Advocacy for Sexual and Reproductive Health: The Challenge in India

Bishakha Datta, Geetanjali Misra

Six years after the Indian government affirmed its commitment to the principles of the 1994 International Conference on Population and Development, there is still a limited understanding of the concept of reproductive and sexual health among policymakers, programme managers and the public in India. Despite some progressive changes, there is a continuing focus on stabilising population growth rates and lack of unity of goals among women's rights advocates, service providers and policymakers. Advocacy efforts need to begin focusing on turning progressive reproductive health policies into concrete programmes on the ground, and continue to push for progressive policies in uncharted areas such as domestic violence. Those who implement programmes need to work with potential allies such as women's groups, development groups, health workers' associations and the media, who all need to be brought on board. What continues to be missing are policies and programmes that promote not only health but also rights and the empowerment of women. Without a strong focus on the links between these, India's reproductive health policies and programmes may become like 'grass without roots'.

Keywords: reproductive and sexual health, women's empowerment, reproductive rights, women's health policy, advocacy and political process, India

LAST year, a full five years after the Indian government had endorsed the Cairo agenda on reproductive and sexual health, we met with the manager of a large non-profit family planning programme in central India. In the middle of escorting us around project clinics and facilities, he suddenly said:

'You know, this new thing has come in now. It's creating lot of problems.'
'What?'
'This reproductive health thing.'
'...And this other new thing has also come in.'
'What?' we asked again.
'This gender thing,' he said.

It turned out to be an interesting conversation, both for what it revealed and what it did not. It showed how reproductive health is perceived at the field level, where programmes are implemented – not as a set of principles for conceptualising programmes based on gender equity, but as some new package which has been dumped on providers and somehow has to be implemented, i.e. an imposition.

Advocating reproductive and sexual health in the Indian context: the challenges

At the International Conference on Population and Development (ICPD) in 1994, the sustained efforts of a wide range of women's health advocates, researchers, service providers and rights activists contributed to a paradigm shift in the global understanding of reproductive and sexual health. Governments, including India's, re-affirmed this commitment at the Fourth World Conference on Women in Beijing the following year.

Today, six years later, many of these concepts remain on paper in India. While advocacy has expanded the understanding of reproductive and sexual health at the international level, there is a very limited public understanding of the concept within the country. Intense advocacy is still needed at the national level to usher in, first and foremost, an understanding of this concept. Only then can policies and programmes start to be implemented, based on empowering reproductive and sexual health principles.

Reproductive and sexual health is an issue not

only of women's health and but also of women's rights. At one level, it is about achieving 'a state of complete physical, mental and social well-being' with reference to a set of issues ranging from abortion and infertility to HIV/AIDS and sexuality. At a more fundamental level, however, it refers to the rights of individuals, particularly women, to make decisions and choices about a wide set of day-to-day issues: relationships, sexual orientation, marriage, childbearing, etc. It also includes the right of women and men to make these decisions free of discrimination, coercion and violence.[1]

Drawing on the experiences of the post-Cairo years, this paper posits that advocating reproductive and sexual health in the Indian context is particularly challenging for the following reasons:

- Advocates have yet to build enough capacity for pro-active rather than reactive approaches.
- The term 'reproductive health' continues to evoke discomfort among some women's rights advocates, health professionals and policymakers.
- Despite its rhetoric, the government still remains committed to demographic objectives.
- The underlying concepts of 'gender' and 'empowerment' are not well understood by many policymakers and programme managers.
- 'Rights' and 'health' are seen as two different subjects altogether by policymakers, programme managers and advocates.

and discusses each of these issues in depth.

Advocates have yet to build enough capacity for pro-active rather than reactive approaches

India has a long tradition of advocacy in struggles and campaigns surrounding development and politics, from Mahatma Gandhi's campaign against colonial rule to the landmark struggle against the construction of the Narmada Dam, and countless actions to secure housing, land, food security, education, employment opportunities, health facilities and other human rights in the last 50 years and more.[2]

This trend is echoed in the reproductive health sector, where advocacy and action have created public awareness of contraceptive side effects, raised uncomfortable questions about the ethics of clinical trials, and forced government agencies and pharmaceutical companies to maintain some level of accountability to civil society. For example, the 1980s saw crucial struggles against the introduction of hormonal contraceptives and sterilisation abuses under a population control regime. The campaign against Depo-Provera by groups such as Jagori, and the All India Democratic Women's Association peaked when women's activists forced their way into a press conference hosted by the manufacturers and made their perspectives known through the media. Following a court case, the Supreme Court disallowed Depo Provera from being included in the national programme.[3]

In 1985, women's groups investigating a clinical trial of the injectable contraceptive Net-En in southern India found that the women had not been informed of the side-effects or contra-indications of the method; groups such as Stree Shakti Sanghatana and Saheli went to court to get a stay on these unethical trials.[3] The case closed in August 2000, with a recommendation that the mass use of Net-En not be allowed in the National Family Planning programme, and that its use be restricted to women who would be aware of all the implications of its use.

Although reactive advocacy campaigns have prevented injectables and implants from being included in the national family planning programme so far, these campaigns have had only limited success. Net-En, Norplant, and Depo Provera are all available over-the-counter in pharmacies across India, and the Ministry of Health and Family Welfare is proposing to introduce Net-En as a new contraceptive in the national programme in places 'where adequate facilities for follow-up and counselling are available'. The campaign against Net-En, which was on hold, is again starting up, once again reacting to this possibility.[4]

Advocates such as Rural Women's Social Education Centre (RUWSEC), Society for Education, Action and Research in Community Health (SEARCH), International Institute for Population Sciences (IIPS), Foundation for Research in Health Systems (FRHS) and Centre for Enquiry into Health and Allied Themes (CEHAT) have also drawn policy attention to a range of reproductive health issues: the neglect of women's health needs at family, community and policy

levels; the absence of quality health care; the high prevalence of maternal mortality and reproductive tract infections; the directive nature of the state's population programme; the lack of real contraceptive choice; and the absence of safe, affordable abortion services.

Many of these activities have been reactive against something – using democratic mechanisms of protest, court action, street theatre, etc. More proactive mechanisms such as research, documentation and public education have also been used, but to a much lesser extent. A well-known example internationally of using research for advocacy purposes is the study by SEARCH in Maharashtra that discovered a high prevalence of reproductive tract infections (RTIs) among tribal women.[5] This study contributed in large measure to the attention that RTIs have gained in recent years among researchers, policymakers and programme managers alike. Furthermore, a large amount of research has thrown light on the poor quality of services for family planning, pregnancy care, abortion and problems in client-provider interaction.[6] But much of what has been learned through research and documentation has rarely been used to initiate, change or implement policy, and it is rarely designed, written or disseminated in a manner that is likely to catch the attention of policymakers.

As long as human rights violations and other abuses continue to occur and policies are poor or poorly carried out, there will always be a need for advocacy 'against'. But in the post-Cairo era, there is an equally pressing need for a different kind of advocacy – pro-active advocacy, or advocacy *for*.

Advocacy is not just about pushing for new policies, or changing existing policies; it is as much about getting both new and existing policies implemented.[7] This is a real challenge in the Indian context, where the absence of political will and an unwieldy bureaucracy are as constant as the everyday sun. In the health sector, where policies are set at national or central level and implemented at state, district and sub-district levels, an absence of effective communication and co-ordination between these different layers and sectors also hampers implementation.[7]

But implementation is also slow partly because advocates themselves rarely pay enough attention to this aspect of their goals. There are innumerable examples of this. Advocacy efforts mounted in the mid-1980s succeeded in getting several Indian states to pass laws against sex-determination tests in the mid-1990s. These laws restrict pre-natal sex determination but not abortion, even if suspected to be for reasons of pre-natal sex determination.[8] Yet to date there has not been a single conviction for having such a test. But neither have any sustained efforts been mounted to get these laws implemented.

India's rape law[9] is not the most progressive in the world, though offenders can certainly be convicted under it. Yet there have been very few rape convictions over the years. In 1996, the total number of rape cases that came to trial, including pending cases, were 51,734 whereas only 16.3 per cent of these were tried and only 4.5 per cent convicted.[10] However, only a handful of organisations, such as Sakshi in New Delhi and the Special Cell for Women and Children in Bombay are actually working with the police and the judiciary to get this law better implemented. By and large, women's groups continue to focus on adding new clauses to the law rather than on making sure the law, as it stands, works for women. Thus, some groups are campaigning for the law to include forced sex within marriage and penetration by objects other than the penis as rape. Others are pushing for omission of the victim's sexual history from admissible evidence, since this has no relevance to the case at hand and creates biases against sexually active women. Although it is clearly important to expand the law to take on board such issues, it is equally important to push for more rapists to be caught, arrested and convicted.

Organisations such as Health Watch are actively working with the government to ensure the inclusion of RTIs, training and community needs assessment in the new Reproductive Child Health (RCH) programme and to devise alternate indicators for evaluating the performance of staff in this programme.[11] They are also using a new set of strategies – collaboration rather than confrontation, persuasion rather than protest, devising performance indicators rather than damning non-performing staff – advocating for, not against.

The term 'reproductive health' continues to evoke discomfort among some women's rights advocates, health professionals and policymakers.

After Cairo, the Indian government announced two major policy changes: first, it dropped

the use of contraceptive targets, which had been firmly in place for 50 years. This was an important step in working to implement the Cairo agenda. Second, it said that the existing Family Welfare programme should be expanded into a broader Reproductive and Child Health programme. Advocacy will be needed, however, to ensure that women-centred policies are actually implemented on the ground, rather than remaining paper policies. There is also no doubt that existing efforts to oppose population control policies will need to continue as well.

Now, more than six years after Cairo, some women's rights advocates and health professionals continue to view the term 'reproductive health' with suspicion. This is partly rooted in the political legacy of a 50-year-old government obsession with controlling numbers through any means available, which has left little room for anything but scepticism. Many women activists justifiably refuse to buy into the government's shift from 'population control' to 'reproductive health' and continue to view reproductive health as old wine in new bottles – simply a new term for family planning.

Some of this discomfort can also be traced to the concept of reproductive health having originated in the West, where it grew out of the feminist struggle for reproductive rights. But in India, some of this discomfort is justified as the term 'reproductive health' is used in many quarters, masking many different connotations.

For health professionals, 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 related to the reproductive system and its functions and processes'.[1] For women's rights advocates, the emphasis is on rights – the rights of human beings, particularly women, to make choices in the intimate, yet complex, realm of relationships, sexuality, childbearing, contraception and so on. For many policymakers in India, however, reproductive health continues to be an instrument to stabilise population growth rates, making the principal goal of a reproductive health programme to reduce fertility safely and to provide high-quality services to do so, thereby responding to the needs of individuals at the same time.[12]

Three different meanings, three different emphases, but also, ultimately, three different programmes. Is it any wonder that many women's health activists feel uncomfortable allying themselves with this term?[13] The outcome of such dissonance and discomfort has been polarisation; instead of one united constituency striving to make reproductive health a reality for men and women, there are numerous factions in conflict with each other, each striving towards different realities. And those who see themselves as championing 'reproductive health' pit themselves against those championing 'women's health', as if one were not part and parcel of the other.

Allied to this are several other discomforts. In a country where the annual per capita income is US$ 1,240,[14] development action groups tend to view reproductive health as a luxury, not a necessity. Like everybody else, Indian men and women experience health alongside other needs. But although health is a key aspect of development, reproductive health and economic development are rarely conceptualised in an integrated manner. Historically, the two discourses have remained separate. Reproductive health has been seen by many development professionals and policymakers as a soft issue whose primary consumers are women; economic development on the other hand is a hard issue whose constituents are largely male. Reproductive and sexual health problems are rarely seen as life-and-death issues, even though they might result in suicide, murder and death from other causes, including but not only medical ones.[15]

One consequence of viewing reproductive health as a luxury is that issues of reproductive health are seen as separate from the 'necessities' of development. We may know that health, water, food security, livelihoods and employment are all connected – but policymakers still have to buy that argument. We may know that menstrual hygiene is as connected to water supply as it is to anything else, but 'menstruation' and 'water' occupy separate realms in the policy universe. We may know that rural women are prone to uterine prolapse because they carry heavy loads at work,[15] but 'employment' and 'uterine prolapse' are different universes where policymakers are concerned. 'Policy still sees them as separate,' asserts a women's rights advocate. 'A woman will be asked: "Do you want water at your doorstep? Or do you want your prolapsed uterus fixed? Or do you want more income?" How is she supposed to answer that question?'[16]

Despite its rhetoric, the government still remains committed to demographic objectives

Since the early 1950s, when the Indian government initiated the Family Welfare Programme, control of a growing population has been a key policy objective. Almost from the beginning, the government sought to control population size through a complex system of targets for each contraceptive method. The highest targets were set for sterilisations, since this permanently sealed women's capacity to bear children. In effect, the system worked like a top-down chain: the central government allocated separate yearly targets for the desired numbers of sterilisations, IUDs, condoms, oral pills, etc, to each state. States, in turn, allocated these targets – 'numbers of sterilisation cases', 'numbers of IUD cases' – to districts, sub-districts and primary health centres.

Targets were expected to work like magic wands, producing the correct number of cases come what may. But when these targets did not match the reproductive health needs of citizens, all that the system ended up producing were highly-pressured government officials, anxious to fill targets, and a system that slowly degenerated into abuse of people's rights. Officials desperate to notch up the required numbers resorted to any and every trick in the book: e.g. forcing women to undergo repeated sterilisations, falsifying records, cadging women going through menopause to be sterilised. A system which occasionally ended up sterilising women as old as 80 years obviously left the public with an abiding horror and deep distaste for both sterilisation and targets.

In 1996, the Indian government dismantled this decades-old system for the first time. This was a historic moment, a slow step in the right direction that reproductive health advocates widely applauded.[17] However, it is not yet clear if targets have actually vanished in practice. For some time at least, targets were being re-packaged as 'Expected Levels of Achievements', a new terminology that continued to put pressure on government health officials. In states like Rajasthan, Uttar Pradesh, Andhra Pradesh and Madhya Pradesh, targets continued to be assigned by health administrators and district functionaries and client's needs were still rarely being considered.[18]

Reporting requirements of the central government continue to focus on district-level contraceptive achievements. Health workers at the field level continue to be evaluated on the basis of how many acceptors of contraception and sterilisation they have been able to recruit. At one level, for the target system actually to be dismantled, the evaluation system needs to be revamped, based on new reproductive health indicators. In fact, the abrupt withdrawal of targets, with little preparation of the health workers who are meant to implement the programme without them, and without any alternative monitoring and evaluation system, could undermine the potential achievements of this changed approach.[18] NGOs such as RUWSEC have begun to advocate for new evaluation indicators for reproductive health programmes and plan to engage with the state government to implement these on a trial basis.[19]

India was one of the first developing countries that in 1952 initiated a national Family Planning (FP) programme to lower birth and population growth rates. Since the mid-1960s the government has attempted in succession to integrate family planning with other programme such as Minimum Needs (MN), Maternal and Child Health (MCH), and Child Survival and Safe Motherhood (CSSM). In the 1990s it added on reproductive tract infection (RTI) services, along with the target free approach. Thus, in the 1950s-1970s, India had FP. In the 1970s-1980s, it was FP + MCH /CSSM, and in the 1990s, it has expanded to FP + MCH/CSSM + RTIs = Reproductive and Child Health.

But just as the target-free approach is being implemented in a limited manner, so is the Reproductive and Child Health programme. Even though the policy speaks of a comprehensive reproductive and child health programme, what is being implemented is a medicalised fragment of the whole. All that has been added on to the basic formula after Cairo has been RTIs. The central government has a separate vertical programme for HIV/AIDS – so in effect, even today, the government reproductive health programme addresses family planning, maternal and child health, abortion, RTIs and HIV/AIDS.

What is totally missing from the big picture is the concept of empowerment, as are other vital pieces: infertility, adolescent needs, the needs of

older women. Thus the Reproductive and Child Health Programme stands in some danger of becoming yet another separate, vertical programme, with few links with primary health care or even other components of reproductive health, such as HIV/AIDS. Furthermore, the whole concept of bringing child health in with reproductive health is questionable from many perspectives: will women always continue to be viewed in their maternal role (i.e. with children) by policymakers in India? Will women never be seen to stand alone, as independent, active, free-thinking agents of their own destinies, who deserve a reproductive health programme even when they are not having children? And even within the programme, will women's needs again be overlooked – as was the case with the 'Maternal' in the Maternal and Child Health programme?

Critics point out that the government's basic commitment to population control, rather than reproductive health, is again articulated in its population policy. The new population policy, announced in February 2000, still articulates a long-term objective of stabilising the population by 2045.[20] The immediate objective of the policy is to address unmet need for contraception, health care infrastructure and health personnel, and to provide integrated service delivery for basic RCH care. The medium-term objective is to bring the total fertility rate to replacement levels by 2010 through vigorous implementation of inter-sector operational strategies. The long-term objective is to achieve stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environmental protection.

Some of the progressive measures contained in this new policy include: giving local governments incentives to reduce infant mortality, promoting primary education and providing crèches and child-care centres, measures that directly benefit children rather than women.[21] But the policy also contains measures that reflect an underlying preoccupation with population control. For instance, the policy states that health insurance will be provided only to those below the poverty line who undergo sterilisation after two children, so that it is treated not as a right but as a reward.

At the state level, such rewards are accompanied by strict punishments for those who have more than two children. A bill was recently moved in the Delhi assembly barring persons having more than two children from contesting state-level elections. The bill has yet to be passed, but the Health Minister of Delhi, AK Walia, had this to say on the matter: 'Our main objective is to put a check on the population menace, which has been playing havoc with the city's infrastructure.'[22] Thus, the same old song continues to be played.

The underlying concepts of 'gender' and 'empowerment' are not well understood

Indian women operate within an unbelievably tight box in the domain of reproductive and sexual health, and are rarely allowed to take decisions on such matters. An ideal woman is still seen as one who marries within, not just her own caste, but her own sub-caste.[23] Society, community, and family make these decisions, not the woman herself.

If women have little societal space to deal with the software of reproductive health – love, romance, relationships – neither do they have any power to wrestle with the hardware; everything from abortions to gynaecological check-ups remain family decisions. If reproductive health is about the rights of individuals, particularly women, to make decisions about these issues, then women's empowerment is clearly the order of the day.

Empowerment, however, is also a much-mangled term. We understand empowerment to be a process that enables women to analyse their own situation, decide their priorities, develop solutions to their problems, and take collective action to improve various aspects of their lives.[24] Empowerment goals view women as active subjects, determinants and agents, not as passive objects or pawns of social change.[25]

Policymakers and programme managers, however, appear to see empowerment as a means, not an end. If stabilising population or higher literacy rates is the objective, empowering women becomes a strategy. Poverty alleviation, public health, drought prevention, employment generation – you name it and hey presto! – empowering women will make it happen. However, we would assert that empowering women for themselves is the only legitimate form of women's empowerment.

Figure 1

Intra-personal	Inter-personal	Group	Community
Building confidence in self, shedding shame, owning one's body, starting to talk about what affects body and health.	Increasing awareness, control of relationships through which the body is affected.	Appropriating health services that rightfully belong to the group.	Organising for collective action on better health care, taking on issues, e.g. violence.

Empowerment therefore cannot be conceived only in mechanistic terms of providing women with education, literacy and livelihood opportunities. Going to school, being sterilised, and weaving baskets do not necessarily add up to an empowered woman, although they are enabling mechanisms. What is crucial – and often overlooked – in the process of empowerment is what lies at its centre. What is the content of the curriculum at the school this woman attends? Who is the locus of the sterilisation decision? Will the sale of the baskets she weaves make the woman herself financially independent? These are some of the questions that those promoting women's empowerment actively need to consider.[26]

In this context, it is critical for women's rights advocates to:

- make policymakers understand that gender relations are central to reproductive health, and
- translate this concept into actual programmes that empower women.

The question is how. At the policy level, this means blitzing policymakers and society with information on the holistic nature of women's lives, of which reproductive health is one aspect. At the programme level, this means that programmes must operate at two related levels: one, they must address immediate health needs. Two, they must simultaneously chip away at longer-term issues of power relations. The difference can be illustrated as that of an anaemia intervention that distributes folic acid to pregnant women versus one that distributes folic acid and simultaneously tackles the gender issue of inadequate nutrition among girl children and adolescents.

Programmes need to have respect for individual women, include women's perspectives and be sensitive to women's expressed and unexpressed needs, to begin the process of empowerment. However, empowerment is a broad term: one possible way of conceptualising empowerment, as it relates to women's health, is through a matrix.[11] (See Figure 1)

As this matrix indicates, empowering women is a process that occurs along a continuum, and needs responses at many different levels. Empowerment has to result not just in better health, but must also improve the status of women within their families, communities and in society at large.[11] Empowerment also cannot root itself without certain enabling changes in the basic structures and institutions of society. Law is a case in point. Judicial pontifications on rape, divorce, sexual assaults and dowry deaths regularly draw on a theory of sexuality that emphasises the 'eternal bond of loyalty' created by a woman surrendering her virginity through marriage, and the bonding created by the 'natural' desire of every couple to procreate. Until these persons start to change, reproductive and sexual rights will remain a pipe dream for most women.[27]

'Rights' and 'health' are seen as two totally different fields

Over the last few years, there has been some convergence of the discourses of 'rights' and 'health' at the international level. Violence against women, for instance, is increasingly being seen both as an issue of women's rights and of women's health. Gender-based violence violates the basic right of women to live as full human beings with dignity and respect, and as such is an issue of women's rights. But violence also affects the overall health and well-being of women. In addition to morbidity and mortality, violence against women leads to psychological trauma, depression, substance abuse, injuries, sexually transmitted diseases, suicide and murder.[28] And at yet another level, violence reduces the control that women have over their own bodies.

Despite overwhelming evidence that violence against women is a health issue, key actors in India – from advocates to policymakers – still continue to view violence as an issue of women's rights alone. This evidence includes estimates that rape and domestic violence take away almost one in every five healthy years of life of women in the reproductive age group (15-44 years).[29] Violence can lead to unwanted pregnancies, undermine contraceptive use, increase the risk of STDs and HIV, and reduce women's sexual autonomy inside and outside of marriage.[30] It is interesting to note that marriage is seen to give men the 'right' to unconditional sexual access to their wives, but women are not given the right to say no to conjugal sex. In the same vein, forced sex within marriage is still not defined as rape.[31]

This treatment of health and rights as two parallel but never intersecting universes affects reproductive and sexual health policies and programmes in many ways. First and foremost, issues such as gender-based violence are considered outside the domain of reproductive and sexual health. Although the health sector can play a vital role in addressing violence, this will not happen until violence is acknowledged as a health issue.

Even within the field of sexual and reproductive health, 'rights' and 'health' are often treated as conflicting rather than mutually reinforcing concepts.

In December 1998, a doctor sought compensation from a reputed private hospital for disclosing that he was HIV-positive to his fiancée's family. His wedding was called off as a result of this. The Supreme Court ruled that the hospital had not violated any rule of confidentiality or the right to privacy, because the woman he married also had the right to lead a healthy life. The court further ruled that persons with HIV do not have the absolute right to marry.[32] The relevant issue here is not whether an HIV-positive person's right to confidentiality is more important than another person's right to know about something that might affect their health, though this is an important question. The issue is that the judge pitted (one person's) rights against (another's) health.[33]

Another example involves the way in which the state tries to protect sex workers from contracting HIV. It does this, not because it is sex workers' right to enjoy good health, but so that their clients may enjoy good health. Hence, although the state provides health facilities for sex workers, it also routinely arrests them for soliciting,[34] thereby violating their right to earn a living. Thus, intensive, sustained advocacy efforts are needed to make policymakers aware of the linkages between health and rights. Otherwise, we will end up with a set of regressive health policies that routinely violate human rights – ostensibly to promote public health.

Finally, in the broadest sense, in terms of its development over the last 50 years, India has jumped from a 'needs' approach to a growth paradigm. What has always been missing from this picture is the notion of rights. While the government professes a commitment to meeting the needs of its citizens, there is still no talk of citizens having any rights. The result is a skewed picture where 'too many people' continue to be blamed for creating poverty, but where poverty is never examined in terms of inequality of resource allocation or distribution.[35]

Conclusion

Advocacy efforts to promote the Cairo agenda have succeeded in ushering in some critical policy changes in the area of reproductive and sexual health in India. Now the focus needs to be on turning policies into concrete programmes on the ground while continuing to push for more progressive policies in a range of related areas, e.g. on domestic violence.

On one level, advocacy efforts need to focus on those who implement programmes: state health officials, district health officers, service providers in the public and private sectors who actually run reproductive health programmes. This applies all the way down the line: it is as important for a village midwife to buy into the concept of reproductive health as for the programme planner working ten rungs above her.

At another level, reproductive and sexual rights advocates need to target potential allies: women's rights advocates, development action groups, health associations, medical and nursing associations and community-based organisations. All these constituencies have yet to embrace the reproductive health concept fully. What bars them from doing so arises from longstanding misgivings caused by a history of

population control and these will need time to clear away. Many of these doubts could be reduced more quickly through an advocacy process that emphasises engagement, discussion, debate and documentation.

The media are another potential ally. While the concept of reproductive and sexual health is gaining currency within a growing circle, it is still as far removed from the public arena as the man on the moon. For reproductive health to establish itself in public discourse, a wide range of people need both to understand and accept the concept as legitimate, meaningful and relevant. Hence, it is critical to work with the media. In India, however, mainstream media institutions continue to highlight the 'population scare', while paying little attention to reproductive health. The birth of the billionth baby in India attracted so many flashbulbs that the baby herself almost lost her eyesight. On World Population Day, every major national newspaper had similar images of crowds bursting at the seams, yet there was not one leading article in any major publication devoted to reproductive and sexual health.

In India, the media are critical for another reason: films, and particularly Hindi films, are writing the reproductive and sexual scripts of millions of young people in India today. In the absence of any information, young people often take their cues for sexual behaviour from popular culture. In recent years, for instance, obsessive love has become a theme in the movies; its real-life variant is seen in a sudden spate of acid attacks on young women by 'spurned lovers' that newspapers prominently highlight. Such trends underscore the need for increased relations with the media, but not only through advocacy that is reactive. In addition to the scope for protest, e.g. against the sexual representation of women in Hindi films, there is an equal need to persuade the makers of soap operas, talk shows and nightly television serials on human relationships to devote some of that prime time space to reproductive and sexual health issues for ordinary people.

Building coalitions with potential allies is an important task for reproductive rights advocates who are committed to implementing the Cairo agenda. At the same time, potential enemies must be taken on, such as right-wing fundamentalist forces who are constantly reiterating their opposition to non-traditional expressions of sexuality. In November 1998, two dozen men belonging to a religious organisation forcibly stopped screenings of Fire, a film that explores a sexual relationship between two sisters-in-law living in the same house, on the grounds that 'the film's theme is alien to our culture'.[36,37] The same tactics were used to ban the shooting of Water, another film by the same director, on the subject of widows in Benares. Fundamentalist ideologies are increasingly asserting their power in the domain of relationships: young rural men and women who dare to marry outside their 'caste' – who dare to choose – are ostracised, even killed. Women and girls are still made to undergo virginity tests in parts of the country. One of the goals of the Cairo agenda is to open up sexual choices for men and women. Advocacy efforts need to safeguard and expand this threatened space.

Lastly, a strong focus is needed on the links between reproductive health, women's empowerment and rights. How can reproductive health programmes empower women? Why should reproductive health programmes address behaviour that disempowers women, such as gender violence? These are questions that need conceptual clarification, before they can begin to be given shape as programme objectives.

'Rights' are a blind spot even in the context of reproductive health. If reproductive rights are considered at all by those still grappling with 'this reproductive health thing', they are still often seen in isolation from other rights. Yet millions of poor women will never be able to assert their reproductive rights without access to other basic rights – food security, livelihood, mobility and safety.[35] LC Jain, a member of India's planning commission and former high commissioner to South Africa, once equated development without people's participation to 'grass without roots'. Unless sexual and reproductive health policies and programmes promote and protect human rights, this is exactly what they will become – grass without roots.

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Correspondence

Geetanjali Misra, Programme Officer, Sexual and Reproductive Health, Ford Foundation, 55 Lodi Estate, New Delhi 110003 India. Fax: 91-11-462-7147; E-mail: G.Misra@fordfound.org

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Reconsidered: Health, Empowerment and Rights. International Women's Health Coalition, Harvard School of Public Health, New York.
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Résumé

Six ans après que le Gouvernement indien a affirmé son attachement aux principes de la Conférence internationale de 1994 sur la population et le développement, les décideurs, les gestionnaires de programmes et l'opinion publique en Inde comprennent encore mal le concept de santé génésique. Malgré quelques progrès, la priorité demeure de stabiliser la croissance démographique, et les défenseurs des droits des femmes, les prestataires de services et les décideurs n'ont pas unifié leurs objectifs. Les activités de plaidoyer doivent commencer de transformer les politiques de santé génésique progressistes en programmes concrets sur le terrain, et continuer de faire pression pour des politiques progressistes dans des domaines inexplorés, comme la violence dans la famille. Les responsables de programmes doivent travailler avec les groupes de femmes, les groupes de développement, les associations d'agents de santé et les médias, autant d'alliés potentiels qu'il faut associer à la mise en œuvre. Des politiques et des programmes pour promouvoir la santé, mais aussi les droits et le potentiel des femmes continuent de faire défaut. Sans une forte priorité aux liens entre ces domaines, les politiques et programmes indiens de santé génésique risquent de dépérir faute de racines.

Resumen

Seis años después de que el gobierno de la India haya afirmado su compromiso con los principios de la Conferencia Internacional de Población y Desarrollo, la comprensión del concepto de salud sexual y reproductiva entre las autoridades políticas, los administradores de programas, y el público en la India es todavía limitada. A pesar de algunos cambios progresistas, se mantiene el enfoque en la estabilización de las tasas de crecimiento demográfico y la falta de metas unificadas entre los promotores de los derechos de la mujer, los proveedores de servicios, y las autoridades políticas. Los primeros deben empezar a enfocar sus esfuerzos en la implementación de las políticas de salud reproductiva a través de programas concretos en terreno, además de seguir impulsando políticas progresistas en áreas nuevas, tales como la violencia doméstica. Los encargados de implementar programas deben fortalecer las alianzas potenciales con los grupos de mujeres, los grupos que promueven el desarrollo, las asociaciones de trabajadores de la salud y los medios de comunicación, entre otros, y lograr que todos participen. Faltan aún políticas y programas que promuevan no solamente la salud sino también los derechos y el empoderamiento de la mujer.