

Amnesty International's Policy on Sexual and Reproductive Rights*

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My admiration for Amnesty began decades ago when I began to work as a human rights advocate during the Marcos dictatorship. I worked in the rehabilitation of torture survivors. At that time, illegal detention and torture often came together. Time and again, in appeals for individuals or in scathing reports and statements, Amnesty used its moral and organizational strength to uphold the rights of Filipinos.

But we eventually had our People Power Revolution. My own paths led me to a different set of advocacies and Amnesty faded from my consciousness. When I joined some of you last December for an experts meeting, it was a bit like revisiting with an old friend. At the same time, there was both surprise and explanation why we had lost touch.

Let me explain. I never left human rights work. After the downfall of the Marcos regime, we had a brief period of hope when we thought the rule of human rights had finally come to the Philippines. It was time for my colleagues and I to think about our work. This led me to an interest in women's rights, particularly reproductive rights. The shift to reproductive rights came with a realization that women were discriminated against in human rights theory and practice. My emphasis on reproductive rights also seemed to me congruent with an approach that links human rights to human development. When I shifted to the advocacy for reproductive and later, sexual rights, many things that bothered me about my own experiences as a doctor and a human rights advocate became more understandable.

* Message delivered at the International Meeting on Amnesty International's Sexual and Reproductive Rights Policy, London June 10–12, 2005.

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As a medical intern, I was exposed to the discrimination against women in the big public hospital where I trained. In Philippine society as in many others, women are given sole responsibility for the health care needs of their families. It is poor women who crowd government hospitals to beg for services. I might add that those services were severely inadequate even then. These women thronged the hospital corridors where they were treated with contempt by the upper class doctors and nurses seeking to get their degrees. I might add here that the Philippines is one of the top exporters of medical personnel in the world. Those in the industrialized North owe much to the poor, especially the women, whose bodies and emotions have served as live training material for the Filipino health professional.

The epitome of contemptuous behavior towards poor women happened in obstetric wards. There is a peculiar subculture that pervades medicine when the patients are exclusively women. Women with normal deliveries were considered boring burdens that added very little to the training experience. Instead of focusing on their anxieties and pain, personnel focused on whether they were “demanding” women. This label was used on any woman who did not quietly labor. Personnel were also irritated with women who misunderstood their bodies and claimed wrongly that they were about to deliver.

For demanding women, you would hear such comments as, “You enjoyed making this baby but it isn’t much fun now, is it?” But even the quiet ones were treated badly if they had no money, “You are here again? All you seem to do is make these babies. Then you have nine months to prepare and you can’t even save up!”

The most horrible behavior was reserved for women seeking post abortion care. Our training was that we would have to get them to confess whether they had induced the abortion or not. Thus, most women coming in after abortions were put through serious violations of their right to privacy. To put it bluntly, it was not only military interrogators in the Philippines that learned harsh interrogation techniques. A stint in obstetrics gave most aspiring doctors the same skills.

This was justified by telling us that we needed to initiate different treatment protocols depending on whether abortions were induced or not. Abortion is illegal in the Philippines under all circumstances. We were therefore supposed to assume that all induced abortions would lead to infections while spontaneous ones were safer. Much later, I learned that we did not have to upset our patients so much. Current post abortion care protocols do not require that we know whether an abortion has been induced or not.

Although I am talking about Philippine situations and practices 25 years ago, they are current to this day, both in the Philippines and in other countries. The situation has gotten worse if not better.¹ Recent newspaper articles reveal the same discriminatory treatment towards women in our hospitals. For example, it has been reported that a woman who sought post abortion care was forced to wear a sign that said, "I tried to get an abortion."² Likhaan studies have revealed that discriminatory practices in obstetrics are genuine barriers to access and determine maternal morbidity and mortality outcomes.³ I also understand that Amnesty members are well aware of the erosion of basic social services such as health care in the light of structural adjustment programs, privatization, decentralization and health sector reform. Before I left for this meeting, one of the few remaining private contraceptive providers in the city of Manila was forced to close its doors because the pro-life mayor had threatened them with arrest. He invoked his right under the decentralization law to disobey international and national health standards as well as the Philippine constitution.

After graduation from medical school, I worked in community based health programs, the only kind of non-governmental organization the Marcos regime allowed. I worked with very poor peasant and indigenous communities. We tried to deliver primary health care within an approach that organized people around their health needs. I thought we were doing a good job but I do not think we served women as well as we served men.

In the poor communities I served then, women had unceasing burdens in terms of pregnancy, childbirth and childcare. Our community based health programs did not carry contraceptives because many were

based in the Catholic Church. But even the secular ones were critical of population control. True enough, there was medical abuse as well in the Philippine population program. But our own community based health programs failed to grasp the difference between the technology and the socio-political context in which it was used. We were not sensitive enough to women, otherwise we would have realized their need for contraceptives outside the parameters of population control.

Then, as it is today, many women were unaware of the workings of their body and would find themselves pregnant even as they had not even finished breastfeeding the youngest child. But even those who knew that sexual intercourse led to pregnancy could hardly avoid getting pregnant. Many felt obligated to obey their husbands who assumed male privileges in the marital bed as a matter of course. If the ideology of marital obedience was not sufficient, then their economic dependence also imposed their sexual compliance. Then of course, there were many whose husbands were violent and forced non-consensual relations. Thus, whenever I think of all those taunts about women enjoying the baby making and then not having the integrity to brave childbirth, I am deeply angered.

I will never forget my first case of maternal death. She was a woman whose eighth and ninth children were in and out of our clinic due to malnutrition. She had almost lost her life during the birth of her youngest child. Our relationship was a roller coaster one. There were moments of joy whenever we could move her children from second degree to first degree malnutrition. But they would slip back into malnutrition after a while and she would be back in the clinic. As you may have guessed, she finally came in for help with her tenth pregnancy. Her numerous health problems prevented the use of any contraceptives except the condom. The problem is that her husband was alcoholic and abusive. With nine children, she could not leave him. He had come home drunk one night and raped her. She begged me for an abortion which I did not know how to get for her. She died in childbirth and I lost track of her children.

At that time I wondered how a simple medical procedure such as a manual vacuum aspiration could not be made available to save her life. I also wondered why I, an agnostic, could not perform an abortion because

of laws that uphold Catholic religious dogma over all other beliefs. At my most pessimistic, I fear that my patient's two youngest children died in the care of their negligent father. I wonder too, what lives her seven other children lead and where they are now. I know that there are over 500,000 women who die yearly in childbirth, many due to illegal abortions. It is the final assault on lives lived in oppression.

When I worked with detainees and torture survivors, I realized that even this less controversial area of human rights defense had its gendered components. My first encounters with rape survivors and pregnancies that resulted from rape, came because of my work in the Marcos military jails. The fear of sexual assault, even if it did not actually happen, was a continuing cause of anxiety for most of the women detainees until the day of their release. Sexual threats were also very much a part of interrogation and torture techniques for women. This was not as true for men except for priest detainees.

Most priests who were arrested and detained were Catholic priests. Sodomization was a common occurrence. I believe that the torturers needed to degrade priests and bring them down from their sacred status. Sodomization achieved the goal of making them less sacred by having them engage in the evils of sex and also in making them less human by feminizing them. In this way, the Catholic torturers could overcome their godly fear of the priest in ways consistent with the sexually repressive and misogynist standards of mainstream Catholic morality.

I have often enough been accused of being too Western and too feminist because of my work in sexual rights. But a very inhuman concept of sexuality underlies the mistreatment of women who are giving birth, seeking contraceptives, seeking abortions or post abortion care, seeking rape treatment. It is the same construction of sexuality that causes male desire to be predatory and the female submission to this desire. It is this same sick view that sees rape as a torture technique and sodomization as a way of torturing Catholic priests. It is the same view of sexuality that causes women's bodies to become markers for a cultural community, thus making rape a method of warfare. It is the same sick sexuality that makes

many incest and rape victims turn to a life of prostitution because they feel worthless and dishonorable.

I do not know whether this is too Western or too feminist. I have seen it in my experiences working with the poor, the marginalized and the violated in the Philippines.

My understanding of what women in poor communities want includes reproductive rights. It is true they want homes, livelihoods, education for themselves and their children. But they wish also to be relieved of the endless labor of housework, childbearing and childrearing. They long to put their bodies to their own pleasures rather than to the pleasures of their men folk alone. They wish they could say 'no' sometimes, even as sometimes, they wish they could say 'yes.' They want their sexual choices and their right to privacy in making these choices upheld. When they get pregnant without their wanting it, too many of them put their lives on the line to get an abortion. When they make abortion decisions they often consider the needs of their other children who are already malnourished, unable to go to school, and so on. Unlike human rights categories and developmental frameworks, they make no distinctions between their reproductive rights in the private sphere of intimate relations and their civil and political rights in the public sphere. I also do not think that Western concepts of autonomy are necessary to understand the desire of women to control their bodies and the validity of reproductive rights in upholding their dignity.

But I have no intention of totalizing things. I do not think that all Philippine doctors and nurses are misogynist, inhuman and materialistic. Hospitals are overcrowded, understaffed and under funded. Many health workers brave the frontlines daily in the most difficult conditions. Many times I have seen humane and expert care, delivered at miraculously low cost, by doctors who have put forth the best of their minds and hearts in order to achieve these results. I also do not think that all men are sexual predators and that all women are saintly victims.

Similarly, I know that Amnesty has been doing a lot of good work in the area of sexual and reproductive rights. The matrix sent to us before

this meeting makes this clear. I particularly admire the campaign on violence against women that has highlighted the gendered aspects of conflict. It is a wonderful attempt to put an end to violence that seems to have become accepted as inevitable through the centuries.

Last December, I admired the depth and breadth of Amnesty's elucidation of the indivisibility of rights. The women's movement in the Philippines has learned from Amnesty's developing frameworks. One of the more controversial press conferences I joined in recent years was one where several feminists came out to the media against the execution of a man convicted of having raped his daughter repeatedly. It was the first execution undertaken after the reintroduction of the death penalty in the Philippines. Our press conference made the front pages of two leading dailies. Our decision to do this was partly informed by AI's anti-death penalty campaign.

I was surprised to learn however, that there is much to be done about sexual and reproductive rights. Amnesty has very rarely been at par with international human rights standards, not because it lags behind, but because it often tries to raise these standards. Why then does it fall short of the reproductive and sexual rights standards established during the Cairo and Beijing conferences in 1994 and 1995? When I came last December, the Beijing + 10 process had not been completed. I read the resounding defeat of the US resolution in New York as an affirmation of the international community's acceptance that new standards were indeed created to accommodate women's needs and women's experiences in human rights.

I do not merely refer to standards relating to abortion, although I will return to this issue later. For example, I will bring up the issue of emergency contraception that is mentioned in the matrix sent to us for this meeting. The emergency contraceptive, *levenorgestrel*, is endorsed by the World Health Organization, as well as the International Association of Gynecology and Obstetrics. Study after study has proven that it is not an abortifacient.⁴

I bring up this issue as well because there is another tale to tell. For a brief period in 1999, emergency contraception was legal in the Philippines. In principle this meant that it could be made available to rape

survivors in government centers as stated in a Department of Health position paper and the issuance of a Bureau of Food and Drug registration. By December 7, 2001, the Department of Health had withdrawn the registration claiming that the drug, known by its brand name Postinor, was an abortifacient. The story of this ban and the attempt by Philippine women's groups to repeal it cannot be told in full due to time constraints. Suffice it to say that the ban was put in place without consulting the end users like women's groups, reproductive health and family planning advocates, rape crisis centers. The ban was undertaken on the basis of a single petition by a group closely related to the Catholic Bishop's Conference of the Philippines. In truth an experts' panel convened to hear our appeal, filed in March 2002, decided in our favor.⁵ But it was a pyrrhic victory. Despite regulations that require our Secretary of Health to come to a quick decision, he kept the panel findings to himself for more than two years. Eventually he declared the issue moot, because there was no party interested in actually importing the drug into the Philippines.

Similarly, threats to access to services and information for adults and adolescents are happening daily in many parts of the world. The opposite is also true, that standards of access are being evolved at the ground level by organizations such as Likhaan or by international organizations. Amnesty may find that it does not need to take the lead in setting these standards.

However, I know that the process that Amnesty is going through on these issues is different not merely because women always tend to get a bad deal. I recognize that reproductive and sexual rights standards encompass a whole new range of concepts and challenge the original formulations of human rights in liberal political philosophy. Yet this is what is so cutting edge about reproductive rights! It is the way to go beyond the limitations imposed by classic formulations that evoke the rational and autonomous individual of Western liberal democracy. That rational and autonomous individual has been an imposition on human rights discourse because it ignores various other subjectivities that nonetheless demand human rights protection. The ability to go beyond the public/private divide upon which classic civil and political rights are premised opens up new

horizons. It allows us to talk about how human rights makes sense in the intimate reaches of our individual lives as these play out in the context of global systems of oppression. Of course the challenges are both frightening and exhilarating. Of course, the debate can become emotional and fraught, particularly around the issue of abortion.

My organization, Likhaan, was in a similar situation some years ago. Many of the elements that are included in the concept of sexual and reproductive rights were part of our daily work. Likhaan is a non-governmental organization that delivers comprehensive primary health care to four large urban poor communities in Metro Manila. Last month, we began to work with two rural communities in central Philippines. When I say comprehensive health care, I mean that in addition to what was defined as primary health care in Alma Ata, we have included most elements of reproductive health care: maternal care, family planning, reproductive tract infections, violence against women, adolescent education and services, infertility, reproductive system malignancies, male involvement.

Our approach is one that empowers communities, especially the women, to take charge of their health care needs. For us, community organizing is one of the elements that ensure quality of care. We train community health workers, chosen by people's health organizations. Although the people's organizations are open to men and women, most of the health care workers are women. This is reflective of women's traditional role, but it is fine with us. These women are also often the ones elected to lead the people's organization in their community, thus they are both healers and leaders. Their work has been excellent. Despite a focus on health care, the people's organizations they lead have become important players in other community struggles such as those for water and electricity services and security of land tenure. The feminist perspective has also made our women-led organizations focal points in the organizing of youth as well as gay, lesbian, bisexual and transgendered groups. In situations where criminal syndicates control almost all aspects of community life, they are making headway in carving out alternative power structures. In our most successful community, talks are ongoing with the city government that would put in place a new system of emergency obstetric care

that we hope will make a significant impact on maternal mortality and morbidity. The interest of the local government and its health managers in this effort is not merely because they wish to serve the public. It is recognition of the power of the people's organization Likhaan works with.

But until a few years ago Likhaan had not taken an organizational position on abortion. This was partly due to the extremely repressive moral climate in the Philippines. We are only one of two countries where divorce is not allowed, one of only 8% of countries where abortion is illegal under all circumstances. We also have no laws protecting against discrimination based on sexual orientation. Whenever laws are filed for approval in our legislature on reproductive health, divorce, or gay and lesbian rights, the Catholic Church pulls out all the stops. Pastoral letters are read in all churches nationwide. Politicians are threatened that the flock will not vote them back into office. The Church stand against contraceptives can be particularly uninformed as when they say that condoms do not protect against HIV-AIDS. They also label all proposed legislature on reproductive health, "abortion bills", even if these very same bills uphold the continued illegality of abortion. In one such period of frenzy, doctors at a local hospital revealed to the parish priest who among their patients were using IUDs. The priest threatened excommunication and many of the women succumbed and had their IUDs removed.

Obviously, taking a pro-choice position in the Philippines is not an easy exercise of our right to free expression. You have organizational concerns. One progressive media practitioner whom we consulted warned us that if we were to come out publicly for legalization or decriminalization, it would be the "the kiss of death" for our advocacies. In other words, in Amnesty jargon, there was absolutely "no value added."

But we made a distinction between framework or vision, strategies and tactics. Even if we were to take a pro-choice stand, it did not mean that we necessarily were going to shout that position from the rooftops forthwith. It was important for us however to be clear about our basic values and to make our framework morally coherent. In other words, with all due respect, I do not think that concerns about what reproductive rights advocacies are in terms of the "value added" criteria are very relevant

to the decision you must make in the coming months. I also do not think that issues of focus, emphasis, general applications as opposed to particular standards, are pertinent. These merely sidestep what is essentially a question of morals, values and vision.

Likhaan is made up of people with different approaches to spirituality, various faiths, agnostics, atheists. Two of us held doctorate degrees while the same number had attended grade school for only a few years. Some of the women needed to weigh what Likhaan's stand on abortion would mean to their relationship to their partners, mothers, fathers and siblings. They also need to worry about what social effect a pro-choice position would have on their children and families. They also had to worry about the effect of their personal and organizational positions on the people's organizations they led. I must remind you that the women health workers, their families and people's organizations we work with, are embedded in their communities. Because of these added considerations we attempted a careful and dialogical process. We hoped that whatever stand we took would not be a moral imposition on any one of us.

We had a series of discussions where each one stated their beliefs about abortion. One of us stated that theoretically, she would think that a woman should have access to an abortion at any time during her pregnancy and for whatever reason. The only real limitation would be what was medically healthy for the woman. Others thought that the age of viability, as determined by the state of Philippine health care, might be a good cut-off point. Others, who had come from community consultations, repeated the common cultural concept that the pregnancy was merely a lump of blood and not a person in the first trimester or before quickening. One of the men stated that while his head could deal with a very liberal position, his gut could not stomach the thought of a fetus, already looking quite like a baby at 24 weeks, being aborted. None held the belief that abortion was immoral under any circumstance. In the end, we took a position for legalization for economic reasons, in cases of threat of life to the mother, in cases of severe fetal deformity, in cases of rape. We also set the cut-off point for access to below the age of viability.

It was not an easy decision for our organization. I can imagine the difficulties will be multiplied several-fold for Amnesty. Certainly I am aware that our processes would not be applicable. But perhaps something about our approach is.

That approach is captured by the concept of moral inclusiveness and its underlying psychological mechanism, moral recognition. In the sometimes intense debate between pro-choice and pro-life, I think we fail to recognize that this is a false dichotomy. I do not think Amnesty can afford to be trapped by this binary thinking. For one thing, making people think this way tends to skew the debate towards moral absolutism on either side. This is what makes this decision so difficult.

My organization's nuanced pro-choice position sums up our assessment of women's situations, the scientific literature on women's health, our understanding of the needs of women, our ideas on human rights, as well as our collective judgment of what is right and wrong. It is a position taken by billions of other people, a position codified in an increasing number of national laws and a position supported by international human rights instruments. Nonetheless my understanding of the profound and complicated issues that abortion brings up, also allows me to recognize that positions that are diametrically opposed to mine are also moral.

Recognizing the anti-abortion position and allowing it moral inclusion has convinced me further in the correctness of seeking the decriminalization of abortion or if possible, its legalization. For me it is simply a matter of ensuring that laws do not impinge on the right to practice one's moral and/or religious beliefs. As I have tried to show you, laws in the Philippines that are premised on the moral exclusion of those who do not believe in the pro-life position, have curtailed our right to believe differently without intimidation, to speak freely and to give medical care that we consider life saving. It also brings into serious question the principle of the separation of church and state. I do not think that liberalizing abortion laws would have the same effect on those who believe differently from me.

Perhaps some of you are thinking that my pleas for moral recognition are merely a disingenuous way of convincing you towards a pro-choice position. I will not defend myself against accusations of bias except to say that there has been no attempt on my part to hide my position.

On the other hand, I think the way by which we arrive at a decision is just as important as the particular decision itself. If we can recognize the morality of the other person despite our differing beliefs, we are less likely to fall into rancorous and divisive debate that can tear apart friendships, working relationships and organizations. You may also find that there is a position to take that goes beyond the binaries of pro-life and pro-choice, good and evil. As you can see, the Likhaan position is a nuanced one. I also think that Amnesty's position on emergency contraception and abortion for rape-related pregnancies falls way below accepted international standards.

My belief in the necessity for moral recognition and inclusiveness goes back to my experiences working in the rehabilitation of torture survivors. As each survivor told me his or her story, it became clear to me that torture can only occur if the torturer allows himself to see his victim as less capable of moral agency. The torturers believed all those who opposed the Marcos dictatorship were communists or communist lackeys. In their minds, the triumph of communism in the Philippines would have been the worst possible disaster that could befall their families, their communities and the country. In short communism was evil and torturing communists prevented that evil.

This inability to extend moral recognition to those whose actions or characteristics offend us, is at the basis also of the death penalty, of rape and other forms of violence—indeed of all forms of human rights violations.

Human rights work has taught me, the ends do not justify the means. With regard to the abortion debate, whatever position Amnesty takes is just as important as the manner in which the debate is carried out. If we do not begin a discourse of moral inclusiveness and recognition then we do not invest in a world where human rights and human dignity prevail.

Indeed, after the meeting in December, I developed this insane wish to go out and have a heart to heart talk with each of Amnesty's two million members. This being impossible, I can only wish Amnesty well. You have great internal resources and many friends. (You shall have more friends if you decide to expand your mandate on sexual and reproductive rights.) It is not a naïve thing for me to believe that when this chapter is told, perhaps Amnesty can show the world yet again, how a firm commitment to human rights including all its challenges and imperfections, is still the way to approach questions of personhood, dignity, spirituality and the beginnings and fullness of human life.

Endnotes

1. "Gender Issues in Cancer Care," Paper delivered at the Mid Year Convention of the Philippine Society of Oncologists, June 29, 2002. Published in *Gender Issues in Medicine*. Reyes, D, (ed.) University of the Philippines Center for Women's Studies and Ford Foundation, 2003.
2. "Dark Stories Born in Delivery Rooms," by Christian Esguerra, *Philippine Daily Inquirer*, May 30 2005; and "Abused Patients Urged to Come Out," same author and newspaper, June 1, 2005.
3. Linangan ng Kababaihan. Investigating Responses to Obstetric Complications and Access to Emergency Obstetric Care Among Urban Poor Women. Study done in collaboration with Columbia University, 2005. In publication.
4. <http://www.cecinfo.org> is an excellent website for information.
5. Womenlead, Philippines. Confronting Legal Impediments to Reproductive Freedom: The Legal Battle to Re-register Emergency Contraception in the Philippines, February 2003.