

# Reproductive rights: a long way to go

Tanya Saroj Bakhru

Women's reproductive health needs and desires – as well as their very understanding of what constitutes reproductive health – are shaped by nationality, race, class, ethnicity, religion and culture. For ethnic, religious and linguistic minority and indigenous women, there is often a wide gap between how they would best like their self-identified reproductive health needs to be met and the services that they receive, thanks to the intersecting and overlapping discrimination that they face as women, and as members of minority and indigenous groups. This can range from poor or culturally inappropriate provision of services in the areas that they live, to outright denial of access to reproductive health care. Poverty further compounds this discrimination for many minority and indigenous women, leading to high rates of maternal and infant mortality, and other poor reproductive health outcomes, in comparison to majority groups. In addition, in some cases minority and indigenous women have been specifically targeted for programmes aimed at reducing the number of births in a given community.

These systematic violations of minority and indigenous women's reproductive rights occur despite the emergence over the past 20 years of a global reproductive rights movement. This movement has linked women's health movements in different contexts, and has pushed for acknowledgement of the relationship between the social, economic, and political empowerment of women and their ability to control their own fertility and sexuality, with minimal risk and maximum decision-making power (as Rosalind Petchesky argued in 2003).

One of the key events in regard to the emergence of the global reproductive rights movement came in 1994 when the United Nations Population Fund (UNFPA) convened the International Conference on Population and Development (ICPD). The conference was attended by representatives from 179 nations and 11,000 individuals from non-governmental organizations (NGOs), international agencies, citizen activists and governments. At the conference, a 20-year Programme of Action (POA) was created, calling for a shift away from earlier focus on population control to improving women's lives; from demographic targets to individual needs; and relying on a rights-based approach to reproductive health. Minority women activists

played an important role in drawing up the POA, particularly in regard to negotiating for the term 'reproductive rights' to be accepted and included in the POA. This followed the rejection of the proposed term 'sexual rights' by some conservative and religious constituencies, and led to a discussion addressing the link between individual rights and a community's conditions, which may limit or enhance those rights. This is a discussion that has particular relevance to minority and indigenous women, and is one that also contributed to the 1995 Beijing Platform of Action, and the UN Millennium Development Goals (MDGs).

The definition of reproductive health in section 7.2 of the ICPD POA is as follows:

*'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. [...] It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.'*

The input of minority women at the ICPD included the point that notions of reproductive and sexual rights must incorporate both personal freedom and social support, and affirmed that an individual's health is inextricably linked to her community's health. Further exploring this point, Sonia Correa and Rosalind Petchesky, writing in 1994, discuss the idea of 'enabling conditions' as a requirement for the full realization of all women's reproductive and sexual health. Enabling conditions include those 'material and infrastructural factors' that one needs to carry out the decisions one makes about one's reproductive health. Factors such as access to transportation, the means to economic subsistence, comprehensive and accessible services (including information in the appropriate language), protective laws, as well as freedom from discrimination (racism, sexism, xenophobia) are all part of those enabling conditions that must be present in order for minority and indigenous women to have control over their sexual and reproductive lives.



Minority and indigenous women's reproductive lives are shaped not only by such 'enabling conditions', and by forces from the dominant society based on their marginalization as part of a minority group, but also from within their own community, based on their status as women. This is because of the associations often made between women's bodies and the cultural and ethnic identity and integrity of a particular group, as Fareda Banda and Christine Chinkin argued in a report for

MRG in 2004. This can mean restrictions being placed on women's sexual and reproductive rights from within their own communities (e.g. pressure to abstain from using contraception, or to marry early), as well as discriminatory policies aimed at women from particular ethnic groups. Examples of this can be seen in instances of forced sterilization of women from minority and indigenous groups deemed 'undesirable', which are explored later in this chapter.

**Left:** Indigenous Achuar women from Ecuador learn about safe birthing techniques. They are then able to take these skills back to their communities in the Amazon. *The Pachamama Alliance*.

The potential for minority and indigenous women to be reduced to their biology as ‘physical vessels for genetic messages’ (a term used by Rosalind Petchesky in 1997) by both the dominant culture and within their own community is great. As Naila Kabeer writing in *Reversed Realities* in 1994 notes: ‘For feminists, the issue of reproductive rights crystallizes in many ways the whole question of women’s rights over their own bodies, a critical element to women’s full participation in society’. In this way, denial of minority and indigenous women’s reproductive rights (either from within or outside their communities) justifies and perpetuates gender, racial, ethnic and cultural discrimination, limits a woman’s ability to realize her full reproductive health and marginalizes women within already existing social minority groups even further. In 1998, Dorothy E. Roberts pointed out that: ‘Without the ability to determine their reproductive destinies, women will never achieve an equal role in social, economic, and political life and will continue to be politically subordinate to and economically dependent on men.’

### **Poverty, marginalization and maternal mortality**

The social and political marginalization of minority and indigenous women – as well as the pressure and discrimination they face from within their own communities – is often compounded by poverty. Poverty remains one of the most significant barriers to the full actualization of reproductive health, and the link between health, income and minority status is well established (as argued by Alicia Armstrong and Yvonne Maddox, writing in 2007 for *Ethnicity and Disease*).

Women are not only the fastest growing portion of the world’s most poor; they also lack the tools and resources necessary to recover from poverty in relation to men, according to Joni Seager (2009). For minority and indigenous women the challenge to overcome poverty is even greater, as systemic racism, ethnocentrism and xenophobia continues to be an endemic part of social institutions and results in barriers to economic autonomy, bodily

safety, or access to services including health and education. For example, findings from a 2009 comprehensive study by Cara James, Alina Salganicoff, Megan Thomas, Usha Ranji and Marsha Lillie-Blanton of health disparities among women in the United States show that in nearly every state, women of colour and Native American women are more likely to live below the poverty line than white women, have lower median household incomes than white women, earn less than white women, are less likely to hold a high school diploma, are more likely to be part of single female-headed households, and more likely to live in socio-economically disadvantaged neighbourhoods. These social factors greatly impact on minority and indigenous women’s ability to realize full reproductive health, in that those living in poverty are less likely to have access to care, less likely to have routine care and more likely to delay care. Poverty also determines factors such as nutrition and stress that can exacerbate reproductive health problems. Outside the US, both within and between countries, the disparity in reproductive health care and reproductive health outcomes between rich and poor and along racial, ethnic and cultural lines is just as notable.

According to a 2005 study on maternal mortality undertaken by the World Health Organization (WHO), the UN Children’s Fund (UNICEF), UNFPA and the World Bank, reproductive health issues are the leading cause of death for women worldwide. Complications during pregnancy and childbirth are the leading cause of death and disability among women of reproductive age, particularly among those living in the global South. While complications during pregnancy and childbirth are often fatal for poor women in general, they are, in the majority of cases, preventable.

For poor minority and indigenous women, barriers to safe pregnancy that can contribute to high rates of maternal mortality are exacerbated by circumstances specific to their racial, ethnic or cultural status, which can include geographical remoteness, lack of provision of services in the areas where they live and linguistic barriers. For example, the Karen ethnic minority group in Thailand has one of the highest maternal mortality rates in the country. This is due to poverty, their remote geographic location, and consequent inaccessibility of health clinics. In order to combat high maternal

mortality, the Thailand Department of Health in conjunction with UNFPA began a programme to train village health workers to educate within their own community on maternal and child health, thereby providing resources in a culturally appropriate way that would reduce the negative experiences women endure during pregnancy and childbirth. A similar set of circumstances shapes the experiences of women of the Hmong minority group, who live in a mountainous region of north-western Vietnam. Poverty, remote geographic location, language barriers and cultural traditions that place traditional reproductive health practices in opposition to seeking mainstream medical attention characterize the obstacles to care that prevent Hmong women from accessing reproductive services. These circumstances result in high levels of maternal mortality. According to Maria Larrinaga, writing in 2009, campaigns to 'raise awareness about maternal health, to train local women in midwifery skills and to respect the local culture' have resulted in more Hmong women accessing reproductive health services, and a decrease in maternal mortality. Similar approaches have been taken to combat poverty, inaccessibility of services, and cultural traditions that hinder women to seek reproductive health services among Tai, Giay, Nung and Clao minority groups also living in Vietnam. Recruiting and training women locally and from the communities for which they serve has '[inspired] trust and [encouraged] more women to receive appropriate services'.

Another study of the challenges to maternal health care utilization among ethnic minority women in China (by Amanda Harris, Yun Zhou, Hua Liao, Lesley Barclay, Weiyue Zeng and Yu Gao, writing in *Health Policy Planning* in 2010) shows that maternal mortality rates are highest in the remote and impoverished areas where minority women live. This study took place in southern Sichuan Province, along the foothills of the Himalayan mountain range, where over 80 per cent of the population belong to Yi, Mong and Naxi ethnic minority groups. Services marked by poor accessibility and low quality as well as high costs proved to be detrimental to maternal health and service utilization. The study concluded that 'utilization of maternal health care services is associated with a range of social, economic, cultural, and geographic factors' specific to one's minority status.

The examples above illustrate how the existing socio-economic, political and physical marginalization of many minority groups can serve to perpetuate indirect discrimination against minority women in regard to access to reproductive health care (mainly as a result of poor or inadequate provision of health care services). But there are also instances where minority or indigenous women face direct discrimination. A 2009 report by Human Rights Watch (HRW) on reproductive health in Uttar Pradesh, in northern India, found that many of the Dalit and lower-caste women interviewed for the report had faced direct, caste-based discrimination from health workers. This had included nurses refusing to visit Dalit communities to provide ante- or postnatal care to women, or, in the event that they did visit, refusing to touch the woman or her baby. In another instance recorded in the report, a Dalit woman who gave birth in a state health facility was discharged without being properly examined by medical staff, meaning that health complications relating to her recent delivery were not picked up. As a result, she suffered serious and debilitating health problems, incurring US \$1,000 in health care expenses, and she and her family experienced verbal abuse when they complained about the poor treatment that she had received. Other cases where Dalit women had received inadequate care as a result of caste-based discrimination were also not properly investigated. In other instances, reported by Healthwatch Forum Uttar Pradesh, scheduled caste women were physically abused by medical staff, or denied access to treatment because their families could not pay for medicines or refused to pay bribes to medical staff (antenatal, delivery and postnatal care are meant to be available free of charge). Such discrimination no doubt contributes to the fact that lower-caste and tribal women were found to make far less use of reproductive health services, and that they accounted for 61 per cent of maternal deaths in six north Indian states, according to a 2007 report by UNICEF.

At the global institutional level, the connection between poverty, gender inequality and minority status pervades international assessments of maternal mortality. Several United Nations (UN) resolutions parallel the findings noted above by acknowledging 'the unacceptably high global rates of preventable-maternal mortality and morbidity'. For example,

the UN Commission on the Status of Women passed a resolution (contained in UN Document E/CN.6/2010/L.6) in 2010 stating that these high rates:

*'are directly related to poverty, the presence of persistent gender inequalities, including inequitable and unequal access to adequate health services and facilities, gender-based violence, harmful traditional practices, lack of education, lack of economic opportunity, [and] lack of participation in decision-making.'*

Perpetuating cycles of disenfranchisement, the death of a mother due to pregnancy or childbirth can further entrench her children in poverty, according to UNFPA. Furthermore, there is a consensus in the international community that addressing maternal mortality will reduce poverty, improve overall health services and increase gender equity, as reflected in the fifth MDG to improve maternal health.

### **Coercive reproductive health practices**

In addition to direct discrimination in regard to access to reproductive health care, minority and indigenous women in some contexts have faced coercive reproductive health practices, representing direct violations of their sexual and reproductive rights, and rights to bodily integrity. For example, in the United States, eugenicist ideology embedded in government policy tacitly sanctioned the forced sterilization of ethnic minority women throughout much of the twentieth century. Between 1929 and 1941 the US government funded over 700,000 involuntary sterilizations, including of women of colour, women who relied on federally subsidized clinics, and women who came into contact with the state through, for example, the prison system or state psychiatric facilities. Evidence reported by Jennifer Nelson in 2003 showed that in 1970 black women had been sterilized at over twice the rate of white women, while data from 1975–6 showed that women who used state-funded medical care were sterilized at a rate 2–4 times higher than those using other forms of health care. Based on this evidence, it has been argued that sterilization was pushed on women who were deemed unworthy to reproduce based on racist notions of the inferiority of people of colour. Alarming, documented cases of forced sterilization continued into the 1980s.

Discriminatory ideology regarding minorities has

continued to inform coercive reproductive health practices in the contemporary era. For example, a Czech Public Defender of Rights report in 2005 documented and investigated 87 claims by Roma women in the Czech Republic of coercive sterilization practices in state-run hospitals. The women claim that they were specifically targeted for sterilization because of their race, and were either pressured at the time of giving birth into being sterilized or were sterilized without their full knowledge or understanding of the procedure. As reported by Dinah Spritzer for WeNews in 2005:

*'Concerns that Roma women were sterilized without their consent in post-Communist Czech Republic were raised by Roma advocacy groups in the 1990s, but it was not until earlier this year that actual victims – encouraged by several Roma advocacy groups – began to talk publicly about their experiences and demand justice.'*

The practice of sterilization of Roma women in the Czech Republic is embedded in ideology from the communist era to 'sterilize women the government deemed undesirable'. Similar cases were also reported in Hungary and Slovakia, where in 2004 eight Roma women lodged an application at the European Court of Human Rights (ECtHR) in order to gain access to their medical records. In 2009, the Court found in their favour, and requested that the Slovakian health authorities release the medical records.

### **Voices of reproductive health activists**

Issues of the intersection of identity and barriers to reproductive health care provision, and advocacy around poverty, discrimination and social justice emerged in my own research with reproductive health NGOs in Dublin, Ireland, and San Diego, USA. The examination of reproductive health NGOs is significant, given the multifaceted roles they play simultaneously as advocates, educators and service providers.

In interviews with programme administrators from a reproductive health NGO in Dublin, issues of social justice for all members of society came to the fore. Several of my respondents noted the situation of refugee and asylum-seeking women (largely coming from the African continent) who were most marginalized in the Irish context. My interview respondents asserted that poverty and

the invisibility of poor women in an economically prospering Ireland of the time, as well as racism, underpinned many of the problems the organization encountered in helping the women they worked with to gain access to reproductive health services. They also saw clear connections between poverty, migrant status, and the ethnic minority status of refugee and asylum-seeking women in Ireland. These elements linked in turn to the necessity of confronting racism and ethnocentrism within a greater reproductive health advocacy context. One NGO administrator, Sharon, said:

*'In terms of poverty, I mean poverty is a huge issue ... because it can be one of the biggest issues for separated women [or] refugee women. Then of course you're dealing with situations where you know because they are in [a] financial bind and there are a great many women in that position here and it's really escalated for the refugee women which of course, the added problems for getting visas etc. to get out of the country. There are no funds available to help those women. And with the refugee and asylum-seeking women it's very stressful. Because those women are in dire situations, they've often come into this country from you know desperate situations and are in awful positions, they're in hostels, they're overcrowded, they're lonely, they're isolated. They're in a perfect set of circumstances if they don't already arrive pregnant, for becoming pregnant here. I mean ... for someone like me what the refugee women represent is the poor women in Ireland.'*

In relation to accessing comprehensive reproductive health care, Sharon highlighted several key points by using the example of the situation of refugee and asylum-seeking women experiencing a crisis pregnancy. For her, the refugee women living in Ireland that she interacted with as a crisis pregnancy counsellor and reproductive health advocate were representative of poor and disenfranchised women across Ireland, both currently and historically. Issues such as lack of financial resources, limitation on travel, lack of privacy or confidentiality, encountering gender-based discrimination, the effects of violence both within one's personal life and wider society, were all matters that greatly influenced clients' decision-making about their reproductive (and wider) lives. Sharon also expressed her own frustration at how lack of financial resources and restrictive immigration policy

hampered her in helping women to navigate their decision-making under such circumstances.

In addition to the role that NGOs have increasingly come to play in providing reproductive (and other) health services as the state's role has decreased in many countries, they have also led advocacy efforts in relation to reproductive health, rights and justice. In speaking about her grassroots outreach activities, one respondent from San Diego, Renee, said:

*'We get so many people that just say, why do I care about [reproductive] choice? And seeing the huge cross-connections between so many issues. You just can't separate issues like poverty, race, and sexuality, and gender from issues of reproductive choice.'*

Similarly, when speaking about working with the Latina community in the border area of San Diego, Serena, an administrator from the Bi-National Affairs Department, said:

*'It [poverty] also can limit choice to reproductive health. They keep saying how can you choose what to do with your life when you don't have the means to do it. You don't have education, food on your table, health care, insurance ...'*

Keeping issues of poverty, race, gender equity and sexuality interlinked was a growing part of the organization's policy and practice. At the heart of such an approach was the idea that people cannot have full access to reproductive health care when they face limitations concerning transport, funds and accurate information, as well as a lack of equity. Reproductive decisions cannot be made in any real and meaningful sense under such circumstances of deprivation and denial. Veronica, another respondent confirmed this, stating:

*'if you think about the fact that a lot of the patients that we see, they don't have transportation, you know so, or can't even get to the clinics, so you have to address their basic needs in order for them to even think about getting birth control or whatever because they're thinking about how they're going to get food or where they are going to sleep.'*

## Conclusion

In order to address the challenging situation that many minority and indigenous women face around

the world, advocates – including policy makers, activists and scholars – must make an analysis based on ‘both the experience of oppression and the strengths that individuals and communities bring to bear on particular issues by explicitly addressing the intersections of gender, race, class, and other identities and experiences that affect individuals and communities’, as stated in a report by Asian Communities for Reproductive Justice (2009).

We must embrace the notion that women’s control and right to take decisions over their own bodies is closely linked to equality and poverty reduction in general, and the empowerment of minorities and indigenous peoples in particular. Governments must repeal laws and policies that are discriminatory and enforce policies that aim at preventing violence against women and supporting the well-being of girls, as these are integral to the capacity of women to enjoy their full reproductive rights. In this way, we can move towards a global society in which all people have the economic, social, and political power and means to make decisions for themselves and their communities about their bodies and reproductive lives, and in which *all* women can participate in society as full human beings, regardless of geographic or social location. ■