Advocacy for Reproductive Health and Women's Empowerment in India

This report was prepared by Bishakha Datta, Consultant and Geetanjali Misra, Program Officer, Reproductive Health, Ford Foundation, New Delhi.

We wish to thank Mallika Dutt, Zarina Rao, Sagri Singh, Fatima AI-Talib, Srilatha Batliwala and Poonam Muttreja for their assistance in completing the report.

*Executive Summary

The Ford Foundation recently commenced a planning exercise to define a strategy for the program area entitled "Advocacy for Reproductive Health and Women's Empowerment" in India. This report outlines the findings of this exercise, with special reference to a meeting that was held from December 16 to 18, 1996 at Kumarakom, Kerala to identify the key issues and challenges for advocating women's reproductive health in India.

The nine-month consultative exercise addressed the following questions:

Why is it important to advocate for reproductive health? How is advocacy understood by key reproductive health actors?

Since the Indian government has made a policy shift from a population control approach to a reproductive health approach, participants felt efforts need to focus on translating this policy into concrete program. In this context, advocacy means systematically enabling key players to understand what reproductive health means and how to operationalise it.

What is the appropriate concept of reproductive health for India?

Reproductive health was defined as a question of women's health, rights and empowerment, rather than a medical question of RT1s, UTIs and STDS. Although reproductive health has traditionally been viewed as a medical issue, provision of medical services alone will not lead to significant improvements in women's health. A key underlying factor that influences women's reproductive health status is the complex web of gender relations and power structures that bars women from participating in crucial decisions that affect their reproductive

lives. Thus the key challenge for advocacy is getting reproductive health program to address issues of power and gender relations.

Who are the key actors towards whom advocacy efforts need to be directed?

Advocacy efforts need to focus on a constellation of actors in government, non-government and other sectors. Within government, it is critical to focus on implementers, rather than legislators at the state and district levels, where programs are operationalised. Although a broad range of NG0s need to understand the link between reproductive health and broader areas of development, it is vital to advocate this concept to NG0s which have undertaken integrated or single-issue health program's. The media, health associations and donors were identified as other strategic choices in terms of advancing an empowering reproductive health agenda.

What are some specific reproductive health issues that have not beenadequately highlighted in the Indian context?

Reproductive health is an "umbrella" concept consisting of several distinct, yet related issues such as abortion, sexuality, maternal mortality, etc. Thus advocacy needs to legitimize the concept as a whole and make visible key pieces of it. Sexuality, abortion and male involvement were identified as the three most neglected reproductive health issues. Each requires different advocacy goals and strategies, since the need for advocacy differs in each case.

Is violence a critical health issue and should reproductive health programs work on issues of violence against women?

Although violence is not part of the conventional definition of reproductive health, it is critical to position violence as a health issue for two reasons. One, violence affects women's bodies and psyches and has adverse health consequences ranging from injury and death to sexually transmitted diseases and unwanted pregnancy. Two, violence is an issue of power relations between men and women; that it takes away control of the body is one outcome of this larger struggle. If the goal of reproductive health is to empower women, it must empower women to reclaim control over the body and self by addressing the issue of violence.

Given a wide range of reproductive health issues and limited resources,how should resources be directed?

Participants of the nine-month consultative exercise strongly recommended that program strategies for advocating reproductive health be based on the following principles:

- Grounding reproductive health policies and program's in a holistic concept of women's lives and a framework of women's empowerment. This means expanding reproductive health and rights to the broader concept of women's health and empowerment.

- Locating reproductive health program's in the context of primary health care. This means that reproductive health and primary health cannot be treated, as separate program's, where one can be undertaken without the other.

- Influencing key actors to change from viewing reproductive health as a `package of services' to viewing reproductive health within the framework of women's empowerment. This means placing reproductive health program's on a base of interventions that address issues of power inequality and gender relations.

- Strengthening links between reproductive health and its socio-economic context at the programmatic level. This means that reproductive health programs cannot be narrowly framed without addressing the related, broader issue of socio-economic conditions.

Introduction

Worldwide, advocacy has only recently been recognized as a vital mechanism for effecting change and ensuring accountability. Advocacy has been a critical aspect of the Ford Foundation's international reproductive health program, since the program's inception in the early 1990s. Before that, Foundation programming had centered primarily on demographic, and maternal and child health concerns. The focus changed after an extensive international review of the Foundation's work in the late 80s, which mandated a worldwide shift to a broader reproductive health approach.

Emphasizing the cultural, social and economic factors that influence sexual and reproductive health, the Ford Foundation has directed its support to three general areas since 1990: strengthening social science research; enabling women and their partners to be more directly involved in the design and implementation

of reproductive health programs and policies; and promoting discussion of religious and ethical values related to reproductive behavior.

In India, the Foundation's reproductive health program aims to stimulate both the non-government and public health delivery systems to better address reproductive health needs. The program currently supports social science research; innovative community-level projects that can serve as replicable models for the public sector; HIV/AIDS prevention activities; and a wide range of media, documentation, networking, and training initiatives to advocate reproductive health and women's empowerment. The final component- Advocacy for Reproductive Health and Women's Empowerment - is the most recent addition to the reproductive health program. As such, it is also the least developed.

Women's groups and health organizations in India perceive advocacy as one concrete way to hold governments accountable to international commitments made at the recently held conferences in Cairo and Beijing [1]. Advocacy initiatives have managed to change policies in the field of reproductive health, both at national and international levels. Advocacy has also been critical in shifting the focus of health programs from a population control approach to addressing 's rights and development.

Encouraged by these developments, the Foundation recently commenced a planning exercise to define a strategy for the program area entitled "Advocacy for Reproductive Health and Women's Empowerment" in India. This report outlines the findings of this exercise, with special reference to a meeting held from December 16 to l8, 1996 at Kumarakom, Kerala to identify the key issues and challenges for advocating women's reproductive health in India.

Background

The meeting held at Kumarakom from December 16 to l8, 1996 marked the culmination of a nine-month process that began in March 1996. The objectiveof this process was to inform the Foundation's programming in the area of advocacy for reproductive health and women's empowerment in India.

The need for such a consultative process was rooted in two key factors:

1. The history of population program's in the country.

2. The concern that the interests and needs of those affected by population program's were not reflected in the program strategies of aid agencies and government policies.

Methodology

The nine-month consultative process consisted of two phases:

Phase 1: The consultancy

Wide-ranging discussions were conducted with several researchers, NG0s, women's organizations, academics, policy-makers, and donor organizations. Discussions took place primarily in the states of Gujarat and Maharashtra, where the Foundation's funding program in reproductive health is concentrated. Several key actors in reproductive health or women's empowerment in Delhi and Bangalore were also consulted. (A list of those consulted is on the inside back cover of this document.)

The discussions addressed the following questions:

- Why is it important to advocate for reproductive health?
- How is advocacy understood by key reproductive health actors?
- What is the appropriate concept of reproductive health for India?
- Who are the key actors towards whom advocacy efforts need to be directed?
- What are some specific reproductive health issues that have not been adequately highlighted in the Indian context?
- Is violence a critical health issue and should reproductive health program's work on issues of violence against women?
- How can mechanisms such as media, research, networking, and training be effectively used to advocate an empowering reproductive health agenda?
- Given a wide range of reproductive health issues and limited resources, where should resources be directed?

Phase II: The meeting

Thirteen key actors who had been consulted participated in a brainstorming session with program officers from the Ford Foundation at a three-day meeting in Kumarakom, Kerala in December 1996.

The meeting, which marked the culmination of the consultative process, specifically aimed to:

- Share with a small group of women's health advocates the substance of the wide consultations;
- Understand the need and scope for advocating reproductive health and women's empowerment in India;
- Identify key priorities for advocacy from an infinite range of reproductive health needs and discuss these in greater depth;
- Collectively evolve advocacy strategies that would be appropriate in the Indian context.

Developing a program strategy is ultimately a question of choosing between competing needs. Therefore, the central idea behind the meeting was to develop a strategy based on grassroots priorities. The meeting aimed to draw on the diverse, collective experience of participating activists, health advocates and researchers, and to link grassroots priorities with funding strategies. Participants were asked to explore issues from two perspectives: a grassrootsperspective (i.e. in determining priorities) and a funding perspective (i.e. given infinite needs, where should resources be allocated to have maximum impact?). In line with the objective of evolving collective strategies, the meeting was deliberately kept informal and participatory. Small group exercises formed the backbone of each session and individual presentations were kept to a minimum.

This report summarizes both phases of this consultation process. The recommendations contained in this report will help inform a strategy for the Ford Foundation in its development of the "Reproductive Health Advocacy Initiative". The Foundation hopes that the report will also prove useful to other institutions in framing their reproductive health programs.

The Role of Advocacy

Discussions with individuals and participants at the meeting revealed the following perceptions of advocacy.

- While activists, NG0s and women's organizations have advocated several issues through a wide range of mechanisms ranging from protest to legal actions, the concept of "advocacy" is still relatively new. Advocacy is commonly mistaken for a "campaign". It is not clearly understood that a

campaign is one method of advocacy. There is as yet no clear conceptual framework of what advocacy means, what are its potential, and what mechanisms can be used for advocating an issue.

- Although different individuals and groups understand advocacy in different ways, there is a consensus that advocacy involves "efforts at evolving some kind of policy". This can mean one of three things:

    1. Pushing for a new policy where none exists.

    2. Changing an existing policy.

    3. Getting an existing policy implemented.

- All felt that advocacy should be based on the needs and insights of grassroots experience. Grassroots actors should participate in advocacy, rather than it being a separate activity undertaken by advocacy "experts", having no links or accountability to the grassroots. There was a consensus that "advocacy needs to be deeply rooted" and should always be a means to get something done, rather than an end.

- In the context of reproductive health, most advocacy efforts have so far concentrated on dismantling an insensitive, even abusive, population control regime. Thus the concept of advocating against is well understood. However, in the current post-Cairo context, advocacy efforts against population control need to be complemented by advocacy efforts pushing for women-centered reproductive health policies and programs. The concept of advocating for is not well understood. Consequently, there is less experience with strategies of constructive, rather than reactive, advocacy.

- Since the Indian government has publicly committed to moving from a population control approach to a reproductive and child health approach, efforts need to focus on the third component of advocacy, i.e. getting an existing policy implemented. In this context, advocacy means "systematically enabling key players to understand what reproductive health means and how to operationalise it".

Health, Empowerment And Rights

Although reproductive health has often been linked with women's empowerment and rights at a rhetorical level, there is little understanding of how to translate this into action. It is critical to bridge this gap between rhetoric

and reality, by exploring how reproductive health programs can, in practice, become more empowering for women.

Locating reproductive health in the broader context of women's health

The need to understand how reproductive health relates to women's health has emerged from recent critiques of the concept of reproductive health, which is often seen as:

- A vision emerging from population-control ideologies rather than a concern for women's health;
- a new term for family planning;
- A term in which the underlying, critical issue of sexual health gets lost or submerged;
- A term which ignores the social, cultural and political contexts of health;
- A medical approach which offers technological fixes rather than structural and social changes.

Two definitions were offered to distinguish between reproductive health and women's health [2].

Reproductive health:

"A state in which people have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and childbirth safely; the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; and couples are able to have sexual relations free from fear of pregnancy and contracting disease." *- Mahmood Fathalla, WHO, 1988*

Women's health:

"Health is a personal and social state of balance and well-being in which a woman feels strong, active, creative, wise and worthwhile; where her own body's power of healing is intact; where all her diverse capacities and rhythms are valued; where she may make choices, express herself and move about freely."

- Women & Health Program, India, 1996

Several women's activists who were consulted found the concept of "women's health" more meaningful than the concept of "reproductive health". Other women's groups, researchers and activists felt that an artificial dichotomy was being created between "reproductive health" versus "women's health". These actors understood reproductive health as a legitimate question of women's health, rights, needs and empowerment.

"Reproductive health issues need to be understood as life and death issues for women repeatedly in a way that tuberculosis (TB) and malaria are not - in that TB and malaria are acknowledged as illnesses, whereas reproductive tract infections are not," one researcher asserted. In this sense, reproductive health occupies the crux of women's subordination and is "a political question, a question of choices and the right to choose," rather than a medical question of Reproductive Tract Infections (RTIs), Urinary Tract Infections (UTIS) and Sexually Transmitted Diseases (STDs).

The key challenge for advocacy efforts defined by most groups and individuals are getting reproductive health programs to addressissues of power and gender relations. In this context, it was recommended that the concept of reproductive health be broadened and deepened by:

1. Several community health groups asserted that in India, where poverty and social injustice result in a widespread neglect of all health needs, the concept of "primary health care" is more appropriate than a narrow, vertical reproductive health approach. Reproductive health care should form one important strand of primary health care.

2. Linking concepts of reproductive rights to human rights of women such as the right to livelihood, safety and mobility, health care, and food security. Practically all those consulted emphasized the need to link the concept of reproductive health with broader socio-economic conditions. For example, menstrual hygiene is often related to issues of water; nutrition is often related to food security; pelvic inflammatory disease is often associated with load bearing. These larger concerns need to shape understanding and inform programming in the area of reproductive health.

3. Enhancing women's information base, validating their knowledge and experiences and empowering women. The example of diaphragms was used to illustrate the difference between a technical fix and a broader change in social relations. If thediaphragm is pushed merely to control fertility, it gets reduced to a technical fix. But if using the diaphragm is advocated in the context of women's lives, the social issues underlying reproductive health get addressed. This would mean relating diaphragm use to women's lack of

power and decision-making, and advocating the diaphragm as a user-controlled, safe, effective, and reversible contraceptive.

4. Working with men for there own sexual well being as well as those of their partners. Participants felt that often the root cause of men's lack of participation lies in social "gender conditioning", the roles and responsibilities that men and women learn as children, from parents and other role models, in the mass media, schools and other social institutions. Increasing men's involvement will require this conditioning to change as well as create initiatives that incorporate the unique circumstances of an individual's community and culture.

5. Changing power relations in families and societies. In the current climate, reproductive health has been reduced to a medical-technical problem. What is missing are the underlying social factors - of gender and sexual relations, decision-making, power, choices and lack of choices, access to basic needs - all of which determine reproductive health status. Social factors need to be seen as central to the concept of reproductive health. The current approach needs to be reversed: social causes must be seen as the basis on which technical solutions rest, rather than vice-versa.

The following are essential to assure women's health care:

- Equal status in society with control over one's body
- Equitable distribution of work
- Assured and just income
- Safe working and living conditions
- Comprehensive health care including safe effective contraception
- Enough clean food and water
- Education and growth opportunities
- Freedom from violence

Locating reproductive health program's within the framework of empowerment

Empowerment means "enabling women to analyze their own situation, to decide their priorities, develop solutions to their problems and to take collective action to improve various aspects of their lives". Although the concept of empowerment is generally understood, it has not yet been adequately put into practice at the programmatic level.

The critical challenge is to advocate reproductive health not as "a package of medical services", but within the power of empowerment. This means looking at issues of gender discrimination as part of reproductive health interventions. In practice, this entails addressing the invisible sub-structure of power relations within households, at caste and community levels, and in relation to health systems. However, this is a much longer-term and more complex process than offering technological solutions.

The following example illustrates the difference between the two approaches:

Package of medical services	Empowerment framework Approach
Treats anemia by distributing	Treats anemia by distributing folic acid and addressing its long-term causes: low status, Inadequate nutrition.

In this context, it may be more meaningful to define a program's goals as "empowerment" rather than "improving women's health". In order to be truly empowering, programs have to function at two related levels:

1. They must take care of immediate health needs.

2. They must simultaneously chip away at embedded issues of power relations.
Thus reproductive health programs need to have both a short-term and a long-term approach.

Programs need to embody the following principles to be considered empowering interventions:

- Respect for individual women.

- Sensitivity to women's expressed and unexpressed needs, and responsiveness to these needs (unexpressed needs would be based on socio-cultural-economic analyses of women's situation in that particular area).

- Inclusion of women's perspectives (in developing educational material and monitoring programs).

- Mechanisms to take into consideration what women see as empowering in their own areas as well as by increasing self-esteem, and enhancing negotiation capacities.

- Mechanisms to shift power relations within families, within communities and within health care systems.

- Mechanisms to increase men's awareness of, sensitivity to, and knowledge of women's needs.

In order to determine whether programs have incorporated an empowerment approach the following questions need to be considered:

- Is my program sensitive to women's expressed and unexpressed needs?

- How are women's perspectives being incorporated into the program?

- Exactly how - and who - are the women being empowered through this program?

- How are power structures changing through these programs?

- What kind of structures have been institutionalized in my program and at the community level for empowering women and sensitizing men?

- How does my reproductive health program relate to the larger public health needs of the community?

- Is this intervention addressing only symptoms, manifestations or also underlying causes?

Key Issues In Reproductive Health

Reproductive health is an "umbrella" concept, consisting of several distinct, yet related issues such as abortion, sexuality, contraception, and maternal mortality. This implies the need for a dual approach to advocacy in this arena:

1. Advocating the concept as a whole.

2. Advocating key issues in reproductive health that has individually not received enough attention.

During the meeting a participatory exercise was used to identify and prioritize key reproductive health issues.

Themost neglected reproductive healthissuesthat emerged from the discussions were: sexuality, abortion, and male involvement. asexplained in Table1. In the case of sexuality, there is a need to create spaces to raise and discuss the issue. A few tentative needs were identified with respect to each issue. In the case of abortion, advocacy must de-link contraception and abortion. While there is an understanding of the need to make men responsible for their own and their partners' sexual well being, there is little understanding of how this can actually be accomplished in health programs. Each of these issues merits moreattention in terms of advocacy and programmatic interventions. Each requires different advocacy goals and strategies, since the need for advocacy differs in each case.

Table 1: Three priority reproductive health issues were selected from this list, which participants collectively developed. Participants also identified five key tenets underlying all reproductive health issues.

Key Reproductive health Issues	
1. Sexuality- Sex education, sexual health	9.RTI's/STD's/HIV
2. Violence- sexual abuse	10.Adolescent Health
3. Men- male involvement, responsibility needs	11.Maternal health
4. Infertility/sterility	12.Mental health
5.Abortion	13.Women's gynecological health
6.Contraception	14.Older women
7.Access to Socio-economic rights (food, water, environment, income)	15.Alternative health care
8.Occupational Health	16.Anaemia/nutrition
	17. Empowering women in health.
Key Tenets Underlying Above Issues	
1. Empowerment	4.Accountability
2. Right to information	5.Access to primary health centers
3. Women's Political Participation	

Three groups were constituted to discuss these issues in depth. Each group was asked to structure its discussion around the question: **What are the advocacy needs with respect to each issue?**

A synopsis of the group discussions follows.

Sexuality

Sexuality is an important issue because of the close link between sexual well being and gender relations; sexual well being and other facets of health and well being; sexuality and violence; sexuality and HIV/AIDS.

These links are rarely acknowledged, adequately discussed or understood given the culture of silence that surrounds the issue of sexuality. There is a need to arrive at an understanding of sexuality that incorporates concepts of sex education, sexual health and sexual well being. It is important to take the issue of sexuality beyond sexual health to sexual well being, which is a more positive and affirmative concept. It is also critical to address sexuality, though a deeply personal issue, both at individual and societal levels.

Participants shared the following insights gleaned from their experience in working on issues of sexuality:

- Interventions need to be directed at individuals, keeping in mind that individuals are unique and also belong to a community.

- Anonymity is an important issue in addressing sexuality.

- There is a need to create safe spaces for the articulation of fears, needs and apprehensions in this aspect of people's lives.

- In the arena of sexuality, the underlying message is often more important than an overt message. For example, overt messages such as "HIV kills", give an underlying message of fear. Such messages may work well in the short-term, but do not have long-term impact. Messages centered on improving well being are likely to have longer-term impact.

- It is important to identify the perspective and value base from which sexuality-based interventions are being made.

- Addressing men's sexual well being is a critical need. For example, men calling a reproductive and sexual health helpline [3] for assistance, often ask their partners to call up for help. However, there is a need to address male sexuality as an end in itself, not just as a means to improve women's health.

It is difficult to identify advocacy priorities in the area of sexuality, given the large gaps in understanding grassroots situations and realities. The first priority, therefore, isto promote strategies, including action research that would

contribute to building a knowledge base. Targets and priorities for advocacy could then be identified more meaningfully.

The following priorities for action were identified:

- Creating a mix of individual, community-based and mass-scale messages, identifying distinct target groups. Everybody, from teenagers to truck drivers, needs information on sex, sexual health, and sexuality in different ways.

- Creating an information base on sexuality through multidimensional research projects. Although research exists, the implications of its findings, or insights for action, are missing.

- Undertaking pilot projects using, a mix of approaches - individual, community and mass-based interventions.

- Identifying and involving informal and formal service-providers (from quacks and sexologists to dais) and informal counselors (such as sex workers, or community-based educators such as peers and nanis).

- Advocating the concept of sexual well being to all key actors (for example, by making explicit the connections between contraception and sexuality).

Any program strategy in the area of sexuality needs to address the following issues:

The need for capacity building: This is a critical underlying need. People are not equipped to deal with the issue of sexuality at the individual or community level.

The need to examine the ethics of researching sexuality: Although there is need for more research in the area of sexuality, it is critical to address the ethics of researching deeply personal issues. The ethics of asking others questions that researchers are themselves unwilling to answer needs to be discussed.

The need to clarify the value base within which interventions are framed: Values are rooted in cultures, and these values shape and inform interventions. Many assumptions shaping sexuality in other cultures run contrary to those in India. Therefore, there is a need to clarify our perspective on sexuality, especially given the rapid changes in cultural values.

The need to discuss sexual choice: This refers to the need to include lesbians, homosexuals and those making alternative sexual choices within any discussion

of sexuality. Sexual choices are also made in the context of social choices in India. (For instance, many lesbian women and homosexual men are married.)

The need to identify informal counselors: People go to a range of actors - from quacks to sexologists and doctors - with their sexual concerns. Is it possible to identify potential counselors among these actors who would be willing to address issues of sexuality? (It is not in the interest of quacks to provide information on sexuality, since their livelihood thrives on misinformation.)

The need to develop prototypes or training modules on sexuality: People from different backgrounds working on a range of issues from poverty and housing to health, need to converge to create prototypes for working on sexuality at the community level.

Abortion

Despite the existence of the Medical Termination of Pregnancy Act (MTP Act) of 1972, very few women's groups or health groups are addressing this issue. Abortion is not readily available on demand to all women. Studies [4] have documented the status of abortion services in India and have identified critical gaps.

The following issues need to be considered with respect to improving abortion services.

Quality of care: given the problems of free access to abortion, women take whatever is available.

Choice of provider: abortion providers often demand the husband's signature, push contraception along with abortion, and do not maintain confidentiality.

Decision-making: no decision-making is really possible for women in this narrow arena because women have no decision-making powers in any sphere.

Health services: private providers are expensive, while public providers are disrespectful.

Sex determination: amniocentesis has become strongly linked to abortion.

Guilt and relief: women often experience one or both of these on undergoing abortions.

Confidentiality: lack of confidentiality affects choice of provider.

MTP Act: this only allows women access to abortion in certain circumstances [5]; it is not an Act that sees abortion as a right. The Act is also not implemented effectively.

Unavailable infrastructure: abortion services are not freely available or accessible.

The following priorities for advocating safe abortion were identified:

- Creating a national abortion task force in the public sector.

- Reviewing both the MTP Act and the Sex-determination Act, to ensure that the latter is censured not the former. The need for the Sex-determination Act to not punish women, but to focus on the provider, was highlighted.

- Better implementation of both the acts, rather than amending the MTP Act.

- Removing constraints to access such, as the husband's signature, which is not a statutory requirement, but has become a custom.

- Providing information and enabling more discussion on abortion and related issues.

- Providing access to quality abortion services at the primary health center and community health center levels.

- Defining quality in the context of abortion, medical qualifications and physical standards.

- Looking at the role of menstrual regulation in abortion.

- De-linking abortion from sterilization and family planning.

- Looking critically at newer forms of abortion facilities.

- Strengthening women's negotiation powers in the arena of sexuality and decision-making.

There is a need to advocate abortion as an issue of empowerment and as a woman's right, rather than as a family planning technique. Both providers and

clients view abortion as an expensive family planning measure; women see abortion as a defense against unwanted pregnancy. The need to separate abortion from sterilization or contraception was highlighted. The MTP Act, which does not connect contraception to abortion, was seen as a possible strategy to distinguish the two. The target-free approach provides a window to implement this separation. However, although contraception and abortion need to be de-linked, both services need to be provided at the same place, in line with the long-term goal of creating health centers that address all women's reproductive health needs in a holistic manner.

Abortion remains a complex issue, every aspect of which is tinged with dilemmas. Questions that need further discussion include: Is it politic to touch the MTP Act? Can confidentiality really be maintained given the need for keeping records? Does demanding more access to abortion automatically increase access to sex-determination?

Male needs and responsibilities

Men need to be involved in reproductive health issues, both to improve their own health and to improve the health of their partners. It is critical to empower men to empower women. since male decision-making often determines women's health status. For example, even when health camps are held in accessible community locations, a large percentage of women cannot attend because they have not received permission from their men.

The following goals were identified for advocacy efforts aimed at involving men:

- Establishing more healthy relationships between men and women sensitive to women's needs.
- Creating appropriate male role models for the next generation of men.
- Improving women's social status.
- Providing better and specific services for male reproductive health needs.

These outcomes can be realized through a mix of the following inputs:

- Deconstructing old myths about masculinity and femininity i.e. stereotypes of "macho" and "frail" and addressing new myths as they arise.

- Deconstructing myths about sexual relationships i.e. myths such as sex is a natural marital right, only women are infertile, masturbation is a crime.

- Addressing misconceptions about sexual relationships i.e. misconceptions about male and female physiology, sexual response, frigidity, and the role of the Y chromosome in sex-selection.

- Providing information on issues related to sexuality i.e. information related to bodies, sexual needs, hygiene and reproductive health needs.

- Making men understand the complementarily of male-female relationships.

- Changing traditional notions of roles and responsibilities.

- Providing information on violence i.e. violence committed by men, and violence committed on men.

- Researching male attitudes, biases and perceptions.

- Creating positive male role models through media.

- Instituting legislative mechanisms such as paternity leave.

- Highlighting the issue of male sexual violence and developing deterrents at the community and legal levels.

- Mainstreaming gender sensitization in training curricula and programs.

- Making the internal culture of an organization accountable to its external vision of gender justice.

Two complementary advocacy styles are needed to involve men in reproductive health issues. The first approach would use strategies to enable men to unlearn old values and patterns, which result in violence and discrimination. The second approach would aim to reinforce new roles, values and responsibilities. However, any advocacy strategy to involve men in reproductive health would need to address the issue of power. Men and women have different stakes in employment, reproduction and other social systems. The power relations between men and women often have negative consequences for women.

Within the public-sector health system, Male Health Workers (MHWS) need to be empowered to understand themselves and their own health needs, before

addressing other men's health needs - a methodology that has successfully been followed with female health workers or Auxiliary Nurse Midwives (ANMs) [6]. However, men cannot be empowered by disempowering women - thus, MHWs cannot be empowered by disempowering ANMS. A power balance needs to be struck between these two categories of health workers.

Participant's experiences of working with men have shown that men do not necessarily enjoy the roles they are in. However, although men find these roles oppressive, they do not know how to change their circumstances. In several community projects, men are demanding knowledge of themselves and women. For example, many men say nobody ever told them what to do that they are scared of women, and have no space to talk of abuse. When looking at cases of marital rape, a women's organization [7] found that social pressure often makes men feel they should have penetrative sex in order to be perceived as playing the appropriate male role. One NGO reported that several men wanted to join the Body and Health Awareness Training sessions held by it, [8] but the trainers were not prepared for this. In some communities, men have been given access to women's health camps. But when male colleagues enter the discussion, the dynamics often change. Therefore, there is a need to retain women's spaces while working with men. Separate and joint spaces for discussions on sexuality and health are necessary in program design.

Socio-Economic Rights And Health

It is critical to understand the socio-economic conditions that women live within and how these conditions mediate and are mediated by their health needs. Meeting participants overwhelmingly endorsed the position that narrow reproductive health programs cannot be sustained without addressing the related yet broader issues of socio-economic conditions.

Several illustrations of this were cited:

A participant from Andhra Pradesh explained how the issue of water scarcity has adversely affected women's reproductive health in her area. Re-usable menstrual hygiene kits are distributed at a subsidized cost to women as part of a reproductive health project. However, women are unable to find water to wash and re-use these kits. The women say they do not even have water to wash their hands so how can they wash cotton pads in water?

A participant from Maharashtra described how lock of food securely adversely affected an intervention attempting to improve women's nutritional status. Since anemia and malnutrition abound in the area, the women are advised to prepare simple, affordable household remedies. However, the area is prone to drought,

the cropping pattern has changed, and the Public Distribution System doesn't function. Basic foods are unaffordable. "What do we talk about when we talk about food?" asked the activist.

A participant from Maharashtra said the organization she works for address women's multiple needs through overlapping programs in income-generation, savings and credit, and health care. All staffers, be it in the area of health or credit, have a strong social-political ideological base and understand how other issues relate to their own program area, "so that they know what they're doing is part of a much larger vision."

A participant from Karnataka shared her experience of holding an Information fair attended by almost 1500 rural women. Simultaneous tents were set up on Economic Issues, Health, law, and Women's Expressions. A woman doctor was placed inside the health tent. By the second day, there were long queues outside the health tent, while the others remained empty. Almost 30% of the women were found to have uterine prolapsed as a result of hard farm labor; the women demanded that the doctor come to their villages too. "We had not recognized this enormous latent health need that women felt," said the researcher.

It was agreed that all issues ranging from water to food security to health are critical in women's__lives; women experience these simultaneously not sequentially. A prolapsed uterus does not merely affect women's health; it also affects her ability to work. Thus, it is meaningless to privilege one issue over another. "No woman's life is compartmentalized in these ways - she experiences all of these issues at the same time,' summed up one participant.

Is Violence A Critical Health Issue?

Although violence is not part of the conventional definition of reproductive health, several groups and individuals consulted identified this as a key health issue for the following reasons:

- At the most basic level, violence affects women's bodies and psyches. Ill health is direct fallout of violence.

- Violence is an issue of power relations between men and women. If reproductive health aims to empower women, Programs must address violence against women.

- Violence takes away control of the body. If reproductive health, in its best sense, imbues the concept of reclaiming control over the body, then violence against women must be incorporated into its definition.

Several activists emphasized that the intersections between health and violence repeatedly come up in their areas of work, be it Grassroots mobilizing, service delivery, women's development programs, and/or research.

Many aspects of women's lives are affected by violence. Included below are a few examples, which illustrate how violence against women impacts women's health.

Mental health: This is a key intersection between violence and health, i.e. violence isseen to not just affect women's health, but more specifically affect mental health.

Pregnancy: Sometimes, women become pregnant to avoid being beaten, although repeated pregnancies affect the health of women adversely. However, violence increases during pregnancy in other situations.

Infertility: Domestic violence is typically seen to increase when a woman is "suspected" of being infertile. This has often led not just to violence, but to desertion.

Maternal mortality: Violence is one of the main causes of maternal deaths.

Sexual relations: The male presumption of the right to sexual intercourse leads to forced intercourse, another form of violence against women that affects health.

Sexual violence: Rape and other forms of sexual violence badly affect women's health, including reproductive health (for example, through pregnancies and/or abortions resulting from rape). The State is often a perpetrator of violence. Taking women's sexual histories during rape trials, and limiting the definition of rape to penile penetration also constitute violence against women, by the State.

Contraception: The abuses surrounding the use and propagation of contraceptives, as well as routine sterilization abuses, are forms of violence within the health system.

Violence on mentally and physically disabled women: This has emerged as a concern in Maharashtra, where the State has conducted hysterectomies on women residents of an institution for the mentally disabled.

Violence in the health services: Violence against women is implicitly and explicitly seen in the day-to-day functioning of the health system. Communal, gender and caste biases among health workers are seen in every practice. For