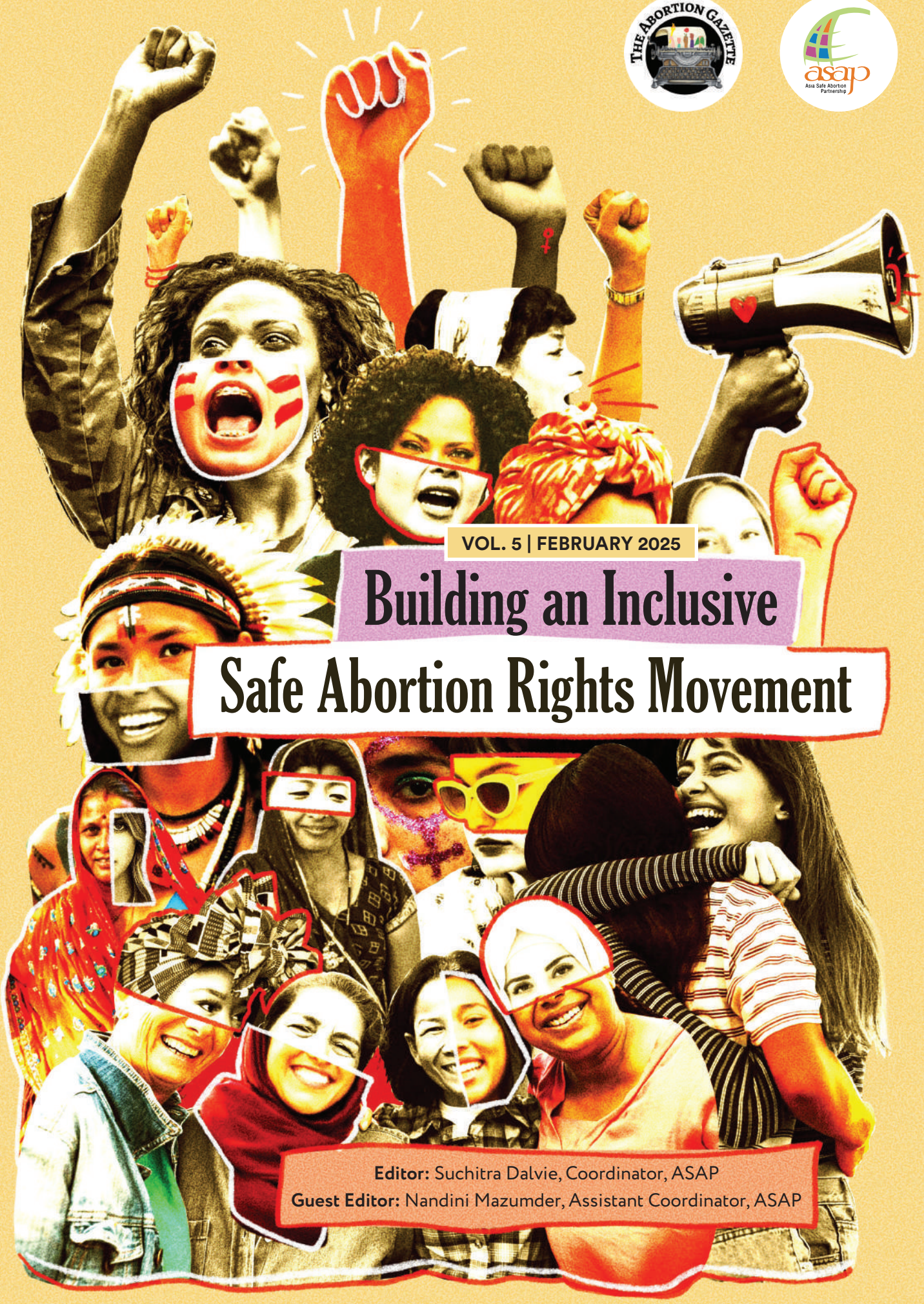

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Building an Inclusive Safe Abortion Rights Movement

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Building an Inclusive Safe Abortion Rights Movement

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Why this Gazette?

The Asia Safe Abortion Partnership is the only safe abortion rights advocacy network in Asia. Founded in 2008 it has members from over 20 countries across South Asia, South East Asia, South West Asia and the Oceania region.

As new members and partners join the safe abortion rights' movement we realized that there are hardly any collated or curated resources that they can engage with in order to gain a deeper understanding of some of the key issues or challenges in this work.

There are search engines and journals and many websites dedicated to safe abortion rights information and even services which people can access. However, there is no dedicated space where you can get a snapshot of a core topic within safe abortion rights that can offer someone the highlights of the scope of the issue and a range of perspectives that are relevant to us as a movement.

In order to address this gap, we have launched The Abortion Gazette.

This will be an immersive repository for a reader who would like to learn more on the landscape and depth of the issue in a relatable and practical way without having to search through pages and pages on the internet and sifting through multiple sources.

It will be a short quarterly publication and will include lead articles, clinical updates, thought pieces, interviews, statistics and of course links to other key articles, videos and other relevant material. It will be published on the ASAP website as a pdf that can be downloaded and printed for use by anyone in the safe abortion rights movement. For those who would like to engage in deeper learning and a structured program, stay tuned for more updates!

Editorial

By Suchitra Dalvie

Why do we need to build an inclusive movement?

It made us wonder when we started discussion on intersectionality some years ago. Yes of course all of us have multiple layers of identities and issues and it's a complex bag of challenges and privileges. But isn't that obvious? Why was this something that needed any formal discussion or policies or strategies?

But as our own understanding evolved we realized that recognizing intersection was just the first tiny step. The really big work ahead of us was how to create **inclusion**, and that too **meaningfully**. Recognizing and accommodating for intersection was still coming from a place of privilege and power. 'We' were recognizing 'their' intersectionality.

Of course that is still an important first step because those who are so deeply vulnerable, so systematically marginalized that they have not had a voice or power to even be visible in such discourse have to be recognized. Advocacy on their behalf may still have to come from those of us who have the opportunity and the capacity. But the key is to always remember that this is only a milestone and not the final destination.

The ultimate aim of this inclusion will be not just 'a seat at the table' for 'them', but an equal opportunity, space and power to decide the menu and shape the table, bring others along!

Inclusion isn't just a circular from HR or a motivational meme. It needs to be integrated at every level –from our mindset and ideological understanding to the actions in policies, programmes, budgets and implementation.

As a community we have been broken apart by so many forces for so long that we will need to purposefully put in the additional work to achieve this. Without glorifying the 'good old days' which had their own problems, we did have cohesive communities, whether a village or a tribe where everyone would get taken care of whether by the family unit or through free food at the place of worship or a shelter in the outhouse.

Industrialization, feudalism, colonization, capitalism, uber capitalism aided by organized religion and patriarchy, amplified by the modern medical systems that pathologized and gaslighted instead of offering true healing, held together by military-industrial complexes are our current inheritance and reality. Our multiple intersectional identities have been used to tear us apart rather than celebrate the richness of the multitudes.

It is time for us to reverse this wounding and start the work of healing!

Building bridges and strengthening solidarities between diverse movements and communities.

By Guest Editor Nandini Mazumder, Assistant Coordinator, ASAP

Personal is political: I began my journey with a lot of hopeful idealism when I joined the development sector wanting to contribute towards meaningful change for greater rights and freedom for all and including myself. However, over the years of working in the development sector and particularly on gender and sexuality, with sex workers, LGBTQI+ communities and women drug users' communities, it led me to reflect on what truly does 'change for all' mean?

As I introspected, I realized that very often than not we reproduce the same inequalities and injustices that we are trying to change in the mainstream. Civil society spaces are also often fragmented, homogenous or over-represented by 'one' kind of people/community/issue which prevents us from building solidarities between movements and communities.

This way of working in silos is rooted in the post-colonial funding and global-aid framework which is routed through the Political North to the Political South, and increases competitiveness between organizations and movements bidding for the limited resource pool leading to greater fragmentations within communities and movements (in her article, The NGO-ization of Resistance, Arundhati Roy has articulated this well and you can read it here). But the rise of regressive right-wing forces around the world tells us how urgent and critical is the need to build bridges between communities and movements in order to amplify each other's voices to collectively demand our rights.

The million rupee question is: given our limited time, money and human resources, how do we build inclusive movements? (And, is it even possible to do so?)

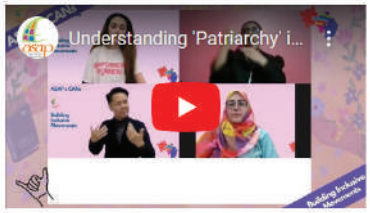
Learning through the work: In 2020 ASAP was part of a webinar which had a sign language interpreter. But no deaf people were participating! This got us thinking and figuring things out. It was then that we fully comprehend the scale of the issue and the tragic fact that even today basic feminist and sexual and reproductive health and rights terminology is not available in sign languages across Asia (and the world). We started working more closely with sign language interpreters who expressed unfamiliarity and consequent discomfort with terminologies related to Sexual and Reproductive Health (SRHR).

This initiative really catapulted us into deeper engagement with the issue of inclusivity and we adopted it as a strategic direction.

In the meanwhile we also worked extensively with sign language interpreters and the deaf and hard of hearing community and developed one of its kind SRHR primer videos (resources) in sign languages. These videos are available in our Youtube channel and can be used by anyone who is working with deaf and hard of hearing people on SRHR and safe abortion rights:

By Druk – Youth Initiative for Sexual Advocacy (D-YISA)

Understanding Sexual and Reproductive Health and Rights in Sign Language by ISAY



Understanding 'Patriarchy' in Sign Language by Pakistan Advocacy Network

What is Intersectionality? The idea of 'intersectionality' was proposed by scholar Kimberly Krenshaw in 1989 and she described it as:

> A lens through which you can see where power comes and collides, where it interlocks and intersects. It's not simply that there's a race problem here, a gender problem here, and a class or LBGTQ problem there. Many times, that framework erases what happens to people who are subject to all of these things.

She further explains: *"Intersectionality is simply about how certain aspects of who you are will increase your access to the good things or your exposure to the bad things in life."*

She suggested that the way towards building an intersectional lens is possible through self-interrogation.

"If you see inequality as a 'them' problem or 'unfortunate other' problem, that is a problem. Being able to attend to not just unfair exclusion but also, frankly, unearned inclusion is part of the equality gambit. We've got to be open to looking at all of the ways our systems reproduce these inequalities, and that includes the privileges as well as the harms."

Moving from intersectionality to inclusion: Safe abortion rights remain a contested and fragmented issue even within the larger women's rights movement, as we discovered at a recent global conference which had hardly any mention of it. Women's rights and pregnant persons' rights ought to be located everywhere in a landscape of diverse social justice movements such as indigenous peoples rights, environmental protection, sex workers rights, LGBTQ rights and other socio-political struggles of diverse communities.

As Audre Lorde stated:

> There is no thing as a single-issue struggle because we do not live single-issue lives.

Therefore all our movements need to build solidarities to amplify our voices for rights which are inherently interlinked and non-hierarchical in nature. Yet even today feminist movements are divided on several important issues including safe abortion rights. There is often a reluctance to recognize the fact that safe abortion rights is a core feminist human rights issue that upholds human dignity, agency over our lives and bodies, and freedom to decide for ourselves, and can save lives (of those who are forced to opt for unsafe abortions which can prove fatal at times.)

ASAP's Building Inclusive Movement Strategy: As a network we acknowledged that one single initiative is not enough. Yet we also understood and acknowledged the power of that single step forward and decided to deep dive into working with a few communities such as, the deaf or hard of hearing people, trans men and non-binary people who are assigned female at birth, and sex workers to begin with.

In consultation with the CANs (Country Advocacy Networks) we developed the Building Inclusive Movement (B.I.M.) strategy document. An excerpt:

> *As our name suggests the Asia Safe Abortion Partnership believes in the power of partnerships and in the interest of building cross movement solidarity in planning to strategically and pro-actively engage in building inclusive movements as our guiding principle for 2021.*

We will work towards finding synergies and developing solidarities between various human rights, sexual and reproductive rights, and social justice movements in order to encourage the integration of safe abortion rights within their advocacy agenda and program strategies. At the same time, we will also encourage our members and partners in the safe abortion rights movement to step up as a strong ally for the various marginalized groups and be more inclusive of their issues and concerns.

Significant achievements under BIM: In 2020 we launched the **ASAP Conversations Series** and reached out to our members and partners from groups like sex workers, queer and trans people, those from minority and marginalized communities, refugees, migrants, working classes and Dalit communities, indigenous people in order to offer them a forum to create awareness about the specific issues faced and to build solidarity. The COVID Conversation series is available on our Youtube channel and you can watch them here.

'In many ways COVID has brought feminist issues at the forefront' with Dr Barbara Klugman

Comprehensive Sexuality Education can help solve the crises of 'baby dumping' in Malaysia

'With abortion highly stigmatized in Latin America PROMSEX shares why we need more than just laws'

The other important group we engaged with was **trans men and non-binary people** who are assigned female at birth (AFAB) to understand their specific issues when it comes to accessing safe abortion rights.

We continue to work with **sex workers' groups** as well. We organized a Labour Day panel in 2021 and you can watch it here.

While much has been done, it will always be a work in progress. I would like to leave you with a few more questions to reflect on:

According to you, what does true solidarity look like? How should one go about building meaningful inclusivity?

After all, the way ahead is neither easy nor short. And yet this must be done!

As civil rights activist Fannie Lou Hammer said, *"Nobody's Free Until Everybody's Free".*

Women Who Use Drugs (WWUD) and their need for safe abortions too!

By Parina Subba Limbu, Dristi Nepal

Dristi Nepal is a pioneering organization established in 2006, led by and for women who use drugs, with over 17 years of experience in HIV prevention, harm reduction services (until 2021), capacity building, and advocacy for health and human rights. The organization has been actively engaged in promoting Sexual and Reproductive Health (SRH) and human rights, fostering inclusion in feminist movements, and empowering women who use drugs, including those living with HIV, single mothers, female sex workers, and survivors of violence within the Kathmandu Valley.

The Constitution of Nepal guarantees the right to free basic healthcare services and emergency care for all citizens, recognizing health as a fundamental human right. However, this promise remains unfulfilled for many, including women who use drugs, who face significant barriers to accessing these rights. Disparities in access to healthcare are compounded by societal judgment and stigma, particularly against women who are poor, vulnerable, and marginalized. Women who use drugs, along with subgroups such as those living with HIV, young and single mothers, female sex workers, and survivors of domestic violence, are disproportionately affected.

These barriers discourage women from seeking, engaging with, and remaining in healthcare services, including essential Sexual and Reproductive Health (SRH) services. Fear of stigma and a lack of awareness about available SRH services and legal protections further exacerbate the issue.

The absence of targeted programs for these communities has posed challenges in ensuring comprehensive support. To bridge this gap, we have focused on strengthening coordination and referral mechanisms to ensure women are not left behind in accessing critical services in the Kathmandu Valley.

Dristi Nepal has collected numerous case studies and supported hundreds of women with essential services, including providing information, referrals to service centers, and access to safe homes for those overwhelmed by stress or unable to make decisions.

Many women in our constituency face compounded challenges, such as discrimination due to drug use or intersecting stigmas, which leave them vulnerable to violence and unhealthy relationships. Advocating for intersectional issues at local and national levels remains a challenge, as women in these marginalized groups are often judged and excluded from policy discussions. To address this, we are committed to amplifying digital advocacy efforts and fostering broader societal acceptance of the unique struggles faced by these women.

To create meaningful change, we must prioritize collaboration, coordination, and inclusive action that ensures no woman is left behind. At Dristi Nepal, our goal is to build a safe, stigma-free space where the women we work with can not only access essential services but also confidently advocate for their right to safe abortion at all levels—community, national, and beyond. By empowering these women to speak out, we aim to challenge the systemic barriers that perpetuate exclusion and ensure that safe abortion rights are a fundamental part of reproductive health advocacy.

Access to safe abortion in Korail, Bangladesh's largest low income settlement

By Nujhat Jahan Khan, Bangladesh

> "The situation of young people in slums and other urban areas are not very different. There is no reason to separate the two groups, or look at us differently."
>
> - A resident living in Korail slum, one of the largest slums in Bangladesh

It is estimated that around 33 million people in Bangladesh live in slums. These slums are characterized by substandard housing conditions, lack of basic services, and limited access to healthcare and education. One of the largest slums in Bangladesh, Korail slum, is located in the heart of Dhaka. Often referred to by many as a city within a city, Korail slum has a population of more than 50,000 people. Being located at the city's center, Korail is a hotspot for NGO interventions, including access to abortion, which is legalised under the name of menstrual regulation (MR).

Sexual practices among young people in diverse urban settings, be it high income or low income, is very similar. In both societies, it would be wrong to assume that young people are not involved in sexual relationships despite moral boundaries, family restrictions, and religious values. Conversations with low income or 'slum' residents after building a long

term relationship with them will reveal that young people are actively involved in sexual relationships. Unwanted pregnancies and abortions are not rare, and take place discreetly.

Shabnam (pseudonym), a 16 year old adolescent girl living in Korail slum underwent an abortion, and was soon married off to another man to 'save her honour'. Her abortion too, was forced, as she stated that she would have kept the child if given the option. When it comes to choices made by women about their own bodies, abstract values like honour and religion are weighed upon their shoulders to suppress their voices and choices. Religious and moral frameworks are used by the family's decision makers to selectively enforce or disregard reproductive rights.

Unwanted pregnancies are treated differently among unmarried women and married women with children. Abortion or menstrual regulation is socially accepted among married women who already have one or more children as a family planning method. In the case of pregnancies among unmarried women, family members prefer abortion over religious beliefs to protect a girl's honour. As seen in the case above, unmarried women do not have a say in whether they want the abortion or not. It is forced on them.

It takes two to get pregnant, but the shame and stigma is a woman's alone

Abortion is seen as a woman's issue and a woman's problem. Even during sessions led by NGOs, men's involvement is rare. Jony, a young health volunteer from Korail slum, says "In spite of so much work being done to involve men, they still look at women as sex objects. When my friend became pregnant, her partner blocked her from everywhere, leaving her all alone to deal with the shame and stigma. This did not happen because we live in a slum. I heard that students from expensive private universities go through this experience from men too."

According to Jony, we have a long way to go in teaching men on being respectful and responsible towards women. She has seen situations of men using their positions of having a job to lure school going girls with the promise of marriage, only to abandon them at a later stage of the relationship. She emphasises the need for comprehensive sexuality education through which boys and girls can foster a healthy relationship with each other. "Aside from raising awareness on contraception and abortion, respecting each other's bodies should be a major part of sexuality education."

Why do safe abortion programmes ignore women living with disabilities?

By Zargoona Wadood, Pakistan

In Pakistan, about 15% of the population lives with disabilities, and half of them are women and girls. Women with disabilities face extra challenges when it comes to getting reproductive healthcare. Many people, including family members and doctors, assume they don't need this care because they think these women won't marry or have sexual relationships. This leads to neglect and even forced medical procedures, like sterilization or abortion, without consent. A lack of accessible information and services makes things even harder, leaving many women unsure of their rights or too scared to ask for help.

MY STORY: FACING BIAS IN HEALTHCARE

When I went to a doctor for irregular periods, I was shocked when she rudely suggested, *"Just get your uterus removed."* That comment hurt deeply and stopped me from seeking help again. But it also motivated me to work on this issue in Pakistan. My experience shows how biased attitudes in healthcare can push women with disabilities away from getting the care they need!

THE VOICES OF WOMEN WITH DISABILITIES

During a consultative workshop, many women with disabilities shared similar experiences. One participant, who is deaf, expressed: *"I want doctors to talk directly to me, not through someone else!"* Another shared that *"I only learned about reproductive health by overhearing conversations because no one explained it to me!"* Yet another participant revealed that *"My mother avoided discussing reproductive health, believing I didn't need it!"*

BUT WHAT REALLY NEEDS TO CHANGE?

1. Along with being the most vulnerable group to sexual harassment and exploitation, women with disabilities also encounter physical inaccessibility of information and services. These obstacles force many to rely on unsafe options, putting their health and lives at risk.
2. Advocacy is needed to include safe abortion rights in national policies with an emphasis on disability inclusion. Healthcare workers should receive training on inclusive practices.
3. Efforts to address these challenges must focus on raising awareness about the legal circumstances under which abortion is permissible in each country and ensuring that training programs are accessible to women with disabilities through formats like Braille, easy-to-read materials, and sign language interpretations.
4. Cross-movement collaboration and inclusion between disability rights advocates and safe abortion rights activists is essential to create such a unified approach.
5. Dedicated funding streams are required to support projects at the intersection of disability and SRHR, develop accessible educational materials, and improve healthcare accessibility. Researching the experiences of women with disabilities regarding unwanted pregnancies and safe abortion will build an evidence base to inform policies and programs.
6. Global networking and advocacy are also crucial to include the unique challenges faced by women with disabilities in broader international conversations. By sharing best practices and attracting global support, these efforts can foster more inclusive and equitable solutions.

Organizations like PAN are already making significant progress. They have conducted numerous workshops and trainings and created videos and sign language guides to helpwomen understand their rights, with continuous support from ASAP. These tools have made a substantial impact on the lives of deaf and hard-of-hearing women.

Women with disabilities deserve the same rights and respect as everyone else when it comes to making decisions about their healthcare. By working together and making our advocacy inclusive, we can break down barriers and ensure every woman can make informed, independent choices about her body and her life.

Invisible Struggles: The Barriers Trans Men Face in Accessing Safe Abortion and Reproductive Rights in Pakistan

By Mani

Pakistan's approach to human rights, especially when it comes to sexual and reproductive health and rights (SRHR) for individuals assigned female at birth, is complex and fraught with unpredictability. The restrictive laws, combined with societal and religious stigmas, make accessing SRHR services in Pakistan exceptionally challenging. For transgender men assigned female at birth, this landscape is even more difficult to navigate, leaving them marginalized in a system that largely ignores their specific healthcare needs.

Abortion is only legally permitted in a few narrowly defined circumstances, typically when the mother's life is at severe risk. This restrictive policy bars countless individuals from safe, legal abortion services, pushing many to resort to unsafe, unregulated methods that carry serious health risks. The burden of these restrictions falls heavily on marginalized communities, especially those who cannot afford costly private healthcare options. Trans men, who may require abortion services, are particularly impacted, facing a healthcare system that doesn't recognize or accommodate their needs.

For trans men, seeking reproductive healthcare can be a profoundly isolating experience.

Most healthcare providers are neither trained nor prepared to address the needs of transgender patients. This lack of sensitivity and inclusivity often leads to trans men being misgendered, judged, or even denied care altogether. Many providers still cling to rigid gender stereotypes, struggling to acknowledge that trans men may require reproductive health services, including access to safe abortion. The medical community's lack of understanding creates yet another barrier, leaving trans men in a constant struggle to be seen and respected as they seek essential healthcare.

Outside of medical institutions, societal stigma surrounding transgender identities and abortion deepens the struggle. Pakistani society is steeped in traditional gender roles, and those who do not conform, such as transgender individuals, are often shunned and marginalized. For trans men, the social risks of seeking SRHR services are daunting, as they face judgment from a society that views both abortion and transgender identities as taboo. This hostility intensifies when trans men experience unintended pregnancies, as it amplifies public scrutiny and condemnation. The societal rejection forces many trans men to pursue clandestine, unsafe abortions, which carry serious health risks and long-term consequences that could be prevented with proper care.

Religious beliefs also profoundly impact public policy and societal attitude as they emphasize gender conformity and strictly oppose abortion. Trans men, in particular, face increased judgment under religious precepts that do not acknowledge their unique need and many fear ostracism from their religious communities. These fears drive some trans men away from safe medical options, discouraging them from seeking help for fear of rejection, and limiting their ability to exercise control over their own bodies.

Many families, influenced by societal and religious norms, struggle to accept transgender identities. This lack of acceptance can lead to severe restrictions on trans men's lives, pressuring them to conform to the roles assigned at birth. Family members may discourage or outright forbid trans men from seeking an abortion, particularly in cases of unintended pregnancies, further isolating them and cutting off access to crucial healthcare. Some families go as far as attempting to erase trans men's identities altogether, controlling their choices and denying their needs, forcing them into secrecy.

> The cumulative impact of these societal, religious, and family pressures creates an environment where trans men's reproductive rights and healthcare needs are often disregarded. They are left navigating a healthcare system that is neither prepared nor willing to support them, within a society that views them as an aberration, and in families that may seek to deny their identities altogether. **This complex web of restrictions leaves trans men physically vulnerable and emotionally isolated in their fight for basic rights and healthcare.**

Ultimately, the journey for trans men seeking safe abortion in Pakistan is a fraught one, marked by layers of legal and cultural obstacles. Without inclusive healthcare, societal acceptance, and religious understanding, their struggle remains largely invisible and unaddressed. Addressing these barriers requires not only reforming healthcare policies but also fostering a societal shift towards acceptance, inclusivity, and respect for individual autonomy. Only then can Pakistan begin to create a more supportive environment for all individuals, regardless of their gender identity, to exercise their fundamental reproductive rights.

Tackling Abortion Stigma in Georgia

By Medea Khmelidze

Access to abortion services in Georgia is neither state-funded nor covered by private insurance, leaving many women, particularly those facing financial hardship, without viable options. Marginalized groups—including ethnic minorities, LBTQI individuals, and women living with HIV—bear the brunt of this inequity.

Unwanted pregnancies are a persistent challenge compounded by stigma, restrictive regulations, and systemic barriers. Civil society organizations have long shouldered the burden of supporting individuals seeking safe abortion services. Yet, these efforts face growing challenges as anti-rights rhetoric and legal hurdles tighten the space for advocacy and service provision.

According to a 2024 study supported by the Safe Abortion Action Fund (SAAF), abortion stigma pushes many individuals toward unsafe practices, heightening health risks. Financial, geographical, and systemic barriers delay access, while stigma deters many from seeking timely medical help. These challenges are compounded by state policies that exacerbate rather than alleviate the problem.

Recent legal amendments, ostensibly aimed at improving service quality, have created additional barriers. The introduction of mandatory pre-abortion consultations involving psychologists and social workers, coupled with questionable requirements like an additional ultrasound, imposes unnecessary delays. The legally mandated five-day waiting period not only treats women as indecisive but also reinforces stigma, positioning abortion as a morally suspect decision rather than a healthcare right.

Georgia permits medical abortions only up to 10 weeks, yet many women miss this window due to delays caused by these policies. Service providers, too, face mounting pressures, with some clinics ceasing to offer abortion services altogether. Within healthcare institutions, stigma manifests in judgmental attitudes and resistance from medical staff, undermining patients' autonomy.

TO DISMANTLE ABORTION STIGMA AND IMPROVE ACCESS, BOTH THE STATE AND CIVIL SOCIETY MUST TAKE URGENT STEPS:

1. **Legislative Reform:** The existing laws on abortion should be revised to remove systemic barriers like the waiting period and unnecessary consultations. These changes must align with international human rights standards.

2. **Awareness and Education:** Campaigns should focus on educating healthcare providers and the public about reproductive rights and patient autonomy. Clear communication about the realities of unwanted pregnancies and the importance of safe abortion is essential.

3. **Ensuring Patient Autonomy:** Policies should prioritize informed consent, empowering individuals to make decisions about their bodies without undue interference.

4. **Intersectional Advocacy:** Advocacy efforts must address the unique needs of marginalized groups, including women living with HIV, LBTQI individuals, and ethnic minorities.

5. **Dedicated Funding:** Financial resources must be allocated to sustain CSO-led initiatives, ensuring equitable access to sexual and reproductive health services.

6. **Public awareness campaigns** are vital to challenging entrenched stigma and creating a supportive environment for those seeking abortion. Stronger coalitions among NGOs, healthcare providers, and international organizations can amplify advocacy efforts, ensuring a unified response to regressive policies.

Georgia's struggle for safe abortion rights is part of a broader battle for human rights and democracy. By resisting restrictive policies and centering marginalized voices, the country can make significant strides in protecting bodily autonomy and reproductive freedoms. Only through collective action, both local and global, can the fight for reproductive justice succeed.

Support to girls and women who are survivors of sexual violence and needing safe abortion services in Peru

By Brenda Alvarez Alvarez, Lawyer and President of Proyecta Igualdad and Justicia Verde Perú

Peru is characterized by a conservative approach to reproductive health, reflected in the widespread criminalization of voluntary abortion. This procedure is only permitted under specific exceptions, when the pregnancy poses a risk to the life or physical or mental health of girls, adolescents, women, and trans individuals who are pregnant.

However, even within these restrictive frameworks, access to abortion remains severely limited due to widespread ignorance about reproductive rights and the prevalence of structural stigma, a phenomenon perpetuated by the lack of effective public policies on the matter.

The State shows little interest in guaranteeing access to information or the availability of sexual and reproductive health services, which contributes to the vulnerability of pregnant individuals in need of such care.

In response to these legal and social barriers, community organizations assume key functions in primary health care, offering accurate information on options such as the safe use of misoprostol, a medication that has become one of the few alternatives available to individuals facing unwanted pregnancies in the Peruvian context.

Furthermore, emerging and increasingly consolidated support networks provide emotional, psychological, and logistical assistance. This support becomes essential in a restrictive environment, contributing to destigmatization and providing resources for those experiencing unwanted pregnancies in a system that lacks effective and accessible alternatives.

In this regard, **community-driven actions serve as a crucial intervention mechanism, responding to the structural deficiencies in the public health system regarding reproductive rights.**

The organizations I represent, Proyecta Igualdad and Justicia Verde, have included the defense of safe abortion as a fundamental right in their agendas, a right that should be accessible to girls, adolescents, women, and trans people. At Justicia Verde, we provide support to girls and women who are survivors of sexual violence throughout their process within the Health System to request legal abortions.

This process is often extremely complex, as **they face not only the structural violence within the health system but also the social stigma associated with abortion.** Additionally, we engage in strategic litigation, defending cases of women criminalized for abortion or for experiencing obstetric emergencies.

The challenge we face is substantial, which is why **it is crucial to continue developing strategies of resistance against criminalization** and the barriers that hinder access to safe abortion. In this context, our work focuses on highlighting and removing the legal, social, and cultural barriers affecting pregnant individuals who need these services, while also legally supporting networks of accompaniment, promoting a comprehensive response that guarantees their right to decide over their bodies and access sexual and reproductive health.

THE SAFE ABORTION RIGHTS MOVEMENT PLAYS A FUNDAMENTAL ROLE IN SUPPORTING THIS WORK THROUGH THREE KEY STRATEGIES:

1. First, it should enhance the visibility of human rights violations stemming from the criminalization of abortion, both in judicial settings and in the public sphere. This includes ensuring that women, girls, and trans individuals who are criminalized have access to adequate resources and legal support, facilitating fair defenses, and reducing the associated social stigma.
2. Equally crucial is securing sufficient funding for local community organizations to continue their efforts and maintaining a focus on strategic legal advocacy to drive systemic changes, such as decriminalizing abortion and improving reproductive health services.
3. The movement can strengthen its impact by promoting inclusive public policies and supporting the creation of comprehensive networks for legal, emotional, and health-related support.

This massive and comprehensive approach is critical to ensure that pregnant individuals access safe services and fully exercise their sexual and reproductive health rights, contributing to structural change that removes legal, economic, and social barriers and lead towards true Reproductive Justice!

Where is the reproductive justice for migrant and refugee young people in Australia?

By Sharanya Napier Raman

Australia is an extremely diverse populace, with over 50% of Australians being born overseas or having one or both parents born overseas. Migrants and refugees thus constitute a significant proportion of the Australian population. Between 2015 and 2024, the Australian government has granted over 111,000 refugee and humanitarian visas – though the number of rejected applicants for entry is almost four times this figure.

The most common countries of origin of migrants to Australia are India, China and the Philippines, while humanitarian and refugee entrants come primarily from the Middle East and Asia, with high proportions of Afghan and Iraqi populations.

Research with migrants and refugees both in Australia and internationally has fixated on abortion stigma and shame in these communities and repression of sexual and reproductive rights.

I spoke to eight young female-identifying migrants who had undergone abortion **– their experiences were *not* of repression, but of agency and autonomy within contexts of stigma and silence.** Indeed, these young people navigate around community silence and stigma, turning to online resources and support.

Despite abortion being fully decriminalised in every state and territory in Australia, access to care and experiences of abortion are not equally realised. There is very limited exploration of abortion rights among migrant and refugee youth, with little information on how these young people realise their reproductive rights.

Within Australian migrant and refugee communities, abortion remains highly taboo. So much so that my attempts to work with community services and migrant resource centres around abortion and sexual and reproductive health were consistently unsuccessful.

At community centres and youth organisations catering to migrant and refugee communities, I was repeatedly told that abortion was too sensitive a topic to discuss in these contexts. This silence around abortion was echoed by the young abortion-seekers I spoke to – all of whom took pains to keep their abortion secret from family or community members. These young migrants described a palpable tension between needing support and needing to stay silent to ensure their social safety. This need for silence left young people without emotional support – a lack of support and sense of isolation which was often exacerbated by separation from home-country networks.

WHAT NEEDS TO CHANGE?

Abortion care across Australia is largely privatised and can therefore be prohibitively expensive – one of the young migrants I interviewed paid $2000AUD for care ($1244USD). While all the young people I spoke to were able to access abortion care, they often struggled to afford care, had to forego necessities to pay for abortion, or were financially beholden to partners, some of whom were "toxic".

There must be efforts to make safe abortion care affordable across the nation, especially for the most vulnerable groups.

Lack of adequate sexual and reproductive health education is a consistent issue raised by migrant and refugee youth – even those who have received education in Australia. These young people have no education regarding options for unplanned pregnancy or abortion. For migrant and refugee youth, lack of formal education regarding reproductive rights is compounded by silence within family and community settings, leaving the internet as one of the sole resources for information and help-seeking.

There must be significant improvements in the Australian education system regarding abortion and sexual and reproductive rights.

Further, given the reliance of young people on the internet, **there must be improved online networks disseminating information on options for unplanned pregnancy.**

Given the lack of community support for migrant and refugee youth around unplanned pregnancy and abortion, other avenues for gaining emotional support must be fostered. Some young migrants turn to online vlogs and social media discussions on abortion experiences.

Having more formalised online resources would benefit young migrants and refugees. Creating online platforms for sharing abortion stories, seeking information and support confidentially and ensuring that young people have access to these platforms is essential.

In Australia, migrant and refugee young people are accessing safe abortion care, but risk their financial, social and emotional wellbeing doing so. Lobbying the Australian government to make abortion free for these young people, improving access to information and educational resources on unplanned pregnancy options, and bolstering existing online support platforms will be crucial to improving outcomes for migrant and refugee youth.

Image Source: Adapted from picture by Diego Fedele for AAP of Abortion Rights Rally in Melbourne, 2022

Sex workers, unwanted pregnancies and safe abortions

By Tejaswi Sevekari, Executive Director, Saheli HIV AIDS Karyakarta Sangh, Pune

Radha, a 47-year-old sex worker and mother of three, found herself grappling with an unplanned pregnancy caused by a torn condom. The situation left her anxious and fearful of her children's reaction, as they believed she was a daily wage laborer and were unaware of her actual profession.

Seeking a solution, Radha approached Saheli Sangh, a sex workers' collective in Pune. The collective promptly facilitated her access to medical care through the Family Planning Association and Sassoon Hospital. At the hospitals, Radha's elevated blood sugar and blood pressure were managed before a safe abortion procedure was performed. To further support her, Saheli provided counseling sessions for both Radha and her family, helping them come to terms with the situation and fostering acceptance and solidarity during this challenging time.

Sex workers in India are predominantly women, many from scheduled castes and other vulnerable communities. They often have little or no education, are migrants, and face systemic discrimination. They are unjustly criminalized, routinely humiliated and frequently denied access to essential services. These women are unjustly judged and treated poorly, with their needs often ignored or actively resisted by mainstream systems.

While high condom usage among sex workers has contributed to lower rates of unintended pregnancies, those that do occur can present serious challenges. Most pregnancies among sex workers are planned, often in the context of steady relationships. However, circumstances such as deteriorating health, economic hardships, or an unwillingness of partners to take responsibility often compel sex workers to seek abortions. Their options for accessing abortion care include private medical facilities, government hospitals, and NGOs. Many also rely on over-the-counter abortion pills purchased from pharmacies.

Yet, this path is fraught with obstacles: societal stigma, prolonged waiting times at healthcare facilities, documentation requirements such as government-issued IDs, and the necessity of an attendant all act as barriers to timely and safe abortion services.

In response to these challenges, sex worker collectives and community-based organizations (CBOs) have recently begun expanding their focus beyond HIV/AIDS prevention to include sexual and reproductive health (SRH) and the importance of safe medical abortion services.

A key component of this effort is educating women about the provisions of India's Medical Termination of Pregnancy (MTP) Act and referrals for safe abortion service providers. These collectives also actively advocate with healthcare providers to ensure that stigma-free and respectful care is extended to sex workers seeking abortion services.

The safe abortion rights movement needs to support sex workers by addressing their unique needs, issues, and constraints and giving them a safe platform to voice their issues.

Looking at the ambiguous, discriminatory, and criminalized legal status of sex work and sex workers in most countries, as well as the criminalization of abortion in these countries, as a movement we need to work together to improve access and provision of safe abortion services to sex workers and also lay the groundwork for systemic changes that are needed.

A good 'sign' of inclusion?

Working with the deaf and hard of hearing community

By Ayesha Bashir, Communication & Networking Manager, ASAP

Globally, over 72 million people are deaf or hard of hearing, with 80% residing in developing nations where access to essential resources, including education and healthcare, remains limited.

Asia is home to one of the highest populations of deaf individuals and presents unique challenges. Many countries in the region fail to recognize sign languages officially, depriving deaf communities of basic rights and access to critical information. In countries like India, where an estimated 18 million people are deaf, sign language remains unrecognized, perpetuating communication barriers.

WHAT IS MEANINGFUL INCLUSION?

During 2021 there were so many online webinars taking place and some of them had sign language interpreters. That looked like a great idea on the face of it but when we checked about the number of deaf participants we drew a blank!

That's when we started to reflect—why are we focusing so much on inclusivity, spending time and money on interpreters, without making sure the people who need this the most are even part of the conversation?

Sourav, one of the interpreters from India then shared similar concerns. During our calls with the interpreters, they highlighted some key issues—for instance, there are no signs for words like "patriarchy," and the sign for "abortion" often portrays it as "throwing away," which casts a negative light on the service and spreads biases and misinformation within the community.

Sourav introduced us to Saudamini Pethe, a remarkable feminist and the country's first deaf lawyer. Sadly, she passed away in 2023, but her work and ideals have left a lasting impression on us. She played a vital role in shaping ASAP's Safer Online Spaces campaign, which focuses on making digital safety a standard for abortion rights advocates across Asia. She helped us understand the unique challenges faced by deaf and hard-of-hearing individuals, who often rely on third-party apps to access the internet or social media. For them, ease of access is a key part of feeling safe. But using these apps means sharing a lot of personal data—so how can the community navigate that?

She also highlighted how deaf people are more vulnerable to online fraud and scams, raising important questions about protecting themselves in the digital world. Her contributions continue to guide us in addressing these critical issues.

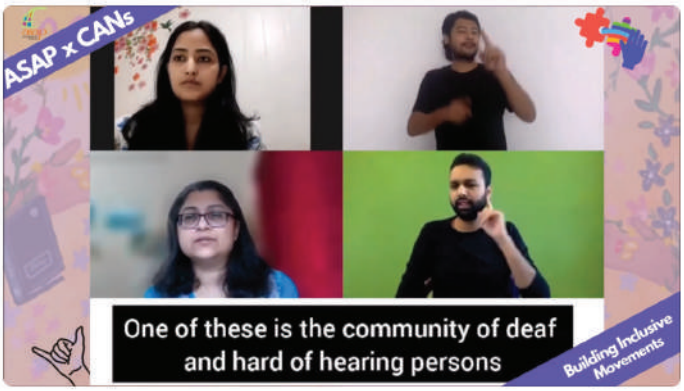
WHAT ARE THE CHALLENGES?

Deaf women get treated as "double minorities." On one hand, deaf people are desexualized, but on the other, their bodies are violated—through sexual assault, forced abortions, or even forced uterus removal to stop their monthly periods. Tragically, these violations are often committed by family members or people they trust.

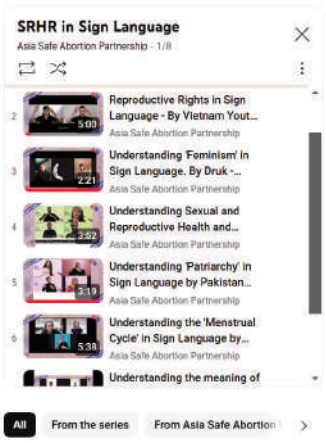
We realized early on that the lack of sign language terminologies for important SRHR issues was a major barrier. If people don't understand what terms like "feminism" or "safe abortion" mean, how can they engage with these topics? Addressing this gap became our first priority.

Once we started this initiative in India, we reached out to our networks in Bangladesh, Bhutan, Indonesia, Nepal, Pakistan, Sri Lanka, and Vietnam. We encouraged them to engage with their local deaf communities and create similar sign language videos in their own languages. Through focus group discussions, these networks developed standardized resources tailored to their contexts.

Together with our Country Advocacy Networks (CANs), we created videos in languages like Hindi, Nepali, Sinhalese, and Vietnamese, explaining critical concepts like safe abortion, feminism, and patriarchy. They can be watched here.



#InternationalDayOfSignLanguages -ASAP and CANs Building inclusive movements (Intro Video)



These videos have been shared widely with deaf and hard-of-hearing communities through our networks. They have helped us connect more closely with these communities, fostering meaningful engagement and mutual learning.

Through these conversations and meetings, we realized how much we, as a safe abortion rights movement, have yet to do to bridge this gap. As abortion rights advocates, we saw the shared struggles—particularly around access, choice, and bodily autonomy. This understanding pushed us to take a step back, start listening, and take small but meaningful steps toward addressing these challenges. It's only the beginning, but it's a start in the right direction.

Inclusion also demanded additional resources, including time, funding, and skilled interpreters. The need to slow down discussions to accommodate interpretation highlighted the importance of patience and flexibility in creating accessible spaces.

These challenges underscored that inclusion is not a one-time effort but a continuous, resource-intensive process.

Inclusion, as a deliberate act, requires movements to adapt and evolve continually. By addressing systemic barriers and prioritizing marginalized voices, the safe abortion rights movement can become a true representation of diverse identities and experiences.

How are we doing in Mexico with Comprehensive Sexuality Education?

By Claudia Morales

I can proudly share with you that in the 70's, Mexico was the first country in Latin America to incorporate in an article of its Political Constitution the right of men and women "to decide in a free and informed manner on the number of children to have and the spacing between them" (Article 4 of the Mexican Political Constitution).

But at the same time, it is necessary for me to also recognize that to go from word to deed there are still many alliances that are necessary to continue building so that this decision becomes a reality. and that is where we find tThe dissemination of Comprehensive Sexuality Education ias the necessary tool for every birth in Mexico to be desired.

In continuity with the above, it is necessary to clarify that aAlthough Article 4 recognizes information as a fundamental element for the decision to procreate or not, it was only as recently as not until 2019 that , in Article 3 of this same Constitution was amended to include , the obligation of the basic education sector to include comprehensive sexuality education as a necessary learning for the integral development of people. was included. It was also accompanied by the obligation to mainstream the gender perspective in all curricula and programs.

Reading the above, we might think that in Mexico we have already concluded the task of creating a universal awareness but putting the common ground so that Mexican women can decide on their maternity, but this is not the case, it is an unfinished task. Since the teachers in charge of initial education have not received training in comprehensive sexuality education, therefore they omit the topics or provide them based on their knowledge and personal ideologies. This in fact is increasing the risk of disseminating incorrect information or information based on gender stereotypes.

We are still on the path of generating or strengthening learning processes that cross bodies, that is, learning processes that not only fill our heads with knowledge, but that identify each individual as a generator of knowledge and above all identify us as beings capable of making decisions based on each of our stories and our well-being.

We are generating; processes where the objective is to live and decide from pleasure, rather than from fear!

In order to contribute to this ambitious goal, from Fundación MSI Mexico we have set up these two dissemination channels: the "Sex Education Program for All", which proposes educational activities in school and non-school spaces where sexuality, pleasure and abortion can be openly discussed, as well as our Educational Platform "For more Pleasure INFOSEX", where we provide information through the web and of course through the social media. , I share part of our job through this.

It is only through integration of sexuality education can we hope to create a vibrant and supportive environment for safe abortion rights!

What does it mean to leave no one behind?

Exerpts from A framework for implementation by UNDP

All disadvantages and deprivations that leave people behind should be considered across five factors:

1. DISCRIMINATION:

Exclusion, bias, or mistreatment based on some aspect of a person's identity (ascribed or assumed), including, but not limited to, gender, ethnicity, age, class, disability, sexual orientation, religion, nationality, and indigenous or migratory status.

"I can't access public transportation. Even if someone offers to take me out, I can at most stay outside for two hours before returning home, because there aren't any bathrooms accessible. I'm an archery athlete, and often compete in other countries. When I go abroad, I have to suffer on planes for over ten hours. The bathrooms in the airplanes are too narrow."

- China.

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2. GEOGRAPHY

Physical isolation, vulnerability, deprivation, or inequity based on a person's area of residence.

"Once I saw in the newspaper a story that said my community was the dirtiest in Rio de Janeiro. That moment changed everything. I dropped everything and decided to work with recycling. I faced all kinds of difficulties. People criticized me, and drug dealers wanted my land. But I continued. I started gathering cans, PET bottles, plastic bags, and cooking oil. History is made by those who move on. If I can change a person, I can also change the world."

— Brazil

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3. GOVERNANCE

Global, national, and/or sub-national institutions that are ineffective, unjust, exclusive, corrupt, unaccountable, and/or unresponsive; and/or laws, policies, and budgets that are inequitable, discriminatory, or regressive (including taxes and expenditures).

"With a growing family, I need the government now. The government is going to help me get most of the things I need, like medicine today. But that only happens when the authorities are really listening to the people and being responsive. I would like to see better job opportunities. My wife is working, and my job is only part-time. Before I found it, just thinking about the future made me really angry. Now I'm hopeful, but more work would make me happier."

— Rwanda

4. SOCIO-ECONOMIC STATUS

Disadvantages in terms of income, wealth, life expectancy, educational attainment, or chances to stay healthy, be well-nourished, and be educated; and access to energy, clean water and sanitation, social protection, financial services, vocational training, etc. status.

"I am Taqaih and I am 75 years old. I have three sons, they are all married and have children, but they forgot about me. I was hoping they would remember their mother when they had children of their own, but they left me at an age when I cannot take care of myself anymore. I pray that God will guide their children to obey their parents, and I hope my sons will not come to live the deprived life I am living now."

— Yemen

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5. SHOCKS AND FRAGILITY

Vulnerability and exposure to the effects of climate change, natural hazards, violence, conflict, displacement, and health emergencies.

"I lost everything in the tsunami, and still years later we don't own another home. I started working in a factory as a stitcher at the age of 15. Now I have 6 employees. I have to pay my stitchers more and more, just so these ladies can eat. If food cost less, everything would be easier."

— Sri Lanka

REALIZING THE OPPORTUNITY TO LEAVE NO ONE BEHIND

To implement the pledge to leave no one behind, countries should consider an integrated framework consisting of three mutually reinforcing 'levers': **examine, empower and enact.**

EXAMINE: Monitoring SDG progress of all relevant groups and people by collecting, analyzing and making available disaggregated and people-driven data and information on who is left behind and why. Track the progress of those furthest left behind relative to everyone else.

EMPOWER: Enable people that are being left behind to be equal agents in sustainable development, ensuring their full and meaningful participation in decision-making by providing safe and inclusive mechanisms for civic engagement.

ENACT: Develop integrated equity-focused SDG policies, interventions and budgets to support rights-holders and duty-bearers to address the intersecting disadvantages and deprivations that leave people behind.

Leaving no one behind: WHO spearheads health services for Syrian refugees in Turkey

Exerpts from WHO article based on a 2020 report

More than a decade of conflict in Syria pushed more than 3.7 million Syrian refugees into Turkey. By 2016, Turkey's health system was heavily strained. In response, a system through which refugees could access free primary health care services was developed. Syrian refugees in Turkey faced multiple challenges: language barriers when seeking care, a lack of information on their rights to healthcare services and limited knowledge of modalities of the Turkish healthcare system. Between 2017-2021, the WHO Country Office in Turkey supported the Government of Turkey in establishing the Refugee Health Programme, reaching over two million Syrian refugees through a three-dimensional approach:

1. promoting access to care
2. training Syrian health workers to expand the workforce
3. enabling culturally sensitive health services in beneficiaries' native language.

The WHO Country Office's seven refugee health training centres provided practical training, bilingual patient guides, built on existing skills and talent, and offered a unique pathway for Syrian health professionals to enter the Turkish health workforce. The training centres came to serve as a model, providing a comprehensive service package, services which have now been adopted in other similar centres established by the Turkish Ministry of Health. As a result of WHO support, over 720 000 consultations were provided in seven refugee health training centers to refugees and migrants, two-thirds of which were women and children in seven provinces. In the two years prior to the COVID-19 pandemic, the number of consultations increased by 20% due to improvements in availability, access, and quality of consultations. The increase in consultation visits also reflected growing trust in the services provided. Over 30 000 home visits were conducted by community health workers to assist the most vulnerable (women, children, elderly, and the disabled) with basic health-related home care services annually. Support included blood pressure monitoring, blood sugar monitoring, vaccination, and delivery of health-related messages.

HOW DID TURKEY DO IT, HOW DID THE WHO SECRETARIAT SUPPORT TURKEY?

1. Refugee health training centres established – In late 2016, the WHO Country Office provided support to renovate and equip seven refugee health training centres in seven provinces to:
    a. provide training for Syrian health workers;
    b. alleviate stress on human resources; and
    c. enable cultural competence in health service provision.
2. Migrants strengthened Turkey's healthcare system – The WHO Country Office training programme, developed with the Turkish Ministry of Health:
    a. trained over 1000 Syrian doctors, over 1000 Syrian nurses, and 81 technicians;

b. developed over 1300 bilingual patient guides; and

c. offered on-the-job training to over 5000 Syrian and Turkish health workers serving refugee populations to meet WHO standards of quality in care.

Syrian doctors, nurses, translators and community health service support staff were hired by the Ministry of Health to serve in a network of 180 migrant health centres, supported by the European Union under the Facility for Refugees in Turkey.

1. **Adaptation during COVID-19 pandemic –** To prevent a standstill due to the COVID-19 pandemic, in the second half of 2020, trainings for health workers were adapted to be accessible via a WHO Country Office-developed distance-learning platform, restructured to create a user-friendly e-learning experience. In cooperation with the Ministry of Health and with funding from the European Union, the first-of-its-kind platform became operational in January 2021 and became the reference Ministry of Health/WHO Country Office training programme for health workers providing services to refugees and host communities in Turkey.
2. **Prioritizing mental health –** Refugees have faced war, persecution, and extreme hardship. Upon migration they lose protective supports, face language and cultural challenges, among numerous other realities that can affect their mental health. To address these needs, the refugee health centres applied a holistic approach since the outset. The WHO Country Office supported 42 688 psychosocial support consultations for refugees and set up a training programme for service providers to provide quality mental health and psychosocial support services. Between 2018-2021, over 1500 Syrian and Turkish doctors completed the WHO Mental Health Gap Action Programme training, equipping them with skills to identify, diagnose, treat, and refer cases needing mental health and psychosocial support in non-specialist health settings. A 2021 impact assessment revealed improved diagnosis of mental health disorders and high patient satisfaction with mental health and psychosocial support services from the trained doctors.
3. **Home care consultations –** 42180 homecare consultations were provided to disabled and elderly Syrian refugees.
4. **Research –** To increase knowledge about refugee and migrant health, and support planning, implementation and evaluation, the WHO Country Office conducted research between 2020-2021 covering areas such as mental health, pharmaceutical care, and health worker satisfaction among the Syrian refugees.

Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. Achieving universal health coverage for refugees requires addressing many barriers to health care utilization and strong government support, demonstrated by the Government of Turkey's decision to ensure access to free primary healthcare services for all registered refugees.

Humanitarian crises need responses to be adaptable to changing needs. Effective cooperation between the WHO Country Office, the Ministry of Health, and other partners (European Union, KfW Development Bank, United States Department Bureau of Population, Refugees, and Migrants, Norwegian Agency for Development Cooperation, and academic institutions) was key to success.

Intersectionality in Action:
How Identity Shapes Access to Safe Abortion

By Laxmi Chaudhary, Asika Ghemosu, Lirisha Tuladhar, Sunena Tamrakar, Pranjal Khadka, Manjari Shrestha and Shraddha Prajapati from YSERHA-Nepal

THE WAY SAFE ABORTION ACCESS EVOLVED IN NEPAL:

Abortion services in Nepal have evolved significantly over decades, driven by the need to reduce maternal mortality and protect women's reproductive rights. Before 2002, abortion laws were restrictive which led many women to resort to unsafe abortion with high risks. The legalization of abortion provided women with safer options. The legal reforms that followed, including introduction of Comprehensive Abortion Care (CAC) services in 2004, medical abortions in 2009, Constitution 2015 and the 2018 Safe Motherhood and Reproductive Health Rights Act (SMRHR Act) further strengthened abortion rights by conditional decriminalization of abortion and ensuring women's access to safe abortion services.

Since then, Nepal has made notable strides, with an increase in the number of service providers, introduction of medical abortion, and free abortion services in government hospitals increasing accessibility. These changes have led to a substantial decline in maternal mortality from 539 deaths per 100,000 in 1996 to 151 per 100,000 livebirths in 2022.

However, challenges persist within healthcare, social, and legal systems.

WHO IS STILL LEFT OUT?

Despite legal progress, systemic barriers persist, creating uneven access that disproportionately impacts marginalized communities.

1. **Geographical Barriers:** Women from remote and rural areas frequently need to travel extensive distances to reach healthcare facilities and face the additional challenge of timely and free health services as ensured by the Government of Nepal.
2. **Disability:** There is a lack of disability friendly infrastructure or sign language interpreters and even discrimination and harassment within healthcare settings.
3. **Gender and Age:** Societal norms mostly prioritize male authority over reproductive decisions, while young women aged 15-19 encounter significant barriers stemming from the stigma surrounding adolescent sexuality.

WHAT DOES THE FUTURE HOLD?

Youth-led organizations like YSERHA play a vital role in advocating for better healthcare infrastructure in rural areas and training providers in disability-inclusive and gender-sensitive practices.

Additionally, promoting comprehensive sexual education and raising awareness through targeted campaigns can help reduce stigma and empower individuals to make informed reproductive health decisions. Ensuring a steady supply of abortion-related medications, integrating post-abortion care with family planning services, and fostering collaboration between the government, NGOs, and community leaders are also essential.

By focusing on these areas, Nepal can make further progress toward safer, more inclusive reproductive health services, ensuring that all women, regardless of background or location, have access to the care they need.

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Access Denied? Roadblocks to Safe Abortion in Public Health

By Saraswati Palnitkar, ISAY

Amidst the chaos of the OPD, while I attend to a line of patients waiting to get their blood pressure checked, I pause to look at her. With clammy hands and an anxious gaze, she almost whispers to me, "Ma'am, I don't want this pregnancy. Can I tell this to the senior doctor?"

A 24 year old mother of two is asking for an abortion in a public hospital. She further tells me that she requested for a sterilization procedure after her last pregnancy, but her request was denied. Her abusive husband refuses to use contraception.

Will the doctor listen to her this time?

A 2022 study found that 67% of abortions in India are unsafe. According to a United Nations Population Fund report close to eight women die every day of causes related to unsafe abortions, one of the contributors to the high maternal mortality rate. While our country's comparatively progressive abortion laws may paint a rosy picture, women still struggle to access safe, free, legal and easily accessible abortion services even 50 years after the MTP Act was passed. The Act actually has fewer protections for seekers and far more provisions for the protection of doctors conducting medical terminations. It acts as an exception to the IPC (now BNS) sections 312-316 that criminalize 'causing miscarriage' of a woman.

Though the MTP law was amended to replace the words "by any married woman or her husband" with the words "by any woman or her partner" in the clause for failure of contraception, the forms have not yet changed in hospitals. This minor technical difficulty, easily rectifiable by simply updating the paperwork, adds another hurdle for unmarried women seeking abortions.

There is also a lack of comprehensive training in the medical curriculum, leading many doctors to lack understanding of the socio-cultural factors surrounding abortion. Institutional pressures contribute to this, with resident doctors often instructed by senior faculty to "counsel" married women to continue a pregnancy, and contraceptive failure not being considered a "valid" enough reason for seeking an abortion. Some healthcare providers hold conservative views on abortion, which results in service denial, moral judgment, and unnecessary delays.

Image Source: Adapted from picture by Poulomi Basu for NPR of women waiting for an abortion

The law itself creates a power imbalance, skewed toward service providers, as they are the ones who ultimately decide whether or not an abortion can be granted.

Although abortion services in the public healthcare system are meant to be free of cost, many government hospitals do not stock medical abortion (MA) pills. Patients are often required to purchase these pills. Even in pharmacies outside, about 79% of chemists no longer stock MA drugs to avoid legal issues and excessive documentation requirements. A report published by Foundation for Reproductive Health Services India (FRHSI) states that the non-stocking of MA drugs in pharmacies seems to be linked with overregulation by drug control authorities but nothing has been done to rectify the situation.

The road to change is long, but it begins with action—by advocating for policy reform, improving healthcare training, and dismantling the stigma that surrounds abortion.

KEY SUGGESTIONS:

1. Decriminalization of abortion
2. Gender sensitisation and training for healthcare providers
3. Expanding access to self managed abortion
4. Tackling stigma and anti-choice propaganda
5. Judicial activism and accountability

Safe abortion access is not only a life-saving healthcare procedure, but it is also a life-giving choice! A choice that enables women to reclaim their existence by exercising bodily autonomy. The struggle for reproductive rights is a shared responsibility. It is not just for women to fight, but for all of us, as a society, to ensure that nobody is left behind, including queer, disabled and marginalised groups.

As Audre Lorde said…

> "I am not free while any woman is unfree, even when her shackles are very different from my own."

Rwanda Women Doctors For Reproductive Justice

By Girimpudu Revocathe

In Rwanda, abortion is permitted under five specific grounds and must be performed by licensed medical doctors.

These grounds include:

1. the pregnant person is a child
2. the pregnancy resulted from rape
3. the pregnancy resulted from a forced marriage
4. the pregnancy resulted from incest with a person within the second degree of kinship
5. the pregnancy poses a risk to the health of the pregnant person or the fetus.

Abortion cannot be performed if the gestation exceeds 22 weeks, except when the pregnancy endangers the health of the pregnant person or the fetus.

Abortion services are only provided in public or private health facilities licensed as hospitals or polyclinics by the Minister of Health, even though a month ago the ministry of health has recently expanded the services down to the health centers, facilities smaller and closer to the community.

Recognizing the significant role that medical doctors play in the accessibility and quality of abortion services, it is crucial to focus on sensitizing them to both the legal and medical aspects of safe abortion care.

In Rwanda, Rwanda Women Doctors For Reproductive Justice, in collaboration with partners, has made notable progress since 2021. We have conducted over 20 training sessions for medical doctors, covering both theoretical knowledge and practical skills for providing safe, legal, and compassionate abortion care, including hands-on simulations of medical and surgical procedures.

The training has reached over 200 young women doctors and emphasizes the importance of pre- and post-abortion counseling and follow-up care, ensuring comprehensive patient-centered services.

**DESPITE THESE EFFORTS,
THERE IS STILL A NEED FOR IMPROVEMENT:**

1. Expanding training opportunities, especially in health facilities located in low resource settings
2. Integrating comprehensive abortion care, including counseling and patient rights, into medical curricula
3. Fostering a supportive environment within medical institutions to reduce stigma and provide resources for emotional support.

The possibility that the Global Gag Rule will be reinstated or strengthened, will restrict U.S. foreign aid from going to any international NGO that provides, promotes, or advocates for abortion services.

While Rwanda's own policies are moving towards expanding reproductive health services, the potential reimplementation of the Global Gag Rule could limit external funding for these programs, especially if they are provided through NGOs that depend on international aid.

The positive impact that local government policies could have on reproductive health, as the financial support and resources available to NGOs may be restricted.

Separated by 13,239 kms and halfway across the world, the restrictive and punitive policies of one country could result in more deaths of women from unsafe abortions in another!

It is time for us to collectively build inclusive movements so that we can all move forward together.

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Reaching the unreached through telehealth

By Prof. Angela Dawson, Associate Dean Research, Faculty of Health, University of Technology, Sydney

A key strategy to improve access to abortion in Australia has been telehealth in primary care. In 2013 mifepristone and misoprostol were added to the Pharmaceutical Benefits scheme which subsidises the medication and registered as MS-2 Step.

During the Covid-19 pandemic in 2020, the Government introduced temporary telehealth Medicare benefit items that included sexual and reproductive health consultations via video and telephone. Once certain restrictions were lifted, there was an increase in telehealth use for medical abortion with 42% of patients in regional areas opting for telehealth compared to 20% in cities[1].

A telehealth consultation, either online or via the telephone and involves assessing whether patients are eligible, for example they do not have a known or suspected ectopic pregnancy or miscarriage, allergy to the medications, or specific medical conditions. A prescription is then issued via SMS to be filled at a local pharmacy or sent via post. Follow up is provided around 7 days post abortion involving a phone call to assess a serum hCG test result and check the abortion is complete[2].

This has been streamlined with new evidence-based clinical guidelines for abortion care from the Royal College of Australia and New Zealand Obstetricians and Gynaecologists that supports early medical abortion (until ten weeks' gestation) without anti-D administration, and abortion to fourteen weeks' gestation without ultrasound examination, eliminating requirements that had delayed timely access to abortion. Recent changes by the TGA have removed restrictions on prescribing and dispensing MS-2 Step allowing nurse and midwives to provide this service under specific circumstances, but this depends on state and territory legislation.

While telehealth has increased access, barriers remain including inconsistent legislation across the country, low knowledge of the availability of this option, poor digital literacy and legislation.

Policy and law advocacy must focus on ensuring public facilities provide abortion and are adequately resourced with trained health providers. Advocacy is required to reduce out of pocket costs and poor-quality care that deny safe abortion to low-income women, adolescents and Indigenous, multi-cultural, LGBTQI Australians and those with disabilities. Education on abortion laws, reproductive rights, and patient-centred, culturally safe care should be incorporated into all medical curricula, sadly this is not the case.

Health provider education and training are essential to addressing stigma for empathetic and nonjudgmental abortion care. Public health campaigns can normalize discussions about abortion and educate communities about the availability of services and reproductive autonomy. Much work is still to be done!

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LBT+ and safe abortions in Bhutan

By PuKu, DYISA, Bhutan

In Bhutan, unwanted pregnancies remain a complex issue, particularly for LBT+ individuals (lesbian and bisexual women, non-binary individuals, and trans men assigned female at birth). While the broader community grapples with legal restrictions and stigma surrounding safe abortion, LBT+ communities face an additional layer of discrimination due to their gender and sexual identities. These barriers are compounded by invisibility and exclusion from mainstream reproductive health discussions.

Bhutan's maternal mortality rate, currently at 53 per 100,000 live births as of 2023, highlights the significant risks associated with restricted abortion access and unsafe practices. While this rate is relatively low compared to global averages, Bhutan's small population (around 800,000) means that even a small number of deaths can have a profound impact on individuals and families. This emphasizes the need for improved reproductive healthcare policies and inclusive services to minimize avoidable risks and ensure safe, timely access to care.

Though the LGBT+ population in Bhutan is officially registered at around 400 individuals, many remain unregistered due to fears of judgment, societal prejudice, and stigma. Among this group, LBT+ individuals face extra challenges when it comes to unwanted pregnancies. People often harshly judge them, particularly when their pregnancies are seen as contradicting their sexual or gender identities. This judgment further alienates them and discourages them from seeking help.

Currently, addressing unwanted pregnancies at the community and organizational levels in Bhutan is reactive rather than proactive. Many people turn to informal networks for advice or emotional support, while others resort to unsafe methods or travel across borders for abortion services. For the LBT+ community, these barriers are particularly overwhelming and conversations around reproductive health in Bhutan remain largely cis-normative, leaving those outside traditional gender binaries feeling alienated.

One key change needed is the explicit inclusion of LBT+ individuals' reproductive health needs in advocacy and policy discussions. Safe abortion is not just a women's issue as it affects people across the gender spectrum. Advocacy efforts must amplify their voices and ensure they are not erased from the conversation.

In Bhutan, abortion remains a taboo subject, forcing people to navigate it in secrecy. Public awareness campaigns must work to normalize safe abortion as a healthcare right while including culturally relevant messages that address the unique social dynamics.

THE SAFE ABORTION RIGHTS MOVEMENT CAN SUPPORT LBT+ COMMUNITY IN SEVERAL WAYS:

1. First, it can facilitate partnerships with organizations working on LGBT+ issues, amplifying the voices of marginalized communities.
2. Second, it can push for policy reforms that include LBT+ perspectives, such as decriminalizing abortion and ensuring equal access to services.
3. Thirdly, organizations working on LGBT+ programmes have traditionally received HIV funding and not included people like transmen, bisexual women and non-binary people who were assigned female at birth. They need to expand their scope to bring in the issues of unwanted pregnancy also.
4. Finally, the movement can prioritize education and capacity building initiatives to equip advocates with the tools to challenge discriminatory practices and policies.
5. Advocacy must also address systemic gaps in data. Limited research on the reproductive health needs of LBT+ individuals in Bhutan perpetuates their exclusion from policy-making. Collecting disaggregated data can provide the evidence needed to advocate for inclusive healthcare services and policies.
6. The movement should also prioritize long term projects aimed at creating sustainable change. Short term efforts often leave individuals without a support network once the project ends, further isolating them.

Unwanted pregnancies and unsafe abortions are not just individual challenges but reflections of broader systemic failings. The path forward requires collective action.

Healthcare systems, policymakers, and activists must work together to create a society where everyone, regardless of gender identity or sexual orientation, can access safe abortion without fear or discrimination. Only then can we truly achieve reproductive justice for all.

Supporting Inclusive Abortion Movements: Easier Than You Think, More Vital Than Ever

By Jessie Clyde, Senior consultant with Global Health Visions, ex-director of partnerships at International Women's Health Coalition (now Fós Feminista)

Autonomous feminist movements challenge power structures, give voice and agency to communities that have historically been marginalized, and drive systemic change from town squares to the halls of the United Nations. We all benefit from the commitment and dedication of movements and activists, especially in the field of abortion rights where movements have helped legalize and decriminalize abortion from Mexico to Nepal.

However, we often assume this work is done "on the side" or "out of pure love." As a result, funders fail to support movements to the same extent as other philanthropic initiatives that provide direct services in communities (i.e. medical care, education, etc.)

Over the past 20 years, I have had the privilege of supporting many of the fierce feminists at the center of advancing women's rights globally, and while they are certainly committed personally, their work requires financial resources. Just like health and education systems, movements need funding to be inclusive, sustainable, and impactful. An inclusive grantmaking approach operationalizes efforts to support a diversity of organizations to expand the circle of who has the resources to participate in movements by listening to those who are the furthest from power and ensuring it's the movements – and not donors – driving the agenda.[1]

As we look to a new year, we know that the anti-rights movement continues to grow and will implement well-financed tactics to roll back abortion rights. However, inclusive feminist movements are powerful and effective – and need our support. **There are several ways funders can do that:**

1. **Make explicit efforts to diversify your grantmaking portfolio and include those in your selection criteria:** This could include diversity based on budget size, year founded (e.g., nascent organizations versus well-established organizations), or identity of leadership (i.e., does the leadership reflect the communities served – sex workers, indigenous women, youth, etc.). Step out of your comfort zone and cultivate trust-based relationships with movement builders to understand their needs and identify ways that partnerships with donors can elevate and catalyze community-driven solutions.2
2. **Understand and mitigate bias in decision making:** Examine and address how your due diligence and grant-review process might favor some grantees over others (e.g., strong writers in English, staff that exhibit western-style leadership, financials reviewed by well-known auditors, etc.)
3. **Provide general operating support:** Flexible funding is a recognized strategy for advancing equity objectives and is crucial for movements to be able to respond nimbly and quickly to evolving political contexts.[3] With general operating support, movements and activists can rent an apartment for community members near the halls of power when contentious litigation is being debated, buy plane tickets for companions of feminists with disabilities to accompany them to UN negotiations, conduct research on an issue that isn't being prioritized by traditional academic

institutions or host a conference – like the recent Abortion and Reproductive Justice Conference – that holds decision makers to account.

4. **Provide long-term support:** The historic victory of the Green Wave movement in Argentina in 2020 that legalized abortion started decades ago. The National Campaign for Legal, Safe, and Free Abortion – the movement credited with helping to make abortion rights a reality – received flexible funding from many committed donors for years, despite repeated and devasting losses in the Senate. The long-term, flexible funding kept the movement vibrant and strong outside of Buenos Aires by providing support to movement work in the provinces and facilitating the participation of historically marginalized rural communities. That groundswell of national level support showed decision makers that abortion rights weren't an "elite, urban priority."
5. **Minimize the application and reporting burden:** Many of the grassroots organizations that make up inclusive movements don't have the time or resources for lengthy application and reporting processes. Minimizing these processes opens doors for funding for more diverse partnerships. Specific strategies include accepting applications made to other donors; encouraging potential grantees to use their own formats for evaluation frameworks, budgets, etc.; or replacing the application process entirely with a phone call or visit if preferred.
6. **Encourage carving out space for reflection and self-care – and fund it:** Building and sustaining movements is exhausting and can be very stressful, especially for community members working in challenging contexts. Funding for feminist literary circles, team building retreats, and other restorative activities gives all movement members time to draw support from one another, re-energize, and recommit. (Here is my plug to read *Witches, Midwives, and Nurses: A History of Women Healers* that narrates how the patriarchy, capitalism, and modern medicine industry sidelined and delegitimized women healers!)
7. **Apply an inclusivity lens to evaluation:** Use evaluation to highlight the impact of inclusive movements through qualitative data analysis, including case studies. Leverage your access to power by sharing those success stories to encourage other funders to increase support.

In my work at GHV, I'm embracing the role of changemaker at an organization committed to embedding inclusivity in the grantmaking, evaluation, and strategy support we provide to our partners. Grateful for the feminists globally who showed me the power of movements and who are always quick to reassure me that setbacks are just that.

I'm entering 2025 confident that inclusive movements for abortion rights will get the support they need.

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Who does the internet really belong to?

(Hint: It belongs to us!)

By Mahak Agarwal, Facilitator ASAP Academy

Despite Big Tech dominance, algorithmic control and the illusion of choice dictated by advertisers, we can still occupy spaces available and say that the internet belongs to us!

Of course we cannot be naïve about this and we know how real the threats can be and how the politics of online spaces mirrors the real life. The digital world is rife with harassment, discrimination, hatred and violence targeting women, queer communities and other marginalized groups.

Despite this, as safe abortion rights activists, we need to be present in these spaces since this is often the only way that some people can get access to information and services.

The fight for safe abortion rights is now inseparable from the fight for free expression online. As censorship and attacks grow, we must push back, amplify voices, and ensure that vital conversations are not silenced. Our right to information, to speak, and to access safe abortion will not be taken away.

How can we shift this narrative?

We stop being bystanders, we stop being mute consumers and the ideal target demographics to these manipulative algorithms. The narrative we're up against is one of gatekeeping and complexity. Big tech companies, with all their control, want to keep information hidden behind walls, making it difficult to access or understand. But we're determined to change that.

While they work to obscure and complicate, we're committed to simplifying, making information accessible, and amplifying voices that need to be heard. We're here to take up more space, to make sure information reaches those who need it most.

As advocates for safe abortion rights, we've been actively putting out information online through our Facebook and Instagram pages. Time and again, we've come face to face with the horrors of big tech—shadow bans, ad takedowns, and the flagging of words like "abortion" and "sex" as harmful. These roadblocks have only strengthened our resolve. One thing has become clear: the only way to keep this fight alive is to keep pushing, no matter what.

For over a decade, ASAP has been hosting offline workshops, known as the Youth Advocacy Institute, where we've had powerful interactions and deep discussions on issues such as - technicalities of safe abortion, patriarchy, gender, the critical importance of informed advocacy and much more. These workshops have been a foundation for our work, but we realized that this crucial information is not easily accessible in person due to funding and time constraints.

The idea to expand into the online space became a natural progression, particularly when COVID halted our offline workshops and it was uncertain when we could safely resume them. We knew the potential of reaching far more people at a fraction of the cost of offline workshops.

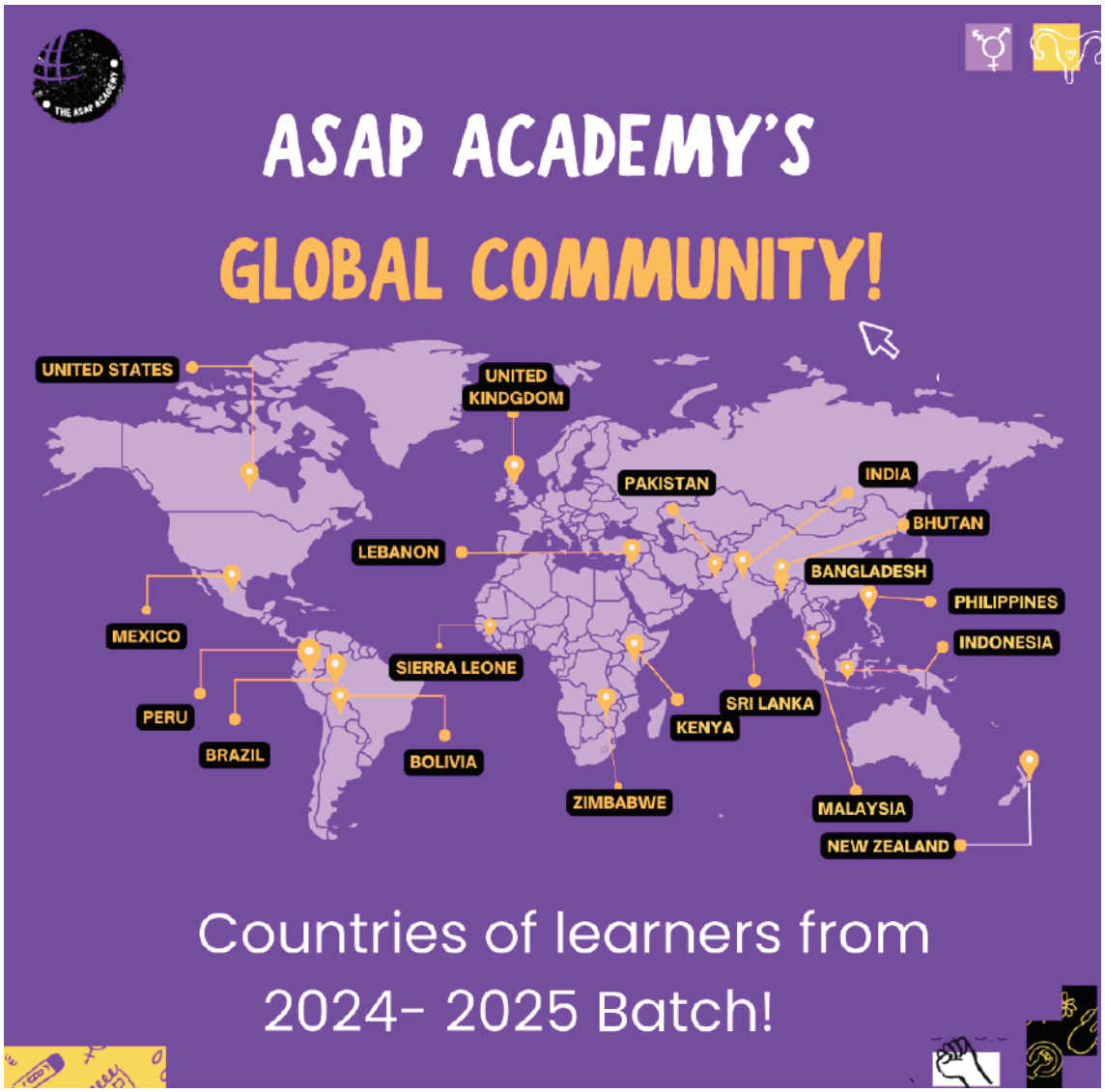
That's how ASAP Academy came to be.

When we launched the first semester of ASAP Academy in August of 2024, we were overjoyed by the response. Over 30 participants from 17 countries joined the academy, and the energy was palpable. The experience was incredibly fulfilling, and it made us realize just how much more potential this platform has.

The ASAP Academy is our response to the misinformation and barriers we've faced. More than just a platform for information, it is a collaborative space that brings together everything about safe abortion: the movement, the people, the need, and so much more. It's where knowledge is shared and applied through collaboration, support, and a collective commitment to the cause.

In February 2025, we're holding the first-ever ASAP Academy Convening. The goal is to harness the benefits of digitalisation to extend our reach while still creating an opportunity to meet in person—so we can soak in the energy of being in the same room, working together towards the same goal: making safe abortion rights a reality for all.

This is our way of building an inclusive, empowering movement—one that welcomes everyone and offers a platform to elevate diverse voices. We're fighting for a future where information is open, accessible, and free from censorship. And we're just getting started.



Climate Change is an SRH Issue Too!

By Jessica Work, Fiji

I am from Fiji, from the Pacific, from Oceania—a part of the globe where the ocean surpasses land. To outsiders, our distance may seem like a disconnection, but as a Pacific Islander, I understand that it is this very distance that connects us. What exists in our distance?

OUR OCEAN. OUR LIFE SOURCE. OUR CONNECTION TO ANCESTRAL WISDOM. OUR HISTORY. OUR HEART. OUR SOUL

Last year, I had the honour of being a panellist at the ARJC. I still remember the shock that rippled through the crowd when I mentioned that the highest point in Tuvalu, a country at the forefront of climate change and rising sea levels, stands at just 4.6 meters. Time and again, I encounter audible disbelief from advocates in other parts of the world when they learn how profoundly our people are affected by climate change. Yet, while discussions often centre on the disruption of our environmental ecosystem, there is a critical aspect that is frequently overlooked: how climate change impacts the ecosystem of women's bodies.

Our SRH services are already crippled by our position in the supply chain, geographical isolation, insufficient education, low healthcare standards, and cultural stigma. In the Pacific, we are experiencing a youth bulge; while our youth population grows, so too do our unintended pregnancies. Abortion is highly restricted across the region and there are only a handful of organizations providing family planning services, so access remains limited, especially in remote areas.

Many women find themselves confronting unwanted pregnancies without adequate support or resources, adding another layer of stress and hardship. We see young women, full of potential and dreams, forced to make life-altering decisions without the necessary care or guidance. The lack of comprehensive reproductive health services and education not only jeopardizes their health but also limits their opportunities for advancement in education and the economy.

As we look to the future, resilience is a value we must continuously nurture; however, we need to go beyond that. We must normalize conversations around these issues—share stories of unsafe abortions, reveal the realities women face, and illuminate how our environment and lack of access complicate our lives.

We don't need to look five years from now to see the adverse effects this has on a women's reproductive health, the rippling effects are happening NOW, the conversations should happen NOW and the investments should happen NOW!

Let us break down the barriers that silence women regarding their reproductive struggles to our changing environments which perpetuates a cycle of disadvantage. We must not only advocate but also create spaces where women feel safe enough to voice their concerns and seek help. Let us draw upon our traditional knowledge, the wisdom of our ancestors—and remember how colonization has contributed to the disadvantages we face. We deserve dignity, autonomy, and respect in this rapidly changing world.

Women's health must not be an afterthought in climate discussions; it should be at the forefront. We need to be heard on our health and autonomy from prenatal care to safe abortion rights. Safeguarding sexual and reproductive health rights is a declaration that women's lives matter and that these choices shape not only women's future but the future of our planet.

Palestine: Abortion rights and reproductive justice amidst violence and occupation

By a Palestinian citizen

BACKGROUND:

Abortion remains a controversial and contentious topic in women's health in Palestine and it takes on a distinctive dimension when examined within the context of occupation and settler colonialism. The longstanding struggle in Palestine has given rise to a range of challenges and implications for various aspects of Palestinian life, including reproductive health. This presentation will delve into the intricacy of reproductive justice in Palestine under Israeli occupation, highlighting the unique challenges faced by Palestinian women and focusing on the ways in which individuals and families navigate reproductive challenges.

In Palestine, abortion is criminalized under articles 321–325 of the Jordanian Penal Code of 1960, which is derived from colonial British mandate and Ottoman laws. In addition, Article 8 of Palestinian Public Health Law No. 20, which was passed in 2004, states that in the West Bank and Gaza, abortion is prohibited by any means unless it is necessary to save the pregnant woman's life, as proven by the testimony of two physicians.

Through a comprehensive analysis of limited existing research, this review aims to highlight the unique cultural, social, legal and political contexts that shape reproductive decisions and experiences of Palestinian families under the Israeli occupation. Additionally, it sheds light on the implications of reproductive issues on the overall health and wellbeing of the Palestinian population. Additionally, by studying abortion in Palestine, we can gain a deeper understanding of broader consequences of individual rights, health and well-being and also contribute to a more informed and empathetic global discourse on the intersection of colorization and women's health.

FINDINGS:

The Palestinian Health Ministry permits doctors to perform abortions only when the woman's life is at risk, but not for mental health reasons. The penalty for illegal abortions is severe, ranging from 1 to 3 years' imprisonment for women and unlicensed abortionists.

The Israeli occupation influences the development and enforcement of reproductive health laws, it has resulted in a multitude of challenges that intersect with reproductive health and the issue of abortion.

A 2007 study conducted by the PFPPA and the UNRWA found that 40 percent of 333 women surveyed in West Bank refugee camps had undergone an abortion but usually no trace of their procedure is left behind in medical records or elsewhere, so it is impossible to determine the exact numbers.

Women in Palestine also face reproductive violence since Israel politicizes Palestinian women's wombs and views them as a demographic threat. It was reported that more than 25% of Palestinian women have been exposed to tear gas inhalation while pregnant and in the West Bank, almost 70 women were forced to give birth at military checkpoints between the years 2000 and 2005 — resulting in half of those babies dying due to insufficient medical resources.

Abortion can also be stigmatized in Palestinian society given the context of occupation in which procreation is seen as a form of resistance. As a result, population growth and control have become crucial instruments for both Israelis and Palestinians, each attempting to outnumber the other to gain control over land, which resulted in the politicization of reproduction, procreation and birthing.

CONCLUSION:

The data is still limited regarding reproductive issues in occupied Palestine. Therefore, identifying gaps in research, developing policy recommendations and raising awareness and building cross-border alliances to improve abortion access and reproductive health is crucial for enhancing reproductive rights in Palestine. Additionally, humanitarian organizations and international aid agencies play a crucial role in enhancing and providing reproductive healthcare services in conflict-affected regions.

Image Source: Adapted from picture by Jose Luis Magana for AP News of Pro-Palestine Demonstration

Further Reading

How and Why Movements Need to be Inclusive

Blog Post: There is no fixed definition of disability, it has shifted over time, through contexts and between cultures. Those of us considered to be disabled are generally constructed as un- or under-productive within the capitalist economic system and are disproportionately also marginalized in other ways. This is because of oppressive diagnostic systems which have a tendency to label marginalized people as defective and because of war and poverty which disproportionately impact marginalized people – especially people in the Global South. So, it is important to build movements that are inclusive of disabled people, not on superficial or tokenistic grounds. It is unacceptable to leave people out of the equation and, inevitably, reinforce the oppression of others as you win justice for some.

4 Things We Can Do to Make Feminist Organizing More Inclusive and Empowering for All of Us

Blog Post: As activists, we need to hold ourselves accountable for being inclusive and intentional in our work for a more equitable world. Building an inclusive movement means we will have to change how we do that work! Inviting someone in is only the first step to inclusion. The next is collectively sharing power and ownership of the movement. We need to make sure we have different perspectives and experiences represented by the organizations, coalitions, and campaigns fighting for equality.

9 Ways to Build an Inclusive Community

Article: Implementing anti-discrimination policies is a crucial strategy in building an inclusive community. These policies communicate a clear message that discrimination in any form will not be tolerated, thereby fostering a culture of respect and equality. They serve as a guideline for behavior, setting expectations for community members about how to interact with each other. Anti-discrimination policies also provide a framework for handling incidents of discrimination, ensuring that such instances are addressed promptly and appropriately. These policies, therefore, play a significant role in creating a safe and welcoming environment for all community members, regardless of their identity or background.

Unsettling 'Inclusion' in the Global South: a Post-Colonial and Intersectional Approach to Disability, Gender, and Education.

Journal: This research countered the hegemony of Northern theory by placing the diverse perspectives of disabled girls and women in Vietnam at the heart of the participatory research process. We moved away from the binary between regular and special education in the global North to engage with the participants' narratives of inclusion and exclusion in and beyond education. Their acts of framing, connecting, and reconstructing their past and present experiences reflect their creative stories. Through the use of innovative methods such as cellphilm productions, their discourses of inclusion were re-constructed. Such discourses expressed hope for change, recognizing their capacity to 'speak back' to male patriarchy and ableism in education. At the heart of inclusive research is an epistemological question: Whose research it is? Whose interest does it serve? (Smith, 1999)

Talk the Walk!

Why is using inclusive language so important in the journey towards building inclusive movements?

Inclusive language is not the same as being politically correct.

Political correctness is focused on not offending whereas inclusive language is focused on honoring people's identities. It can create discomfort, which prevents people from engaging.

On the other hand, inclusive language allows for more flexibility and connectedness. It is focused on education, dialogue, and naming people in accordance with their personal identities.

THERE ARE SIX PRIMARY RULES TO INCLUSIVE LANGUAGE:

1. **Put people first.**

   Focus on the person, not their characteristics. For example, instead of saying, "our millennial sales girl," say "our salesperson who is female and identifies as a millennial." Does the gender of your coworker make a difference to the conversation? Does it matter that she is a younger professional? If not, simply saying "our coworker" will do.

2. **Use universal phrases.**

   Idioms, industry jargon, and acronyms can exclude those who may not have specialized knowledge of a particular subject and impede effective communication. There may even be words and phrases that don't translate well between the multiple generations in the workplace.

3. **Recognize the impact of mental health language.**

   Bipolar, PTSD, OCD, and ADD are official mental health diagnoses. Using these terms to describe everyday behaviors trivializes the impact of someone's real, lived experiences with a mental disorder. For example, your coworker who is feeling grumpy today is not bipolar; they might simply be in a bad mood. There are also many derogatory terms that stem from the context of mental health, like schizo, paranoid, or psycho. These should never be used to joke, mock, or offend.

4. **Use genderless language.**

   Using the word guys to address a group of people is gendered language that can imply men are the preferred gender at your organization. Instead, inclusive words such as everyone, team, or you all should be used. Using words that

encompass all genders rather than those that include only two genders is also preferred. For example, use children instead of boys and girls, or siblings instead of brothers and sisters. This important adjustment includes those who may not identify with the gender binary or with any gender whatsoever.

5. **Be thoughtful about the imagery you use.**

   For example, words like black, dark, and blind are often used symbolically to express negative concepts (i.e. a dark day in history). However, these terms can be offensive to various groups and should be avoided when possible. Another example is the use of white imagery to mean goodness or innocence, as in the phrases "white knight" and "pure as the driven snow." Try to better understand why you choose the descriptors you do and reflect on known alternatives.

6. **Ask if you aren't sure.**

   As I mentioned in the introduction, inclusive language aims to name people in accordance with their identities. So, if you aren't sure how someone identifies, ask! Taking the time to find out how a person self-identifies, rather than making assumptions, is beneficial in communication. Most people are happy to walk you through language that makes them feel properly acknowledged and respected.

   Inclusive language may initially seem complex and overwhelming, especially when you get into the details and realize how many common words and phrases have discriminatory backgrounds. However, it comes down to just one thing: use the names and phrases that a person uses to self-identify. It's that simple. Inclusive language is all about making others feel heard, honored, and respected.

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Asia Safe Abortion Partnership

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Sign up for **ASAP Academy**, a self-paced online learning platform, so we can make the movement stronger together!

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SELECTIVE ABORTIONS AND THE IMPACT ON SAFE ABORTION RIGHTS

Guest Editor: Shreejana Bajracharya, Nepal