdf).

<sup>65</sup> Ifrah Foundation. "Zero Tolerance for Female Genital Mutilation: FGM Factsheet." *Ifrah Foundation*. 2019. [https://37f4e620-94cb-43cc-a3f9-b74a3542b63d.filesusr.com/ugd/74d910\\_1407f5e7adfc4e269b58c4560e4e37a2.pdf](https://37f4e620-94cb-43cc-a3f9-b74a3542b63d.filesusr.com/ugd/74d910_1407f5e7adfc4e269b58c4560e4e37a2.pdf).

<sup>66</sup> Bitong, Liliane. "Fighting genital mutilation in Sierra Leone." *Bulletin World Health Organization*, 2005 83(11): 801-880. <https://www.who.int/bulletin/volumes/83/11/news21105/en/>.

<sup>67</sup> Activist, Sierra Leone. Consultation organized by FAR and CWGL. November 2019.

<sup>68</sup> Activist, Uganda. Consultation organized by FAR and CWGL. November 2019.

<sup>69</sup> Awungija Tetchoukwi, Cameroon. Consultation with FAR. *Zoom*, September 2020.

weakened social structures in Sierra Leone that leave survivors vulnerable and unable to seek redress.”<sup>70</sup>

27. In this context, the grassroots organization Rainbo Initiatives is relevant as it provides free rescue, treatment and psychosocial services to victims of rape and sexual and gender-based violence. The Rainbo Initiative has five (5) centers that they operate in Freetown, Bo, Kanema, Kono and Makeni. Collaboration between the Rainbo Initiative and public hospitals/health facilities has reduced the negative attitudes around teenage pregnancy and seeking reproductive health services when one is not married.

### **B. MAMA Network and Telehealth/tele-counseling Services during COVID-19<sup>71</sup>**

28. The MAMA Network is a regional movement, founded by the organizations Trust for Indigenous Culture and Health and Women Help Women. The Network has opened three hotlines in May 2020 that focuses on women and girls’ SRH in Cameroon, the Democratic Republic of the Congo, and Zambia, in addition to the previous hotlines in Nigeria, Kenya, Tanzania, Malawi, and Uganda. The MAMA Network, and the telehealth and tele-counseling hotlines have opened up access to women and girls during the COVID-19 pandemic to provide crucial and accurate information about how women and girls’ SRHR can and have 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 Zimbabwe<sup>72</sup>**

29. 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”, a 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. Today the Zimbabwean Government has since released the Education Bill that provides for the state funded basic education.
30. The initiative is promising because it promotes comprehensive education including sexuality education and promote girls who become pregnant to be able to return to their education. Currently the challenge is about holding the government, schools, and families accountable and finding funding to maintain access to education for all children which is compounded during the current sanitary crisis.<sup>73</sup>

### **D. Community Health Workers in Kenya<sup>74</sup>**

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<sup>70</sup> Rainbo Initiatives. “Welcome to Rainbo.” <http://www.rainboinitiativesl.org>.

<sup>71</sup> MAMA Network. “Accessing Safe Abortion during Lockdown in Africa.” 2020.

<sup>72</sup> Nyaradzo Mashayamombe. Interview by FAR and CWGL. *Zoom*, 2020.

<sup>73</sup> Nyaradzo Mashayamombe. Interview by FAR and CWGL. *Zoom*, 2020.

<sup>74</sup> Activist, Kenya. Consultation organized by FAR and CWGL. November 2019.

31. In Kenya, services related to SRH is 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 they carry out range from promotive, preventive and partly curative services, including maternal and child health, HIV care, and treatment of malaria.<sup>75</sup> This initiative is relevant because the Community Health Workers add value to addressing SRHR issues in communities, however concerted efforts are important to have a supportive system in place in terms of better training, availability of necessary resources and equipment as well as reporting and welfare infrastructure.

### Recommendations for States

32. The activists that attended the consultation on November 11<sup>th</sup> 2019 discussed and agreed on a number of recommendations that states must take into account for an effective response to SRHR in contexts of crisis.
- a. To classify menstrual products as essential, to make them accessible and free.
  - b. To remove taxes on menstrual products, to help women afford them.
  - c. To establish safe spaces for victims; to provide properly trained resources for survivors of sexual violence and rape centered on healing and safety.
  - d. To establish centers to provide good quality healthcare and social services and provide information on SRHR standards in a proactive manner.
  - e. To provide emergency packages including condoms and contraceptives for women.
  - f. To fund grassroots organizations and civil society organizations that are raising awareness on SRHR.
  - g. To adopt measures to ensure accountability for GBV and SRHR violations in contexts of crisis.
  - h. To 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 that.
  - i. To decriminalize abortion and ensure availability of contraception.
  - j. To ensure access to abortion for victims of sexual violence within a framework of reparations.
  - k. To call for national emergencies towards the rise of GBV and rape culture.
  - l. To provide comprehensive sex education and comprehensive sexuality education that includes LGBTQ+ information, and to implement programs throughout the country.
  - m. To implement nation-wide campaigns that focus on ending rape culture in every home and work place.

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<sup>75</sup> Ormel, Herman and *et. al.* “Salaried and voluntary community health workers: exploring how incentives and expectation gaps influence motivation.” *Human Resources for Health*, 2019 17(59). 2019. Doi: <https://doi.org/10.1186/s12960-019-0387-z>.

- n. To launch campaigns which focus on destigmatizing LGBTQ+ people and providing resources of them.
- o. To ensure sexual reproductive health clinics are established throughout the country, and widespread education about reproductive health rights including access to abortion and contraception.
- p. To increase funding to help women attain SRHR.
- q. To provide online, radio, television and social media support for women and girls struggling due to COVID-19.
- r. To provide safety and permanent residences for refugees and displaced people, particularly women and girls.
- s. To provide incentives for families to keep their children in school.

## II. Asia<sup>76</sup>

The current chapter is based on the 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<sup>th</sup> 2020<sup>77</sup> organized by FAR along with the Forum for Women, Law and Development (FWLD) and FAR's Global Coordinator, 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 whole 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's and girls' SRHR: 1. Natural Disasters; 2. Armed conflict/Political Violence; 3. COVID-19. The sections I and II 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<sup>th</sup>, 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.<sup>78</sup> In 2015, Asia region reported the greatest number of natural disasters

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<sup>76</sup> This chapter mainly focuses on South Asia, East Asia and Asia Pacific.

<sup>77</sup> 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); 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); Flora Bawi Nei Mawi, Latsi Nu Women Agency (Myanmar).

<sup>78</sup> A World Bank study (2019), found that "In 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." <https://blogs.worldbank.org/endpovertyinsouthasia/south-asia-needs-act-one-fight-climate-change>.

globally.<sup>79</sup> 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.<sup>80</sup>

2. Disasters have a particularly negative impact on agriculture, which is the primary source of income for most households in South Asia.<sup>81</sup> Experts estimate that climate change could push 62 million South Asians below the extreme poverty line by 2030.<sup>82</sup> 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.”<sup>83</sup>
3. Social norms constrain women’s mobility, hindering self-rescue during and in the aftermath of an emergency.<sup>84</sup> 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.”<sup>85</sup> This has an effect on their physical and mental health and leave them with little time to seek healthcare for themselves.
4. Empirical data points at the difficulty in raising awareness on prevention plans among women. “Given their role as housewives, women spend most of their time working at home and they do

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<sup>79</sup> Bhavya Joshi. “Sexual and Reproductive Health in Crisis Situations- India’s Case Study.” 2020. *WomenSARRA* (Submission to the Working Group), 1.

<sup>80</sup> Christenson, E., Elliott, M., Banerjee, O., Hamrick, L., & Bartram, J. “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(2), 2169–2192. 2014. <https://doi.org/10.3390/ijerph110202169>.

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

<sup>82</sup> 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>.

<sup>83</sup> National Disaster Management Authority, Indonesia. “Indonesia’s Disaster Risk Management Baseline Status Report 2015.” 2015. *Women and Disaster*, 24. [https://www.preventionweb.net/files/50832\\_5083220161031indobaselinereportfina.pdf](https://www.preventionweb.net/files/50832_5083220161031indobaselinereportfina.pdf).

<sup>84</sup> Sneha Gangwar. “Integrating Gender Issues in Mitigation and Management of Disaster in India.” *International Journal of Environmental Engineering and Management*, Volume 4, Number 6 (2013), 615. [https://www.ripublication.com/ijeem\\_spl/ijeemv4n6\\_15.pdf](https://www.ripublication.com/ijeem_spl/ijeemv4n6_15.pdf)

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



not have access to information regarding safety measures needed during a natural disaster.”<sup>86</sup> 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 beliefs, for example that natural disasters are the result of sins and are God's way of punishment.” These ideas are engrained not only among the general public but also within government representative.<sup>87</sup>

### **State Response and Access to SRHR Services and Supplies**

5. Women’s and girls’ access to essential SRHR services and supplies in the aftermath of an emergencies 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 that: “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.”<sup>88</sup>
6. 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.<sup>89</sup> However, very often women and girls did not have access to essential products for menstrual hygiene management and that there have been other associated problems linked to the absence of gender-sensitive measures like ensuring adequate distribution and designated spaces to utilize them in a dignified and safe manner.
7. In Sri Lanka, distribution of sanitary products was under the control of male camp officials, who handed them out one at a time, so women had to go back and ask repeatedly.<sup>90</sup> This was problematic because culturally women could be reluctant to approach men regarding their personal hygiene requirements. A study in India reported about 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

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<sup>86</sup> Leonora Evriani, Indonesia. Consultation Feminist Alliance for Rights (FAR), Forum for Women, Law and Development (FWLD) and Center for Women’s Global Leadership (CWGL). January 2020.

<sup>87</sup> Leonora Evriani, Indonesia. Consultation FAR, FWLD, CWGL. January 2020.

<sup>88</sup> CH Akmatova, 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.

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

<sup>90</sup> CH Akmatova, Chiang Mai. “Guidelines for Gender Sensitive Disaster Management.” (APWLD, 2006), 12.

reproductive health are not survival issues such as food, water and shelter, therefore any deeper discussion on these topics was not encouraged.”<sup>91</sup>

8. In a number of countries, there are disaster management laws that include women and children among the vulnerable groups that should be prioritized.<sup>92</sup> 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.<sup>93</sup> 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.”<sup>94</sup> In Indonesia, an additional problem was when for political reasons the national level government did not make proper use of the aid that came to Indonesia.<sup>95</sup>
9. Obstacles that women have faced while accessing SRHR services in the aftermath of an emergency included 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 emergency tsunami victims, a majority of expectant mothers in the camps delivered their babies in the tents despite medical aid being available in the camps. 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.<sup>96</sup>
10. In Nepal after the 2015 massive earthquake, 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 address the SRH services soon after the disaster.<sup>97</sup> Hospitals were understaffed, health care providers did not have adequate training<sup>98</sup> and health facilities in different localities reported shortages of SRHR supplies immediately after the earthquake.<sup>99</sup>

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<sup>91</sup> Bhavya Joshi. “India’s case study,” 6. 2020.

<sup>92</sup> For example the Law concerning Disaster Management in Indonesia refers to the protection and priority of vulnerable groups of which only such groups include infants, preschoolers, and children; pregnant women or nursing mothers; the disabled; the elderly.

<sup>93</sup> Leonora Evriani, Indonesia. Consultation FAR, FWLD, CWGL. January 2020.

<sup>94</sup> Flora Bawi Nei Mawi, Myanmar. Consultation FAR, FWLD, CWGL. January 2020.

<sup>95</sup> 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 are 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 Learning Project. “Collaborative Listening Project: Field Visit Report in Aceh, Indonesia.” November 2005. <https://www.cdacollaborative.org/wp-content/uploads/2016/02/Field-Visit-Report-Aceh-Indonesia.pdf>.

<sup>96</sup> CH Akmatova, Chiang Mai. “Guidelines for Gender Sensitive Disaster Management.” (APWLD, 2006), 22.

<sup>97</sup> Kamal Gautam, Nepal. Consultation FAR, FWLD, CWGL. January 2020.

<sup>98</sup> Kamal Gautam, Nepal. Consultation FAR, FWLD, CWGL. January 2020.

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

Moreover, “the government set up birthing centers but deprioritized abortion services.”<sup>100</sup> When abortion services were provided, women raised concerns related to the lack of confidentiality and privacy.<sup>101</sup> Finally the Nepali government requested an organization to supply medical abortion drugs to the affected districts and to conduct training of abortion service providers.<sup>102</sup>

11. Another example that show how the Nepali government failed to address women’s SRHR during a natural disaster include a case that FWLD represented. In such case, while the government used to provide free treatment to the injured during the earthquake, it denied the 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 rather forced to pay all the medical expenses.<sup>103</sup>

### Safe Shelter and Water and Sanitation (WASH)

12. Access to appropriate safe shelter, water and sanitation is particularly important to ensure people’s well-being and reduce threats of gender-based violence, including sexual violence, in the aftermath of an emergency<sup>104</sup> An activist from Indonesia noted that the State 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.<sup>105</sup>
13. 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 shelter did not have access to separate toilets and room.<sup>106</sup> 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.<sup>107</sup> which is evidence of the increased vulnerability of this group in contexts of crises. Unfortunately, redress measures for victims of GBV were not accessible in the aftermath of the earthquake.<sup>108</sup>

<sup>100</sup> Sabin Shrestha, Nepal. Consultation FAR, FWLD, CWGL. January 2020.

<sup>101</sup> Madhavi Bajracharya, Nepal. Consultation FAR, FWLD, CWGL. January 2020.

<sup>102</sup> Madhavi Bajracharya, Nepal. Consultation FAR, FWLD, CWGL. January 2020.

<sup>103</sup> Sabin Shrestha noted there is also the social perception that, if any woman delivers a baby during the time of earthquake than the child will be born with physical incapacities played its role in harmful practices. Sabin Shrestha, Nepal. Consultation FAR, FWLD, CWGL. January 2020.

<sup>104</sup> Chaudhary, P., Vallese, G., Thapa, M., Alvarez, V., Pradhan, L., Bajracharya, K., Goyet, S. *et al.* 2017. “Humanitarian response to reproductive and sexual health needs in a disaster: The Nepal Earthquake 2015 case study.” *Reproductive Health Matters*, 25(51), 25-39. [www.jstor.org/stable/26495949](http://www.jstor.org/stable/26495949).

<sup>105</sup> Emmanuella Kania Mamonto, Indonesia. Consultation FAR, FWLD, CWGL. January 2020.

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

<sup>107</sup> Basnet Bista, Sapana, and Shaurabh Sharma. 2019. “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).

<sup>108</sup> FWLD. “Gender Equality and Social Inclusion in Post-Earthquake Reconstruction.” 2017.

14. 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.<sup>109</sup>
15. 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 -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."<sup>110</sup>

### **Impact on women and girls belonging to marginalized communities**

16. 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."<sup>111</sup> Likewise Dalits 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.<sup>112</sup>
17. Women with disabilities neither receive help for accessing distribution locations and nor is the 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.<sup>113</sup> It is important to note that the Safe Motherhood and Reproductive Health Right Act enacted in Nepal in 2019 requires that the services be implemented considering the needs of adolescents and persons with disabilities, and that this law should be utilized to supplement Nepal's Disaster

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<sup>109</sup> Bhavya Joshi. "India's case study," 3-6. 2020.

<sup>110</sup> CH Akmatova, Chiang Mai. "Guidelines for Gender Sensitive Disaster Management." (APWLD, 2006), 24.

<sup>111</sup> Yasso Kanti Bhattachan, Nepal. Consultation FAR, FWLD, CWGL. January 2020.

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

<sup>113</sup> Pratima Gurung, Nepal. Consultation FAR, FWLD, CWGL. January 2020.

Management Act from 2018. However, activists have highlighted these promising laws are not being adequately implemented.<sup>114</sup>

18. 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.”<sup>115</sup>
19. 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”.<sup>116</sup>

### **Participatory Risk Assessment and Women’s Organization’ Participation**

20. Participatory risk assessments before and after designing and implementing SRHR services are key to understand 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.<sup>117</sup>
21. 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.”<sup>118</sup>

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<sup>114</sup> Sabin Shrestha, Nepal. Consultation FAR, FWLD, CWGL. January 2020.

<sup>115</sup> Committee on the Rights of Persons with Disabilities. “Concluding observations on the initial report of Myanmar.” October 2019: 4.  
[https://tbinternet.ohchr.org/\\_layouts/15/treatybodyexternal/Download.aspx?symbolNo=CRPD/C/MMR/CO/1&Lang=En](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolNo=CRPD/C/MMR/CO/1&Lang=En)

<sup>116</sup> Flora Bawi Nei Mawi, Myanmar. Consultation FAR, FWLD, CWGL. January 2020.

<sup>117</sup> Sara Davidson. “A Review of the IFRC- led Shelter Coordination Group Bangladesh Cyclone Sidr Response.” 2007-2008. July 2008, 29.

<sup>118</sup> Flora Bawi Nei Mawi, Myanmar. Consultation FAR, FWLD, CWGL. January 2020.

22. 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 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.<sup>119</sup>

## B. Conflict and Institutional Violence

23. 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 World Health Organization (WHO) shows a 40.2 percent of lifetime prevalence of intimate partner violence and non-partner sexual violence in the region.<sup>120</sup> 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.<sup>121</sup>
24. GBV in the context of conflict /political crisis have particularly negative impact on women's and girls' SRHR in the region. As the examples below show, it 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 and this may be due to shrinking economic resources within the family or using marriage as a safety net, for example, to protect girls from sexual violence and abduction or as a way to avoid conscription of girls into the military.<sup>122</sup>
25. As noted by Arrow, barriers for women and girls' access to SRHR services in contexts of conflict include; not accessible or universally available 1) 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], 3) prohibitive costs of services, 4) language barriers, 5) lack of transportation and 6) fear of sexual violence during travel.<sup>123</sup>
26. Access to medical and psychological services for women and girls victims of conflict and political-related violence is challenging in most countries. A participatory action research 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 sexual assault;

<sup>119</sup> Sabin Shrestha, Nepal. Consultation FAR, FWLD, CWGL. January 2020.

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

<sup>121</sup> Jacqui True. "The State of Conflict and Violence in Asia." *The Asia Foundation's*. 2017. [https://asiafoundation.org/wp-content/uploads/2017/10/The\\_State\\_of\\_Conflict\\_and\\_Violence\\_in\\_Asia-12.29.17.pdf](https://asiafoundation.org/wp-content/uploads/2017/10/The_State_of_Conflict_and_Violence_in_Asia-12.29.17.pdf)

<sup>122</sup> Biplabi Shrestha. "Redefining Peace: Interlinkages of Conflict, Gender, and Sexual and Reproductive Health and Rights." (Arrow, 2018), 11. 2018.

<sup>123</sup> Biplabi Shrestha. "Redefining Peace." Arrow, 15. 2018.

adequate healthcare was inaccessible or unaffordable in rural communities in each region, and sometimes non-existent. All through 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.”<sup>124</sup>

27. An activist from Indonesia informed that Papua region of Indonesia is facing an ongoing crisis. In a research her organization conducted in 2013, they found that women were victims of systemic sexual violence and that today they struggle to survive, noting it as a very difficult task 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 that the next generation is more vulnerable as they have 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.”<sup>125</sup>

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

### a. Sexual violence during the armed conflict in Nepal<sup>126</sup>

28. 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 also for belonging to the families of security forces personnel.<sup>127</sup> Survivors of conflict-era sexual violence did not register complaints, mostly due to fear of repercussions, or stigmatization, and that, in general, the existing legal framework did not allow them to have access to compensation and other forms of reparation.<sup>128</sup>
29. During the consultation, an activist shared her experience working with victims of sexual violence that seek justice and reparation, “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

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

<sup>125</sup> Emmanuella Kania Mamonto, Indonesia. Consultation FAR and FWLD. 2020.

<sup>126</sup> Nepal Civil War, 1996-2006.

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

<sup>128</sup> Trial International. “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.” 2020. [https://trialinternational.org/wp-content/uploads/2020/05/Reports-and-publications\\_Nepal\\_submission-to-SRSV\\_202004.pdf](https://trialinternational.org/wp-content/uploads/2020/05/Reports-and-publications_Nepal_submission-to-SRSV_202004.pdf).

that these cases would also be taken to the legal mechanism to be heard, the survivors did not 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. 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”.<sup>129</sup>

#### **b. Sexual Violence and Ethnic Cleansing against Rohingya Women and Challenges to ensure SRHR at Cox’s Bazar camp**

30. 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 Burma’s 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 of them had to witness family members, friends and neighbors being slaughtered in front of them.<sup>130</sup> As a result, more than 600,000 Rohingya fled to neighboring Bangladesh.<sup>131</sup> To reach the new country, people had to walk up and down hills for days. This was especially harsh for people in situation of vulnerability 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.”<sup>132</sup>
31. 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.<sup>133</sup> The Inter-Agency

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<sup>129</sup> Salina Kafle, Nepal. Consultation FAR, FWLD, CWGL. January 2020.

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

<sup>131</sup> “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.” UN Women. “Crisis Update: Nearly one million Rohingya Refugees are in Bangladesh now.” *News and Events*, 2018. <https://www.unwomen.org/en/news/stories/2018/8/feature-rohingya-humanitarian-update>.

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

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



Working Group on Reproductive Health in Crisis found that the acute need, post-rape care, including access to 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.<sup>134</sup> Lack of access to adequate materials and facilities for managing menstruation posed further problems for women and girls in the Rohingya camps.<sup>135</sup>

32. 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.”<sup>136</sup>
33. Emergency obstetric and new-born care is not available 24/7 and therefore, deliveries take place at home.<sup>137</sup> 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.”<sup>138</sup>
34. 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.<sup>139</sup>

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

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

<sup>136</sup> Shireen Huq, Bangladesh. Consultation FAR, FWLD, CWGL. January 2020.

<sup>137</sup> IAWG. “Women and Girls critically underserved in the Rohingya Humanitarian Response.” 2018.

<sup>138</sup> Shireen Huq, Bangladesh. Consultation FAR, FWLD, CWGL. January 2020.

<sup>139</sup> IAWG. “Women and Girls critically underserved in the Rohingya Humanitarian Response.” 2018.

### **c. Forced Pregnancies and Involuntary Contraceptive Implants in Sri Lanka**

35. Sri Lanka registered 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.<sup>140</sup> However, political violence has taken a different form affecting women and girls' SRHR in a particular way.
36. As an organization noted, the end of Sri Lankan civil war sparked a new era of Sinhala Buddhist ethno-nationalism and therefore Sinhala women are viewed as '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."<sup>141</sup>
37. The Sri Lankan government, who has administered forced, cohesive or involuntary birth control programs have uniquely targeted Tamil women in the North and East of Sri Lanka.<sup>142</sup> 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."<sup>143</sup>

### **C. COVID-19<sup>144</sup>**

38. World Health Organization declared coronavirus a global pandemic on 11 March, 2020, and called government action to flatten the curve. The pandemic has affected countries all across the globe, including countries in the Asia-Pacific region. Out of 39 countries in the Asia-Pacific Region, 28

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<sup>140</sup> Biplabi Shrestha. "Redefining Peace." ARROW, 11. 2018.

<sup>141</sup> United National General Assembly. "Written Statement of the Pasumai Thaayagam Foundation, a non-governmental organization in special consultative status." *Human Rights Council, A/HRC/28/NGO/94*. 2015. [https://www.ecoi.net/en/file/local/1192764/1930\\_1425549459\\_g1503364.pdf](https://www.ecoi.net/en/file/local/1192764/1930_1425549459_g1503364.pdf).

<sup>142</sup> Ibid.

<sup>143</sup> Shreen Abdul Saroor, Sri Lanka. Consultation FAR, FWLD, CWGL. January 2020.

<sup>144</sup> This section was drafted by the ARROW.

countries have COVID-19 cases. About 5.9 million cases are tested positive in these countries.<sup>145</sup> Many people are still confined within their home to prevent the further spread of the virus.

39. In the past humanitarian crisis, there has always been a devastating impact, especially on women's and girls' SRHR. 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.
40. With lockdown and movement restriction, women, girls, adolescents and other marginalized group around Asia-Pacific region are facing significant barriers in accessing essential SRH information and services. There has been reduced access to contraceptives, increase in the sexual and gender-based violence, increase in harmful and traditional practices like early and forced child marriage and FGM, increase in teenage pregnancy and maternal mortality.

## Country Context

41. The country context is heavily drawn from the Submission to 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 her partners. In order to submit this report, ARROW conducted secondary desk research and also collected information/experience from the national partners to understand the country context of Bangladesh, India, Indonesia, Nepal, Pakistan and the Philippines.

### Bangladesh

42. The on-going pandemic has already overburdened an already strained health system affecting the access and availability of essential services and information, which is affecting women and girls in particular. There is also inadequacy in the number of trained doctors and medics<sup>146</sup> 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. Moreover, the high number of infection rates and COVID-19 related deaths<sup>147</sup> among health and medical practitioners<sup>148</sup> means that the general public is avoiding

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<sup>145</sup> United Nations Office for the Coordination of Humanitarian Affairs. "Impact of the Crisis." 2020. <https://interactive.unocha.org/data/ap-covid19-portal/impact-crisis.html>.

<sup>146</sup> Xinhua. "Chinese medical expert team arrives in Bangladesh to help fight COVID-19." 2020. [http://www.xinhuanet.com/english/2020-06/08/c\\_139124099.html](http://www.xinhuanet.com/english/2020-06/08/c_139124099.html).

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

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

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.<sup>149</sup>

43. Sources from 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 increased due to the outbreak of COVID-19. This information has been collected from Daily newspapers (Prothom Alo), Electronic Media (DIPTO Television) and phone call from DPO (Disabled People's Organization) 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**

44. Abortion and maternal care are time-sensitive interventions. Recognizing this, a Public Interest Litigation petition (PIL) was filed in the Delhi High Court for directions to the Centre 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.<sup>150</sup>
45. There has been a steep rise in violence perpetrated against women across the country amid restrictions imposed due to the coronavirus (COVID- 19) outbreak, with the National Commission for Women receiving 587 complaints from March 23 to April 16, out of which 239 are related to domestic violence. From February 27 to March 22, a total of 396 offences related to women were reported to the NCW, while from March 23 to April 16, as many as 587 such complaints were received, according to the data. The highest numbers of complaints were related to domestic violence.

### **Indonesia**

46. After the Indonesian government labelled COVID-19 as a national disaster, public health facilities were prioritized for COVID-19 responses 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 are limited to certain days and hours, must be by appointment or online consultation, or have temporarily closed the health facility due to insufficient supply of Personal Protective Equipment (PPE).

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<sup>149</sup> UNICEF, Bangladesh. 2020. <https://www.unicef.org/bangladesh/en/press-releases/pregnant-mothers-and-babies-born-during-covid-19-pandemic-threatened-strained-health>

<sup>150</sup> The Wire. "Our Pandemic can't be an excuse to overlook women's reproductive rights." *Opinion on Health*, 2020. <https://thewire.in/health/covid-19-pandemic-women-reproductive-rights-abortion-access>.

47. 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, one of which being that many midwives are afraid to provide services because they don't have optimal protective equipment and that the pregnant women they work with are also avoiding seeking care to the facilities for a pregnancy check.<sup>151</sup>
48. From 16 March – 19 April alone, The Legal Aid Foundation of the Indonesian Women's Association for Justice (LBH APIK) experienced a significant increase (97 case complaints) in reports of violence against women through their hotline and email.
49. Previously, The Women's Empowerment and Child Protection Ministry reported 275 cases of violence against women and 368 cases of violence against children between March 2 and April 25, affecting 277 women and 407 children.<sup>152</sup> The Coalition of Care for Vulnerable Victims of COVID-19 (PEKAD) also reports an increasing burden on women due to their continued household burden including daily shopping at the market, increasing their risk of exposure to the virus.<sup>153</sup> As well as exacerbating the frequency and seriousness of violence in already abusive relationships, the PSBB (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.<sup>154</sup>

### **Nepal**

50. At least 32 women died due to related birth complications in the first two months of lockdown. This is an almost 200% increase in the maternal mortality ratio since the lockdown began, compared to 80 cases in the previous fiscal year. The antenatal and postnatal visits by pregnant women have been halted due to no public transportation. The postnatal visit program in the new mother's home by a trained nurse has stopped. Many health facilities have also stopped 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.<sup>155</sup> Women and girls are facing barriers to

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

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

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

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

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

accessing safe abortion services and including other reproductive health services due to lockdown. Women and girls are reluctant to attain health facilities due to the fear of transmission of COVID-19 and lack of information regarding the continuation of all safe motherhood and reproductive health services.

51. Transgender people living with HIV and AIDS have been affected, as they do not have access to their regular health check-up and ARTs. Though ARTs have been delivered at homes by some organizations, full body check-up for CD4 counts and viral load are not available, which has affected their course of treatment.
52. In regards to a general health check-up, sexual and gender minorities already faced stigma and discrimination prior COVID-19, the stigma has been doubled as normal fever is also highly stigmatized at this point of time. Stigma and discrimination have led to a decrease in health-seeking behavior further among sexual and gender minorities.
53. The transgender women are also being affected by the lockdown. There is a shortage of hormone medications, and due to unavailability of the hormones, side effects like withdrawal symptoms are getting common among Transgender women.
54. Ever since the lockdown was implemented, 1145, the national helpline operated by the National Women Commission has reported that GBV on the rise. In the 30- or-so days since the lockdown began, the helpline received 521 calls, of which 119 have been specifically about domestic violence.<sup>156</sup> Within the 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 perpetrators. According to the Women's Rehabilitation Centre (WOREC Nepal)<sup>157</sup>, it has recorded 336 cases of violence against women and girls from 33 districts of Nepal from 24 March to 15 May 2020. Among the reported cases, 198 cases are of domestic violence, 48 cases are of rape and 10 are attempts to rape case, 29 are of social violence, 12 cases are of sexual abuse and so on. The perpetrators of violence against women are mainly husband (155 cases), family members (67) and neighbors (66). Women and girls of age 17-25 year were affected the most (108), followed by the age group 26-35 (103).<sup>158</sup>
55. The risk of intimate partner violence has also increased among transgender people as they 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. An article published on a national daily covered how a social media site Reddit had communities that were objectifying

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<sup>156</sup> Aditi Aryal. "Fears of a rise in cases of domestic violence due to the lockdown may have come to pass." *Kathmandu Post*, 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>.

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

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

women and sharing their pictures non- consensually, and this article gained a lot of attention as well.

## **Pakistan**

56. 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, contraception counselling and services. In addition, access to health care services for young and newlywed women is also affected.
57. Though the Department of Health and Population, Government of Sindh developed SOPs on for family planning and reproductive health on March 21, the implementation of the SOP is a challenge, and at the same time, people are unable to access the services.
58. 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 Pakistan Demographic Health Survey 2017-2018, almost one-third of women aged between 15 and 40 reported having experienced physical violence since age 15.<sup>159</sup> The percentage was higher among younger women, and women from rural areas while women with higher educational background reported lower incidents of physical violence.<sup>160</sup> Domestic violence, in particular, has been happening at an alarming rate across the country - 90% of women in Pakistan have experienced some form of domestic violence, at the hands of their husbands or families.<sup>161</sup>

## **Philippines**

59. Public health centers continued to offer family planning services, devices and advice during the quarantine period.<sup>162</sup> However, during this period, there were at least two reported cases of pregnant women who died in labor after being denied services by several hospitals and medical facilities.<sup>163</sup>
60. The Philippines' Luzon city saw a total of 804 reported gender-based violence and violence against women and children cases since the beginning of lockdown on 15 March to 30 April, according to the numbers taken by the Philippine Commission on Women (PCW) from the Philippine National

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

<sup>160</sup> Ibid.

<sup>161</sup> United Nations Office on Drugs and Crime. "Gender and Pandemic: Urgent Call for Action." *Government of Punjab, Advocacy Brief 4*. 2020. [https://www.unodc.org/documents/pakistan//Advocacy\\_Brief\\_4\\_Gender\\_-COVID-19-Punjab.pdf](https://www.unodc.org/documents/pakistan//Advocacy_Brief_4_Gender_-COVID-19-Punjab.pdf).

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

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

Police's Women Children Protection Center (PNP-WCPC).<sup>164</sup> The 1,044 reported number nationwide is lower than the reported number of cases in January and February at 1,383 and 1,224 respectively. However, the reason for the dip is questionable.<sup>165</sup>

61. Separately, a report to Congress found that since the implementation of the enhanced community quarantine, 763 cases of crimes against women, and 521 cases of crimes against children were reported.<sup>166</sup>

## Promising Practices

### A. Disaster Risk Reduction and Management Act Nepal<sup>167</sup>

62. The 2015 earthquake in Nepal showed that the government was not prepared, resulting in peoples' increased suffering and violation 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 included a wide range of issues regarding prevention, protection, and immediate measures to be taken during the situation of natural disaster. It also covers the right to protection and services for women and children. The act include provisions such as additional punishment in case of sexual and gender based violence in times of disaster. Previously the government mechanism to deal with disaster only included 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 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 their committees.
63. 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, emergency obstetric and newborn care, including family planning information and contraceptives. It also states that the denial of reproductive health right services is a crime and orders the implementation of services considering the needs of adolescents and persons with disabilities. It also prohibits discrimination

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

<sup>165</sup> Ibid.

<sup>166</sup> Official Gazette, Philippines. "Report to the Join Congressional Oversight Committee." 2020. <https://www.officialgazette.gov.ph/downloads/2020/05may/20200504-Report-to-the-Joint-Congressional-Oversight-Committee.pdf>.

<sup>167</sup> Sabin Shrestha, Nepal. Consultation FAR and FWLD. 2020.



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, 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 does not get suspended during disaster situations.

## **B. Lady Health Worker program in Pakistan<sup>168</sup>**

64. 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 8000 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 is a good practice because it 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 strengthen other women who receive the information.

## **C. All-Acehnese Women's Congress in Indonesia<sup>169</sup>**

65. Evidence indicates that women play an active role in disaster recovery and reconstruction. The collective will of All-Acehnese Women's Congress brought the women in driver's seat in a traditionally orthodox and male dominated society in Indonesia in 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. Also, 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 out the utmost importance of factoring in such capacities for effective disaster risk reduction.

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<sup>168</sup> IFRC. "Gender Sensitive Approaches for Disaster management." P. 18.

<sup>169</sup> United Nations Office for Disaster Risk Reduction, "Issues of Vulnerability with Specific Reference to Gender in the Asia Pacific Post-2015 framework for disaster risk reduction consultations", 4. [https://www.unisdr.org/files/34051\\_backgroundpaperonissuesofvulnerabil.pdf](https://www.unisdr.org/files/34051_backgroundpaperonissuesofvulnerabil.pdf)

## Recommendations

66. The activists that attended the consultation taking place on January 14<sup>th</sup>, 2020 discussed and agreed on a number of recommendations that states must consider for an effective response to SRHR in contexts of crisis.
- a. To implement human-rights based policies to address women and girl's SRHR in contexts of crisis;
  - b. To develop short-term and long-term plans to aid survivors of crisis situations;
  - c. To increase the number of medical professionals to address the consequences of crisis and ensure they act in a sensitive manner;
  - d. To 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. To ensure SRHR services are accessible, available and inclusive during contexts of crisis;
  - f. To adopt special measures to ensure the services are accessible to women with disabilities, indigenous women, the LGBTQ community, women refugees and other marginalized groups.
  - g. To consider that multiple factors of discrimination can affect a woman and girl at the same time so the state responses should be comprehensive and tailored to these multiple dimensions.
  - h. To increase awareness programs on SRHR services;
  - i. To adopt measures to end stigmatization of women who were raped and criminalization of women who have abortions;
  - j. To ensure women are consulted during the planning and implementation of aid plan and health services;
  - k. To integrate local and regional childbirth practices by ensuring traditional birth attendance 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 the information provided by activists, who are the 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<sup>st</sup> 2020<sup>170</sup> organized by the Feminist Alliance for Rights (FAR) and the Arab Institute for Women (AIW). A separate interview was conducted on September 3, 2020.<sup>171</sup> FAR supplemented their inputs with desk research. While it is not an exhaustive section, it aims to bring examples on how different types of crisis situations have had an impact on women's and girls' SRHR in MENA, followed by promising practices and recommendations.

#### Crisis situations

Over the past years, the Middle East and North Africa (MENA) region has seen consistent shifts in state power, civil wars, regional power struggles, occupation, abuses of government power and 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's 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 gender-based violence, 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 to conflict 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

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<sup>170</sup> 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).

<sup>171</sup> Researcher from Egypt who requested anonymity for security concerns.

pregnancies.”<sup>172</sup> In pre-war Syria, an estimated 13 percent of girls under the age of 18 were married and 12 percent of Syrian refugees in Jordan. By 2013, a reported 25 percent of girls under the age of 18 were married.<sup>173</sup> The traditional understanding of sexual violence as taboo, source of stigma and even 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.<sup>174</sup>

2. **Iraq.** The health status of the Iraqi population has suffered major setbacks due to decades of war and economic sanctions.<sup>175</sup> Corruption, prioritization of other areas like security<sup>176</sup>, 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.<sup>177</sup> Other contributing factors include: a lack of health institutions at their three levels, not commensurate with the increase in population; shortage of diagnostic and therapeutic medical devices; instability for medical staff, which affects good follow-up of the health situation; and the immigration of qualified doctors, due to poor security conditions; poor distribution of medical staff according to the places of need; lack of health awareness in large sectors of society.<sup>178</sup> The health system crisis has direct effects on women’s 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.”<sup>179</sup>
3. **Yemen.** In Yemen, five years of a bloody civil war have resulted with an intractable military and political stalemate between the parties to the conflict and their international sponsors, imposing

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<sup>172</sup> International Federation for Human Rights, “Violence against women in Syria: Breaking the Silence”, Briefing Paper, 606a. (April 2013). P. 8.

<sup>173</sup> “Too Young to Wed: The growing problem of child marriage among Syrian girls in Jordan,” *Save the Children Fund*, (London, 2014).

<sup>174</sup> Alsaba, K. and Kapilashrami, A., “Understanding women’s experience of violence and the political economy of gender in conflict: the case of Syria,” *Reproductive Health Matters*, (May 2016).

<sup>175</sup> Hannah Hamood, Iraq. Consultation with Feminist Alliance for Rights (FAR), Arab Institute for Women (AIW) and Center for Women’s Global Leadership (CWGL), August 2020.

<sup>176</sup> According to an article published by *Reuters*, in 2019, a year of relative peace, the government allocated just 2.5% of the state’s \$106.5 billion budget to its health ministry, a fraction of spending elsewhere in the Middle East. By comparison, security forces received 18% and the oil ministry 13.5%. 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>.

<sup>177</sup> Hannah Hamood, Iraq. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>178</sup> Hannah Hamood, Iraq. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>179</sup> Hannah Hamood, Iraq. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

a heavy death toll and a major humanitarian crisis to the population. The conflict has brought food insecurity and the UNFPA found that approximately one million pregnant women were malnourished in 2018 which resulted in pregnancy loss, complications, and death. If the food security situation worsens, the effects can double impacting two million women.<sup>180</sup> Pregnant women in Yemen have also reported fears about going to the hospital when they are in labor for fear of being caught between Yemeni military and rebel group violence.<sup>181</sup> 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.<sup>182</sup> 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.”<sup>183</sup> 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. **South Sudan.** This country has experienced almost continuous ethnic and political conflict since gaining independence from Sudan in 2011. The ongoing crisis has had devastating impacts on the population through violence, displacement and death. Women and girls have borne the brunt of the consequences of the conflict, especially through gender-based violence. While globally it is estimated that one in three women experience violence during their lifetimes, documented rates of violence in conflict-affected areas of South Sudan are almost double the global average with about two in three women experiencing violence.<sup>184</sup> According to a report, there is a direct relationship between experiences of conflict and its effect on prevalence of violence against women and girls, including intimate partner violence, for women and girls in South Sudan. The same report notes that women and girls experience multiple and compounding forms of interpersonal violence that is exacerbated during times of conflict.<sup>185</sup> Effects of this armed conflict are the restricted access to information, contraception, natal care, and labor environments.

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<sup>180</sup> Kelly Ashton. “Looming famine threatens the lives of 2 million pregnant women and new mothers in Yemen.” UNFPA, 2018.

<sup>181</sup> Ibid.

<sup>182</sup> Lena Masri. “U.N. says women and babies at risk in Yemen as funds crunch forces clinics to shut.” *Reuters*, 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>.

<sup>183</sup> 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>.

<sup>184</sup> Murphy, Maureen, Bingenheimer, Jeffrey B., Ovince, Junior, Ellsberg, Mary, and Contreras-Urbina, Manuel. “The effects of conflict and displacement on violence against adolescent girls in South Sudan: the case of adolescent girls in the Protection of Civilian sites in Juba.” *Sexual and Reproductive Health Matters*, 2019. Doi: <https://doi.org/10.1080/26410397.2019.1601965>.

<sup>185</sup> International Rescue Committee. “No Safe Place: A Lifetime of Violence for Conflict- Affected Women and Girls in South Sudan.” *Report*, 2017.

Limited health services in Sudan have resulted in stillbirths, miscarriages, death during childbirth, and other labor complications.<sup>186</sup>

## B. Impact of the occupation of Palestinian Territories on SRHR

5. Palestinian women and girls' 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 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."<sup>187</sup> Thus, the occupation of Palestine Territories combined with the patriarchy is considered the root of the infringement of human rights of women.
6. 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.<sup>188</sup> 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, furthering restricting their movement in and out of Palestinian Settlements and Israeli Occupied Palestine, particularly in the Gaza Strip. Both the issues of checkpoints 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."<sup>189</sup>
7. During FAR's consultation<sup>190</sup>, activists identified a number of connected obstacles in ensuring women's and girls' SRHR: **i.** 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; **ii.** Palestinian women residing in Jerusalem with an irregular migration status do not have access neither to the Israeli health system nor the health care in Palestine; **iii.** traditionally, Palestinian women are in charge of taking care of the well-being

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<sup>186</sup> Skye Wheeler. "No Control, No Choice': Lack of Access to Reproductive Healthcare in Sudan's Rebel-Held Southern Kordofan." *Human Rights Watch*, 2017.

<sup>187</sup> Randa Siniara, Palestine. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>188</sup> Randa Siniara, Palestine. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>189</sup> Randa Siniara, Palestine. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>190</sup> Randa Siniara, Palestine. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

and health of others in the society at the expense of their own health, well-being and safety. Therefore, they do not seek services related to the reproductive rights even if available. **iv.** domestic violence has increased and there is no legal system in place that could provide protection<sup>191</sup>, **v.** there are a lot of constraints with the personal status laws and criminal laws that are being enforced, which include cases of criminalizing, for example, safe abortions or the right of the woman to control her own life and her own body.

8. The Israeli military occupation and armed conflicts has caused thousands of Palestinians to seek refuge in surrounding countries undergoing their own political conflicts in places like Lebanon and Egypt.

## C. Political Crisis

### Sectarianism in Lebanon

9. **Lebanon.** Sectarianism, the basis of a government that amalgams diverse religious communities with a constitutional and political order, is at the center of other crises in this country. Sectarianism also “plays a pivotal role in oppressing women and discriminating women and girls keeping them as second class citizens where they cannot take decisions regarding divorce, inheritance also their own body autonomy.”<sup>192</sup> 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.<sup>193</sup>
10. Gender stereotypes are at the center of religious, social and legal norms in Lebanon. Thus, women’s and girls’ SRHR, are provided through maternal health services and are directly linked to expectation 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.”<sup>194</sup>

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<sup>191</sup> 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 Siniara, Palestine. Consultation with FAR. 2020.

<sup>192</sup> Paola Daher, Lebanon. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

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

<sup>194</sup> Paola Daher, Lebanon. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

11. 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."<sup>195</sup>
12. While the Lebanese government has laws in place to end gender-based violence, including protections for survivors and shelters,<sup>196</sup> the enactment of said laws is limited and/or has written a more subversive form of discrimination against women into it.<sup>197</sup> By doing so, "the laws meant to protect women from 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."<sup>198</sup>
13. 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 the PEP services, should be free of charge for any women on the 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 to be able to obtain only the report and this is without even talking about other services needed under that package".<sup>199</sup> 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."<sup>200</sup>
14. 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.<sup>201</sup>

### Effects of Arab Spring

15. 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 we have seen that women's human rights have been impacted in very unique ways.
16. The Tunisian Revolution, also called the Jasmine Revolution, started a 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

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<sup>195</sup> Ibid.

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

<sup>197</sup> Ibid.

<sup>198</sup> Guida Anani, Lebanon. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>199</sup> Guida Anani, Lebanon. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>200</sup> Roula Seghaier, Lebanon. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>201</sup> Paola Daher, Lebanon. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.



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.<sup>202</sup> 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 and reproductive health services are not available [the same way they were] before. It began before the revolution and continued decreasing until these days."<sup>203</sup>

17. 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.<sup>204</sup> 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's and girls' access to rights.
18. 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, we learned through consultation with activists that publicized data for these issues is still sparse.<sup>205</sup> 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.<sup>206</sup> In some cases, individuals' sexual history and sexuality is used to discredit allegations of sexual violence.<sup>207</sup> Consequently, victims of sexual violence are discouraged from reporting the violence they experience and their limited access to SRH services.

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<sup>202</sup> 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>.

<sup>203</sup> Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

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

<sup>205</sup> Researcher from Egypt. Interviewed by FAR and CWGL. *Zoom*, August 2020.

<sup>206</sup> Ibid.

<sup>207</sup> 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.

## D. Forced displacement

### Palestine women refugees in Lebanon

19. 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. Gender-based discrimination and violence disproportionately affects women and girls in these contexts and have a particularly negative effect on SRHR.
20. 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 refugees face in Lebanon.<sup>208</sup> Her account illustrates the experiences female refugees experienced 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 payed 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

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<sup>208</sup> Women Deliver. Palestinian Women’s Humanitarian Organization.  
<https://womendeliver.org/humanitarianadvocates/>.

sexual and reproductive health care. My message is to take into consideration refugees and highlight their situation.”<sup>209</sup>

### **Iraqi internally displaced women**

21. 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 International Organization of Migration. They 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 one of family member is suspected of belonging to ISIS, have been subjected to assault, sexual abuse, rape, exploitation, and sexual harassment in displacement camps, as well as bargaining them in exchange for foods and basic needs.<sup>210</sup>
22. 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.<sup>211</sup>
23. 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.<sup>212</sup>

### **E. Other concerning trends and systems**

#### **Unwanted pregnancy and abortion**

24. The actual health impact of unsafe abortion in the Arab region is not well known due to lack of data. Access to abortion is limited due to criminalization and government and cultural restrictions.
25. All countries in the MENA region, except Tunisia, explicitly criminalize abortion.<sup>213</sup> 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

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<sup>209</sup> Olfat Mahmoud, Palestine. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>210</sup> Hannah Hamood, Iraq. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>211</sup> United Nations Economic and Social Commission for Western Africa. “Shelters for Women Survivors of Violence.” 2020.

<sup>212</sup> Fatima Outaleb and researcher from Egypt. Consultation and interview respectively, organized by FAR and CWGL. *Zoom*, August 2020.

<sup>213</sup> 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>.

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

26. 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.<sup>215</sup> There is a trend in the region that shows the growing role that social class, marital status, income, age, and education plays. These factors may shape the possibility of accessing abortion care or determine the type of facility women can go to -where abortion is legal- and, consequently, the kinds of experience they have.<sup>216</sup>
27. 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.<sup>217</sup> An activist in Tunisia highlighted that "contraception and abortion [have been] legal since the 60's: contraception was available since [1960] and limited abortion since 1965. It was possible if 5 a woman had children. 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 situation of 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."<sup>218</sup>
28. 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.<sup>219</sup> 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 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 to access the service have money and can pay so this creates inequalities in society. That restrictions plus the privatized nature of the health system really creates and deepens socio-economic

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<sup>214</sup> 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/>.

<sup>215</sup> Ibid.

<sup>216</sup> Activist Egypt. Interview with FAR and CWGL. September 2020.

<sup>217</sup> Ahlem Belhadj and researcher from Egypt. Consultation and interview organized by FAR and CWGL. *Zoom*, August 2020.

<sup>218</sup> Ahlem Belhadj, Tunisia. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>219</sup> Irene Maffi and Liv Tonnessen. "Editorial: The Limits of the Law." *Health and Human Rights Journal*, 2019.

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

29. 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.”<sup>221</sup> Accessing abortion in other places is extremely difficult under occupation given the lack of freedom to travel.
30. 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.”<sup>222</sup> In most countries, post-abortion care is inadequate.<sup>223</sup>

### **Lack of access to contraception**

31. 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.<sup>224</sup> Full access to contraception for women and girls with disabilities is limited.
32. 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 (3) or more children<sup>225</sup> and considers the rising birth rate to be a “national security threat.”<sup>226</sup> Concerns around this policy are about who has access to family planning and health services. This includes the criminalization of abortion, which despite its practice, it would allow them to follow this policy, especially with low-income individuals who are in the most need of government financial assistance. 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.<sup>227</sup>
33. 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 people and

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<sup>220</sup> Paola Daher, Lebanon. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>221</sup> Randa Siniara, Palestine. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>222</sup> A. Behar. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>223</sup> Jocelyn DeJong and Hyam Bashour. “Regional Report.” *UNFPA*, 2016.

<sup>224</sup> *Ibid.*

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

<sup>226</sup> Researcher from Egypt. Interview with FAR. 2020.

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

unmarried women are forced to seek either unsafe SRH alternatives or attend a privatized pharmacy/hospital which are significantly more expensive and limits who has access to these services.<sup>228</sup> 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.<sup>229</sup> Family planning remains very controversial in South Arabia, though some contraceptives can be purchased directly from pharmacies.<sup>230</sup>

34. Outside of labor laws, refugee and undocumented women and girls face further restrictions to access SRH care and family planning programs, due to their lack of citizenship and are, therefore, unable to benefit from public social services.<sup>231</sup>

### Discriminatory systems and their impact on SRHR

35. **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.<sup>232</sup> 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, including pregnancy complications, cancer, and HIV.<sup>233</sup>
36. 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.<sup>234</sup>

<sup>228</sup> Researcher from Egypt. Interview with FAR. 2020.

<sup>229</sup> 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>.

<sup>230</sup> "Regional Report: Sexual and Reproductive Health Laws and Policies in Selected Arab Countries," *UNFPA*, (July 2016).

<sup>231</sup> Roula Seghaier, Lebanon. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

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

<sup>233</sup> Musawah. "Thematic Report on Muslim Family Law and Muslim Women's Rights in Saudi Arabia." *CEDAW*, Geneva, 2018.

<sup>234</sup> Musawah. "Saudi Arabia: Overview of Muslim Family Laws and Practices." 2018.

37. **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. 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 Lebanese citizens and other refugees in efforts to solely exploit them as employees.<sup>235</sup>
38. An expert who participated in FAR’s consultation explained that in Lebanon, women workers under this system face increased risks to 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.”<sup>236</sup>

## F. COVID-19 Impacts on SRHR

39. The COVID-19 pandemic entirely changed the world and will have lasting effects on women’s 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, and its more specific impact is connected to people’s identities and conditions. When referring to the differentiated impact of COVID-19, an activist highlighted, “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.”<sup>237</sup>
40. Activists participating in FAR’s consultation identified the following challenges to women’s and girl’s 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 the difficult situation they were in even more difficult. Women are expected to take care of the 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 the donor dynamics and how donors dictate the agenda, regardless of the priorities that feminist movement wants to

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<sup>235</sup> Roula Seghaier, Lebanon. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>236</sup> Roula Seghaier, Lebanon. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>237</sup> Fatima Outaleb, Morocco. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

highlight. That creates a division between different organizations that forms the feminist fabric.

- 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 the COVID-19 lockdown orders. The 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.”<sup>238</sup>
- e. **Restriction of mobility.** Women and girls have limited mobility for seeking medical emergencies and anxieties surrounding the unknown effects of COVID-19, which has resulted in medical malpractice, especially for those who are pregnant or with HIV (who are already at higher risk for COVID-19 complications). Women’s access to contraceptive decreases as women fear contagion.
- f. **Lack of plan/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.”<sup>239</sup> 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.”<sup>240</sup>
- 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, altering the ways in which accurate information regarding COVID-19’s effects on sexual health affect people differently. In Egypt, “any information that is shared by the state government is solely

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<sup>238</sup> Fatima Outaleb, Morocco. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>239</sup> Guida Anani, Lebanon. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>240</sup> Fatima Outaleb, Morocco. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.



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

- h. **Compound women refugee situation.** 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.<sup>242</sup> 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.<sup>243</sup>
- i. **COVID-19’s worsening impact on other crisis situations.** Hospitals and clinics across countries 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 being overwhelmed with patients and some hospitals even being shut down, like in Morocco<sup>244</sup>, issues that oftentimes fall by the wayside are SRHR. Moroccan women have reported having to give birth at home without access to proper pre- and post-natal care.<sup>245</sup> Egyptians with HIV face discrimination and physical assault at public hospitals, which, until very recently, was the only place to get antiretroviral medications.<sup>246</sup> 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 in by the government to ensure a safe environment.<sup>247</sup>
- 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 show in the above points, this excessively impacts the safety and health care access of women, girls, and

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<sup>241</sup> Researcher from Egypt. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>242</sup> Olfat Mahmoud, Palestine. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>243</sup> Randa Siniara, Palestine. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>244</sup> Fatima Outaleb, Morocco. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>245</sup> Fatima Outaleb, Morocco. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>246</sup> Researcher from Egypt. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>247</sup> Researcher from Egypt. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

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 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.”<sup>248</sup>

- k. **Access to contraceptives.** Governments, like 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.<sup>249</sup> 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.<sup>250</sup>
- l. **Money gouging and medical malpractice related to birth.** In some countries, money gouging and medical malpractice related to birth has seen an increase as well. Despite multiple medical resources, including the World Health Organization, 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 the COVID-19 lockdowns, prisoners have been cut off from their families/visitors. Many of these 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.<sup>251</sup> For those who cannot afford to purchase menstrual necessities, they are often forced to find unhealthy and unsafe alternatives to address their needs, including 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

<sup>248</sup> Fatima Outaleb, Morocco. Consultation organized by FAR, AIW, CWGL. *Zoom*, August 2020.

<sup>249</sup> Researcher from Egypt. Consultation with FAR. 2020.

<sup>250</sup> Researcher from Egypt. Consultation with FAR. 2020.

<sup>251</sup> Egyptian Initiative for Personal Rights. “‘Periods in Prison’ a campaign calls on the prison authorities to provide cotton-based sanitary pads to female prisoners free of charge.” *Press Release*, 2019. <https://eipr.org/en/press/2019/03/international-womens-day-periods-prison>.

violence assistance, which is worsened by lockdown protocols that restrict travel to urban areas that can provide those resources. The situation of migrant women have worsened with the pandemic, and they are left at the mercy of the 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”, high risks of death among them. And the LGBT community is not part of the spectrum at all.”<sup>252</sup>

## Promising Practices

### A. Bourj el Barajnh Palestinian and Syrian refugee camp in Lebanon

41. 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 clinic, psychosocial support and counselling, peer support groups, informal discussion groups, trips, literacy training, English training, self-relaxation, and well-being awareness raising sessions, and raising awareness about how to deal with children and adolescences.<sup>253</sup> The project both directly and indirectly impacted 798 women and girls and 112 men and boys.<sup>254</sup>
42. 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 their 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.<sup>255</sup>

### B. Campaign #LockdownNotLockup in Lebanon

43. The Lebanese organization Abaad launched the campaign #LockdownNotLockup that spreads awareness through the helpline number that is dedicated to women enduring violence at home during the lockdown. The goal is that the GBV survivor can learn about the existence of services and their ability 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 on that day. It also conveyed the message that women are not alone and there is someone who can help. The campaign was also disseminated through social media. In collaboration with community

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<sup>252</sup> Fatima Outaleb, Morocco. Consultation with FAR. 2020..

<sup>253</sup> Women’s Humanitarian Organisation. “Kvinna Till Kvinna Narrative Annual Report.” Unpublished report, 2020.

<sup>254</sup> Ibid.

<sup>255</sup> Ibid.

centers and municipalities, Abaad reached women and girls who might face domestic violence including sexual violence and incest by taking food from door-to-door. They also embedded messages 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 initiatives facilitates women and girls receive essential information regarding their rights and a helpline number to seek help without increased risks of retaliation.<sup>256</sup>

### **C. Reinsertion of women victims of sexual violence in Yazidi communities**

44. 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 the Yazidi society, when a woman is raped the community or the family can kill her, blaming the victim for what happened as she is considered to having committed a mistake. In 2014, two women ran away from Isis. Emma Organization engaged in advocacy actions with the Yazidi community, religious leaders, and the government and was able to convince them it was not their mistake. In 2015, the Committee of Yazidi approved a statement to accept all the women and girls that 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 rthem.<sup>257</sup>
45. As a result of sexual violence by ISIS, some women get pregnant. Emma Organization established a shelter for women and their children and have conducted advocacy for reparations. There is currently a bill before the Iraqi congress. This is another promising practice in the region implemented by an organization.

### **Key messages to States**

46. During FAR's consultation participants came up with specific messages that the Working Group could consider to include within its thematic report:
  - a. Governments are not taking seriously our SRHR and they are leaving women to fight this battle alone, disregarding their international obligations. SRHR are human rights and we should not accept 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 LGBT movement and other social movements – must work together to protect these rights.
  - d. Regarding Palestine, it has to be acknowledged that occupation maintain a system of laws, policies and measures that affect women's SRHR – “unless occupation ends, women's and girls' sexual and reproductive health and rights cannot be guaranteed.”

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<sup>256</sup> Guida Anani, Lebanon. Consultation with FAR. 2020.

<sup>257</sup> Ali, Bahar, Iraq. Consultation with FAR. 2020.

## Recommendations

47. Participants in FAR's consultation discussed and outlined the following priority recommendations for States in MENA:
- a. To make gender equality a priority and allocate budgets for plans and policies that address SRHR and GBV;
  - b. To be more proactive in adopting legislation to eliminate discrimination against women, including sexual violence against women;
  - c. To increase and provide women and LGBTQ+ affirmative medical practitioners, counselors, and social workers to address gender-based and sexual violence; to increase social services that provide safe and affirming spaces for women and LGBTQ+ people;
  - d. To standardize high quality public health resources (including hospitals, pharmacies, and clinics), centering the issues of maternity and HIV;
  - e. To ensure safe abortion are guaranteed in the region, especially for victims of sexual violence;
  - f. To adopt measures to protect domestic workers, refugee women, and statelessness people who are in a very vulnerable situation;
  - g. On the issue of budgeting: to ensure not only access to health services, but specifically to prioritize SRHR in situations of crisis;
  - h. To use an intersectional approach when developing and implementing policies;
  - i. To ensure quality education on SRHR and ensure the curricula includes it;
  - j. To provide economic welfare, legal protections, and SRHR resources for refugees, day laborers, and undocumented people;
  - k. To fund grassroots local organizations providing SRHR health care.

## IV. América Latina y el Caribe

Este capítulo<sup>258</sup> se basa en la información proporcionada por activistas expertas en el campo de la salud y los derechos sexuales y reproductivos en América Latina y el Caribe, las cuales participaron en una consulta en línea el pasado 24 de julio pasado organizada por la Alianza Feminista por los Derechos (FAR), el Centro de Liderazgo Global de las Mujeres (CWGL) y el Instituto de Educación de los Derechos Humanos de las Mujeres (WHRI).<sup>259</sup> FAR llevó a cabo una segunda consulta el 6 de agosto, complementaria a la primera consulta, en donde participó el mismo grupo de activistas. Asimismo, realizó una investigación de fuentes secundarias para complementar estos aportes y recibió información adicional por parte de algunas activistas vía correo electrónico.

### Contextos de Crisis

Prácticamente todos los países de América Latina y el Caribe cuentan con alguna ley o política pública para proteger o sancionar la discriminación y la violencia contra las mujeres basada en género<sup>260</sup> lo cual coloca a la región en la vanguardia en el reconocimiento de este problema. Sin embargo las leyes no brindan el marco de protección debido para asegurar que las mujeres y niñas tendrán acceso a servicios esenciales de salud sexual y reproductivos especialmente en contextos de crisis en donde la violencia y la discriminación basadas en género se exacerba. Como se ilustra a través de los siguientes ejemplos, la discriminación y VBG es una constante en la vida las mujeres que se exacerba durante las situaciones de crisis.

#### A. Violencia endémica

1. **Centroamérica.** Durante los años setenta y ochentas se suscitaron en centroamérica guerras civiles que dieron pie a cientos de ejecuciones y detenciones extrajudiciales, desapariciones, masacres,

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<sup>258</sup> Este capítulo se enfoca principalmente en América Latina y el Caribe hispano-parlante.

<sup>259</sup> Soledad Deza, Presidenta de la Fundación Mujeres x Mujeres (Argentina), Paula Estenssoro, responsable de incidencia política de Católicas por el Derecho a Decidir (Bolivia), Beatriz Galli, Directora de CEJIL Brasil (Brasil) Camila Maturana, abogada de Humanas (Chile), Cristina Rosero, Asesora legal del Centro de Derechos Sexuales y Reproductivos, Rocío Rosero, integrante de la Coalición Nacional de Mujeres del Ecuador (Ecuador) Karen Molina, Directora de INCIDEJOVEN (Guatemala), Sara García, Coordinadora de Incidencia Política de la Agrupación Ciudadana por la Despenalización del Aborto (El Salvador), Norma Carías, integrante de Somos Muchas (Honduras), Oriana López Uribe, Directora de Balance México (México), Mayte Ochoa, Consultora Regional para IPAS Centroamérica y México (Nicaragua), Rossina Guerrero, Directora de Programas de Promsex (Perú), Lourdes Inoa Monegro, Gerente de Programas Mujer y Salud de Taller Salud (Puerto Rico), Cinthya Amanecer, Directora de Conexión Intercultural por el Bienestar y la Autonomía - La Ceiba, (República Dominicana), Estefanía Mendoza, Coordinadora de Planes, Proyectos y Planificación de Mullier (Venezuela), Marcia Aguiluz, abogada de la Dirección Legal de Women's Link Worldwide (Regional), Lisette Alas, Co-coordinadora de La Sombrilla Centroamericana (Regional).

<sup>260</sup> Mecanismo de Seguimiento de la Convención de Belém do Pará (MESECVI), "Tercer Informe Hemisférico sobre la Implementación de la Convención de Belém do Pará", OEA (2017). Págs. 36-58. Disponible en línea en: <http://www.oas.org/es/mesecvi/docs/TercerInformeHemisferico.pdf>.

tortura . En el caso de las mujeres, se suman la violación, esclavitud y la esclavitud sexual, el aborto forzado. Especialmente en Guatemala, las mujeres indígenas fueron receptoras principales de la violencia. Estos crímenes fueron perpetrados tanto por fuerzas del Estado como por grupos paramilitares y guerrilleros. La violencia generada en esta época afectó el tejido social con serias consecuencias en la época actual.<sup>261</sup>

2. Hoy en día, a los muy altos índices de violencia inter-personal y sexual contra las mujeres centroamericanas se suma la violencia ejercida por los grupos pandilleros quienes ejercen control sobre el territorio y son fuente principal distintas formas de violencia incluido homicidio, la extorsión y el reclutamiento forzado. Mujeres y niñas están amenazadas constantemente y han sido víctimas de violencia de género como la violación, violación en grupo en el caso de las pandilleras, así como las relaciones sexuales forzadas con líderes pandilleros.<sup>262</sup> Como resultado, Guatemala, El Salvador y Honduras se ubican entre los cinco países a nivel mundial con las mayores tasas de feminicidio.<sup>263</sup>
3. **México.** Otro de los principales escenarios de crisis para las mujeres en la región de Mesoamérica es México en donde mujeres y niñas están altamente expuestas a la violencia en el hogar, violencia inter-personal y violencia en la vía pública. En 2006 se lanzó una estrategia basada en la militarización de la seguridad pública para combatir a los cárteles del crimen organizado, la cual ha tenido efectos perniciosos en la población. En el caso de las mujeres, se ha documentando como en el contexto de crisis generado por “la guerra contra el narcotráfico” distintas fuerzas de seguridad han perpetrado tortura sexual contra mujeres bajo custodia de forma regular.<sup>264</sup> Por otro lado, el estudio *Las dos guerras: el impacto de los enfrentamientos de las fuerzas armadas en los asesinatos de mujeres en México (2007-2018)*, recientemente publicado concluye que la estrategia de la “guerra contra las drogas”, influyó en el incremento de homicidios contra las mujeres en el corto plazo en los lugares en donde hubo enfrentamientos entre militares y organizaciones del crimen organizado.<sup>265</sup> Cabe señalar que dichos homicidios fueron cometidos tanto en el hogar como en el espacio público.

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<sup>261</sup> “El hecho de que una buena parte de la población presencié, experimenté o participé en esas atrocidades ha generado un trauma psicosocial generalizado” Oficina de las Naciones Unidas contra las Drogas y el Crimen, “Crimen y Desarrollo en Centroamérica”, ONU (2007). Pág. 14. Disponible en línea en: <https://www.unodc.org/documents/data-and-analysis/Central-america-study-es.pdf>.

<sup>262</sup> “El salario del miedo: maras, violencia y extorsión en Centroamérica”, Informe sobre América Latina de Crisis Group N°62, 6 de abril de 2017. p. 19.

<sup>263</sup> Geneva Declaration, “Global Burdens of Armed Violence”, Cambridge University Press, 2015), p. 92.

<sup>264</sup> Centro Prodh Miguel Agustín Juárez, “Mujeres con la frente en alto, Informe sobre la tortura sexual en México y la respuesta del Estado”, Centro Prodh (2018), Pág. 15.

<sup>265</sup> El mismo estudio documenta que la mayoría de los homicidios eran registrados dentro de casas y a partir del 2009, las muertes en el espacio público “rebasaron los cometidos en la vivienda”. Además, los asesinatos de mujeres con armas de fuego incrementaron de manera exponencial después del año 2007. Más aún: los enfrentamientos están asociados a un incremento de los homicidios de mujeres cometidos tanto en la casa, como en la calle, con arma de fuego y sin arma de fuego. Laura H. Tuesta y 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). Pág. 11-15. Disponible en línea en: <http://www.intersecta.org/lasdosguerras/>.

4. La violencia y discriminación basada en género de las mujeres y niñas en Mesoamérica es exacerbada en el contexto de violencia endémica. A ello se suma la debilidad de las estructuras de justicia en la región. Como lo resume una activista, “En la región existen altos índices de corrupción que tiene un impacto en la protección de los derechos de las mujeres, y de los derechos sexuales y reproductivos. No existe un estado de derecho, las instituciones de justicia son débiles lo cual deja desprotegida a las mujeres que enfrentan cada vez más violencia”.<sup>266</sup>
5. Como se analizará más adelante, la restrictiva normativa en materia de aborto en la mayoría de los países de Mesoamérica<sup>267</sup> - el cual incluso está totalmente prohibido en El Salvador, Honduras y Nicaragua- es gravísima tomando en cuenta la incapacidad del estado de proteger a las mujeres. La situación es especialmente grave para aquellas mujeres que pertenecen a los sectores más marginados incluyendo las adolescentes, las trabajadoras informales, las mujeres indígenas y las migrantes.
6. La violencia inter-personal y la violencia endémica ha desplazado forzosamente en los últimos años a miles de mujeres de todas las edades quienes buscan protección como refugiadas en Estados Unidos y México, como desplazadas internas dentro de su propio país. La situación de irregularidad en el país de tránsito o de destino expone a las mujeres a abusos y múltiples formas de violencia sexual. Al mismo tiempo, limita su acceso a servicios de salud sexual y reproductiva ya sea por desconocimiento de la ley, por temor a ser detenida y deportada a su país de origen, por temor a ser revictimizadas.

## B. Conflicto armado

7. **Colombia.** El conflicto armado en Colombia que comenzó en 1960 y -aunque con una menor intensidad- se extiende hasta la actualidad, ha involucrado a “actores armados ilegales y legales que han ejercido diversas modalidades de violencias sexuales y reproductivas sobre niñas, adolescentes, mujeres y personas LGBTI como una práctica ‘habitual, extendida, sistemática e invisible’”.<sup>268</sup> Dicha violencia tuvo un impacto desproporcionado en las mujeres rurales, afrocolombianas e indígenas la cual agravó la discriminación, las desigualdades y la pobreza imperantes que sufren históricamente estos grupos de mujeres”.<sup>269</sup> Cabe señalar que la violencia ocurrida en el contexto de la guerra “no hace sino continuar, recrudesciendo y amplificando la violencia que está presente en las vidas de las mujeres colombianas al margen del conflicto armado”.<sup>270</sup>

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<sup>266</sup> Margarita Guillé, Consulta organizada por FAR y FWLD. Enero, 2020.

<sup>267</sup> Con la excepción de dos estados mexicanos: Ciudad de México y Oaxaca.

<sup>268</sup> Centro de Derechos Reproductivos, Violencia Reproductiva en el Conflicto Armado colombiano, (2020). Pág. 3.

<sup>269</sup> Corporación Humanas, “Situación de las mujeres afrocolombianas e indígenas. Colombia 2011-2014” (2015) Pág. 52-54.

<sup>270</sup> Comisión de Verdad y Memoria de Mujeres Colombianas, “La verdad de las mujeres víctimas del conflicto armado en Colombia”, Ruta Pacífica de Mujeres (Noviembre 2013). Pág. 32. Disponible en línea en: <https://www.rutapacifica.org.co/descargue-los-libros/79-tomo-i-tomo-ii-y-resumen-ejecutivo>.



8. A pesar de que existen importantes reconocimientos respecto a la violencia basada en género en el contexto de conflicto incluyendo el aborto, la esterilización, la anticoncepción y los embarazos forzados, estos delitos “siguen siendo poco documentados o vistos como impactos derivados de la violencia sexual, sin que se analice con la profundidad suficiente la incidencia que han tenido, sus propios impactos físicos, mentales y sociales así como sus consecuencias frente al proyecto de vida de sus víctimas.”<sup>271</sup> El Centro de Derechos Reproductivos realizó una investigación que evidencia que la violencia reproductiva en el contexto de conflicto responde a un contexto estructural de discriminación de género que afectó a mujeres, niñas y personas LGBTI y fue perpetrada por todos los actores del conflicto, contra combatientes y civiles.<sup>272</sup>
9. En Colombia -como parte del Acuerdo de Paz firmado por el gobierno colombiano con las Fuerzas Armadas Revolucionarias de Colombia- se prometió implementar medidas para garantizar la seguridad humana de las defensoras de derechos humanos, incluidas las lideresas sociales. Sin embargo esta parte del acuerdo no se ha implementado adecuadamente. Sólo entre marzo de 2018 y mayo de 2019 se notificaron 482 ataques fueron contra mujeres defensoras de derechos humanos y 19 mujeres lideresas fueron asesinadas el año pasado.<sup>273</sup>

### C. Crisis política

10. **Bolivia.** Éste es uno de los países de Sudamérica que tiene los más altos índices de embarazos adolescentes y mortalidad materna en la región<sup>274</sup> lo cual en sí genera una crisis para miles de adolescentes cada año. Esta realidad no solo se trata de un problema de falta de información, educación sexual para adolescentes, o de poco acceso a métodos anticonceptivos, si no la violencia basada en género contra las mujeres que se ejerce de manera estructural y que afecta con mayor intensidad a las niñas y adolescentes indígenas. Esta situación se agrava actualmente en un contexto de crisis del orden político, social e institucional que impacta la situación de los

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Continúa: “Esta violencia en todos los ámbitos y a lo largo de sus vidas tiene que ver con el acoso, el abuso, el maltrato y la violación presente en las relaciones de convivencia en el hogar, en el trabajo, en el pueblo o comunidad”.

<sup>271</sup> Cristina Rosero, Colombia. Consulta organizada por la Alianza Feminista por los Derechos (FAR), Instituto de Educación de los Derechos Humanos de las Mujeres (WHRI) y Centro de Liderazgo Global de las Mujeres (CWGL), 24 de julio de 2020.

<sup>272</sup> Cristina, Colombia. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>273</sup> *Ibíd.* “En Colombia, la situación de las defensoras y defensores de derechos humanos es crítica, especialmente en medio de un panorama de aumento de riesgo, en donde la pandemia ha dificultado la respuesta institucional directa. Por tal razón, es necesario que se tomen medidas inmediatas para proteger a las lideresas sociales con un enfoque de género”.

<sup>274</sup> Fondo de Población de las Naciones Unidas (UNFPA), “Estudio sobre el embarazo en la adolescencia en 14 municipios de Bolivia”, ONU (2016). Pág. 4. Disponible en línea en: [https://bolivia.unfpa.org/sites/default/files/pub-pdf/Cartilla\\_Embarazo\\_Adolescencia\\_14\\_mun.pdf](https://bolivia.unfpa.org/sites/default/files/pub-pdf/Cartilla_Embarazo_Adolescencia_14_mun.pdf); Arthur Erken, “Estado de la Población Mundial”, UNFPA (2019). Pág. 153. Disponible en línea en: [https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA\\_PUB\\_2019\\_ES\\_Estado\\_de\\_la\\_Poblacion\\_Mundial.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2019_ES_Estado_de_la_Poblacion_Mundial.pdf)

derechos sexuales y reproductivos.<sup>275</sup> La crisis actual ha derivado en la falta de voluntad política para efectivizar las políticas públicas ya existentes y los mandatos garantistas que se tiene en materia de salud sexual y reproductiva.<sup>276</sup>

11. **Nicaragua.** Este país tiene una de las tasas más elevadas de fecundidad en adolescentes en América Central.<sup>277</sup> La situación es especialmente grave en un país en donde, de acuerdo con una encuesta realizada por el Ministerio de la Familia de Nicaragua, el 50% de los embarazos en niñas y adolescentes es producto de violencia sexual<sup>278</sup> y en donde el acceso al aborto está criminalizado en todos los casos. Esta situación se da en el contexto de una crisis política y social que comenzó en abril del 2018 y que se caracteriza por violaciones graves a los derechos humanos, a la libertad de expresión y de prensa agravado por la ausencia de un sistema normativo que garantice elecciones libres, justas, transparentes y legítimas, situación que ha conducido a la alteración del orden constitucional y democrático del país.<sup>279</sup> En este contexto, “la persecución hacia defensoras de derechos humanos alcanzó niveles alarmantes. Las acciones emprendidas por el Estado bajo la política de persecución incluyeron ataques, tales como intimidación, acoso psicológico, campañas de difamación, detención ilegal, tortura y malos tratos e incluso violencia sexual.”<sup>280</sup>
12. **Venezuela.** Desde el año 2016 Venezuela se encuentra en medio de una grave crisis humanitaria causada por una inestabilidad política desde el año 2016. Esta realidad compromete severamente la garantía de los derechos humanos de toda la población y esto se evidencia por el proceso de movilidad humana que revela la situación en Venezuela, ya que genera un impacto económico, social y político en toda la región. Uno de los efectos de la crisis política y financiera del país es el colapso del sistema de salud público.<sup>281</sup> Sin embargo, “esta emergencia humanitaria tiene un impacto diferenciado en las mujeres y niñas, esto se traduce en graves violaciones a sus derechos a la salud sexual y reproductiva, al derecho a vivir una vida libre de violencia, al derecho de las mujeres a no morir por causas relacionadas a su embarazo, tener autonomía reproductiva y el derecho a la alimentación, entre otros”.<sup>282</sup> El colapso del sistema de salud ha resultado en la escasez de métodos anticonceptivos y planificación familiar, el aumento de la mortalidad materna, los embarazos en adolescente, las infecciones de transmisión sexual, incluyendo el VIH y el incremento de abortos inseguros y embarazos no deseados.<sup>283</sup>

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<sup>275</sup> Paula Estenssoro, Bolivia. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>276</sup> *Ibíd.* En Bolivia “se han dado cuatro cambios de ministros de salud de noviembre de 2019 pero hasta la fecha este rector no ha dado ningún lineamiento o atención en el ámbito de la salud sexual y reproductiva”.

<sup>277</sup> UNFPA, “Acelerar el progreso hacia la reducción del embarazo en la adolescencia en América Latina y el Caribe”, (2016). Pág. 24. Disponible en línea en: [https://lac.unfpa.org/sites/default/files/pub-pdf/ESP-EMBARAZO-ADOLESC-14febrero%20FINAL\\_5.PDF](https://lac.unfpa.org/sites/default/files/pub-pdf/ESP-EMBARAZO-ADOLESC-14febrero%20FINAL_5.PDF). Pág. 22.

<sup>278</sup> El nuevo herald, Nicaragua debe atender el embarazo precoz y la violencia sexual, según Unicef, (29 de marzo de 2019), Disponible en línea en: <https://www.elnuevoherald.com/noticias/mundo/america-latina/article228618049.html>

<sup>279</sup> Mayte Ochoa, Nicaragua. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>280</sup> Mayte Ochoa, Nicaragua. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>281</sup> Estefanía Mendoza, Venezuela. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>282</sup> Estefanía Mendoza, Venezuela. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>283</sup> Estefanía Mendoza, Venezuela. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

13. El acceso a servicios y bienes básicos es aún más limitado para mujeres que pertenecen a sectores en condiciones de vulnerabilidad, por ejemplo las mujeres refugiadas y sobre todo las migrantes cuando tienen una situación migratoria irregular. Por otro lado, las mujeres que se encuentran recluidas en instituciones en donde no existe monitoreo externo enfrentan un alto riesgo a la violencia sexual y a la falta de atención salud y reproductiva. La Misión de Determinación de Hechos sobre Venezuela constató que en centros de reclusión donde permanecen mujeres detenidas por razones políticas no cuentan con suficiente provisión de agua potable ni tienen acceso a productos de higiene menstrual.<sup>284</sup> Asimismo, la Misión reportó que funcionarios del Sebin (Servicio Bolivariano de Inteligencia Nacional) están involucrados en situaciones de violencia sexual contra mujeres detenidas.<sup>285</sup>

#### D. Desastres Naturales

14. Los desastres naturales que afectan a América Latina y el Caribe como erupciones volcánicas, terremotos, inundaciones y deslizamientos de tierra causados por lluvias persistentes, tormentas tropicales, huracanes, incendios forestales y sequías están en aumento y generan impactos diferenciados en las mujeres debido a que se relacionan directamente con los roles, las responsabilidades, oportunidades y dificultades de género preexistentes al desastre.<sup>286</sup>
15. Las mujeres, particularmente las mujeres jóvenes y adolescentes, son especialmente vulnerables frente a las diversas manifestaciones de la violencia que se ejerce en contra de ellas en periodos de emergencia humanitaria. La violencia sexual, el acoso, la explotación y abuso sexual, el tráfico de personas o incluso el femicidio son algunas de las formas que presenta la violencia de género en contra de las mujeres en tiempos de crisis.<sup>287</sup>
16. **Puerto Rico.** Luego del paso del Huracán María activistas documentaron una crisis de violencia basada en género a consecuencia del huracán debido a que ésta no fue prioridad en la planificación de la respuesta durante la emergencia, ni durante la etapa de recuperación. Al respecto, una activista señalaba, “ni el gobierno estatal ni el federal cuentan con protocolos para el manejo de casos de acoso, agresión sexual o violencia doméstica en los centros de refugiados. Lo anterior tuvo el efecto de que no se realizaron escrutinios sobre ofensores sexuales en la admisión a los refugios del Gobierno, aún cuando las agencias estatales tienen una lista oficial que identifica a estas personas.”<sup>288</sup>

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<sup>284</sup> Conclusiones detalladas de la Misión internacional independiente de determinación de los hechos sobre la República Bolivariana de Venezuela, A/HRC/45/CRP.11 (15 de septiembre de 2020), párrs. 302, 946, 1924 y 1925.

<sup>285</sup> *Ibidem*, párrs. 303 y 1926.

<sup>286</sup> Fondo de Población de Naciones Unidas (UNFPA), “Violencia de Género y los Desastres Naturales en América Latina y el Caribe”, ONU (enero 2012). Págs. 17-20. Disponible en línea en: <https://lac.unfpa.org/es/publicaciones/violencia-de-g%C3%A9nero-y-los-desastres-naturales-en-am%C3%A9rica-latina-y-el-caribe>.

<sup>287</sup> *Ibid.*

<sup>288</sup> Francisca Vigaud-Walsh, “Sobrevivientes del Huracán María: ‘La Seguridad de las Mujeres No Fue Prioridad’ ”, Refugees International, 2018. Pág. 5.

17. La percepción de las activistas es que los albergues de violencia doméstica no fueron priorizados ni se adaptaron protocolos para atender la violencia basada en género de casos en curso de violencia.<sup>289</sup> Además, “los planes de preparación y mitigación de riesgos ante emergencias de salud y/o ambientales no están atemperados a las necesidades de las mujeres, en especial de las mujeres gestantes”.<sup>290</sup>

## **E. Otras tendencias preocupantes en materia de a derechos sexuales y reproductivos**

### **Influencia de grupos religiosos y anti-derechos**

18. En las últimas dos décadas se ha fortalecido una ola autoproclamada pro-vida y pro-familia a lo largo de América Latina la cual es liderada por la iglesia católica e iglesias evangelistas y grupos afines. Estos actores han logrado penetrar distintos niveles de gobierno y estructuras. Actualmente, “los movimientos conservadores tienen una presencia importante, a veces dominante, en la legislatura de sus respectivos países, lo que explica el papel regresivo que juegan los parlamentos latinoamericanos en todos los derechos sexuales y reproductivos y los derechos de las minorías”.<sup>291</sup> En distintos países, funcionarios públicos, parlamentarios y jueces, e incluso personal médico en hospitales públicos, influidos por actores e ideas religiosas, niegan a las mujeres y niñas servicios de salud lo cual atenta en contra de su derecho a la salud e integridad, la autonomía sobre su cuerpo, su privacidad e incluso su vida.
19. Activistas de la región observan que esta situación ha agravado las diversas crisis abordadas en este documento incluyendo la crisis sanitaria actual que se analiza en profundidad en el último apartado de esta sección. En El Salvador, “además de la crisis que se vive, los grupos anti-derechos continúan atacando, sobre todo a las mujeres que han enfrentado emergencias obstétricas y a las defensoras de derechos sexuales y derechos reproductivos, generan estigmatización, desinformación y ataques virtuales. Los grupos fundamentalistas atentan contra la democracia y los derechos de las mujeres”.<sup>292</sup> En Bolivia “en este contexto crítico y agravado por la pandemia, el Gobierno y el Ministerio de Salud se suman posturas conservadoras religiosas, fundamentalista, anti derechos que se denominan pro-vida... estos ponen en riesgo de retroceso la garantía de los derechos sexuales y reproductivos logrados para las mujeres y niñas. A esto se suma el contexto electoral que todavía no ha sido resuelto”.<sup>293</sup>
20. Hoy por hoy, este movimiento conservador y anti-derechos que ha permeado distintos niveles del Estado y la sociedad ha logrado avanzar exitosamente la idea de la existencia de una supuesta

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<sup>289</sup> *Ibíd.* Pág. 4.

<sup>290</sup> Lourdes Inoa Monegro, Puerto Rico. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>291</sup> Camila Gianella, Marta Rodríguez de Assis Machado, Angelica Peñas Defago, “What causes Latin America’s high incidence of adolescent pregnancy?”, Chr. Michelsen Institute (2017), Bergen: (CMI Brief vol. 16 no. 9). Disponible en línea en: <https://www.cmi.no/publications/6380-what-causes-latin-americas-high-incidence-of>.

<sup>292</sup> Sara García, El Salvador. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>293</sup> Paula Estenssoro, Bolivia. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

“ideología de género” para rechazar planes de educación sexual e incluso cualquier referencia a la discriminación o violencia basada en género. Según un artículo, entre 2015 y 2017, los Ministros de Educación de Brasil, Colombia, Uruguay y Perú han enfrentado una fuerte oposición de grupos conservadores. En Perú, organizaciones conservadoras ganaron un caso judicial contra la inclusión de un enfoque sensible al género en el currículo escolar y apoyaron la destitución por parte del Parlamento de dos Ministerios de Educación.<sup>294</sup> En Colombia, la ideología de género fue utilizada por actores conservadores para rechazar el acuerdo de paz que se refería a “la eliminación de toda forma de discriminación, valorando a las mujeres como sujetos políticos” y el combate a la discriminación “incluidas las basadas en el género y la orientación sexual y la identidad de género diversa” además de la obligación de comprender “el impacto del conflicto y la violencia de género en la niñez y la adolescencia”. En Guatemala, el debilitamiento de la institucionalidad encargada de promover acciones a favor de los derechos de las mujeres, el cual incluye el desmantelamiento de la Secretaría de la Presidencia de la Mujer (SEPREM), está ligado a la influencia de grupos fundamentalistas y la sociedad conservadora.<sup>295</sup> En Argentina, “aparte de las crisis globales que son la pandemia de la COVID-19, el neoliberalismo y el impacto desproporcionado en términos de género, existen otras crisis como los fundamentalismos y conservadorismos religiosos que buscan generar retrocesos en la lucha feminista organizada. A medida que el movimiento feminista conquista derechos, estos grupos se sofistican día a día”.<sup>296</sup>

## **Déficit en el acceso y la implementación de los servicios de salud sexual y reproductiva.**

21. **La baja inversión en los sistemas de salud y en particular en los servicios de salud sexual y reproductiva** predice la casi nula capacidad para atender una crisis. Por ejemplo, en Nicaragua “la salud para la población en general y en particular para las mujeres, no es una prioridad de Estado, esto se evidencia con el bajo presupuesto general destinado hacia la salud”.<sup>297</sup> Ello explica el porque la sociedad civil nicaraguense considera que actualmente el sistema de salud está colapsado y es incapaz de atender las necesidades reproductivas de las mujeres y niñas, incluso aquellas que tienen una protección legal. La poca inversión en los sistemas de salud también se ve reflejado en la ausencia de personal capacitado, equipo y protocolos.
22. Durante la consulta de FAR activistas destacaron la falta de información y educación sexual, la falta de protocolos y regulaciones claras para garantizar la implementación de servicios sexuales y reproductivos, incluso cuando estos son legales, el uso inadecuado de la objeción de conciencia

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<sup>294</sup> Paula Estenssoro, Bolivia. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>295</sup> Karen Molina, Guatemala. Consulta organizada por FAR, WHRI y CWGL. Julio 2020. “El principal desafío en Guatemala es no perder todo lo que se ha ganado en materia de derechos humanos de las mujeres frente a las acciones del Estado contrarias a los derechos humanos de las mujeres. En especial, la institucional que garantiza la implementación de los derechos humanos de las mujeres que ha sido lograda gracias a los esfuerzos realizados desde la sociedad civil”.

<sup>296</sup> Soledad Deza, Argentina. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>297</sup> Mayte Ochoa, Nicaragua. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

que permite al personal médico imponer sus criterios morales y religiosos y negar servicios de salud sexual y reproductiva. Por ejemplo, en Colombia las barreras administrativas que impiden a las mujeres el acceso efectivo a los servicios se vinculan a la falta de información, los prejuicios de funcionarios y la falta de disponibilidad de los servicios de salud sexual y reproductiva.<sup>298</sup> En Puerto Rico el principal problema es que los servicios están privatizados, tienen un alto costo y son inaccesibles, además de que no existen servicios de salud universal. Si bien el acceso al aborto es legal, existe un problema de alcance para las mujeres de las áreas rurales que se encuentran lejos de las zonas metropolitanas.<sup>299</sup>

### **Embarazo no planeado y acceso a servicios de interrupción legal del embarazo**

23. **Altas tasas de embarazo no planeado.** América Latina y el Caribe es la región con la tasa más alta de embarazo no planeado —96 por 1,000 mujeres en edad reproductiva.<sup>300</sup> Lo cual guarda una relación directa con los altos índices de violencia sexual, la falta de acceso a educación sexual e información y a métodos anticonceptivos por parte de la población, incluyendo la Anticoncepción Oral de Emergencia. Al respecto, uno de los principales problemas en materia de anticonceptivos es que éstos se siguen suministrando de acuerdo de sesgos de género en donde las mujeres son visualizadas como las responsables de la reproducción y las relaciones sexuales heterosexuales son la norma.<sup>301</sup>
24. **Acceso a servicios de aborto limitado.** A pesar de que un alto porcentaje de embarazos no son planeados, el acceso a servicios de interrupción del embarazo es desigual en la América Latina por lo que en contextos en donde el aborto está penalizado, éste se practica en condiciones de clandestinidad y de riesgo para la salud y vida de mujeres y niñas. Se estima que en 2008 ocurrieron 21,6 millones de abortos inseguros en el mundo, y el 20% de ellos ocurrió en América Latina y el Caribe. De acuerdo con un estudio del año 2017, evidenció que América Latina y el Caribe tiene la tasa de aborto anual más alta de todas las regiones, de 44 por 1,000 mujeres en edad reproductiva, en comparación con 36 en Asia, 34 en África, 29 en Europa y 17 en América del Norte (todas por 1,000 mujeres).<sup>302</sup> La ausencia de consejería en salud reproductiva, las barreras para acceder a los abortos legales, la escasa disponibilidad de la tecnología adecuada

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<sup>298</sup> Cristina Rosero, Ecuador. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>299</sup> Lourdes Inoa Monegro, Puerto Rico. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>300</sup> Susheela Singh, Lisa Remez, Gilda Sedgh, Lorraine Kwok y Tsuyoshi Onda, "Abortion Worldwide 2017: Uneven Progress and Unequal Access", Guttmacher Institute (2017). Págs. 34-40. Disponible en línea en: [https://www.guttmacher.org/sites/default/files/report\\_pdf/abortion-worldwide-2017.pdf](https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf).

<sup>301</sup> Jane T. Bertrand, Tara M. Sullivan, Ellen A. Knowles, Muhammad F. Zeeshan y 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). Págs. 20-30. Disponible en línea en: [https://www.guttmacher.org/sites/default/files/article\\_files/4102015s.pdf](https://www.guttmacher.org/sites/default/files/article_files/4102015s.pdf).

<sup>302</sup> Susheela Singh, Lisa Remez, Gilda Sedgh, Lorraine Kwok y Tsuyoshi Onda, "Abortion Worldwide 2017: Uneven Progress and Unequal Access", Guttmacher Institute (2017). Pág. 8. Disponible en línea en: [https://www.guttmacher.org/sites/default/files/report\\_pdf/abortion-worldwide-2017.pdf](https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf).

para el tratamiento del aborto incompleto, la amenaza de procesos judiciales, el estigma y la sanción social refuerzan la clandestinidad e inseguridad del aborto<sup>303</sup>.

25. **Criminalización del aborto.** La región de América Latina tiene algunas de las leyes más restrictivas para el ejercicio de los derechos sexuales y reproductivos. A excepción de Cuba, Puerto Rico, Ciudad de México y Oaxaca en México, y Uruguay -en donde las mujeres el derecho a interrumpir su embarazo- el resto de los países oscilan entre legislaciones prohibitivas, restrictivas y moderadamente restrictivas. El Salvador, Haití, Honduras, Nicaragua, Surinam y República Dominicana, penalizan el aborto sin ninguna excepción. El Salvador ha utilizado la ley para penalizar y criminalizar tanto a mujeres que han tenido abortos como emergencias obstétricas. “En la actualidad, 18 mujeres están privadas de libertad por un delito que no cometieron, encarceladas del hospital a la cárcel, se les violar los sus derechos fundamentales.”<sup>304</sup>
26. En Perú y Ecuador existen marcos regulatorios que están en tensión con los derechos humanos. Al respecto, una activista señalaba: “En Ecuador no se ha aprobado la reforma penal en causal aborto por violación en la Asamblea Nacional, el ejecutivo evade responsabilidad y la Corte Constitucional no ha resuelto sobre estos aspectos. A esto se suma la presión anti-derechos de mujeres en la Asamblea Nacional y el caso omiso de aplicación de Recomendaciones de seis Comités de Derechos Humanos sobre despenalización en casos de aborto por violación. El Código sobre objeción de conciencia y el Código de la niñez y adolescencia que no contemplan la inserción de estándares de violencia”.<sup>305</sup>
27. La implementación de leyes que impiden a las mujeres y niñas decidir sobre sus propios cuerpos han resultado en violaciones graves a su derecho a la salud, integridad física y psicológica y su autonomía. En sufrimiento causado, agravado por la edad, la salud, el contexto específico, y otras condiciones, ha constituido formas de violencia que en sí pueden ser consideradas tortura, tratos crueles, inhumanos y degradantes. Durante la consulta organizada por FAR las activistas coincidieron en que la penalización del aborto en sus países no ha disminuido el número de abortos y en cambio ha provoca el incremento de la mortalidad y morbilidad maternas porque empuja a las mujeres y niñas a la clandestinidad y exponiéndolas a servicios inseguros que amenazan su vida.

### **Embarazo adolescente y emergencia obstétrica.**

28. Una de las situaciones más críticas de la región son las altas tasas de fecundidad adolescente en América Latina (73,2 por 1000) la cual es muy alta en comparación con la tasa mundial de 48,9 y la tasa de los países en desarrollo del 52,7%.<sup>306</sup> El embarazo de niñas y adolescentes es en la gran

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<sup>303</sup> *Ibíd.* p. 18

<sup>304</sup> Sara García, El Salvador. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>305</sup> Rocío Rosero, Ecuador. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>306</sup> Camila Gianella, Marta Rodríguez de Assis Machado, Angelica Peñas Defago, What causes Latin America's high incidence of adolescent pregnancy?, Chr. Michelsen Institute (2017), Bergen: (CMI Brief vol. 16 no. 9). Disponible en línea en: <https://www.cmi.no/publications/6380-what-causes-latin-americas-high-incidence-of>.

mayoría de los casos, producto de violación o de estupro en donde existe una relación desigual de poder. Los embarazos adolescentes afectan especialmente a niñas de familias que viven en la pobreza, rurales, indígenas y que es el producto de una cadena de falencias gravísimas en la protección de estas niñas por parte de los Estados.<sup>307</sup> La situación es especialmente grave en los países en donde no se reconoce la causal de violación para permitir y garantizar el acceso a la interrupción legal del embarazo, incluyendo Nicaragua, El Salvador, Perú y Ecuador, entre otros.

29. El embarazo en menores de 15 años ha ido aumentando en la región. En Guatemala, el número notificado de partos en niñas de 10 a 14 años aumentó de 4 220 en el año 2013 a 5 100 en 2014; en Perú, la mayoría de los embarazos infantiles son el resultado de violaciones. El Seguro Integral de Salud de Perú ha informado que cada día 5 niñas menores de 15 años se convierten en madres.<sup>308</sup> En Nicaragua, anualmente más de 35000 niñas y adolescentes llevan adelante su embarazo lo que representa el 25.2% de todos los partos en Nicaragua.<sup>309</sup> Por su parte en Ecuador entre 2009 y 2016, 17 448 niñas menores de catorce años parieron de acuerdo con la base de datos de Estadísticas Vitales y Nacimientos del Instituto Nacional de Estadísticas y Censos (INEC). De hecho en promedio, cada año 2.181 niñas menores de catorce paren en Ecuador, todas ellas víctimas de violencia sexual desde un criterio legal<sup>310</sup> y de acuerdo a los datos del censo, el embarazo adolescente aumentó un 74% durante el último decenio.<sup>311</sup> En El Salvador de enero a marzo de 2020, se contabilizaron a 144 niñas de 10 a 14 años embarazadas.<sup>312</sup>
30. Dada la restrictiva legislación existente en varios países pero también la práctica institucional que no garantiza el acceso a servicios de salud sexual y reproductiva, en gran parte de los casos las niñas y adolescentes fueron obligadas a continuar los embarazos independientemente si éste era planeado o no. En muchas ocasiones, esto tuvo graves consecuencias para su salud y vida. Por ello no es casualidad que, como destaca una activista de El Salvador, “según el Ministerio de Salud

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<sup>307</sup> Amnistía Internacional, 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, (2016). Pág. 37. Disponible en línea en: <https://www.amnesty.org/download/Documents/AMRO133882016SPANISH.PDF>.

<sup>308</sup> Rossina Guerrero, Perú. Consulta organizada por FAR, CWGL y WHRI. 2020. Disponible en línea en: <https://wayka.pe/mas-de-5-mil-ninas-obligadas-a-ser-madres-en-los-ultimos-cuatro-anos/>.

<sup>309</sup> Mayte Ochoa, Nicaragua. Consulta organizada por FAR, CWGL y WHRI. 2020.

<sup>310</sup> Wambra, “Las niñas invisibles de Ecuador”, Medio Digital Comunitario (marzo 2018). Disponible en línea en: <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>.

<sup>311</sup> Ximena Casas Isaza, Oscar Cabrera, Rebecca Reingold y 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). Disponible en línea en: <https://clacaidigital.info/bitstream/handle/123456789/977/Unestudio.multipa%3%ads.pdf?sequence=5&isAllowed=y>

<sup>312</sup> Sara García, El Salvador. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.



de El Salvador (MINSAL), el suicidio es la primera causa de muerte materna indirecta en el caso de embarazo adolescente” en aquel país.<sup>313</sup>

31. Debido a que su cuerpo no está completamente desarrollado, un número de embarazos de niñas deriva emergencias obstétricas. De acuerdo a datos del INEC de Ecuador, en 2019, 226 niñas, entre 10 y 14 años, acudieron a un centro hospitalario por una emergencia obstétrica y casi la mitad de ellas tuvo un aborto espontáneo. Además, 3 809 adolescentes entre 15 y 19 años acudieron al hospital por emergencias obstétrica.<sup>314</sup> La mortalidad materna es una de las principales causas de muerte en las adolescentes y jóvenes de 15 a 24 años en la región. En el año 2012, fallecieron en la región 1887 adolescentes y jóvenes en este grupo etario como resultado de problemas de salud durante el embarazo, el parto o el puerperio temprano<sup>315</sup>.
32. Un estudio observa que el discurso sobre la importancia de la salud integral de los adolescentes no se ha traducido en prioridades presupuestales ni en inversión en infraestructura dedicada a este grupo, o en la incorporación relevante de este grupo en el diseño, planificación, ejecución y evaluación de las acciones para el desarrollo de los servicios.<sup>316</sup>

#### **F. Crisis sanitaria: COVID-19 en los derechos sexuales y reproductivos**

33. América Latina y el Caribe se ha convertido en una de las zonas más críticas de la pandemia de COVID-19, exacerbada por estructuras de protección social débiles, sistemas de salud fragmentados y profundas desigualdades en donde los Estados no estaban suficientemente preparados para manejar una crisis sanitaria y humana de esta magnitud.<sup>317</sup> La mayoría de los estados de la región enfrentan importantes desafíos para garantizar el derecho a la salud de su población, y en consecuencia la salud sexual y reproductiva. Brasil, México y Perú presentan las cifras más altas de casos en términos absolutos y per cápita en América Latina.
34. Las mujeres y las niñas de América Latina se han visto desproporcionadamente afectadas por la pandemia debido a la desigualdad estructural en la que se encontraban: trabajan mayormente en el sector informal en donde no tienen acceso a sistemas de protección, son más pobres, se hacen cargo de los cuidados en el hogar y enfrentan un alto grado de violencia basada en género.

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<sup>313</sup> Sara García, El Salvador. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>314</sup> Wambra, “Las niñas invisibles de Ecuador”, Medio Digital Comunitario (marzo 2018). Disponible en línea en: <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>.

<sup>315</sup> UNFPA, “Acelerar el progreso hacia la reducción del embarazo en la adolescencia en América Latina y el Caribe”, (2016). Pág. 24. Disponible en línea en: [https://lac.unfpa.org/sites/default/files/pub-pdf/ESP-EMBARAZO-ADOLESC-14febrero%20FINAL\\_5.PDF](https://lac.unfpa.org/sites/default/files/pub-pdf/ESP-EMBARAZO-ADOLESC-14febrero%20FINAL_5.PDF).

<sup>316</sup> Agustina Ramón Michel y 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. Pág. 8 y 9.

<sup>317</sup> ONU, “Informe: El impacto del COVID-19 en América Latina y el Caribe, 9 Jul 2020”, (2020). Disponible en línea en: <https://reliefweb.int/report/world/informe-el-impacto-del-covid-19-en-am-rica-latina-y-el-caribe-julio-2020>.

### **Impacto en los sistemas de salud (fragmentación de la respuesta sanitaria, desarticulación)**

35. Durante la consulta organizada por FAR se constató que en varios países de la región, sobre todo los más pobres, los sistemas de salud han colapsado y los diversos contextos de crisis en que éstos se encontraban han exacerbado el impacto de la crisis sanitaria en los grupos marginados. En Nicaragua, durante la pandemia “no se tomo ninguna medida destinada a prevenir y contener la COVID-19. El sistema de salud ha colapsado y se han registrado despidos al personal de salud.”<sup>318</sup>
36. La situación en Perú ejemplifica una situación que se ha dado en otros países de la región: “En Perú hay una fragmentación del sistema sanitario y una insuficiente inversión para implementar un modelo de salud primaria, una debilidad estructural que ha provocado un colapso total sanitario en el ámbito hospitalario, con insuficiente capacidad para atender a los pacientes de COVID-19 impactando en las necesidades y la atención en la salud sexual y reproductiva y la atención de violencia contra las mujeres”.<sup>319</sup> De acuerdo a la activista consultada, en consecuencia de esta situación:
- a. se suspendieron las consultas externas en el primer nivel de atención en salud sexual y reproductiva, sin haber empleado servicios alternativos como visitas domiciliarias, por tele salud o previa cita desde que se decretó el estado de emergencia;
  - b. durante mes y medio, no se emitieron protocolos para atender aspectos de la salud sexual y reproductiva, lo cual se dio hasta abril cuando se emitió una norma que busca garantizar la salud de las gestantes, la continuidad de la atención en planificación familiar y la atención de las víctimas de violencia que hasta la actualidad no se ha garantizado en su implementación;
  - c. los hospitales que atendían partos, fueron destinados a la atención de Covid-19;
  - d. las atenciones prenatales en los establecimientos también fueron suspendidos y con ello la facultad de detectar complicaciones de alto riesgo;
  - e. el acceso al aborto se ha limitado al caso es que está en riesgo la vida de la mujer, dejando fuera los casos de riesgo a la salud reconocidos como causales por la ley y normas nacionales;
  - f. se ha dificultado acceder a métodos anticonceptivos modernos lo cual repercutirá en la alza de número de embarazos no deseados o no planificados. Esto se deben a los precios elevados, la falta de poder adquisitivo, la pérdida de fuente de trabajo, el cierre de los servicios de primer nivel, para acceder a los métodos anticonceptivos modernos.<sup>320</sup>
37. En Ecuador, para hacer frente a la emergencia del COVID-19 se ha restringido el acceso a servicios de servicios sexuales y reproductivos, desviado equipos y personal médico a otras áreas, se ha

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<sup>318</sup> Mayte Ochoa, Nicaragua. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>319</sup> Rossina Guerrero, Perú. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>320</sup> Rossina Guerrero, Perú. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

interrumpido de la cadena de suministros de métodos anticonceptivos.<sup>321</sup> Al respecto, UNFPA ha destacado que en la región existen tres efectos de la pandemia que están afectando al acceso y suministro a anticonceptivos: la reducción de adquisición en el sector privado, el desabastecimiento en el sector público y la reducción de la demanda en el sector público. UNFPA destaca que de asumir que los países en América Latina y el Caribe no incorporen medidas correctivas es posible estimar que resultaría en 1,7 millones de embarazos no planeados, cerca de 800 mil abortos, 2,9 mil muertes maternas y cerca de 39 mil muertes infantiles.<sup>322</sup>

### **Impacto de la crisis sanitaria en las trabajadoras del sistema de salud**

38. En la región, la mitad del personal médico y más del 80% del personal de enfermería son mujeres, el porcentaje más alto del mundo<sup>323</sup>, sin embargo, globalmente las mujeres siguen siendo una minoría en los cargos de decisión y enfrentando una brecha salarial de 28%.<sup>324</sup> En Chile “en su mayoría son mujeres que no cuentan con las garantías para el cuidado de su propia vida como los equipos de protección personal y tampoco con medidas especiales para el cuidado de sus hijos e hijas y otras personas a su cargo”.<sup>325</sup> El Observatorio Género y COVID-19 en México daba cuenta que al 16 de junio de 2020, las mujeres que trabajan en el sector salud representan 57% de los casos positivos al virus y el 29% de las muertes. Las más afectadas por el contagio son las enfermeras, quienes en su mayoría son mujeres.<sup>326</sup>

### **Incremento de violencia basada en género**

39. Una grave tendencia registrada en la región es el incremento de las denuncias de violencia intrafamiliar tras el establecimiento de las medidas de confinamiento y distanciamiento social adoptadas por las autoridades para la contención del contagio del COVID-19. En México, el Observatorio Género y COVID-19 reportó que en dos meses de confinamiento por COVID-19,

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<sup>321</sup> Rocío Rosero, Ecuador. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>322</sup> Federico Tobar, Lucas Godoy Garraza y José Ventura Pinedo, “Impacto de COVID-19 en el acceso a los anticonceptivos en América Latina y el Caribe”, UNFPA América Latina y el Caribe (Septiembre 2020). Págs. 6-11. Disponible en línea en: <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>

<sup>323</sup> Claudia Piras, “Las mujeres en América Latina y el Caribe enfrentan mayores riesgos ante el Coronavirus”, BID (2020). Disponible en línea en: <https://blogs.iadb.org/igualdad/es/mujeres-enfrentan-mayores-riesgos-ante-coronavirus/>.

<sup>324</sup> Organización Mundial de la Salud (WHO), “Gender equity in the health workforce: Analysis of 104 countries”, (2019). Disponible en línea en: <https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf?sequence=1&isAllowed=y>.

<sup>325</sup> Camila Maturana, Chile. Consulta organizada por FAR, CWGL y WHRI. 2020.

<sup>326</sup> Dirección General de Epidemiología (DGE), “Informe semanal de notificación inmediata de muerte materna”, Secretaría de Salud de México (2020)”. Disponible en línea en: [https://www.gob.mx/cms/uploads/attachment/file/564480/MM\\_2020\\_SE29.pdf](https://www.gob.mx/cms/uploads/attachment/file/564480/MM_2020_SE29.pdf).

incrementaron en más de 80% las llamadas y mensajes de solicitud de apoyo a causa de violencias de género. Además solo en el primer mes fueron asesinadas más de 300 mujeres, niñas y adolescentes que cohabitaban con su agresor<sup>327</sup>, en El Salvador “entre el 11 de marzo al 20 de mayo la Fiscalía registró 2318 agresiones contra mujeres, lo que se traduce en alrededor de 33 hechos de violencia diarios; de estas agresiones 481 son casos de violencia sexual. En este periodo también han ocurrido 28 feminicidios.<sup>328</sup> En Colombia, durante la cuarentena -hasta agosto de 2020- se había registrado un incremento de 103% en los reportes de violencia contra las mujeres con respecto al mismo periodo anterior y sólo en Bogotá ese incremento llegó al 230%.<sup>329</sup>

40. En Guatemala, también se observa que “los casos de violencia contra las mujeres han aumentado en el contexto del confinamiento. El Gobierno se ha manifestado preocupado por el aumento de estos índices de violencia, pero el discurso no se corresponde con la realidad porque aunque existen esfuerzos en desarrollar campañas, esto no se logra materializar porque el Sistema de Justicia no permite el acceso pleno a la justicia de las mujeres y las niñas”.<sup>330</sup> En respuesta a la violencia doméstica, en Chile también se han llevado a cabo campañas informativas, de orientación telefónica, y se han creado nuevos canales para la denuncia que ha reforzado la protección a las mujeres. “Sin embargo, no se ha abordado la especificidad y la gravedad de la violencia sexual y la mayor vulnerabilidad de las niñas y adolescentes pese a que las denuncia de delitos sexuales han aumentado”.<sup>331</sup> En este sentido se destaca que “frente a eso no existe una reorientación de las políticas públicas en la campaña y atención a los casos de violencia sexual. El Estado no garantiza la información sobre el derecho al acceso al aborto y lineamientos claros de suministros de anticonceptivos en general.”<sup>332</sup>
41. Hasta el momento de la consulta organizada por FAR a finales de julio, en Perú se habían denunciado 500 agresiones sexuales en contra de mujeres y niñas. Esto se da en un país en donde existe un serio problema de embarazo infantil que son el resultado la mayoría de las veces de violaciones. Durante la consulta organizada por FAR se informó que el Seguro Integral de Salud da cuenta que cada día 5 niñas menores de 15 años se convierten en madres y en lo que va del año el Sistema Abierto del Ministerio de Salud emitió 399 certificados de nacidos vivos cuyas madres son menores de 15 años. Además, de los pocos servicios que prestaba el servicio de aborto terapéutico, que no sobrepasaba de 10 a nivel nacional, en el contexto actual se ha reducido a un solo establecimiento generando una política pública difícil de implementar y donde se ha casi eliminado como oferta como un servicio esencial para niñas y adolescentes<sup>333</sup>.

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<sup>327</sup> GIRE, “Observatorio Género y COVID-19 de México”, (2020). Disponible en línea en: <https://genero-covid19.gire.org.mx/tema/personal-de-salud/>.

<sup>328</sup> Sara García. El Salvador. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>329</sup> Cristina Rosero, Colombia. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>330</sup> Karen Molina, Guatemala. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>331</sup> Camila Maturana, Chile. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>332</sup> Camila Maturana, Chile. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>333</sup> Rossina Guerrero, Perú. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

## Respuesta estatal a la crisis de COVID-19

42. Durante la consulta organizada por FAR se identificaron una serie de desafíos en la respuesta estatal a la crisis sanitaria que obstaculizan el acceso de las mujeres a los servicios sexuales y reproductivos:

- a. **Las crisis pre-existentes a la pandemia han obstaculizado la formulación de planes adecuados para hacer frente a la pandemia.** En Guatemala “el manejo de la crisis sanitaria ha sido deficiente por parte del Gobierno. El Estado ha sido debilitado por mucho tiempo y ahora sufrimos las consecuencias, con la poca capacidad del Estado para responder ante las necesidades de la población. Los casos por COVID-19 están aumentando, y no se está teniendo la capacidad de responder efectivamente”.<sup>334</sup> En Bolivia el marco legal permite que el Estado pueda gestionar en situaciones de crisis, declaraciones de estado de excepción, declaraciones de emergencia, mecanismos de asignación de recursos extraordinarios y medidas de contingencia por medio del órgano ejecutivo pero que deben ser aprobadas por el órgano legislativo. Sin embargo, por la crisis política e institucionalidad, un gobierno de transición, han generado que se actué frente a la pandemia con improvisación, han limitado y reducido las estrategias de gestión de riesgo y recuperación. Si bien se han dictados bonos y planes de reactivación de la económica, tienen un carácter de improvisación generando fallas en la implementación”.<sup>335</sup> En Ecuador, la inestabilidad política y el debilitamiento de la institucional así como la corrupción y el desvío de fondos para fines particulares han amplificado y agravado la crisis sanitaria que actualmente vive el país.<sup>336</sup>
- b. **Los estados han relegado los derechos sexuales y reproductivos de las mujeres y niñas a un segundo plano/ los derechos sexuales y reproductivos no han sido priorizados.**<sup>337</sup> En El Salvador “la crisis ha generado un desplazamiento de las necesidades en materia de salud sexual y reproductiva, las cuales no han sido centrales para el Estado, pero que frente a este contexto, pasan a último plano”; en Guatemala, “en general el acceso de las mujeres a servicios de salud sexual y reproductiva con atención es mínima y en el contexto de la pandemia por COVID-19, se agudizado este problema, porque ahora la prioridad es la atención a casos de COVID-19 y la salud reproductiva, como otras cuestiones de salud, se han dejado de lado”.<sup>338</sup> En Perú “se desarrolló un protocolo de la atención de mujer embarazada en tiempos de COVID-19. Sin embargo, no incluye un plan efectivo de contingencias, inclusive muchos establecimientos de salud especializados se han tenido que cerrar o dirigir únicamente a la atención de Covid-19”.<sup>339</sup>

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<sup>334</sup> Karen Molina, Guatemala. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>335</sup> Paula Estenssoro. Bolivia. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>336</sup> Rocío Rosero, Ecuador. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>337</sup> Sara García. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>338</sup> Karen Molina, Guatemala. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>339</sup> Karen Molina, Guatemala. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

- c. **No existen planes integrales para hacer frente a la contingencia de la pandemia lo que ha resultado en la adopción de medidas desarticuladas, tardías o sin presupuesto adecuado.** En Chile “la inexistencia y el retraso en la dirección de directrices para la de salud sexual y reproductiva en tiempos de pandemia se refleja por el tiempo transcurrido de cuatro meses para dar a conocer las orientaciones y lineamientos para la atención de embarazos y partos. Lo que significa que en muchos casos se incurrió en casos de violencia obstétrica de gravedad y la falta de mecanismos para la exigencia de sus derechos. Por otra parte, tampoco existen lineamientos claros para la atención de otros servicios de salud sexuales y reproductivos. En especial, para asegurar la continuidad de los servicios de la fertilidad, la prevención y diagnóstico de cáncer de cuello uterino y de mama que en Chile, que se constituyen en causa importante de mortalidad.<sup>340</sup> En Perú “se han tomado mínimas medidas de contingencia y estas tienen un carácter denominativo. No se han desarrollado estrategias, ni destinado fondos”.<sup>341</sup> En Brasil se percibe que “muchos factores han contribuido al fracaso de la respuesta efectiva hacia la pandemia; entre estos se encuentran; la ausencia de la autoridad de salud proveniente del Ministerio de Salud, la falta de articulación multisectorial en las políticas destinadas a la pandemia...”<sup>342</sup>
- d. **Se han adoptado medidas adecuadas que han sido implementado deficientemente.** En Chile, la desatención de la salud sexual y reproductiva se relaciona con la ausencia de lineamientos que tomen en cuenta a la baja de personal médico disponible por contagios y que los centros de salud están orientados a la atención de COVID-19”.<sup>343</sup> En Colombia, el Ministerio de Salud ha emitido una serie de lineamientos donde ha reconocido que los servicios de salud sexual y reproductiva son esenciales, no obstante no han tomado suficientes medidas para que esos lineamientos se cumplan.<sup>344</sup>
- e. **La ausencia de información por parte del Estado sobre los servicios disponibles ha afectado el acceso a los servicios de salud sexual y reproductiva.** La falta información en formatos sencillos y accesibles sobre los servicios de salud sexual y reproductiva y las unidades médicas que los proveen, aunado al temor por el riesgo de contagio, incide su acceso por parte de mujeres y niñas. En Brasil se consider que otro de los factores que han contribuido al fracaso de la respuesta efectiva hacia la pandemia es la falta de diseminación de información confiable”.<sup>345</sup> En México, a pesar de que los servicios de atención obstétrica se han declarado como esenciales durante la pandemia, no hay información pública por parte de los Servicios de Salud de las entidades federativas sobre qué unidades siguen brindando atención materno-infantil y, específicamente, para

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<sup>340</sup> Camila Maturana, Chile. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>341</sup> Rossina Guerrero, Perú. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>342</sup> Beatriz Galli, Brasil. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>343</sup> Camila Maturana, Chile. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>344</sup> Cristina Rosero, Colombia. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>345</sup> Beatriz Galli, Brasil. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

urgencias obstétricas.<sup>346</sup> Esta situación resulta especialmente grave cuando, de acuerdo a información oficial emitida por la Secretaría de Salud, la mortalidad materna calculada es de 44.2 defunciones por cada 100 mil nacimientos estimados, lo que representa un incremento del 33.2% respecto a la misma semana epidemiológica del año anterior. Además, es la principal causa de muerte materna es el COVID-19, con 21.7% defunciones confirmadas.<sup>347</sup>

- f. **Existe una ausencia de enfoque de derechos humanos, de perspectiva de género.** Con respecto a la salud sexual y reproductiva, antes y durante de la pandemia en Brasil se han tomado medidas regresivas y posiciones en contra de la constitución política y los estándares internacionales. Además se ve con preocupación que el Ministerio de Salud estará promoviendo un cambio anual de manual de funciones en el cual la dirección general de salud sexual y reproductiva estaría desapareciendo”.<sup>348</sup> La ausencia de marcos normativos adecuados ha dado lugar a la adopción de medidas sin enfoque de derechos humanos y de género que han resultado en abusos de derechos humanos o incrementado el riesgo para algunos sectores, incluidas las mujeres y las niñas. En El Salvador “la pandemia de COVID-19 ha sido abordada por el Estado desde una perspectiva autoritaria; donde la militarización y censura son elementos cruciales, los cordones sanitarios, son cordones militares. Además las medidas impulsadas tiene carácter homogéneo, desde el *Quédate en Casa* hasta la importancia del *Lávate las Manos*, mismas que no consideran que el quédate en casa, implica para muchas mujeres y niñas, quedarse en casa con el agresor y sin considerar que muchos hogares en El Salvador no cuentan con agua potable”.<sup>349</sup> En Ecuador, el gobierno disminuyó el personal encargado de la implementación de la Política Intersectorial de Prevención del Embarazo en Niñas y Adolescentes<sup>350</sup> lo cual resulta especialmente grave teniendo en cuenta los altos niveles de embarazo en este sector, la interrupción en el suministro de anticonceptivos y el hecho que las órdenes de cuarentena podrían incidir en un repunte de embarazo de adolescentes como ha sucedido en otros países.
- g. **Ausencia de medidas enfocadas en sectores marginados o en situación de vulnerabilidad.** La falta de acceso a la atención sanitaria y a la información de calidad en materia de salud es especialmente grave en las zonas rurales y remotas, y afecta particularmente a los pueblos indígenas.<sup>351</sup> En Colombia, “en el contexto de pandemia las

<sup>346</sup> Observatorio Género y COVID-19 de México, “Muerte Materna y Violencia Obstétrica”. GIRE (2020). Disponible en línea en: <https://genero-covid19.gire.org.mx/tema/acceso-a-anticonceptivos/>

<sup>347</sup> Secretaría de Salud de México, “Informe semanal de notificación inmediata de muerte materna”, Semana epidemiológica 36, Gobierno de México (2020). Pág. 1.

[https://www.gob.mx/cms/uploads/attachment/file/576803/MM\\_2020\\_SE36.pdf](https://www.gob.mx/cms/uploads/attachment/file/576803/MM_2020_SE36.pdf)

<sup>348</sup> Beatriz Galli, Brasil. Consulta organizada por FAR, CWGL y WHRI. 2020.

<sup>349</sup> Sara García, El Salvador. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>350</sup> Rocío Rosero, Ecuador. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>351</sup> ONU, “Informe: El impacto del COVID-19 en América Latina y el Caribe”, (2020). Disponible en línea en: <https://reliefweb.int/report/world/informe-el-impacto-del-covid-19-en-am-rica-latina-y-el-caribe-julio-2020>.

barreras se han profundizado y se están presentando barreras nuevas. Por ejemplo, con ocasión de las restricciones a la movilidad por la pandemia, muchas mujeres, en especial en zonas rurales, han enfrentado dificultades para trasladarse para acceder a servicios de salud reproductiva, se han negado estos servicios por no considerarlos un servicio esencial y se ha dilatado los términos para la atención de los mismos”.<sup>352</sup> Durante la consulta organizada por FAR varias activistas indicaron que no se han desplegado esfuerzos adicionales para contrarrestar el impacto de la pandemia en las lesbianas, mujeres trans, personas no conformes con el género y en general el colectivo LGBTQ. En Chile y Bolivia no se está garantizando el funcionamiento de programas de prevención y atención en las enfermedades de transmisión sexual, incluyendo el VIH SIDA lo cual está afectando principalmente a la población joven que no tiene acceso efectiva a retrovirales. Las dificultades también “pueden verse profundizadas de forma grave en el caso de mujeres y adolescentes migrantes... quienes desde antes de la crisis ya enfrentaban obstáculos casi insuperables para acceder a estos servicios.”<sup>353</sup> En Brazil “el Estado no solo ha sido omiso sino ha actuado con la deliberada intención de poner en acción un plan políticas de exterminio en contra de las poblaciones más vulnerables sometiendo a esta a condiciones que pueden ser considerados como genocidio y otros delitos de lesa humanidad. Existe una intención clara del gobierno de someter a ciertos grupos vulnerables a condiciones deplorables que atentan contra su vida”.<sup>354</sup>

## Prácticas Prometedoras

### A. Alianza Nacional para Acelerar la Reducción de la Mortalidad Materna e Infantil República Dominicana<sup>355</sup> (Práctica estatal)

43. República Dominicana es el segundo país con las tasas más altas de muerte materna, solo detrás de Haití, lo cual está directamente relacionados con la calidad de los servicios médicos que reciben las mujeres. En el país el porcentaje de parto hospitalario es del 99%, teóricamente asistido por personal capacitado y con un seguimiento de mínimo 4 consultas de seguimiento durante el embarazo. A pesar de esto, las tres principales causas directas (75%) de las muertes siguen siendo trastornos hipertensivos durante el embarazo, parto y puerperio; hemorragia y aborto. En mayo

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<sup>352</sup> Cristina Rosero, Colombia. Consulta organizada por FAR, WHRI y CWGL. Julio 2020. “La organización recomienda hacer énfasis en cómo los servicios de salud reproductiva deben entenderse como servicios esenciales en las situaciones de crisis. Esto implica establecer protocolos de atención claros para la atención integral de las necesidades de salud sexual y reproductiva, que incluyan medidas como el uso de telemedicina con información suficiente para que las mujeres puedan tomar decisiones con pleno consentimiento”.

<sup>353</sup> *Ibíd.*

<sup>354</sup> Beatriz Gallo, Brasil. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>355</sup> Cinthya Amanecer Velasco Botello, República Dominicana. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.



del 2019, mediante la resolución ministerial número 00004 el gobierno puso en vigencia el Documento Marco: Alianza Nacional para Acelerar la Reducción de la Mortalidad Materna e Infantil, que es una propuesta dirigida a fortalecer las acciones para bajar en 70 por cada 100 mil nacidos vivos la mortalidad materna. Dicha resolución incluye el aumento al presupuesto asignado para la capacitación y contratación de más personal de salud que pueda brindar servicios adecuados a las mujeres gestantes durante el embarazo el parto y el puerperio así como medidas de empoderamiento para la ciudadanía para la exigencia de sus derechos a la salud. Los resultados pudieron verse casi de inmediato, para junio del 2018 se registraron 54 muertes maternas, mientras que para el mismo periodo en 2019 los datos arrojan 46 fallecimientos, esto indica una reducción de un 7% en este periodo.

## **B. Recomendación en torno a los métodos anticonceptivos y la Interrupción Legal del Embarazo en Argentina**

44. La Dirección de Salud Sexual y Reproductiva del Ministerio de Salud de la Nación emitió una circular por la que reconoció que los métodos anticonceptivos y la Interrupción Legal del Embarazo son prestaciones esenciales.<sup>356</sup> Respecto a los métodos anticonceptivos, recomendó que deberá de facilitarse el acceso a la población a través de diversas estrategias incluyendo la entrega a domicilio para la población registrada, la entrega de una mayor cantidad de métodos por persona para evitar nuevas consultas en el corto plazo y la obligación de brindar consejería. Respecto a la interrupción legal del embarazo (ILE), recomendó que se deben de identificarse los circuitos de atención que pueden sostenerse en funcionamiento y el acceso a la población ; coordinar con estos servicios la referencia y contrarreferencia de las mujeres; sostener y fortalecer las vías de acceso a la medicación y promover las prácticas ambulatorias con información y seguimiento. Además indicó que deberán de establecerse los roles dentro del equipo de salud para realizar servicios de Interrupción Legal del Embarazo; brindar consejería y tener un control claro y actualizado del stock de insumos disponible en depósito provincial, en los hospitales y en los centros de salud para asegurar la disponibilidad de la medicación, de instrumental e insumos necesarios.

## **C. Medidas de respuesta a la pandemia en Colombia<sup>357</sup>**

45. En el contexto de la pandemia, el Ministerio de Salud autorizó la realización de actividades de atención en salud con herramientas de telesalud y telemedicina (mecanismos de atención telefónica o electrónica para atender solicitudes de citas médicas, historia clínica, consentimientos informados, entre otros). Se aprobaron algunas orientaciones técnicas para abordar los efectos de la pandemia en la fecundidad, en estas se hizo referencia a la atención de

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<sup>356</sup> Ministerio de Salud de la Nación (Argentina), Comunicación adoptada el 25 de marzo de 2020.

<sup>357</sup> Marcia Aguiluz, Regional. Insumo enviado para la consulta organizada por FAR, WHRI y CWGL. Julio 2020.

la violencia sexual, acceso a provisión de anticonceptivos por 6 meses, acceso a interrupción voluntaria del embarazo. Dentro de las regulaciones proferidas en el marco del estado de emergencia declarado por la pandemia del COVID-19, el Ministerio de Salud expidió los Lineamientos para la Prevención, Detección y Manejo de Casos de COVID-19 para la Población Migrante en Colombia, mediante los cuales encomendó a las entidades territoriales la garantía del acceso a los servicios de salud para la atención del COVID-19 a esta población sin distinción en su estatus migratorio, desde un enfoque diferencial étnico y de género.

#### **D. Recomendaciones para la atención médica a embarazadas durante la pandemia en Ecuador<sup>358</sup>**

46. El Ministerio de Salud Público aprobó las Recomendaciones para los profesionales de la salud para el manejo y cuidado de la salud de las mujeres durante el embarazo, el parto, puerperio, periodo de lactancia, anticoncepción y recién nacidos en caso de sospecha o confirmación de diagnóstico de COVID-19. De acuerdo con estas recomendaciones: i. el servicio de anticonceptivos, la información, asesoría y servicios, incluida la anticoncepción de emergencia, deben estar disponibles y accesibles en el contexto actual; ii. Sobre los métodos anticonceptivos, se recomienda que en una sola consulta se brinde asesoría, se entregue el carné de uso de métodos anticonceptivos y el método elegido por la usuaria. Se pueden entregar pastillas combinadas e inyección anticonceptiva. Para su entrega, se puede acercar un familiar al establecimiento de salud; iii. Anticoncepción Oral de Emergencia: Se garantiza la entrega inmediata de información y AOE; iv. Ni para acceder a anticonceptivos ni para la Anticoncepción Oral de Emergencia se requiere presentar documento de identidad o documento migratorio.

#### **E. Lineamientos de Planificación Familiar y Logística para los Servicios de Salud Reproductiva en Guatemala<sup>359</sup>**

47. Los Lineamientos de Planificación Familiar y Logística para los Servicios de Salud Reproductiva. Prioridad en el Marco de la Pandemia COVID-19, publicados por el Ministerio de Salud Pública, establecen: i. Entrega de métodos anticonceptivos en ciclos orales combinados para 3 meses, o bien, inyectable mensual, bimestral y trimestral, el DIU e implante subdérmico; ii. Entrega de la Píldora de Anticoncepción de Emergencia (PAE): Durante la emergencia sanitaria, deben entregarse a todas las mujeres que la soliciten así no hayan consultado previamente al médico; iii. Respecto a servicios de atención posparto se sugiere definir localmente rutas de referencia que incluyan servicios de información, insumos y servicios de planificación familiar. Se acuerda la entrega de métodos de larga duración en el post parto inmediato y post aborto; iv. Informar a las comadronas para que puedan informar a las mujeres en sus comunidades.

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<sup>358</sup> Marcia Aguiluz, Regional. Insumo para la consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>359</sup> Marcia Aguiluz, Regional. Insumo para la consulta organizada por FAR, WHRI y CWGL. Julio 2020.

## **F. Protección a mujeres migrantes con necesidades de salud por la Corte Constitucional en Colombia<sup>360</sup>**

48. La Corte Suprema de Justicia, en el año 2019 estableció que no se puede negar la atención en salud a las mujeres y niñas venezolanas debido a su condición migratoria, pues ello aumenta su situación de vulnerabilidad y pone en riesgo tanto su salud como su vida. La decisión reconoce que las niñas migrantes víctimas de violencia sexual están en tal situación de vulnerabilidad y necesitan una protección especial por parte del Estado. La decisión se origina a partir de un caso litigado por Women's Link Worldwide relacionado con la atención de una adolescente embarazada, de nacionalidad venezolana de 14 años que migró a Colombia, con diagnóstico de toxoplasmosis, y quien además fue víctima de violencia sexual en Colombia. En este caso, la Corte Suprema de Justicia ordenó -de manera urgente- a las entidades estatales correspondientes realizar todas las gestiones necesarias para prestar los servicios de salud requeridos por la víctima y su hija, en relación con el diagnóstico de toxoplasmosis de la primera, así como los cuidados post natales de las dos.
49. La Corte de Constitucionalidad, en la sentencia SU 677/17, relacionada con la falta de atención pre natal de una mujer migrante venezolana, embarazada y en condición irregular en Colombia, señaló que “el Estado está en la obligación de prestar los servicios de atención básica y de urgencias a todas las personas, independientemente de que la persona que los requiera sea un extranjero con permanencia irregular, especialmente teniendo en cuenta el contexto de crisis humanitaria en el que se encuentra Colombia por la migración masiva de ciudadanos venezolanos, en la que el deber de solidaridad del Estado es cualificado”. Esta sentencia es relevante porque también señala que, si bien el embarazo no ha sido catalogado como una urgencia, “la salud de la mujer migrante sí requería una atención urgente pues se encontraba en un alto riesgo por las consecuencias físicas y psicológicas que se derivan del hecho de estar embarazadas y por encontrarse en medio de un proceso de migración masiva irregular”.
50. En el caso de una mujer migrante venezolana que tenía cáncer en el cuello del útero y a la que no se le brindó el tratamiento de quimioterapia en un hospital en Colombia, la Corte Constitucional en la decisión T210 de 2018 la Corte Constitucional dijo: i. que, de acuerdo con el derecho internacional, los Estados deben garantizar a todos los migrantes, incluidos aquellos que se encuentran en situación de irregularidad, no solo la atención de urgencias con perspectiva de derechos humanos, sino la atención en salud preventiva con un enérgico enfoque de salud pública; ii. que la atención de urgencias, que incluye la adopción de medidas colectivas eficaces con un fuerte enfoque de salud pública (vacunaciones, atención de enfermedades de contagio directo), es necesaria para garantizar el propósito preventivo, proteger la salud y la salubridad pública, y promover el bienestar general no solo de quienes llegan al país, sino también de la comunidad que recibe; iii. que el Gobierno colombiano debe revisar “la normativa vigente que dinamiza el alcance del derecho a la salud de los migrantes irregulares en Colombia, a fin de que tomen medidas para reducir las cargas desproporcionadas que la misma impone actualmente a

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<sup>360</sup> Marcia Aguiluz, Regional. Insumo para la consulta organizada por FAR, WHRI y CWGL. Julio 2020.

esta población. Por ejemplo, las ya mencionadas relativas a las inmensas limitaciones económicas que existen para ingresar a Colombia por la vía regular, y, en consecuencia, ser apto para afiliarse al sistema de salud; iv. Todo lo anterior, debido a que la delicada situación humanitaria que viven los migrantes en situación irregular, los pone en una situación de vulnerabilidad, exclusión y desventaja que demanda la adopción de medidas especiales por parte del Estado y su tratamiento como sujetos de especial protección constitucional.

## **G. Buenas prácticas, prácticas promisorias y lecciones aprendidas de la sociedad civil**

51. **Centroamérica**<sup>361</sup>: Una de las buenas prácticas de la sociedad civil en Centroamérica es la articulación de 25 organizaciones feministas y mujeres independientes que luchan por la despenalización del aborto. Estas han conformado un importante espacio de interlocución sobre población y desarrollo con un alto énfasis en el Consenso de Montevideo, logrando la integración de organizaciones en la capital y otras regiones, organizaciones de mujeres indígenas, afrodescendientes, mujeres trans, mujeres rurales, etc., donde se articulan acciones de investigación, campañas de comunicaciones, incidencia política; incidencia en espacios internacionales; elaboraciones de informes y litigio estratégico entre otras acciones.
52. **México**.<sup>362</sup>: En los últimos años, organizaciones feministas mexicanas han conformado redes de acompañamiento para brindar abortos seguros autónomos con medicamentos fuera de los hospitales. Durante la crisis de la pandemia esta red ha servido para no cargar el sistema de salud cuando éste ya está colapsado. Esta mirada y práctica feminista que estaba pensada para garantizar el acceso a un aborto en territorios clandestinos, también es una práctica que permite en la actualidad hacer frente a esta crisis.
53. **Lecciones aprendidas en Argentina**.<sup>363</sup> En el año 2018, Argentina clausuro el año con un debate parlamentario histórico donde se obtuvo la media sanción para la para la legalización del aborto por voluntad de la mujer, esto proyecto no paso al Senado, pero dejo un movimiento de mujeres aliado con el movimiento de la diversidad, con los movimientos sociales y los movimientos de derechos humanos, la Marea Verde, que actualmente es imparable. A pesar de esto, los fundamentalismos religiosos se reorganizan rápidamente generando retrocesos, lo cual ha sucedido al judicializar parte de las conquistas obtenidas. Al judicializar políticas públicas como la de los protocolos, estos pueden ser utilizados como un arma de doble filo, por estandarizar

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<sup>361</sup> Norma Carías, Honduras. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>362</sup> Oriana López Uribe, México. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

<sup>363</sup> Soledad Deza, Argentina. Consulta organizada por FAR, WHRI y CWGL. Julio 2020.

buenas prácticas clínicas, los protocolos llegan a un peldaño que alcanza casi al de la ley, convirtiéndose en otro obstáculo.<sup>364</sup>

## Aspectos que podría incluir el informe temático

54. Las activistas que participaron en las sesiones consultivas organizadas por FAR en julio y agosto pasado señalaron que los siguientes aspectos para ser considerados por parte del Grupo de Trabajo:

- a. Se deben de nombrar con toda contundencia el hecho de que existe una crisis de los derechos sexuales y reproductivos y que estos encuentran amenazados y en riesgo debido a las barreras culturales y estructurales que impiden su garantía y ejercicio pleno a las mujeres. Se deben de mencionar que esto sucede en contextos de normalidad y de crisis.
- b. Indicar que existe una ausencia de los Estados ante la crisis de derechos sexuales y reproductivos que adquiere un impacto desproporcionado en contextos de crisis asociada al conflicto armado, extractivismos, desplazamiento, crisis climática, militarismo y crisis causada por los grupos anti-derechos..
- c. Deberá de enfatizar el daño a los derechos de las mujeres, niñas y adolescentes por el tiempo transcurrido a partir de la no implementación de los compromisos asumidos por los Estados.
- d. Deberá de subrayar que la penalización del aborto no disminuye el número de abortos y en cambio provoca el incremento de la mortalidad y morbilidad maternas porque empuja a las mujeres y niñas a la clandestinidad.

## Mensaje clave para los estados

55. Las activistas que participaron en la sesión consultiva organizada por FAR, WHRI y CWGL el 6 de agosto del 2020 identificaron los siguientes mensajes clave para la consideración del Grupo de Trabajo:

- a. Si bien es cierto que la discriminación y la violencia basada en el género contra las mujeres y las niñas en los países de la región se ven agravadas en contextos de crisis e inseguridad humana, se debe de hacer un llamado a los Estados para que reconozcan que los altos niveles de discriminación y violencia contra las mujeres en muchos de los países de la región constituyen *per se* una crisis. “La crisis de la desigualdad de género” se debe de abordar a través de medidas transformadoras y de largo plazo.

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<sup>364</sup> *Ibíd.* Una práctica promisorio es la identidad de género, Argentina fue pionera en promulgar la Ley 26746, identidad auto percibida, sin embargo se impide el acceso a terapias y a la educación sexual integral que es lo único que va a fortalecer la autonomía sexual y las denuncias por abusos sexuales.

- b. Organizaciones feministas y de mujeres también hacen un llamado para que se reconozca la existencia de la pandemia de la de violencia contra las mujeres en el espacio públicos y privados.<sup>365</sup> Como tal, es necesaria la adopción de medidas urgentes e integrales que atiendan a las causas estructurales del problema.
- c. Existe una crisis para los derechos sexuales y los derechos reproductivos que hay que atender con el más alto compromiso de los Estados, tanto en los contextos de normalidad como en los de crisis en donde se ven desproporcionadamente afectados.
- d. Se necesitan Estados más fuertes para garantizar los derechos sexuales, los derechos reproductivos y en general en los derechos de las mujeres. Únicamente el Estado laico será capaz de garantizar efectivamente el acceso eficaz a las políticas públicas esenciales destinadas a la determinación sexual y derechos reproductivos.
- e. Entre los países existe mucha disparidad en el avance frente a los derechos sexuales y reproductivos. Para que los derechos se apliquen debemos tener un mínimo común que incluya acceso a espacios adecuados en donde se atienda a las mujeres, haya acceso a métodos de planificación familiar y se puedan tomar decisiones reproductivas, haya el reconocimiento de las tres causales de aborto. Ese mínimo común elevaría a las mujeres y niñas a un nivel de dignidad que no tienen en ciertos países.<sup>366</sup>
- f. Es urgente la implementación de un modelo de educación sexual transformador para abordar la discriminación contra las mujeres, cambiar los estereotipos de género, reducir la violencia basada en género, construir autonomía y normalizar la diversidad sexual.

## Recomendaciones

56. Las activistas que participaron en las sesiones consultiva organizadas por FAR, WHRI y CWGL el 6 de agosto de formularon las siguientes recomendaciones para los Estados:
  - a. Poner en el centro el carácter jurídicamente vinculante de los derechos sexuales y reproductivos como parte de los derechos humanos;
  - b. Acelerar el cumplimiento de los estándares internacionales por parte de los Estados.
  - c. Reforzar las clausuras de no regresividad y progresividad de los derechos.
  - d. Enmarcar los derechos sexuales y reproductivos con su carácter esencial y activar rutas de acceso y garantía que los vuelva una realidad en la vida de las mujeres. Impulsar una

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<sup>365</sup> Al respecto, en El Salvador, “la pandemia de los feminicidios, violencia sexual, embarazos impuestos ya colocaban a las mujeres en una situación de violación sistemática de derecho humanos; la crisis ya se encontraba en El Salvador, y desde hace mucho se viene luchando por transformar esta realidad”. Sara García, El Salvador. Consulta por la Alianza Feminista por los Derechos (FAR), el Centro de Liderazgo Global de las Mujeres (Center for Women’s Global Leadership) y el Instituto de los Derechos Humanos de las Mujeres (WHRI) el 24 de julio de 2020 (en adelante, “Consulta organizada por FAR, CWGL y WHRI. 2020”).

<sup>366</sup> Estefanía Mendoza propuso la idea del “mínimo común” el cual serviría para que las mujeres no piensen “nos falta tanto, entonces podemos aceptar cualquier cosa” o los países más avanzados dan por sentado ese avance y por eso se han visto en muchos países -incluyendo Estados Unidos- algunos retrocesos en esta materia.

categoría independiente de la violencia reproductiva ya que en ocasiones ésta no queda explicada con la definición de violencia sexual.

- e. Reforzar los dispositivos sanitarios y administrativos destinados a asegurar la autodeterminación sexual a las mujeres, lesbianas, trans y personas no binarias y despatologizar la intersexualidad.
  - f. Garantizar el acceso a la justicia, capacitar a los funcionarios que atienden a las víctimas o las personas que levantan denuncias, para que puedan ser recibidas por personal capacitado que eviten la revictimización.
  - g. Invertir en medidas que se enfoquen con profundidad en la transformación de los roles de género para hacer frente a la crisis de desigualdad de género y invertir en la educación integral en sexualidad a largo plazo.
  - h. Transversalizar la perspectiva de género en todos los órganos del gobierno, política y programas.
  - i. Transformar la cultural más allá de las aulas, incluir esta transformación en campañas dirigidas al Estado y a la ciudadanía en general.
  - j. Adoptar medidas inmediatas para reformar problemas estructurales.
  - k. Garantizar el enfoque interseccional y la adopción de medidas específicas para garantizar el acceso a los servicios de salud sexual y reproductiva de mujeres y niñas con discapacidad, indígenas, migrantes, trans y de género no conforme.
  - l. Recomendación para los mecanismos de justicia transicional: La violencia sexual cometida en el contexto del conflicto armado debe ser considerada con una profundidad suficiente que permita comprender sus impactos físicos, emocionales y sociales, así como adoptar formas de reparación integral, incluyendo reparaciones transformadoras como políticas públicas o medidas que mejoren el acceso a servicios de salud sexual y reproductiva en zonas rurales y zonas históricamente afectadas por el conflicto armado. Esto incluiría garantías de no repetición frente a la persistencia de la violencia sexual perpetrada contra niñas y adolescentes indígenas por parte de miembros de fuerza pública.
57. Recomendación para el Grupo de Trabajo: Considerar la posibilidad de presentar estas recomendaciones como unas obligaciones con un plazo para que deje de sentirse como una retórica, imponer una exigencia sobre el tiempo y la urgencia de manera perentoria.