



CONTENTS

INTRODUCTION	1
Section One: Understanding reproductive and sexual rights	2
Emergence of the Rights Approach	2
The history of Reproductive and Sexual Rights	3
Some definitions of reproductive and sexual rights	4
How human rights are related to reproductive health	5
Perspectives and struggles of the women's health movement	8
Violations of reproductive and sexual rights	11
Making Reproductive Rights real	12
Section Two: Issues and debates in India	16
Access to safe methods of family planning, information and means to make reproductive decisions free of coercion, discrimination and violence	17
Healthcare services for safe pregnancy and childbirth, the right to the highest standard of reproductive health	19
Violations of women's sexual and reproductive rights	20
Section Three: Working for the realisation of Reproductive and Sexual Rights	23
Educational interventions	23
Improving service delivery	24
Research	25
Advocacy	25
Implementing a rights approach in reproductive health	26
Claiming a health related right	28
Section Four: Resource Section	29
Further Reading	29
Resource Organisations	30
International Organisations	33
Some Useful website	34

INTRODUCTION

The expression **Reproductive and Sexual Rights (RSR)** gained popularity after the International Conference on Population and Development (ICPD, 1994), although 'rights' language with regard to reproduction had already been used way back in 1968 at the International Human Rights Conference in Teheran. In order to understand the expression Reproductive and Sexual Rights, we need to explore the meaning of the expression 'rights'. It conveys a sense of entitlement, although it cannot always be taken for granted. This is particularly so in the case of women's rights, which need to be constantly defined and even struggled for. The process of defining rights more often than not stems from a perception of ongoing injustice. Yet, even when rights are encoded, they cannot be assumed as a prerogative, and violations are more the rule than the exception.

When we reflect on the exercise of rights, some questions arise, such as: do people have rights before they are aware of them? Or is it imperative that rights have to be known and exercised if they are to exist? Further, can rights be 'given'? Or is it always necessary for those deprived to struggle for them? Does society have any responsibility in this matter? Moreover, can we understand rights if there have been no 'wrongs'? That is, must violations always precede acknowledgements of rights? These are some of the fundamental questions that have to be answered if we are to work on any sort of rights, including reproductive and sexual rights.

Sexual and Reproductive Rights have been encoded in several international documents, some of which are legally binding and some more in the nature of an agreement between states. However, the ICPD document was an explicit statement that brought the term Reproductive and Sexual Rights into popular parlance. It marked a watershed through which the women's health and rights movement was able to generate great impetus for its advocacy work.

This booklet provides some definitions and the history of reproductive and sexual rights. It also highlights their importance and deals with the aspect of their violation. Further, this booklet raises some issues and debates about Reproductive and Sexual Rights in India, and suggests programmatic implications. At the end is a resource section, giving a reading list and some other information which may be useful.

Understanding Reproductive and Sexual Rights

Emergence of the Rights Approach

Equal human rights for all human beings is not only a principle of international human rights, but a core principle of the Indian Constitution. Since the Second World War, the international community has been concerned about protecting human rights of all individuals. This concern was reflected in the formulation of the UN Declaration of Universal Human Rights in 1948 and in the Indian Constitution through Articles 14 and 15. The right to health was articulated in the international arena through the International Covenant of Economic, Social and Cultural Rights, while the Indian Constitution included the Directive Principles to address the issue. The human rights conference organized in Teheran in 1968 came up with a formulation of a right of parents to freely and responsibly decide the number and spacing of their children. In 1979, the

Human Rights

The genocide of Jews in World War II called for the setting up of stringent standards and controls through international mechanisms which would prevent such a holocaust in the future. The history of modern human rights was born when on the 10th of December, 1948, the United Nations adopted the Universal Declaration of Human Rights (UDHR) which proclaims the "inherent dignity and... the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world". This represented "a common standard of achievement for all peoples and all nations".

Human rights are the inalienable rights that a person has simply because he or she is a human being. This means that a person cannot lose these rights or no one can take these away from anyone. Human rights are indivisible which means that no one can be denied a right because it is "less important" than another right. Human rights are also interdependent which means that all human rights complement each other and depend upon one another. For example, the right to participate in elections and participate in making a government is directly affected by the right to free expression, or the right to life is related to right to health.

United Nations adopted CEDAW (Convention for Elimination of All forms of Discrimination Against Women), accepting the need for states to make special provisions for women to ensure and safeguard women's rights.

In the 1990's a number of significant changes took place in the international arena which changed the way of looking at development. The concept of human development was adopted by the United Nations Development Programme with the annual publication of the World Development Report from 1992 onwards. This was a significant departure from the earlier

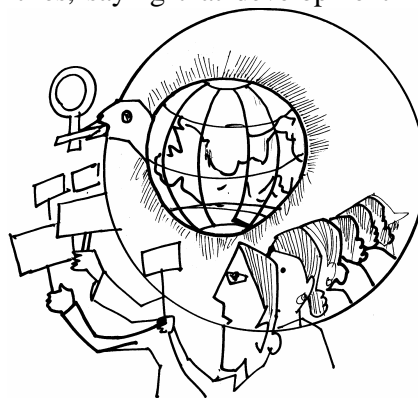
economic development approach that was only concerned with the aggregate income and productivity of nations. Human development included educational achievements and health attainments within the ambit of development. In 1993, the human rights conference organized at Vienna accepted the right to development as an integral component of human rights. Out of the conference on population and development, organized at Cairo in 1994, there had evolved a clearer and more precise definition of reproductive rights. The Fourth World Conference on Women organized at Beijing in 1995 tabled the agenda for women's empowerment. All these changes were possible because of struggles of many national and international movements spearheaded by women's rights and human rights activists on the one hand, and the willingness of governments to sit together and negotiate a common agenda on the other.

A consensus definition of the rights approach may be found with the UN Commission on Human Rights that defines it as "an integration of the norms and standards contained in the wealth of international treaties and declarations into the plans, policies and processes of development". These norms and standards also need to be integrated into the component of domestic legislation, because without appropriate legislation, the rights approach cannot ensure justice in the case of rights violations or mandate the state to ensure enabling conditions to enjoy the rights.

The History of Reproductive and Sexual Rights

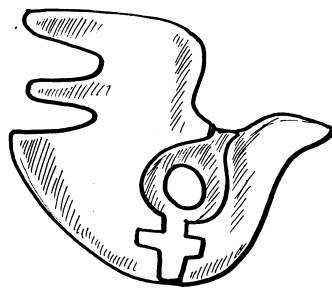
The first statement of rights with regard to reproduction was at the UN organised International Human Rights Conference at Teheran in 1968. This statement said that 'parents have a basic human right to decide *freely and responsibly* on the number and spacing of their children and a right to adequate education and information in this respect'. The catchword here is '*responsibly*', which left ample room for international organizations and governments to carry out coercive measures with the excuse that citizens had not been 'responsible'! This was very much on the agenda, since Paul Ehrlich's *The Population Bomb*, which presented a grim picture of the global devastation resulting from unchecked population growth (especially in Third World countries), influenced the dominant western thinking in those days.

In 1974, at the World Population Conference at Bucharest, a new element was introduced into the debate by developing countries, saying that development affected population, rather than the other way round. The Plan of Action adopted there once again reaffirmed the earlier language with some changes: the word 'parents' was changed to 'all couples and individuals', and to 'education and information' was added the word 'means'. Moreover, the element of 'responsibility' was defined in some more detail.



On the other hand, by 1975, the international women's health movement had articulated its philosophy that every woman must have the right of control over her body, her sexuality and her reproductive life. This was in opposition to the movement to control population growth (especially through focussing on women) in the Third World. At the International Women's Year Conference in Mexico City, the earlier language of the right to reproductive choice was firmly grounded on a notion of bodily integrity and control. "The human body, whether that of a woman or a man, is inviolable and respect for it is a fundamental element of human dignity and freedom" (Article 11, UN, 1976). The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) codified the right of reproductive choice "on the basis of equality between men and women" (UN, 1979).

By 1984, however, a strong Anti-Abortion movement had taken root, especially in the US, and was calling itself the 'right to life' movement, although women's health advocates saw it as 'anti-choice'. It may be re-called these were the days when there was a Republican government in the US with Ronald Reagan as president. This changed the attitude and funding of the US Government towards population growth. Nonetheless, the recommendations of the 1984 International Population Conference at Mexico City urged that "governments can do more to assist people in making their reproductive decisions in a responsible way" (UN, 1984).



This was the context of the Cairo ICPD in 1994. Given the inequities between countries, different view on human rights, and strong pressure from the women's health movement, the conference was able to negotiate a document that may be considered a radical shift forward in the movement for ensuring women's rights. The Cairo Programme of Action recognised the central role of gender relations in women's health and rights, defined reproductive and sexual health and rights, and stressed the need to empower women while increasing men's responsibility.

Some definitions of Reproductive and Sexual Rights

A definition of RSR has been comprehensively set out in the ICPD Programme of Action (PoA) which draws from the explanation about Reproductive and Sexual Health (RH, SH):

(Art. 7.2) Reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive Health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of

*family planning of their choice,... and the right of access to appropriate healthcare **services** that will enable women to go safely through pregnancy and childbirth.... Reproductive health also **includes sexual health, the purpose of which is the enhancement of life and personal relations**, and not merely counseling and care related to reproduction and sexually transmitted diseases.*

*(Art.7.3) Reproductive Rights embrace certain human rights that are already recognised... These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and **the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence...** The promotion of the responsible exercise of these rights for all people should be the fundamental basis for ... policies and programmes in the area of RH...*

(Para 7.37) Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their sexual lives. Equal relationships between women and men in matters of sexual relationships and reproduction, including full respect for the integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour.

Sexual Rights (SR) were further described in the Platform for Action of the Fourth World Conference on Women (1995), which said: *(Para 96) The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. (After this, is the ICPD language from Para 7.37 again, with the significant inclusion of the word ‘consent’).*

Sexual rights further include the right to experience a pleasurable sexuality, which is essential in itself and is a fundamental vehicle of communication and love between people. It also includes the right to liberty and autonomy in the responsible exercise of sexuality (HERA, 1998).

How Human Rights are related to Reproductive Health

As mentioned earlier, the ICPD PoA defines reproductive rights as those which embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant UN consensus documents. The human rights which are directly related to reproductive health, and their specific relationship is described below, along with the human rights documents that include this right.

The Right to Life, Liberty, and Security – The right to life is related to risks of maternal mortality in pregnancy and childbirth and in cases of unsafe abortion. The right to liberty and security should be invoked to protect women currently at risk from or subject to forced pregnancy, sterilization or abortion.

The Universal Declaration - Article 3

The Civil and Political Rights Covenant - Article 6.1

The Children's Rights Convention - Article 6.1, Article 6.2

The Right to Health, Reproductive Health, and Family Planning – It is necessary for enabling all persons to access health care including reproductive health care and family planning services that are accessible, affordable, acceptable and convenient to all users.

The Economic, Social and Cultural Rights Covenant - Article 10.2, Article 12.1, Article 12.2

CEDAW - Article 10 (H), Article 12.2, Article 14.2

The Children's Rights Convention - Article 24.1, Article 24.2

The Convention Against Racial Discrimination - Article 5

The Right to Decide the Number and Spacing of Children - This right is necessary for couples to decide the number of children they will have as well as protect them from pressure and coercion of population control measures.

CEDAW - Article 16.1

The Right to Consent to Marriage and to Equality in Marriage – This right is necessary to protect women from forced marriage. It also protects women from discriminatory treatment within marriage.

The Universal Declaration - Article 16.1, Article 16.2

The Economic, Social and Cultural Rights Covenant - Article 10.1

The Civil And Political Rights Covenant - Article 23.2, Article 23.3, Article 23.4

CEDAW - Article 16.1, Article 16.2

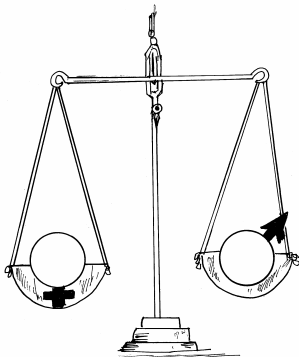
The Right to Privacy - This is necessary to protect the right of all clients of sexual and reproductive health care information, education and services to a degree of privacy, and to confidentiality with regard to personal information given to service providers.

The Civil and Political Rights Covenant - Article 17.1, Article 17.2

The Children's Rights Convention - Article 16.1, Article 16.2

The Right to be Free from Discrimination on Specified Grounds - The right to equality and freedom from discrimination is applied to protect the right of all people, regardless of race, colour, sex, sexual orientation, marital

status, family position, age, language, religion, political or other opinion, or other status, to equal access to information, education and services related to development, and to sexual and reproductive health. Equality also relates to gender equality and the need for special provisions for women.



The Universal Declaration - Article 2
The Economic, Social and Cultural Rights Covenant - Article 2.2
The Civil and Political Rights Covenant - Article 2.1
CEDAW - Article 1, Article 3, Article 11.2
The Children's Rights Convention - Article 1, Article 2.1, Article 2.2, Article 5

The Right to be Free from Practices that Harm Women and Girls – This right protects women and girls from various harmful practices which could be discrimination around care and nutrition, to such practices as the ‘*dayan pratha*’ (witch hunting) or ‘*devdasi*’ system of temple prostitutes.

CEDAW - Article 2 (f), Article 5 (a)
The Children's Rights Convention - Article 24.3

The Right to Not be Subjected to Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment – This right protects women from such treatment at home, in the community and even within state systems like police stations, educational institutions and hospitals and medical camps.

The Universal Declaration - Article 5
The Civil And Political Rights Covenant - Article 7
The Torture Convention - Article 1
The Children's Rights Convention - Article 37 (A)

The Right to be Free from Sexual Violence – This right protects women from all forms of sexual violence at different stages of life.

CEDAW - Article 5 (A), Article 6.
The Children's Rights Convention - Article 19.1, Article 34
The Rome Statute of The ICC - Article 7.1

The Right to Enjoy Scientific Progress and to Consent to Experimentation - This right is necessary both for making available to women all forms of new treatment and drugs and contraceptives as well as protect them from unethical medical experiments.

The Economic, Social and Cultural Rights Covenant - Article 15.1
The Civil and Political Rights Covenant - Article 7

Treaties and Conventions referred to above are as follows

- *The Universal Declaration of Human Rights*

- *The International Covenant on Civil and Political Rights*
- *The Convention on the Rights of the Child*
- *The International Covenant on Economic, Social and Cultural Rights*
- *The Convention on the Elimination of All Forms of Discrimination against Women*
- *The International Convention on the Elimination of All Forms of Racial Discrimination*
- *The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*
- *The Rome Statute of the International Criminal Court*

(Adapted from **Reproductive Rights are Human Rights** – Center for Reproductive Rights, New York)

Perspectives and Struggles of the Women’s Health Movement

The women’s health movement has had to struggle against several fronts. On the one hand were the demographers and planners, who felt the goal of reducing population growth justified coercive and sometimes downright dangerous means for population control, which in most cases affected women. On the other hand were religious fundamentalists, who opposed contraception, abortion, sex education, and promote practices that restrict women’s education and mobility. Then there were countries that brutally sought to restrict women’s sexuality through customs like Female Genital Mutilation. Besides these were the usual biases: against single women, against including men’s responsibility, against providing services and information to adolescents, and so on. The challenge for the women’s movement was to negotiate differences about what constitutes morality; of separating sexuality from reproduction; and defining sexual autonomy and challenging the notion of promiscuity. Then there was also another development-oriented school of thought who held that given widespread poverty and lack of the very basic amenities, it was a ‘western’ luxury to talk of reproductive rights!

Stated simply, reproductive rights provide women with the freedom to control their bodies and obtain needed health services. But reproductive health occupies the crux of women’s subordination and is really a ‘political question of choices and the right to choose’, rather than a medical question of providing care for infections of the reproductive tract or the urinary tract or through sexual transmission. The key challenge in the whole quest for reproductive rights is to address issues of power and gender relations.



Sexual Rights

During the XVth World Congress of Sexology (Paris 2001), the General Assembly of the World Association for Sexology approved the Declaration of Sexual Rights, establishing that "...Sexual rights are universal human rights based on the inherent freedom, dignity and equality of all human beings. Since health is a fundamental human right, so must sexual health be a basic human right." It further states that in order to ensure that human beings and societies develop a healthy sexuality, it is necessary for all societies, through all means available, to recognize, promote, respect and defend the rights to sexual freedom and sexual autonomy. This includes the

- right to sexual integrity and safety of the sexual body;
- rights to sexual privacy and sexual equity;
- rights to sexual pleasure and emotional sexual expression;
- rights to sexually associate freely and to make free and responsible reproductive choices;
- rights to sexual information based upon scientific inquiry;
- right to comprehensive sexual education and to sexual health care.

"Sexual health is the result of an environment that recognizes, respects and exercises these sexual rights," affirms the Declaration.

Women's health advocates have viewed RSR as 'constellations of legal and ethical principles that relate to an individual woman's ability to control what happens to her body and her person by protecting and respecting her ability to make ... decisions about her reproduction and sexuality' (Freedman, 1995). Yet respect for these rights has profound consequences. All women would then increase their chances of enjoying good health, accessing quality reproductive healthcare, entering only into consensual sexual relationships and deciding the number and spacing of their children by using safe and acceptable contraception. But the right to control reproduction remains elusive for most women. Their bodies are often pawns in the struggles among individuals, families, religions and states. Women continue struggling to reclaim their bodies, given the context of denial of some of the basic rights: to liberty, to security, and to decide whether, when and with whom to found a family.

Moreover, when we talk of the freedom to access services, such services must be provided in a context that respects women's moral agency and that treats women as principal decision makers in matters of reproduction and sexuality. Unfortunately, the opposite has often been the case, and women have also been denied the right to access to contraceptive services or other healthcare, the right to quality of care (including counseling), apart from not being provided with appropriate healthcare for women's needs. The right to informed consent has also been violated, with researchers and service providers conducting invasive procedures on women's bodies without bothering to ask.

Further, women's health advocates have urged that RSR be viewed in the context of present gender disparities. It has been noted that 'a definition of RR must include women's economic, political, legal, educational, and general health rights. It is only when these rights are recognised as ... having a focal role in their reproductive choices that population and demographic patterns can be properly understood...' (Shirkat Gah, 1994). One of the key obstacles to women exercising rights over their own bodies is their disempowered status in family and community decision-making processes. Thus women in India and the entire subcontinent are unable to make choices on whether to or not to marry, have children or not and so on. The consequences of exercising these rights are known to be barbaric – honour killings, acid throwing, retaliatory rape and similar acts are meted out to women who dare to do so, sending a clear signal to others on what are the boundaries of reproductive autonomy for women. Interestingly the state, which is mandated to protect the rights of women, looks the other way with the excuse that these are personal issues. The link between women's RSR and larger structural issues like neo-liberal globalisation can be understood if one looks at increased incidents of international as well as in-country trafficking or the increased vulnerability of single-partner women to STIs and HIV due to migration of male partners which is becoming imperative in the absence of livelihoods in rural areas.

RSR also stem from the philosophy and struggle of the feminist movement. As Rosalind Petchesky said in a pre-Cairo women's conference:

"Four basic ethical principles lie at the heart of RSR: bodily integrity, personhood, equality and diversity. All four have both negative and positive applications - that is, they involve both protection against coercion and abuse, whether by state officials, medical personnel, kin, or sexual partners; as well as the fulfillment of basic needs..."

Bodily integrity involves people's rights not only to be free from physical abuse, coercion or violence but also to be enabled to enjoy their body's full potential for health, procreation and (safe) sexual pleasure.

Personhood ...refers to women's right to be treated as principal actors and decision makers in matters of reproduction and sexuality; as subjects, not objects, of medical, social and family planning policies.

Reproductive and sexual equality - both between women and men and among women, has to do not only with prohibiting discrimination... but also with providing social justice and the conditions of development.

Finally, *the diversity principle* requires respecting the differing values, needs and priorities among women - based on culture, ethnicity, religion, sexual orientation, and nationality - but as women themselves, not male kin, politicians, or religious leaders who define those values, needs and priorities. (Petchesky, 1994)

Women's health advocates have also asserted that 'a right is no right if those for whom it is meant do not know of its existence, and if services are not provided to ensure its enjoyment. It is the responsibility of governments and organisations ... to ensure that individuals and couples are given access to both information and services. In addition to this, societies should make all

effort to free their citizens of practices, taboos and constraints which deny them other reproductive rights and freedoms'. When governments seek to deal with some of the most private and intimate aspects of people's lives through forced family planning programmes, or do not ensure informed consent, or do not provide women with adequate and accessible services, they are infringing women's reproductive rights.

Violations of Reproductive and Sexual Rights

Violation of RSR takes place from early childhood. **Child Sexual Abuse** is a widespread phenomenon that is rarely discussed, and little documented. One reason is that the abusers are frequently known to the child and her family. Studies confirm that apart from physical trauma, children suffer from long term psychological effects that lead to low self-esteem, depression, poor ability to delay or even negotiate safe sex, or enjoy intimate relationships. Child sex abuse can happen with both boys and girls.

LGBT rights

Around the world, lesbian, gay, bisexual, and transgender (LGBT) people are considered as aberrations or criminals, and their human rights are violated on a regular basis. People are beaten, imprisoned and killed, sometimes even by their own governments simply for engaging in homosexual acts. Those suspected of being LGBT are also routinely the victims of harassment, discrimination and violence. Where real or perceived homosexuality often constitutes the basis of a violent act against a person, there is a growing global movement to recognize the rights of LGBT people and the need to combat these human rights violations.

Harmful traditional practices such as **female genital mutilation** (FGM) involves cutting-off of the clitoris and the labia, sometimes even sewing the two sides of the vulva together, so as to prove to the marriage partner that the girl is a virgin, and control her sexuality. The entire exercise is done with crude implements that can lead to uncontrolled bleeding, blood poisoning and death, apart from chronic urinary and reproductive tract infection, pelvic pain, immense difficulty in intercourse and childbirth, and even sterility.

Another harmful traditional practice involving girls is **child marriage**, prevalent in cultures that set a premium on virginity or have a well entrenched dowry system (a child would need less dowry). The child usually married to someone much older has to cope with the pain and trauma of early sexual activity, is unable to negotiate safe sex, and has to undergo pregnancy and childbirth before her body is ready, which could lead to prolonged labour, obstructed birth, tearing, and loss of control over the bladder or rectum.

Adolescents are also exposed to **sexual coercion, assault and rape**, and often faced with unwanted pregnancy, unsafe abortion or sexually transmitted infections. This stems from a popular belief that sex with a virgin can cure STDs. The stigma of rape can even drive girls to suicide, since the prevailing social attitude demands virginity before marriage. Another vicious practice involving young girls is burning the face with **acid** when she refuses to reciprocate ‘declarations of love’ from a man. This has been happening in South Asian countries for some time now. Then again, there is **trafficking** in girls from poor families who are often turned into commercial sex workers (CSWs), at an age when they cannot negotiate safe sex.

Women in the reproductive age group are faced with **domestic violence**, including physical abuse as well as emotional and psychological abuse. Women go through this because they have been conditioned to think that this is a part of marital relations, and also because they are dependent on their husbands in various ways. As a result they are unable to negotiate contraceptive use or safe sex and **forced sex** can result in unwanted pregnancies and unsafe abortion. Sometimes premature labour may start because of being beaten during pregnancy, and abused women also suffer from chronic abdominal pain, headaches and muscle pain apart from sleeping disorders.

Apart from this, women also face **rape and assault** outside the home, including rape in conflict situations involving caste, class, religion, ethnicity and so on. Women’s bodies are used to ‘teach men a lesson’, since a woman’s chastity is the ‘honour’ of her family, apart from a display of power over women themselves. Rape survivors face severe injuries, including reproductive tract injuries, unwanted pregnancy, infection from sexually transmitted diseases, as well as sexual dysfunction, depression and suicidal tendency.

If we look beyond the obviously violent situation faced by women, women face a serious denial of reproductive and sexual rights because of **missing health care services**. This can be seen in the absence of female doctors in peripheral hospitals and clinics which means that women do not have access to gynaecological services. It is very obviously manifested in the absence of proper services for obstetric emergencies which leads to thousands of deaths each year. This also happens when women are coerced into undergoing female sterilization camps or treated like cattle in family planning camps or when no service are available for complications or failures resulting from such poorly conducted operations.

Making Reproductive Rights Real

Reproductive health, especially that of women is an area shrouded with ignorance, shame, silence and mystery. At the same time, it is one area where there are large number of societal expectations and prescriptions, at least in traditional societies like India. Menarche, menstruation, pregnancy,

childbirth, the number and sex of children are all issues which are guided by societal norms. Many of these have specific practices around them. With societal expectations and norms on the one side, and woman's own needs and desires on the other, reproductive health becomes one of the most contested area of 'rights'. Who will decide whether or not to marry? Who will decide the age at marriage? Who will decide whether to have children or not? Who will decide the number and spacing of children? Who will decide whether to wait for a son or not? Who will decide whether to use contraceptives? Who will decide whether to carry a pregnancy or abort it? These and many similar questions form the crux of reproductive rights.

However, reproductive rights are not limited to these decisions alone. The ability of an individual to make these decisions depends upon the amount of information that is available to make these decisions. Informed choice, a key element of reproductive rights, is the outcome of the possession of adequate knowledge and information, the ability to make abiding decisions, and having access to the appropriate services that are needed. The role of the state or the government in providing the knowledge/ information as well as ensuring the services is key to the enjoyment of reproductive rights. At the same time, the state also has a responsibility to ensure that women are able to make decisions, free of coercion, in the context of their reproductive lives, which in actual practice are curtailed by family members and societal norms. Thus education of family members, making legislation to prevent discriminatory practices is also a role of the state. The Child Marriage Restraint Act and the Pre-Natal Diagnostic Techniques Act have to be seen in this light.



Role of the state

It is the responsibility of the state to respect, protect and fulfil the rights of its citizens. In order that this may happen in the realm of reproductive health and rights, it is necessary to

- Interpret health related conditions in terms of human rights violations,
- Identify, reform or create appropriate legislation
- Create rights awareness/ consciousness among citizens
- Create enabling environment through policy and programme interventions
- Ensure provision of appropriate, affordable, acceptable, quality services
- Ensure provision of information on entitlements and responsibilities, advantages and risks
- Ensure informed decision making by citizens
- Monitor the realisation of rights
- Create spaces for hearing of grievances
- Ensure justice in case of rights violations

Pregnancy, childbirth and the post partum period are one of the riskiest stages of a woman's life. Every year over one hundred and thirty thousand Indian women lose their lives to pregnancy. This preventable death can be interpreted in human rights terms and right to life can be seen extended to include the reproductive right of mothers to go safely through pregnancy and childbirth. However this right has not been explicitly guaranteed, though as mentioned earlier, the Indian Constitution does make reference to maternity related benefits.

Abortion – contested right

Safe abortion services have been available to women in India since 1971 when the Medical Termination of Pregnancy Act came into force. However abortion is illegal in a large number of countries around the world. In as many as 72 countries, abortion is prohibited or only permitted to save a woman's life. Women's activists assert that access to safe abortion is a part of reproductive rights of a woman – emerging from her rights over her own body. At the same time, unsafe abortion is an important cause of maternal death – linking safe abortion services to the right to life. Prohibiting abortion to women is also linked to gender discrimination, because unwanted pregnancies and unsafe abortion are risks only women face. Many unwanted pregnancies are also the result of coerced sex and forcing a woman to carry such pregnancies to term is a clear violation of her reproductive right to determine the number and spacing of children. However discussion on abortion, especially in international fora, is fraught with controversies because conservative and religious interests contest that abortion violates the right to life of the unborn child. This debate is referred to as the debate between the pro-choice or anti-natalists and the pro-life or pro-natalists. The stand of human rights bodies in this discussion has been clear. In 2000, the United Nations Human Rights Committee called upon all states to take measures that women do not have to undergo life threatening clandestine abortions. The European Court of Human Rights has made it clear that "it is neither desirable, nor even possible as matters stand, to answer in the abstract the question whether the unborn child is a person" (*Vo vs France, app. No. 53924/00, European Court of Human Rights*). Abortion was illegal in Nepal till a few years ago but it was legalised in 2002 as a result of a successful campaign by women's health and rights activists.

The terms contraception and family planning often appear synonymous. Family Planning is usually seen as a government priority, as a part of policy and programmes focussed on the number of children that a couple should have and that it should be consonant with that which is considered desirable by the state. Contraception on the other hand, is a matter of individual practice to limit pregnancies and childbirth. While the purpose of both may appear the same, especially in India where the national priority is limiting childbirths, there is a big difference between the two when seen in the light of reproductive rights. A family planning programme which is driven by

state agenda has been known to violate the reproductive rights of individuals by not providing them appropriate contraceptive information and options, subjecting citizens to coercion through targetting, disincentives and outright force. The emergency period (1975–77) in India is well known for the forced sterilisation campaigns and over 11 million sterilization operations were conducted in two years, a figure which has not been exceeded even though the base population now is far higher.

Female sterilisation and the rights approach

Female sterilisation is the most widely used contraceptive method in India. However there is little documentation available about the number of failures that take place each year (international estimates of failure are 0.5%). By these conservative estimates, around 25,000 women will conceive even after undergoing tubectomy. Many more women face severe complications like wound infection or abdominal adhesions. But the rights approach may be applied to female sterilisation and there are examples and precedents. In a case related to sterilisation failure, the Supreme Court has held the government responsible, and ordered it to pay compensation (Santara vs State of Haryana). The Supreme Court has also directed the Government to ensure strict adherence to surgical standards and ensure monitoring of and compensation for complications, failures and death (RK Rai and another vs Union of India - Writ Petition (Civil) No. 209/ 2003).

A family planning programme which respects the citizens right to informed choice needs to be based on a few simple principles. Information regarding the disadvantages of early marriage, early pregnancy, multiple pregnancies should be available to adolescents and their parents. Informed consent during marriage, consensual sex and sexual negotiation, and gender equality should be part of adolescent education. Information about the kinds of contraceptives and their advantages and disadvantages and complications should be available to all adolescents (male and female), especially before they begin their sexual lives. A variety of high quality contraceptives should be easily accessible. Failures and complications should be strictly monitored and services should be available for dealing with them.

SECTION TWO

Issues and Debates in India

India has one of the most progressive constitutions in the world, incorporating many of the features of the 'rights approach' within its framework. There are many appropriate laws in the penal code. The Indian Government also readily endorsed the changes in international understanding that took place in the 1990's by the formulation of National Policies and programmes meant to translate these principles into action. The Target Free and Community Needs Assessment Approach, the Reproductive and Child Health Programmes, the National Population Policy (2000), the National Policy on the Empowerment of Women (2001) and the National Health Policy (2002) are testimony to the state's commitment. At the same time, redressal mechanisms like the National Human Rights Commission and the National Commission on Women were also set up to safe guard human rights. The Indian legislative and courts too have adopted a pro-human/ women's rights approach. The Pre-Natal Diagnostic Techniques Act (1996) and its subsequent amendment because of Supreme Court directives and the Vishakha judgement (1997), are some examples of this change in approach.

When we look at the situation regarding Reproductive and Sexual Rights in India, we find on the one hand, some progressive legislation and policies, like

- the law permitting abortion (something that women of many 'developed' countries are still struggling for),
- laws prohibiting sex pre-selection and female infanticide,
- provision of free contraceptive services and free abortion services,
- government programmes for safe motherhood and reproductive health (including RTIs, STD, HIV/ AIDS),
- shelter homes/ women's police cells/ family counseling units/ National Commission for Women, and
- laws prohibiting child marriage and immoral trafficking.

Sources of health related rights in India

- *Indian Constitution* – Articles 14, 15, 16, 21, 39, 42 and 47.
- *Indian Laws* - Sections of the IPC, Child Marriage Restraint Act, MTP Act, PNDT Act, Consumer Protection Act etc.
- *Policies* – National Population Policy, National Policy on the Empowerment of Women, National Health Policy, National Youth Policy etc.
- *Programs* – RCH programme, other national programmes.
- *International Law and Agreements* – Right to Health (ICESCR), CEDAW, ICPD PoA.

On the other hand, we also see several violations of reproductive and sexual rights, both by the state and society. This includes legislation against

homosexuality, rape laws that are inadequate in dealing with the problem or ensuring justice, lacunae in dealing with domestic violence/ state-sponsored violence, and health policies that do not provide for safeguarding RSR. A discussion on the actual situation on the ground with respect to some of the crucial aspects of RSR is provided below.

Access to safe methods of family planning... information and means... to make reproductive decisions free of coercion, discrimination and violence:

Right from the beginning of the Family Planning programme in the early 1950's, the main objective of population policy has been demographic control. The principal victims of this approach have been women's health and women's rights. Acts of commission - such as the coercive use of sterilisation targets, incentives and disincentives, and the introduction of contraceptive technologies without adequate safeguards - and of omission such as ignoring the wide prevalence of RTIs and STDs, the high incidence of cervical cancer and the risks of unsafe abortions, have been all too prevalent (Gita Sen, 1996).

Although a concern with reducing fertility has led to a national 'family planning programme' that has provided some women with access to contraceptives, the government does not adequately address the underlying socio-economic conditions in which its women citizens live, and as such, its policies possess the potential to aggravate the continued violations of Indian women's rights.

Despite the millions spent on information, education and communication (IEC), detailed information on the different contraceptive methods and their pros and cons is still unavailable to the majority of women. What they get instead is a lot of propaganda on why they should have fewer children. Knowledge of adverse effects is based solely on the experiences of other women, and nothing is known regarding contra-indications.

One of the most detrimental factors in service provision has been the limited choice of methods available. Women are expected to be mute recipients of whatever the programme makes available to them. What is available is decided on the basis of programme efficacy, not on women's needs and preferences. Those who have no children can have the oral pill, those with one child may have the IUD inserted, and those who have two or more children are given no choice other than sterilisation. In fact, health facilities have been known to pressurise women seeking abortion into accepting sterilisation (Sundari Ravindran, 1993).



Women's health activists in India have been struggling against the government, donors and research institutions that seek to introduce unsafe and heavily provider-controlled contraceptives for Indian women, such as

new hormonal technologies, transplants and even the anti-malarial Quinacrine! At the same time, non-invasive user-controlled barrier contraceptives like the diaphragm or female condom are unavailable in the country. Whatever testing has been done has often violated the right to informed consent of the test subject, and has usually excluded women who are undernourished or anaemic, although this is the characteristic of most of the population of women in this country. Moreover, given the lack of adequate pre-examination and follow-up by the service providers, any invasive provider-controlled method is unsuitable. Resistance movements over several years have finally prohibited the promotion of insufficiently tested contraceptives, but they are still being offered to women privately.

Despite the latest policies on the contraception programme, which declare that there will be no more method-specific targets imposed from above, and announce a 'community needs assessment approach', there is no evidence on the ground to support the assertions of a 'client-centred, quality of care, people-driven programme' which goes beyond provision of mere contraceptive services to providing care for reproductive health as a whole. The mindset of programme managers and service providers has not been changed from their view that poor women are incapable of making rational reproductive decisions. As such, while India supports RSR in providing free contraceptive and abortion services to women and men, the interest has always been 'population stabilisation' rather than the health of poor women, and as such the quality and purpose of these services remains questionable.

Two Child norm

The two child norm is usually seen as an attractive method to reduce 'alarming population growth' in India. However, evidences gathered from the census over the last few decades shows that the population growth rate at this point in time is the lowest in the last fifty years. Added to this, the very young and reproducing population in the country adds an additional but temporary 'momentum effect' which will see the growth rates reduce further in a few years time. The two child norm made its entry into Panchayat level elections in the six states around the same time as the 73rd and 74th Constitutional Amendments which gave Panchayat bodies constitutional validity but also provided for reservations for women and the marginalised groups. A review of the disqualifications made on the basis of the 2 child law in all the six states points to a systematic discrimination. Women, dalits and young persons form a disproportionately large section of the disqualified group. The reasons are not hard to find. In male-dominated Indian society, when women are faced with a choice between parenting and political leadership, parenting wins every time. Actually it is often not a matter of choice but of family pressures as well. The two child norm violates the reproductive right of women and couples to decide the number and spacing of their children. The two child norm also violates the right to equality (a fundamental right) and is also leading to sex pre-selection and decline in sex ratio.

Healthcare services for safe pregnancy and childbirth.... the right to the highest standard of reproductive health:

Illness and death from reproduction related causes are particularly significant for women, but have been recognised only very recently in India. Estimates of the percentage of Disability Adjusted Life Years (DALYs) lost by Indian women due to reproduction related causes (maternity, cervical cancer, STDs, HIV) were as high as 10% in 1990. This does not include losses in the postnatal stage, or due to unsafe abortion, or anaemia, or malnutrition. Yet, public health and primary health services are also in a poor shape, with large numbers of people unable to access clean water, sanitation, and other basic needs. There has been a resurgence of infectious diseases which reflects this. A major dilemma is how to address women's reproductive health needs when the primary health infrastructure is in this appalling state, and budgets for health have been cut back (Sen, 1996).

While 16% of the world's population lives in India, Indian women have very



little say in global policies. The maternal mortality rate of Indian women is one of the highest in the world at over 500 per 100,000 live births. Major causes include anaemia (18%), haemorrhage (16%), and unsafe abortions (12%). Maternal morbidity is projected to be 20 to 30 times higher than the number of maternal deaths. All this in a country which has had a programme for maternal and child health for a long time and where abortion has been legal from 1972, apart from the fact that contraceptive provision had started as early as 1952.

It becomes obvious that mere launching of appropriate-sounding programmes will not enable the millions of poor women in India to 'attain the highest standard of reproductive health'. In fact, given the current scenario, women's right to life itself is being violated, for they are unable to access life-saving healthcare/ referral services. There are many reasons for this, one being state apathy, echoed in the indifference of government service providers. But there is also women's lack of power to make decisions concerning their reproductive health care, their lack of economic decision-making, their inability to negotiate contraceptive use in a patriarchal society, and low literacy and mobility which prevent their access to information which could have protected their health and lives.

The government has just completed implementing the 'Reproductive and Child Health (RCH) Programme', which was supposed to ensure a certain standard of reproductive health for women by providing services for safe motherhood and child survival, family planning, safe abortion, management and prevention of RTIs, STDs, and prevention of AIDS. However this programme was not successful in reaching many of its objectives. Now the RCH 2 programme has begun within the National Rural Health Mission. It is a better designed programme and has possibilities, but in the absence of

continued political will to address women's health needs, may not be able to bring about much change.

Section 377

No discussion on reproductive and sexual rights in India is complete without a discussion on Section 377 of the Indian Penal Code (IPC). Section 377 of the Indian Penal Code criminalises “voluntary carnal intercourse against the order of nature”. Under this law, all sexual acts which do not constitute peno-vaginal intercourse are considered unnatural. Thus oral sex between hetero-sexual couples is considered unnatural. However the main furore caused by this law is that it is used against same-sex activity especially against the MSM community (Men who have Sex with Men). This law was framed in the 1860's and reflects the sexual mores of Victorian England. It is interesting to note that homosexuality was decriminalised in England and Wales in 1967 with the passing of the Sexual Offences Act. Homosexuality was for long considered immoral and also a mental disease. The perception that homosexuality is unnatural, is still widespread in India. This has been reflected in the use of this law against workers who were involved in HIV/ AIDS related work with MSM (*Naz - Bharosa case 2001*) and also in the Government of India's submission to the Delhi High Court in the petition filed by Naz Foundation India.

Homosexuality is a form of sexuality that has been described since ancient times both in India and in other cultures. An increasing understanding of sexuality led to the removal of homosexuality from the list of mental diseases in 1973.

Violations of women's sexual and reproductive rights:

Child Sex Abuse - The incidence of Child Sexual Abuse (CSA) and incest has remained shrouded in secrecy and silence for long, but a recent study of 600 English speaking, upper or middle class women mostly living in the metropolises of India, revealed that 76% had been sexually abused in childhood or adolescence. 82% of the abusers were either family members or persons known to the girl. Male cousins and uncles account for 84% of the abusers. 45% of the abuse took place between the ages of 4 and 12 years. All this when 60% of the mothers were housewives (RAHI, 1998). These chilling statistics about a 'privileged' class of women leave questions hanging about what may be happening in more deprived homes, where perhaps less attention is paid to the girl child. However since a high premium is placed on virginity in Indian society, no one would want to publicly admit that they have been abused. At present, the Indian legal

framework only recognises penile penetration of children under the law for 'Rape of Minors'. Other forms of sexual violation are not recognised.

Child Marriage and the Right to Choice in Marriage - Child marriage in India has been prevented by the law called Child Marriage Restraint Act (1978) that sets the minimum age at marriage for women at 18 years. However the median age at marriage all over India is less than sixteen and a half years (NFHS II 1998- 99) and in states like Rajasthan, MP, Bihar and UP, it was found to be less than 15 years. However the age at cohabitation, while a little higher, is 17 years for the country as a whole, and between 16 and 17 years in the states mentioned above. While the delay between actual and effective marriage may protect the girl child from early sexual activity and pregnancy, it still means that marriage is taking place at an age when she is unable to give informed consent. The right to consent and equality in marriage is assumed in arranged marriages, but this may always not be so. The fact that women in India do not have this right is most evident in cases from Western Uttar Pradesh and Haryana where communities sanction punishment even to the extent of murder when couples opt to marry out of choice.

Trafficking - Trafficking in girls and young women continues to flourish in the poverty- stricken zones of the country (86% of the sex workers are from UP,



AP, Tamil Nadu, W. Bengal, Karnataka and Maharashtra) and there is also influx of girls sold into prostitution from Nepal and Bangladesh, who end up in the established red-light areas of metropolises. According to a Government of India survey done in 1991, there are around 70,000 to 100,000 girls and women engaged in prostitution. Younger virgins are especially in demand because of a popular belief that sex with a virgin can cure STDs. 15% of the sample surveyed (500) were below 15 years, and another 25% between 16 and 18. Also interesting is that 60% were from Scheduled castes and tribes or backward classes.

The current legal provision for this is called the Immoral Traffic (Prevention) Act, 1986, which does not seek to abolish prostitution or even punish the client who asks for commercial sex services, but certainly penalises a sex worker for soliciting in a public place. It does make procuring and brothel-keeping an offence, but protection money is paid by brothel-keepers to local 'toughs', police personnel and politicians, creating an important source of income for the underworld.

Rape - Rape is one of the most common and frequent crimes against women in India. It includes the categories of landlord rape, police/ custodial rape, caste rape, Army rape, communal rape, marital rape, rape of sex workers, of children and family members. There are incidents of mass rape, of an entire community of women, and of course individual rape. However, rape remains an extremely under-reported crime. Since most - if not all - rape is an assertion of power and rights over the women concerned, aiming to hit at

their most vulnerable sense of 'honour', it is not surprising that women and their families often attempt to cover up the incident to avert the stigma. Moreover, rape law in India insists that only penile penetration constitutes rape and demands proof of guilt; all other forms of sexual violation are termed as assault, which is a lighter offence. It is only in custodial rape that the onus of proof is on the accused. Then again sex with minors of 16 years or below is taken as rape, but the law contradicts itself in that if a man has married a girl of 15 years or more, he can legally have sex with her (although the legal age at marriage is 18!). Another serious issue is of women in situations of armed conflict such as in the North-East and in Kashmir. Civil rights have been suspended: the Army has the authority to enter people's homes to flush out insurgents, and has raped and assaulted women with impunity.

SECTION THREE

Working for the realisation of Reproductive and Sexual Rights

Work for Reproductive and Sexual Rights may be done at several levels such as services, education, research, law/ policy advocacy and so forth. It is distinctive in that the 'rights approach' addresses the question of women's entitlement - entitlement to health, especially reproductive and sexual health, and the responsibility of social institutions to ensure those entitlements, including the family, the community, the state and all its machinery, and so forth. The 'rights approach' means that women's rights are human rights.

Unfortunately, most of those working on a 'rights approach' remain occupied in fighting against rights violations, and demanding redressal for the wrongs that have been perpetrated against women by various social institutions, starting right from the family. This is a protracted and exhausting struggle, for many of these wrongs have been done from the assumption that women have no rights at all, in fact they are seen as less than human, because they are not men. Addressing the legal system or the state for redressal of wrongs is often futile, for these institutions do not have the 'rights perspective' to begin with, and tend to offer paternalistic protection to women at the most.



It is therefore important to work towards building a widespread understanding of women's rights as human rights, and this has to be done not just with those who violate women's RSR, but also with women themselves. This is because a right cannot be exercised or demanded if the person is not aware of it to begin with. However, it must be kept in mind that work which addresses very personal questions of sexual abuse at home, domestic violence, sexuality, sexual relations and reproductive relations between partners, will never be as acceptable as work which tackles 'external' issues like lack of water, education, housing, healthcare, and so on, which are problems in the public sphere. This includes acceptability even with women, who are the suffering group!

Given below are some ideas for working with RSR through services, education, research or advocacy.

Educational Interventions - Educational interventions are key to rights' awareness. This can be for women in the community where women are made aware of their entitlements from the government and no longer look at health related adverse events as a misfortune but a denial of rights. Women and men in the community can be organised to claim these entitlements from their health care providers through monitoring the services that they ought to receive.

Adolescent boys must be taught that violations of women's rights is not part of male prerogative, and enabled to develop a concept of male-female relationships that are not based on inequality and power imbalances, but are mutually respectful and harmonious. It is also important to work with adult men on this through social norm-setting in communities. Both boys and men should learn about their responsibilities in women's reproductive lives, especially about preventing unwanted pregnancy and disease, and also about when to seek out referral health services.

Sexuality education has to be provided to all age groups (no children are too young, given the reality of CSA) that affirm the principles of gender equality and bodily integrity, as well as informed about RSR. This has to be provided in both formal and informal education, and through all possible youth groups. The positive aspects of sexuality need to be highlighted, rather than projecting only the need for preventing disease and pregnancy. Moreover, it should not be prescriptive: instead, it should encourage youth to develop a sense of responsibility about their bodies and their partners. Sexuality education should include aspects of reproductive and sexual health, the fact that women's reproductive rights are human rights, the fact that the man's sperm determines the sex of the child, about where to access services, how women can protect themselves from harm, women's right to decide about sex, and what to do if RSR are violated in any way.

Training and education on RSR is also urgently needed for health service providers, educators, lawyers, police and judges. Mediapersons also need to be sensitised to portray violations of women's rights responsibly, with full confidentiality, without sensationalising them, but ensuring that the public concern is aroused.

Improving Service delivery – The availability of services are important for the fulfilment of sexual and reproductive rights. This may include access for all women to high quality reproductive and sexual health services, regardless of age, marital status, income or sexual orientation. This would mean actively reaching services to currently under-served groups such as adolescents, single women, sex workers, women who/ whose partners have undergone sterilisation, post-menopausal women and survivors of abuse. Services should follow clearly defined therapeutic standards. The minimum package of services should at the least include skilled care during pregnancy, delivery and post-partum care, contraceptive choices including user-controlled and barrier methods, prevention, diagnosis and management of infertility/ reproductive tract problems/ STDs/ reproductive system cancers and safe abortion services.



Given women's reluctance to report the abuse

they have been suffering, it is up to health service providers to be keenly alert to the possibility that their clients have been abused. Many of the consequences of violations of RSR such as trauma, unwanted pregnancy, abortion complications, miscarriages and STDs are likely to come up before service providers. It is imperative that they understand these rights, and are motivated to monitor their violation by collecting legal evidence for prosecution. It is also imperative that they ensure privacy, confidentiality and sensitive treatment during examining and counseling. For this, RSR should be incorporated in the training courses.

New services in the form of hotlines, crisis centres, shelters and rehabilitation homes are required which can be accessed by women whose rights are being violated, are required. It is imperative that these provide a secure, non-judgemental, friendly atmosphere so that women start healing from their emotional trauma.

Research - Reproductive and Sexual Rights are an emerging area and it requires greater theoretical understanding as well as more information is needed on various forms of violations of RSR, the consequences - both physical and mental, and the effectiveness of support services provided. This could include investigation of the links between violence against women and reproductive health, like safe motherhood, unsafe abortion, incidence of miscarriage, contraceptive use, AIDS/ STD prevention and so on. Greater clarity is also required on how unavailability of services constitutes rights violations.

Advocacy - Advocacy is an important component of the rights based approach. Policy or public advocacy is different from legal advocacy in the sense that it does not necessarily involve courts or the judicial system. However it is closely concerned with the rights of the underprivileged or the marginalised. Public or policy advocacy involves the creation of public pressure for influencing policy formulation, programme implementation in the interest of the poor, underprivileged or the marginalised. Such advocacy efforts are usually directed towards those groups or individuals who are in decision making positions and could include policy makers, legislators, senior programme managers and so on. The advocacy initiatives can be taken by the affected groups themselves or by other members of civil society who are concerned. Advocacy can include the following demands:

- Developing networks of women's organisations to promote recognition of, and monitoring of RSR.
- Asking for reform in court systems and procedures to enable women to testify more easily, especially in cases that involve someone who has considerable power over them (such as husband or male family members).
- Asking for reform in existing laws to eliminate sexual violence, including rape within and out



of marriage, and in situations of armed or communal conflict, CSA, trafficking and female foeticide/ infanticide, and decriminalise homosexuality.

- Enforcement of laws that regulate age at marriage and sexual activity, to allow for informed and consenting relationships.
- Removal of reservations to human rights instruments such as CEDAW (the GOI has a reservation on ‘interfering in marriage or other cultural institutions’).

Implementing a ‘rights approach’ in reproductive health

Implementing a ‘rights approach’ in reproductive health is a multidisciplinary initiative requiring a knowledge and appreciation of technical health issues, policy and programme provisions and legal positions around different reproductive health areas. The table below provides a comparative picture of how technical, policy and programmatic provision and legal position can be integrated into a holistic implementation of a rights approach. However some programme and policy or legal provisions may be counterproductive to the implementation of a rights approach. Two examples are Section 377 of the IPC or the Two-child norm which have been mentioned earlier.

<i>Technical Understanding</i>	<i>Policy and Programme Provisions</i>	<i>Legal Position</i>
<ul style="list-style-type: none"> • Causative factors : bio-medical and socio-cultural • Investigation and treatment • Drugs • Preventive and promotive measures • Quality of Care etc. 	<ul style="list-style-type: none"> • Community Needs Assessment Approach • Reproductive and Child Health Programme • Other National Health Programmes • National Aids Control Programme • National Population Policy • National Policy on Empowerment of Women • National Youth Policy • National Health Policy • National Drug Policy etc. 	<ul style="list-style-type: none"> • Indian Constitutional provisions • Child Marriage Restraint Act • MTP Act • PNDT Act • Medical Negligence related sections of the IPC • Informed consent related sections of the IPC • Consumer Protection Act and so on

A simple framework that can be used for implementing a ‘rights approach’ is to see each reproductive health condition in terms of entitlements of the individual from the state and the responsibilities of individual/ community. The entitlements and responsibilities emerge out of the technical health interventions, government laws, policies and programmes. Two examples are given below.

Antenatal Care

<i>Entitlements (Rights) from the state</i>	<i>Responsibilities of the individual and community</i>	<i>Legal, Policy and Programme framework from where the entitlements emerge</i>
<ul style="list-style-type: none"> • Registration • 2 TT injections at the appropriate time • 100 iron and folic acid tablets • Three antenatal examinations for high risk screening • Advice for minor problems • Referral for major problems / high risk etc. 	<ul style="list-style-type: none"> • Rest • Contact ANM for Antenatal check up and injections • Diet and IFA as per advice • Contact the ANM for problems • Follow other ANM advice • Follow referral advice • Husbands support and sharing of responsibility etc. 	<ul style="list-style-type: none"> • CNA Approach • RCH Programme • National Population Policy • National Health Policy • Consumer Protection Act • Articles 38, 39 and 42 of the Indian constitution etc.

Contraception

<i>Entitlements (Rights)</i>	<i>Responsibilities</i>	<i>Legal, Policy and Programme framework</i>
<ul style="list-style-type: none"> • Information about variety of contraceptive options to both men and women. • Advantages and disadvantages (side effects) of different contraceptives. • Access to contraceptive of choice, with clear instructions about how to use it. • Good quality service and compliance with the standards of care. • Services for complications and failures. 	<ul style="list-style-type: none"> • To use the contraceptives as directed. • To inform the provider when new supplies are required. • To inform the provider in case of side effects, complications and failure. • Male partners sharing responsibility. and so on 	<ul style="list-style-type: none"> • RCH Programme. • National Population Policy. • National Health Policy. • National Policy on Empowerment of Women • MTP Act. • PNDT Act. • Consumer Protection Act. • Medical Negligence. • Articles 14 and 15 of the Indian Constitution. and so on

In order to implement a 'Rights approach', it is necessary to inform both health providers and the clients/ community of their rights and responsibilities and the legal or policy/ programme framework which applies.

Claiming a health related right

The following is a list of activities that may be undertaken to claim a health related right. These activities are ideally undertaken by the community whose rights are being violated or those who are health advocates. These activities may be classified as – Identifying the Rights Violation, Creating a Rights Awareness and Claiming the Right.

A. Creating a Rights Awareness

1. Increasing/ sharing knowledge of rights and responsibilities.
2. Increasing/ sharing knowledge of state-mandated health programmes and services.
3. Preparing citizens charter of rights.
4. Increasing the strength of the community by making collectives.
5. Making alliances and finding allies.
6. Training of health providers and managers in the rights approach.
7. Training of community leaders in the rights approach.

B. Identifying the Rights in relation to health problems in the community

1. Identifying the health problems of the community.
2. Preparing the list of rights that are violated in terms of each health problem.

C. Claiming a Right

1. Creating forums for dialogue between community members/ leaders and service providers for sharing problems and making plans.
2. Creating an administrative grievance redressal mechanism for community to make complaints to senior officials.
3. Filing complaints/ cases in the police station by community members.
4. Making demands at the collectorate or CMO's office by sending deputations; or meeting local MP, MLA.
5. Filing cases in a court of law.

SECTION FOUR

Resource Section

Further Reading

The following books and reports were useful in preparing this booklet:

Akhter, F. et al. 1991. *Declaration of Comilla*. Dhaka: UBINIG.

ARROW. 1994. *Towards Women-Centred Reproductive Health - Part 1* Kuala Lumpur. ARROW.

Asian Forum for Human Rights and Development, The. 1997. *Reports of a Consultation on Reproductive Rights and Human Rights: A Challenge for Human Rights Activists*. Bangkok: The Asian Forum for Human Rights and Development.

Canadian Women's Committee on Population and Development. 1996 *Bill of Rights for Contraceptive Research, Development and Use*. Canada: Canadian Women's Committee on Population and Development.

Centre for Reproductive Law and Policy, The. 1999. *Silence and Complicity: Violence against Women in Peruvian Public Health Facilities*. New York: The Centre for Reproductive Law and Policy.

Centre for Reproductive Law and Policy, The. *Reproductive Freedom around the World: Reproductive Rights in the Refugee Context*. New York: The Centre for Reproductive Law and Policy.

Centre for Reproductive Rights. 2004. *Women of the World: Laws and Policies affecting their Reproductive Lives – South Asia*. New York: CRR.

Coordination Unit. 1995. *Indian NGOs Report on CEDAW*. New Delhi. CU.

Das A (2004) *Improving Quality of Care of Reproductive Health Services in India: An Advocacy Handbook*, New Delhi, Population Foundation Of India.

Dutta, B. 1997. *Advocacy for Reproductive Health and Women's Empowerment in India*. New Delhi: Ford Foundation.

East and South East Asian Women and Health Network. 1996. *On Our Own Terms: Building Trust and Unity on Women's Health and Reproductive Rights from the Perspective of Asia*. Philippines: East and South East Asian Women and Health Network.

Gosine, A. (2004) *Sex for pleasure, rights to participation, and alternatives to AIDS: placing sexual minorities and/or dissidents in development*, Sussex, Institute of Development Studies (IDS).

Gomez, A. and D.M. 1998. *A Human Rights Perspective: Women, Vulnerability and HIV/AIDS*. Chile: LACWHN.

Gupta Anuja . 1998. *Voices From the Silent Zone* New Delhi: RAHI.

Gupte, M. et al. 1997. *We Shall Bring in the Dawn: Women Resisting Alcoholism*. Pune: MASUM.

Hardon, A.et.al,1997. *Reproductive Rights in Practice: A Feminist Report on Quality of Care*. London: Zed Books Ltd.

Hardon,A. et.al. 1997. *Monitoring Family Planning and Reproductive Rights: A Manual for Empowerment*. London: Zed Books Ltd.

Heise, L.et.al. 1995. *Sexual Coercion and Reproductive Health: A Focus on Research*. New York: Population Council.

HERA. 1998. *Women's Sexual and Reproductive Rights and Health: HERA Action Sheets* New York; HERA.

Human Rights watch 1995. *Global Report on Women's Human Rights* . Washington Human Rights Watch.

Jayawardena,K. and M. De A. 1996. *Embodied Violence: Communalising Women's Sexuality in South Asia*. New Delhi: Kali for Women.

Kumar Radha.1997. *The History of Doing*: New Delhi ; Kali for Women.

Kumar, R. *Reproductive Rights As Human Rights: Studies in the Asian Context*. Hamilton: University of Waikato.

Lindahl Katarina. 1995. *Sexual and Reproductive Health and Rights in Relation to ICPD 1994* .Sweden. RFSU.

Mann Jonathan et al. (eds.), 1999 *Health and Human Rights: A Reader* New York: Routledge,

Petchesky, R.P. and K.J. 1998. *Negotiating Reproductive Rights*. London: Zed Books Ltd.

Rehman Anika, Raghuram Shobha.1995. *Rethinking Population - Technical Report Series 1.4* Bangalore . HIVOS, and New York. CRLP.

Semler,V.J. et.al. 1998. *Rights of Women*. New York: The International Women's Tribune Centre.

UNFPA 1999. *Violence against Girls and Women - A Public Health Priority*: New York: UNFPA.

UNFPA. 1998. *Ensuring Reproductive Rights and Implementing Sexual and Reproductive Health Programmes Including Women's Empowerment, Male Involvement and Human Rights*. New York: UNFPA.

Voices Against 377(2004) *Rights for All: Ending Discrimination against Queer Desire under Section 377*.

Whelan, D. 1998. *Recasting WID: A Human Rights Approach*. Washington: International Centre for Research on Women.

Resource Organisations:

Within India, the RSR approach has included work on support systems, on struggling with the state and legal system when rights have been violated, and on advocacy: with the community, with the government, and the legal system. Some of the organisations working on this issue include the following (many of these organisations work on more than one of the issues

given below, and these areas are not discrete as it may appear from the classification):

Women's Reproductive Health and Rights

Sakhi

TC 27/1872, Convent Road,
Trivandrum - 695035.
Ph- 0471-2462251
Email: sakhi@md2.vsnl.net.in

Forum for Women's Health

c/o Swatija Manorama,
9, Sarvesh, Govind Nagar,
Thane (East),
Maharashtra - 400603,
Ph- 022-2542 3532

KRITI Resource Centre

C-1485, Indira Nagar,
Lucknow - 226016, Uttar Pradesh
Phone: 0522-2310747, 2341319
E-mail- kritirc@sahayogindia.org

Human Rights Law Network

65, Masjid Road, Jangpura
New Delhi – 110014
Tel: 91 – 11 – 24324501
Email: hrlndel@vsnl.net;
slicdelhi@vsnl.net

SAHELI

Unit Above Shop 105-108, Defence
Colony Flyover Market (Southside),
Defence Colony, New Delhi 110 024
Phno.(011) 24616485
Email- saheli@indiatimes.com

Women's Human Rights

AALI

407, Dr. Baijnath Road Near Post
Office, New Hyderabad, Lucknow
Email- aalilegal@yahoo.co.in
Phone- 522-2782066, 2782060

Aikya

377 Jayanagar, 42nd Cross, 8th
Block
Bangalore - 560 082 (Karnataka)
Phone 080-6645930, 8432363
Fax 080-6631565, attn. Aikya

CEHAT

Sai Ashray, Aram Society Road,
Vakola, Santacruz (East)
Mumbai- 400055
Phone-91-022-26673154,
26673571

Email- cehat@vsnl.com

Healthwatch UP Bihar

Secretariat
C-1485, Indira Nagar,
Lucknow-226016, Uttar Pradesh
Phone: 0522-2310869; 2310747,
2341319

E-mail- hwupb@yahoo.co.in

PRAYAS

B -8, Bapu Nagar, Senth,
Chittorgarh 312 025
Rajasthan
Ph – 1472.243788/243674
Email – prayasct@sancharnet.in

Sama

G-19, 2nd Floor, Saket,
New Delhi 110017 India
Telephone +91-11-55637633;
Fax : +91-1126562401;
Email :
sama_womenshealth@vsnl.net

Vanangana

Purani Bazar, Near Mahindra
Tractor,
Karvi, Chitrakoot, U.P.
Phone-05198-236985
Email-
vanangana@rediffmail.com

Jagori

C – 54, South Extension Part II, New Delhi-110049

Tel.-11- 26257015/2625-7140

Email: jagori@spectranet.com

Web site- <http://www.jagori.org>

PLD

18, First Floor, Jangpura Extn., New Delhi – 110014.

Phone – 011-24316832, 833

MASUM

11, Archana Apartments,
163 Solapur Road, Hadapsar,
Pune –28.

Ph-0212-675058, Fax 0212-611749

E-mail- masum@vsnl.com

Sexuality and Sexual Rights**TARSHI**

49, Golf Links, 2nd Floor,
New Delhi 110003

Pphones – 011-2462-2221, 24624441

[Email-info@tarshi.org](mailto:info@tarshi.org)

IFSHA

C-52, Second Floor,
South Extension Part - II,
New Delhi - 110049.

Tel. : 11-26253289 / 98

email: ifsha@vsnl.com

LGBT Rights**Naz Foundation (Trust)**

D-44, Gulmohur Park,
New Delhi.

Phones 011-2686 2422, 2685 1970,
2685 1971

Email- anjali@naz.unv.ernet.in

Humsafar Trust

Second Floor, Vakola Municipal
Building, Nehru Road, Santa
Cruz(E),

Mumbai-400 054

email – humsafar@vsnl.com

IWID

No.2107, 13th Main Road,
Anna Nagar (West), Chennai – 600
040.

Phone – 044 - 26220578/26222856

Email - iwid@vsnl.net

Sanhita

P-108 B, CIT Road, Calcutta 700 014,
West Bengal, India

Phone: 91-33-2216 1471

Email: sanhita@cal.vsnl.net.in

**Women's Rights Initiative- Lawyers
Collective**

63 / 2, First floor, Masjid road,
Jungpura, New Delhi.

Ph: 11-24316925 / 24313904 /

2432101.

Email: wri@vsnl.net.

CREA

2/14, Shantiniketan, Second Floor
New Delhi-110021, India.

Phone: 91-11-24107983, 26874733

Telefax: 91-11-26883209

Email: crea@vsnl.net

RAHI

H 49 A , 2nd Floor Kalkaji,
New Delhi

Phone –91-11-26236466

Email – rahi@vsnl.com

Naz Foundation International

9, Gulzar Colony,

New Berry Lane, Lucknow, UP, India.

Phones: 0522- 2205781,82.

Email – arif@nfi.net

Sangama

Flat 13, 3rd Floor, 'Royal Park'
Apartments, 34 Park Road, Tasker
Town,

Bangalore - 560051, India

Phone : 080 2868680/9180 2868121

Website: www.sangamaonline.org

Child Sex Abuse

TULIR

F- 183/A, 9th Street Anna Nagar
East
Chennai 600102,
Phone – 044-26282833
Email- iccwtm@md3.vsnl.net.in

SARC

147, Vindhyavasini Colony, Ardali Bazar,
Varanasi
Phone- 0542-2509584,
E-mail- sarc@rediffmail.com

International Organisations

There are a number of groups working on the Health and Rights Approach, outside the country, contact information of some of these is given below:

**International Women's
Health Coalition**

24 East 21st Street
New York, NY 10010
Tel: 212-979-8500
email – info@iwhc.org

**ARROW (Asian-Pacific
Resource & Research Centre
for Women)**

Ground Floor, Block G, Anjung Felda,
Jalan Maktab
54000 Kuala Lumpur, Malaysia.
Tel : 603-26929913

**Catholics For A Free
Choice**

Email: arrow@arrow.po.my
1436, U Street NW, Suite 301,
Washington DC, 20009 USA.
Phone 202-332 7993
Email- cffc@igc.apc.org

**Center for Health and
Gender Equality**

6930 Carroll Avenue, Suite 910, Takoma
Park, MD 20912 USA
Phone: 301-270-1182
Email – change@genderhealth.org

**Centre for Reproductive
Rights**

120 Wall Street,
New York NY 10005, USA.
Ph- (917) 637-3600
Email – info@reprorights.org

**DAWN (Development
Alternatives with women for
a New Era)**

Dawn Secretariat,
PO Box 13124, Suva, Fiji
Tel/Fax: (679) 314 770,
Email: admin@dawn.org.fj

**WGNRR (Women's Global
Network for Reproductive
Rights)**

Vrolijkstraat 453 D, 1092 TJ Amsterdam,
The Netherlands.
Tel: (31-20) 620 9672,
E-mail: office@wgnrr.nl

Some Useful Websites

- Amnesty International <http://www.amnesty.org>
- Center for Reproductive Rights www.crr.org
- Equality Now <http://www.equalitynow.org>
- Human Rights Education Associates <http://www.hrea.org>
- Human Rights Law And Ethics –in HIV/AIDS <http://www.youandaids.org/themes/HumanRights.asp>
- Human Rights Watch <http://www.hrw.org>
- International Gay and Lesbian Human Rights Commission <http://www.iglhrc.org/>
- International Women’s Health Coalition – Sexual Rights Homepage <http://www.iwhc.org/issues/sexualrights/index.cfm>
- International Women's Rights Action Watch (IWRAP) <http://iwraw.igc.org>
- LGBT Rights – Human Rights Watch <http://www.hrw.org/doc/?t=lgbt>
- Office of the United Nations High Commissioner for Human Rights (OHCHR) <http://www.unhchr.ch/html/hchr.htm>
- Stop Violence Against Women <http://web.amnesty.org/actforwomen/index-eng>
- The Application of Human Rights to Sexual and Reproductive Health <http://www.acpd.ca/compilation/Intro.htm>
- UN Human Rights - Homepage <http://www.un.org/rights>
- Universal Declaration of Human Rights <http://www.unhchr.ch/udhr/index.htm>
- University of Minnesota Human Rights Library <http://www1.umn.edu/humanrts>
- Women’s Health Project <http://www.wits.ac.za/whp/index.htm>
- Women’s Human Rights net <http://www.whrnet.org>
- Women’s Rights <http://www.hrw.org/women>
- Women's Human Rights Resources <http://www.law-lib.utoronto.ca/Diana>
- Women's Rights Unit, Division for the Advancement of Women, United Nations <http://www.un.org/womenwatch/daw/cedaw/>

Booklet prepared by -

Research and Text – *Jashodhara Dasgupta, Abhijit Das*

Additional text and review – Laxmi Murthy

Layout - *Deepak*

Illustrations - *Ganesh*

UNDERSTANDING REPRODUCTIVE HEALTH

A Resource Pack

This Resource Pack is an introduction for those who wish to learn about different facets of Reproductive Health. Reproductive Health as a concept is relatively new and , despite the name, is not exclusively a 'health' subject. In its ambit it involves social sciences, medical sciences, women's issues, human rights, population sciences, demography and so on. Thus it could be of relevance to individuals with a wide range of interests. Reproductive Health is an issue of interest to Government planners and managers because of the overwhelming concern for population. Reproductive Health is also a matter of great interest to the NGO sector, because of their concern for the health of women. Concern for women, their rights, well being and health is the underlying theme for the entire Resource Pack.

This Resource Pack has been designed as a series of booklets so that the interested reader may straight-away refer to the issue of her/his interest. The matter and presentation of the material in the different booklets has been kept simple as well as provocative as it is meant for the first-time user. Each booklet has been divided into four sections - the first dealing with theory and concepts, the second with issues of relevance, the third on best practices in the field. Keeping the interest of the practitioner in mind there is also a small resource section at the end of each booklet.

The booklets in this pack are as follows -

Booklet 1	An Introduction to Reproductive Health
Booklet 2	Understanding Numbers : Population and Demography
Booklet 3	Changing Paradigms : RH Policy and Advocacy
Booklet 4	Exploring New Frontiers : Reproductive and Sexual Rights
Booklet 5	Maternal health is still important
Booklet 6	The Promise of better health : Women's Health
Booklet 7	Beyond Family Planning : Contraception
Booklet 8	The Emerging Agenda : Adolescents
Booklet 9	Forging new partnerships : Men's Health and Responsibility
Booklet 10	Coming to terms with reality : HIV/AIDS and STDs
Booklet 11	Acknowledging ourselves : Sex and Sexuality
Booklet 12	Women have Minds Too! : Exploring the interface between Reproductive Health and Mental health
Booklet 13	Taking a stand : Violence, Women and Health
Booklet 14	Data Digest

**KRITI Resource Centre
for
Women's Health , Gender and Empowerment**

The KRITI Resource Centre, is involved in providing training support, production and distribution of material, and engaging in creative partnerships with other institutions to strengthen their work of empowering women at the grassroots level, enabling women to lead healthier lives. The primary activities of the KRITI Resource Centre for Women's Health, Gender and Empowerment are as follows

TRAINING - KRITI has considerable experience and expertise in trainings related to Women's Health and Gender and has provided training support to over 100 organisations as well as Government projects and departments in the states of UP, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Delhi, Rajasthan, Haryana and Himachal Pradesh. The Resource centre has been involved in partnerships with other gender training organizations like JAGORI, IWID, and the South Asian Network of Gender Trainers (SANGT).

PRODUCTION AND DISTRIBUTION OF LEARNING AND COMMUNICATION MATERIAL - KRITI is also involved in designing and producing appropriate material for the special needs of those involved in working with communities on these issues. Much of the material is in Hindi. Copiously illustrated material has also been produced keeping grassroots needs in mind. For the practitioners KRITI has produced newsletters, field manuals, training manuals and kits, briefing kits and information sheets on various relevant issues.

RESEARCH AND DOCUMENTATION - KRITI Resource Centre engages in field level documentation, to get a more holistic understanding of women's health and the socio-economic conditions that influence it. Some of the studies it has conducted and participated in include a study of traditional birthing practices, Abortion and women's health in rural areas of Uttarakhand, customs and practices around menstruation, the possibility of HIV/AIDS, implementing the Target Free Approach in Family welfare programmes in UP, quality of care of health care service in UP, violence against women and so on.

ADVOCACY - The resource centre is also actively involved with advocacy on the issues of Women's Health and Population Policies and Violence against Women. It is closely working with other networks and organisations working on these issues.

SERVICES PROVIDED BY KRITI RESOURCE CENTRE

- ❖ Library and documentation centre
- ❖ Books, posters and other materials
- ❖ Training and internship
- ❖ Support for developing gender sensitive community based interventions/training programmes