

***THE***  
***INDIAN***  
***WOMEN' S***  
***HEALTH***  
***CHARTER***

**International Women's Day**

**March 8, 2007**

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# 1 THE PROCESS OF MAKING THE CHARTER

The *Indian Women's Health Charter* emerges out of the Women's Health Movement in India with a history spanning more than three decades since the 1970s. At this point in our long, eventful and ongoing struggle for women's health, it is time to bring together and consolidate women's positive demands relating to health and health care.

The process of formulating this Charter began in 2004-05 through 11 state-level and 6 zonal-level meetings with over 2000 women and some men participants, who identified issues of health concern specific to their States and regions. This 'zonal process' preceded the 10<sup>th</sup> International Women & Health Meeting (10<sup>th</sup> IWHM) in September 2005 at New Delhi, in which about 100 grassroots women delegates participated from India.

To continue the process after the 10<sup>th</sup> IWHM, a plan was adopted for a national-level consultation after one year so as to translate women's health issues into action and advocacy. The idea for the Charter emerged during the two preparatory meetings, and a drafting committee emerged. This committee examined various health rights charters from within India and abroad to see that our Charter would resonate with the situations and needs of diverse sections of women.

Thus, at the 'National Dialogue: Women, Health and Development' (Mumbai, 23<sup>rd</sup>-25<sup>th</sup> November 2006) about 280 participants gathered as delegates from most of the States of India. They included activists, development workers, academics, journalists, artists, film makers, health care professionals and community health workers. They were associated with various campaigns and movements that address and fight for women's health and well-being from feminist and human rights perspectives. They envision a society based on equality, democracy, peace, secularism and respect for diversity – against imperialism, patriarchy and militarism, and opposed to fundamentalism of all kinds. The three days of deliberations included more than 60 presentations in 5 plenaries, 16 parallel workshops, two theatre presentations and a roundtable in which 12 movements were represented. After sharing their experiences, insights and analysis on current issues of 'women and health', the participants issued a declaration (included here as Chapter 3). In it they reaffirmed their commitment to struggle towards a humane and just world for ALL, particularly for women, despite the constraints and risks that each faces from fundamentalist and nationalist repressions that threaten progressive movements all over the world. The draft Charter was presented at the National Dialogue, to which the participants suggested numerous modifications and additions. These contributions have considerably enriched the various specific sections.

Subsequently we have shared the draft Charter with health groups, women's groups and representatives of concerned movements. With the responses thus obtained, it was finalised on International Women's Day and put up on the People's Health Assembly (PHA) National Co-ordination Committee website. While the *Indian Women's Health Charter* has thus arisen out of wide-ranging discussions with many persons, groups and movements in India, still for the next six months it will be open to a process of perusal, response and refinement in detail.

It is with a sense of pride, hope and affirmation that the *Indian Women's Health Charter* is being released on behalf of Indian women in the opening plenary of the National People's Health Assembly (II).

Bhopal, 23<sup>rd</sup> March, 2007

## 2 PREAMBLE

The world has never been as rich in economic terms as it is today. Yet substantial sections of people lack the resources or environment to lead healthy and fulfilling lives. All over the world the health indices, including those of mental health, have stagnated or decelerated. Levels of hunger remain unacceptably high and many communities worldwide lack access to safe water and sanitation. Inequalities between and within nations have grown. Paradoxically, the implementation of the global health sector reforms are leading to a decline in access to health care among the poor and marginalised, and women in particular. Maternal mortality rates are still high because of the State-led collapse of health services, not for lack of being on policy agendas. Preventable and communicable diseases are re-surfing, often unchecked, and taking their great toll.

This state of affairs is the result of new macro-economic policies grouped under the terms of Liberalisation, Privatisation and Globalisation ('LPG'). These policies deny social, political, economic and cultural justice to people through international trade agreements like GATT (General Agreement on Trade and Tariffs) and TRIPS (Trade Related Intellectual Property & Services). They affect people in the global South as well as the poor in the North, and concentrate power in the hands of capitalism and patriarchy. The re-structuring is destroying the livelihoods everywhere, while changing socio-economic structures to suit the neo-liberal market ideology. Intolerable economic stresses, cultural contradictions and social vulnerability are combining to increase the incidence of mental health disorders among ordinary people, and women bear the brunt of such illness both as sufferers and as caregivers.

In tune with the neo-liberal macro-economic policies, allocation to the social sectors of education, health care and food security has reduced sharply, while military spending has increased, transforming the role of the State away from its re-distributive functions. These radical changes are accompanied by a worldwide rise of religious fundamentalisms that strengthen patriarchy and profoundly challenge the democratic aspirations of women to social equality and justice. The hard-won rights of women stand profoundly threatened, not least the right to abortion and reproductive health. Partly in view of these changes we are seeing a huge global increase in violence against women, both within the home and outside. More women than ever before are being displaced because of civil conflict and development policies. The global decline in female-to-male child sex-ratios, particularly sharp in the more 'developed' parts of our country, reflects the surge of anti-woman values.

New global 'industries' have emerged to add to the burdens, like assisted reproductive technologies (ART), wherein the bodies of women from poorer countries become resources of production. While the global medical industry is now the third largest in the world after arms and food, medical care is increasingly unavailable or unaffordable for women and the poor. With most states reneging on provision of public health care, private healthcare and insurance industries have grown, often with outright State support. As a policy, privatization of health services with fees-for-services is not only exclusionary but also represents taxation of the poor. Within countries it has led to a 'health divide' between the regions and between the rich and poor.

At the same time in the face of the new diseases the World Health Organisation (WHO) is increasingly powerless. The medical-industrial complex sets the agenda along with economic institutions like the World Bank, International Monetary Fund (IMF) and World Trade Organisation (WTO). Under their pressure in 2005 the Indian Government changed its model Patent Act of 1970 from provision of 'process' to 'product' patents, raising the cost and reducing the availability of essential drugs for groups of people and countries that now cannot afford them. Private insurance companies, healthcare management firms, medical technology interests and the pharmaceutical industry of developed countries are all seeking opportunities to expand their markets. Third world countries have become sites for clinical testing of drugs and pharmaceuticals especially on women. The corporate health sector is poised to play a prominent role in countries like India with a base of private health services and an elite class willing to pay for them. In India the trend of corporate globalisation represents an onslaught on the country's poor and a second wave of neo-colonialism. Both as a result and as

distraction away from genuine problems, fundamentalist and ethnic violence erupts. It threatens not only the minorities but women in general. Degradation of both social and natural environments proceeds at an unprecedented pace.

Thus we witness so many results that are harmful to women's physical and mental health:

- sharp decline in formal sector employment with more and more women taking up insecure and informal employment,
- increasing pressure on women's time and energy with decline in real wages,
- increasing destruction of habitats with displacement and insecurity of livelihoods, and resources slipping out of people's and women's control,
- increasing commercialisation of agriculture with decline in per capita food availability,
- dismembering of social and labour benefits like maternity care, PDS and education,
- increasing migration of people from economic desperation, with more women-headed households,
- increasing subjugation of women in families and communities,
- objectification, commodification and trafficking of women and women's bodies, and
- with increasing violence against women and the poor and marginalised.

At the same time, resistance has grown to the policies that back these trends. So, too, has Government repression on the poor and marginalised. The curbing of people's civil rights by the State in the name of national security is shrinking the democratic spaces for expression and redressal. The total scenario amounts to women bearing an unsustainable load. The triple burden of market labour, service in the household and reproduction of the family leaves them chronically underfed, overworked, tired and faced with despair. Moreover, as repositories of family and cultural 'honour', women bear the brunt of communal and ethnic violence.

At the level of economy, State spending on health as percentage of GDP (Gross Domestic Product) in India has come down from 1.3 percent in 1990 to 0.9 percent in 1999 – less than what is spent on health in sub-Saharan Africa. It has led to collapse of India's already poorly funded public health care services, with spending on mental health being a very small fraction. During this period the proportion of people unable to access any health care has doubled, primarily among dalits, adivasis, religious minorities and other marginalised groups. Straining to meet increasing health care costs leaves people unable to fulfil their nutritional needs, and it reflects in the continuing high infant and child mortality rates. Disaggregation of data on class-and-caste lines shows stark disparities. At one extreme are the over-consumption of junk food and overuse of medical technologies like caesarean section and ultra-sonography, and at the other extreme are starvation and the absence of maternity care. Dalits face 1.5 times higher infant and child mortality and several times higher prevalence of tuberculosis than the general population. Experience of mistreatment in the public health system is found to be more frequent among dalits, adivasis and Muslims, as also with people who are HIV-positive, disabled, and of non-conforming sexual orientation.

Several old and new anti-female trends in India – son-preference, two-child norm, spurt in medical industry – come together to explain the recent sharper decline in female-to-male child sex ratios. New technologies are being used for pre-determining male embryos, and poor women are being hired as surrogate mothers even by parents abroad, with scant regard for ethics or informed consent. While the cost of drugs has increased on one hand, the Government withdraws from health care on the other. Vertical disease-control programmes, such as pulse-polio immunisation, drive our country into the exploitative arms of medical industry. The growing consumerism and commodification of women presents hazards not only to women's health but to their self-esteem and well-being.

We Indian women, as part of one of the largest women's movements in the world, now seek to raise all of women's health concerns to the level of importance they deserve. Through this Charter we state to policy-makers of the State, and to the would-be guardians of patriarchy our view of the grim realities of women's health status in India and the challenges they pose to all of us at this time of shrinking democratic spaces.

## 2 DECLARATION AT THE 'NATIONAL DIALOGUE' IN NOV. 2006

*[The following declaration was proposed and adopted by participants on the third day of the 'National Dialogue: Women, Health and Development' held at Mumbai, 23-25 November 2006. At the same time, the participants were part of the process of drafting and debating the Indian Women's Health Charter, and so we include the declaration in this document.]*

### – DECLARATION –

We the participants in the National Dialogue: Women, Health and Development, and as women of India, declare and affirm the following:

1. The right to health and health care are basic human rights. All health related policies must be gender-just, holistic and equitable. Comprehensive health services must be universally available and accessible irrespective of people's ability to pay, without stigma or discrimination and should accommodate the requirements of people with special needs.
2. Women's health must not be relegated to maternity as their concerns transcend reproduction and the reproductive age. Women's occupational health needs to be given importance, and mental health should become a cross-cutting theme in all health care programmes. Expensive vertical programmes that hamper the development and provision of health care for all need to give way to State-led universal comprehensive health care to serve the needs of ALL people.
3. Freedom from violence is a human and health right of all women, especially of women in compromised situations, such as mentally ill and disabled women.
4. Adequate budgetary allocation needs to be made by the State at the level of five percent of GDP (as recommended by the WHO) to fulfil the health care needs of people, especially of women and children, without regressive and socially harmful policies that aggravate inequalities, such as fee-for-service and wasteful public-private partnership (PPP).
5. Choice of health technologies needs to be appropriate and rational, based on epidemiological need rather than on market-driven policy, so that all people's right to access necessary technology is facilitated and fulfilled, when and if they require it.
6. Full respect and recognition is to be given to women's wisdom, traditional knowledge and healing practices, and serious steps need to be taken to integrate the indigenous healing systems into the public health system.
7. There must be no discrimination against any woman on the basis of gender, caste, class, religion, ability, sexual orientation, HIV status, marital status, fertility status and so on, in access to health care, education, employment, credit facilities, government schemes, or in the right to use public places and facilities.
8. Women must have the right to choose and express their reproductive and sexual rights without restriction and pressure from patriarchal norms.
9. Women have the right to access safe, effective, reversible and user-controlled contraceptives that increase men's participation. However, we reject all coercive population policies, whether pro- or anti-natalist.

10. Trade-related laws and patents must not restrict people's access to essential medicines and technologies. We say NO to patents on life forms and to corporate monopolies on trade in biodiversity and peoples' knowledge.
11. Socially exclusive economic growth is proven to be harmful to people's health and well-being. Similarly, military expenditures, and war, are at the cost of people's health.

We do not accept the State's withdrawal from providing basic facilities to assure access to the social determinants of health - including water, food, housing, education, employment and health services. Neither must the State turn away from its duty towards tackling discriminatory and oppressive structures in society based on hierarchies of caste, class and patriarchy. Nor must it shy away from the imperative to contain the forces of fundamentalism and intolerance that impinge directly on people's lives, human rights, security, health and livelihoods.

Considering that women suffer doubly in times of conflict and war, peace and social justice also become essential determinants of health. Our over-riding concern for peace and justice stems not only from their intrinsic value but also as a cherished legacy to leave for our children and the future. The world we aspire for is free from discrimination and prejudice, intolerance and fear, greed and domination, violence, aggression and hatred.

Only such a world can be truly healthy.

## 4 SOCIAL DETERMINANTS OF HEALTH

Health is an outcome of factors or 'determinants' in the physical and social environment. Safe and wholesome living conditions, complete education, work that is satisfying and safe with adequate pay, reasonable hours and leisure time for self-fulfilment, friendship and love, without discrimination on the basis of class, caste, ability and so on. All these, in addition to health care services, are necessary for assuring genuine health. Equally essential are positive rights over life-supporting natural resources, such as land, forest, water bodies. Particularly for women, equitable rights to land and property and equal distribution of resources, access to health education including information about sexual and reproductive health and rights, and participation in decision-making at all levels including local governance, all of these are also essential for well-being.

Therefore, at the level of the social determinants of health, certain **demands** are to be met in fulfillment of our rights, namely,

### **Regarding the Right to Food:**

1. To make adequate resources available to assure food security from childhood to old age, especially for girls and women.
2. To adequately implement and regulate all schemes relating to right to food for girls and women.
3. To make the public distribution system (PDS) universal, efficient and easily accessible.
4. To universalise the coverage of the Integrated Child Development Scheme (ICDS), assuring nutritious, locally available and culturally suitable food to adolescent girls, pregnant women and lactating mothers in both urban and rural areas.
5. To issue ration cards on a priority basis to all vulnerable women including single women, sex workers, homeless women, mentally ill women and disabled women.

### **Regarding the Right to Water and Sanitation:**

1. To cease the privatisation, commercialisation, commodification and deregulation of water and water bodies.
2. To make adequate safe drinking water freely available, within or near all households or habitations without discrimination.
3. To assure water for cultivation of at least one staple food crop, considering it next-in-priority to drinking water.
4. To include women integrally in the process of planning and managing water resources.
5. To provide women with access to safe hygienic toilets in homes, institutions and public places (markets, streets, bus-stands, railway stations), along with adequate water supply and proper waste disposal system for sanitary waste.
6. To strictly implement the law banning manual scavenging and night-soil carrying and to provide decent livelihood options for those involved in this occupation up to now.



### **Regarding the Right to Housing:**

1. To ensure adequate housing with legal entitlements for women, reiterating women's rights as joint or sole owners of home, field and other assets.
2. To assure that homes become free from violence against women and that women's right to housing is protected during domestic conflict.
3. To provide alternative shelter/housing (by the State) should any woman be evicted.
4. To desist from eviction of people in the name of development and 'beautification'.
5. To ensure, in event of displacement after due process, that people are relocated and rehabilitated with dignity and access to health care, education, livelihood, water and transportation.
6. To guarantee protection of women's right to housing after disasters or strife, enabling them return home without fear and providing for construction of decent new homes.
7. To prioritise the rehabilitation of vulnerable sections including women with special needs (pregnant, elderly, disabled) during and after relocation.
8. To ensure housing for women left in mental hospitals and other institutions.

### **Regarding the Right to Livelihood:**

1. To enable and enhance sustainable livelihood options for women by assuring equal inheritance and ownership of land and property irrespective of religion, marital status or 'customary' practices, and without fear of backlash.
2. To recognise, value and compensate women's unpaid work within homes or in family-owned land or occupations.
3. To provide women equal opportunities for employment including under the National Rural Employment Guarantee Act (NREGA) and to make the prescribed facilities available, like crèche, toilets, drinking water and so on.
4. To assure future livelihood for girls through easy and uninterrupted free access to primary and secondary education.
5. To immediately cease the indiscriminate commercial felling of forests and the promotion of monoculture which deprives tribal people (adivasis) of their traditional forest rights.
6. To protect the ownership and access of adivasi women to natural resources, including land, water and forests.
7. To recognise that mentally ill and disabled women have full legal capacity, and so to protect their right to livelihood, work and equal opportunity.

### **Regarding the Right to Healthy Environment:**

1. To desist from inflicting devastation on any community in development's name.
2. To ban mining of hazardous minerals like asbestos and radioactive substances.
3. To refrain from imposing destructive projects like interlinking of rivers with series of large dams, submerging the forests, lands and livelihoods of communities.
4. To refuse the dumping of hazardous chemical/radioactive waste and to establish strict environmental and workers' safety regulations on chemical industries.

## 5 WOMEN'S HEALTH RIGHTS AND HEALTH CARE

Here we consider health care from the perspective of women's health rights, firstly in the context of 'General Health' and then specifically focussing on the areas of Mental Health, Reproductive Health and Sexual Health, as they are critical areas of health care and health rights for women. The latter two areas represent two intimately related and often inter-dependent aspects of health usually clubbed as 'Sexual and Reproductive Health'. Here we present them separately in order to make it clear that sexual health and rights extend beyond reproductive health issues. Sexual and reproductive rights are for everyone. This includes the youthful and the elderly –women, men or transgender – whether heterosexual, gay, lesbian or bisexual, and also those who live with disabilities or with HIV/AIDS. All people have the right to make their own sexual and reproductive choices, provided they are non-violent and respect others' rights to bodily integrity. The right to health care includes the right of access to information and services needed to support responsible choices that optimise health and wellbeing.

### A) General Health

The emotional, social, cultural, spiritual and physical aspects of wellbeing – determined within cultural, socio-political and economic contexts – combine to make up the general health status of women. It is sustained by adequate nutrition, physical and mental activity and many kinds of supportive relationships. Appropriate, timely and easy access to woman-sensitive comprehensive health care services is also crucial to meet and pre-empt various challenges to women's health.

Infectious and communicable diseases, as manifestations of poverty and hunger, take the largest toll of women's lives. Data reveals that prevalence of TB in women and men in India is about the same, but men have greater access to care in the private sector than women who depend on the public health system. Yet exclusive concentration on vertical programmes (control of specific diseases, family planning) has resulted in neglect and collapse of the public sector services for general health care. Retreat of the State from providing free medical care and instead introducing user fees, privatising services and dismembering the public medical institutions is placing an intolerable burden on the poor and women. State subsidies to the corporate sector, such as for medical insurance, favour those who can pay and leave out the vast majority of people who fall ill more often and need free health care services.

At the level of general health services, therefore, our **demands** are:

1. To develop the health services beyond mere provision of medical facilities or vertical programmes, to respond to the needs of all and especially girls and women.
2. To increase the number of women health professionals at all levels and to sensitise the entire system, including medical and paramedical education, to how gender issues relate with health.
3. To assure allocation of 5 percent of GDP for development and strengthening of the public health services, with holistic integration of non-allopathic (AYUSH) systems, and to address Inter-regional and intra-regional disparities in health care access.
4. To provide adequate human resources and facilities within the public health system to assure quality health care that is gender- and disability-sensitive, at primary, secondary and tertiary care levels.
5. To ensure better management practices and accountability in accordance with the principles of gender budget and audit, and to make the health services accountable to the people, including to all women.

### B) Mental Health

We view the area of mental health, including mental health disorders and mental disability, mainly from a psycho-social perspective. While not constraining ourselves in a bio-medical framework, we take the various biological, psychological, socio-economic and medical factors into account. Women experience mental disability ranging from severe confusion, fear and anxiety, to depression and despair

to the point of suicide, and also the thought disorder-and-disconnect of schizophrenia. Sometimes there are physical factors that contribute to the condition, from genetic factors, to birth injury or accidental head injury, reduced mental function with aging, and so on.

However for women the social determinants that bring on or aggravate mental disorder and disability are especially important. Due to their unequal social status women are subjected to greater stresses of all kinds and their vulnerability to abuse is high. This is even more so for women living in socially compromised or marginalised circumstances, for those who deviate from traditional roles or lifestyles, and for women living in situations and regions of communal and military conflict. Conversely, mental disability is one of the determinants of violence against women, and in turn violence and untreated depression precipitate self-harm and suicide attempts.

Since the canvas of mental disorders and disability for women is so very broad, the challenges faced by the mental health care sector with regard to women are also great and diverse. In India it is estimated that about 10 million persons require mental health care, but it is hardly available excepting in overcrowded, unsanitary and poorly managed mental hospitals. There are only 0.2 psychiatrists per 100,000 population and even fewer professionals to provide the crucial psychosocial services. Hence, there is urgent need for developing the facilities and capacity to train mental health personnel. The solution is not to build more mental hospitals for the poor and the vulnerable to be dumped, but to design and implement robust community mental health programmes.

At present the linkages between community and hospital-based care are virtually non-existent. Moreover, institutional frameworks are restrictive and the services for women are grossly inadequate. There is no national policy, and so the mental health sector is governed solely by The Mental Health Act, 1987. This law leans heavily on institutionalised care where patients' choice in admission, treatment and discharge is minimal, allowing women to be dumped into mental institutions for life by their families. There is great need for a programmatic focus with budget allocation for the overall reform and development of mental health. Within it a 'woman-centred' approach is needed that takes into account women's socially disadvantaged position and the role it plays in precipitating distress. The right to freedom from violence must be protected especially in case of mentally ill and disabled women. Coercive care and treatment policies and laws must be changed.

In the mental health context, our **demands** as women are:

1. To provide to women with psychosocial disabilities sensitive comprehensive health care including mental health care, whenever needed in the lifespan in the least restrictive and intrusive environments.
2. To ban inhuman, cruel and degrading treatments, including solitary confinement and direct shock treatment.
3. To provide gender-sensitive and women-centred training for service providers and professionals across different systems, including police and judiciary.
4. To induce maternal health services to be more sensitive and responsive to the mental health implications of reproductive health.
5. To increase the financial and human resources to provide free mental health care (medical and non-medical) for women at Primary Health Centre level with referral to appropriate levels of care.
6. To make the whole range of mental health services available for women, including crisis centres, treatment, psychotherapy and counselling, non-drug treatments like yoga, meditations and art-based therapies, at all the care levels, with support services including rehabilitation homes, self-help groups and vocational training.
7. To include rational psychotropic drugs in the essential drug list for use at all levels including PHC.
8. To develop and provide effective, efficient and adequate community-based mental health care, including promotion, prevention, treatment and rehabilitation, with linkages to the primary, secondary and tertiary health services.

9. To establish adequately staffed Crisis Intervention Centres for specialised psychiatric care at District Hospital level; to establish guidelines of practice for such centres, including rational assessments of mental health status, risk and treatment
10. To institute mechanisms for regulation of private mental health care providers including standard treatment protocols and an accreditation system.
11. To protect confidentiality and enable informed consent for treatment.
12. To oppose the use of 'aversion therapy', particularly in the name of 'curing' homosexuality and other such irrational and harmful practices, and to monitor and restrict the indiscriminate use of electro-convulsive therapy (ECT).
13. To protect women from physical and emotional cruelty and torture, as well as from unauthorised or non-consensual experimentation.
14. To recognise a person prone to mental illness as a 'person' before the law with due respect for her capacity to act on the basis of will and preferences.
15. To restrict involuntary commitment, following standard protocols for assessing 'danger to self and others'; to assure the right to appeal for review and to legal aid.
16. To ensure inclusion of coverage for mental health care expenses in both public and private insurance schemes.
17. To promote both social justice and security for mentally ill persons, ensuring adequate standard of living and prioritised treatment and care in times of calamity, strife or conflict.
18. To protect women's right to voluntary contraception without coercion, and to oppose tubectomy and hysterectomy operations on girls and women under institutional or non-institutional custody and care.
19. To protect a woman's right to make decisions about her children, and to the custody and care of them, or to adequate access to them, and also her right to give her up child in adoption; to not assume that she is incapable because she is mentally ill.
20. To protect mentally ill and disabled women's rights to liberty, to freedom of speech, to all life choices including treatments, and to spirituality.
21. To provide independent living options with community support and after-care supervision programmes, and to address quality-of-life issues such as education, work, income, sport, leisure and relationships.
22. To create mass awareness about mental health, including the gender aspects of vulnerability care and rehabilitation, through community and school programmes.

### C) Reproductive Health

Reproductive health is not just a concern during a woman's so-called 'reproductive years' customarily defined from age 15 to 45. It concerns the life-time from infancy to old age for both women and men. Reproductive rights include the basic right of all people to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. It is also their right to make these decisions free of discrimination, coercion and violence, as expressed in human rights documents. Under certain situations, violation of reproductive rights may also occur in childhood when potential reproductive capacity of children can be reduced by exposure to factors such as disease (like tuberculosis) and radioactive material (e.g. near uranium mines).

Reproductive rights are violated by coercive population policies and excessive use of irrational and invasive medical and contraceptive technologies. (Also see *Chapter 8(B) on Population Policies and Chapter 9(D) on Medical Technology.*)

With respect to reproductive health and rights our **demands** are:

1. To include the concerns of adolescents and older women, assuring them of accessibility to the reproductive health services.
2. To make available to all adolescents information about contraception, abortion and sexually transmitted diseases as a part of sexuality education

- that is non-judgmental, non- moralistic and free from biases, homophobia and fear-mongering.
3. To provide antenatal, safe childbirth and postnatal care irrespective of capacity to pay.
  4. To assure provision of maternity benefits, abortion and sterilization-related leave, availability of crèches and space for breast-feeding for all working women.
  5. To prevent unnecessary caesarean sections and hysterectomy operations.
  6. To ensure access, irrespective of women's marital status, to safe, effective, reversible, user-controlled contraceptives that encourage male participation.
  7. To provide access to safe abortion services, and to prohibit coercion for long-acting contraceptives following abortion.
  8. To protect women against coercion for contraception, sterilization, abortion, forced marriage, pregnancy or motherhood, female genital-cutting, etc.
  9. To include diagnosis and treatment of infertility within the public health services, and to ensure confidentiality and sensitive handling of related emotional issues.
  10. To enable early diagnosis of sexually transmitted infections and to promote mass awareness about how sexually transmitted infections (STIs) and human immuno-deficiency virus (HIV) infection spreads.
  11. To enable early diagnosis of reproductive cancers through the primary health services, backed up with quick referral to specialised treatment centres.
  12. To assure early diagnosis and treatment (through exercise or surgery) of uterine, bladder or anal prolapse.
  13. To provide information and counselling for women around menopause about possible effects and adjustment with the new natural hormonal balance, and about the hazards of 'hormone replacement' therapy.
  14. To abandon the target-oriented population control programme that singles out women and the poor for irreversible or long-acting hormonal, provider controlled contraceptives.
  15. To abolish all coercive laws, policies and practices that violate the reproductive and democratic rights of people, including the two-child norm which withdraws maternity benefits, etc. on the basis of number of children.
  16. To identify clinical trials related to contraception or abortion as unethical and make them punishable by law; in case of legitimate drug or contraceptive trials, to make written informed consent mandatory; to prosecute those who violate these ethical norms.
  17. To include the topics of 'Violence against women' and 'sexuality and gender' as part of the training related to reproductive health in medical and paramedical curricula.
  18. To train forensic experts on the social aspects of sexual assault and rape, collecting and retaining proof in cases of individual or mass sexual violence.
  19. To promote mass awareness about sex-determining (X and Y) chromosomes and infertility as part of efforts to prevent violence against women.
  20. To strictly implement the Child Marriage Restraint Act.
  21. To prosecute and convict violators of the PCPNDT Act, including doctors who detect and convey the sex of the foetus.
  22. To respect women's right to adopt children irrespective of marital status, sexual orientation, HIV status, ability, and religion or culture.
  23. To protect women's right to custody or unrestrained access to their children after divorce.

#### **D) Sexual Health**

Sexual health and rights are most often seen together with reproductive health. However it is important for the health services to also address sexual concerns that fall outside of childbearing, contraception and HIV-AIDS. In particular, single women face various challenges related to their sexuality, as in the eyes of society their singlehood is not approved. Thus in formulating our demands we consider this area separately. Furthermore, we resist the artificial dichotomy of women being considered as the 'reproductive' beings and men as the 'sexual' ones.

Moreover we need to resist the artificial divide of heterosexual women as being reproductive and LBT women as needing merely sexual rights.

Sexual health and rights imply aspects of mental, physical and social wellbeing in relation to sexuality and sexual relationships. Healthy sexuality encompasses a mental attitude open to sexual desire and pleasure unencumbered by fear and a body free of disease and responsive to desired sexual stimuli. Moreover it implies a social environment of respect towards sexual relations without bias to sexual orientation or partner preference. Also, it requires a positive knowledge and acceptance of one's own sexuality and a personally responsible attitude to sexual relations to ensure freedom from coercion and protection from infection, injury and unwanted pregnancy. Healthy sexual relations are never violent and accept sexual and gender diversities as well as disabilities. The health services need to address the sexual concerns around unintended pregnancy, abortion, infertility, HIV, STI/RTI and cancers, as well as the sexual needs and abilities of disabled persons.

This complex area of health foregrounds the respect, protection and fulfilment of a person's sexual rights, and so our **demands** are:

1. To affirm every woman's right to express her sexuality, to enjoy sexual relations beyond reproduction, and to be treated with dignity as an equal sexual partner.
2. To protect women's right to choice of sexual and life partners and to enjoy sexual relations with them irrespective of caste, class, ethnicity, religion, nationality, ability and sexual orientation.
3. To provide enabling environments that can assure freedom from unwanted pregnancies, infection and sexual violence.
4. To ban the discriminative, harassing and humiliating practice of 'virginity' examination on single women.
5. To provide at PHC level facilities to meet sexual health needs, including interventions by trained health providers and a functioning referral system, that are available and accessible irrespective of marital status or any other discrimination.
6. To provide available and easy access to free or low-cost, good quality condoms.
7. To guarantee non-discrimination within the health services on the basis of sexual identity, preference, behaviour, non-marital status or sexual occupation.
8. To repeal Section 377 of the Indian Penal Code, and other laws, policies and practices that discriminate on the basis of sexuality.
9. To guarantee freedom from being trafficked for any purpose, including for sex work.
10. To prevent, investigate, prosecute and punish child sexual abuse.
11. To maintain confidentiality and refrain from judgement about sexual problems, illnesses, assaults and occupations.
12. To avoid moral panic and sensationalism by media and police with regard to sexuality.
13. To promote demystification of myths surrounding virginity, infections, masculinity and sexuality and raise awareness based on knowledge.
14. To impart sexuality education at school and college levels that provides relevant information and guidance for making choices and that introduces students to a sexuality that is pleasurable, responsible and free from violence and discrimination.

*For specific demands relating to the rights of LBT women, HIV-positive women and sex workers, see Chapter 10.*

## 6 STATE OBLIGATION TO PROMOTE WOMEN'S HEALTH RIGHTS

The State is obliged to provide health services that are physically and economically accessible, available, adequate for early diagnosis and treatment as well as for prevention of diseases, appropriate with regard to rational treatment as well as cultural relevance, and accountable to the people. Services availability is in terms of human resources, drugs and other supplies, and infrastructure. Rationality in treatment is expected to be based on individual, group and epidemiological concerns. Also, the State is obliged to remove all impediments, including financial limitations and cultural restraints, in women's access to health care. Finally, the State is obliged to create an enabling environment wherein women can become healthy and stay healthy. The fulfilment of these obligations calls for a multi-sectoral approach and co-ordinated efforts between Health and other related Departments and Ministries.

Often we face a dilemma when we ask for State interventions in people's lives. The irony of appealing for rights from the very structure that violates them is not lost on us. However, Governments rule in our name, are elected by us and collect various taxes from us. From a rights-based approach, therefore, it is an obligation and not a favour of Government to provide for people's basic needs. Our demands from the State are not to replace the call for wide community mobilisation, but to strengthen it for progressive change towards a society based on equality, justice and freedom. The State has to be sensitive to the fact that all the marginalised including women are denied adequate access to health care and are subjected to violence by families and communities. With respect to human rights the State must be answerable for its acts of commission as well as its acts of omission.

The Indian State is a signatory to various international human rights treaties and thus also obliged to fulfil the rights stated therein. It must prove that it was unable rather than unwilling to safeguard the rights of its people. Inability quoted on the basis of inadequate resources cannot stand forever, as progressive realisation of rights is the obligation of every State.

Therefore, our **demands** from the Government with respect to its State obligations to protect, promote and fulfil the health rights of women are:

1. To include Right to Health in the Fundamental Rights of the Indian Constitution and provide mechanisms for redressal in case of violation or non-fulfilment of this right.
2. To respect the specific needs of different groups of women and to ensure that health rights are enjoyed by all women within the jurisdiction of the country.
3. To enable and ensure easy access for women to enjoy all their rights including health rights and to remove all impediments.
4. To refrain from interfering directly or indirectly with women's rights, and also to prevent third parties from doing so.
5. To adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards full realisation of health rights.
6. To ensure non-discrimination and achievement of substantive equality (of access, opportunity and result); to prohibit violations even in the name of religion or culture.
7. To guarantee comprehensive quality health services that are accessible, accountable and universally available irrespective of people's capacity to pay.
8. To exercise due diligence in prosecuting and punishing the perpetrators of violence against women and in adequately compensating the survivors, as deterrence of violence lies in the surety and not in the severity of punishment.
9. To make non-State actors (family, community, employers, private and trans-national corporations, etc) answerable to non-fulfilment and violation of rights.
10. To provide maximum available human and financial resources towards the realisation of women's health rights.

## 7 MEDICAL ETHICS AND THE RIGHTS OF WOMEN AS PATIENTS

Here we consider the range of ethical issues in medical education, research, clinical trials and practice. Most patients and especially women are more or less at the mercy of the health system without access to information about their health condition or right to decision regarding choice of treatment. With a large number of women being illiterate, it is even more important to set ethical standards in treatment and research. It is essential to obtain a patient's informed consent after giving full information on the risks, benefits and alternatives of any treatment or procedure in language that she can understand.

In the new scenario privatisation, unethical practices flourishing for some time in the private sector are now assuming prestige and acceptance. Thus, racketeering and kick-backs between general practitioners, specialists and laboratories are now getting organised as large health management establishments. This results in diagnosis and treatment driven by corporate interests and not by the needs of patients. Women are seen as particularly easy targets. With its emphasis on population control, the State focuses exclusive attention on women for contraceptive and reproductive research. Here men are conspicuous by their absence, yet in all other medical research gender-neutrality is fiercely guarded. Failure to implement ethical research norms has enhanced the exploitation of women, so it is no wonder that several scandals have emerged in the past two decades. These relate to contraceptive injectibles and implants, use of quinacrine as contraceptive, vaginal microbicides, fertility vaccines, human papilloma virus, and the natural history of carcinoma of cervix. Making women bear the exclusive burden of contraceptive and reproductive research violates the principles of fairness and justice. Since research on contraceptives involves healthy women, side-effects cannot be justified and the standard of ethics must be set very high.

On the other hand, the so-called 'neutrality' in medical research leaves out women! There is no stipulation to include them and so gender-disaggregated data is not generated. The findings of clinical trials on men are simply extended to women, treating the male as 'standard'. This kind of gender-blindness also reflects in most medical textbooks.

With regard to ethics in medical research and treatment, our **demands** are:

1. To enable a woman patient to give informed consent by providing full information in language that she can understand about her state of health and the benefits, risks and alternatives of the proposed diagnostic or treatment procedure(s).
2. To recognise the capacity of women with mental illness to give consent, and to conduct no research on them unless valid consent is obtained.
3. To protect the right to total confidentiality in respect of medical records of women patients, allowing disclosure of information only if the patient gives her consent.
4. To respect personal privacy of every woman in the course of any medical examination, treatment or surgical procedure, and even during medical camps, and to ensure that such procedures take place in the presence of a woman staff member.
5. To ensure that the health services are free of negligence and malpractice.
6. To respect patients' right to complain about any aspect of hospital service; to have the complaint investigated by the Local Competent Authority (LCA) or an equivalent relevant body and to provide for legal redressal and compensation in case of medical negligence or infringement of patients' rights.\*
7. To guarantee the respect for patients' rights as laid out in Section 16 (Rule 14: Standard Charter of Patients Rights) in the draft Bombay Nursing Home Regulation Act (BNHRA).
8. To take special care in obtain informed consent in writing when institutionalised women are included in clinical trials and not to accept the consent of 'gatekeepers' such as wardens or custodians as adequate.
9. To respect the right of women patients to refuse to participate as a 'case' for teaching medical students and to take part in clinical trials or research concerning use of new drugs or medical devices, and to seek the patient's prior consent in writing.
10. To recognise the right of patients to buy prescribed drugs or pharmaceuticals of any brand from any medical store.
11. To involve women's organisations as well as 'experts' in setting high ethical standards especially for research on contraceptives.



12. To not compare (or justify) side-effects of contraceptives with those caused by drugs, since contraception involves healthy women.
13. To make mandatory the inclusion of women's organisations and women's health advocates on ethics committees, from national to local and institutional level.
14. To make mandatory the declaration of potential conflict-of-interest by policy-makers and members in Government committees, and by all persons in public life, and to include as mandatory the disclosure of funding and of potential conflict-of-interest in all clinical trials, medical research and publications. To ensure transparency and accountability in all clinical trials, and to guarantee that the post-trial benefits of research are made available to women even in remote areas.
15. To improve the quality of medical education to be more people-centric and gender-sensitive, to regulate the fees and quality of medical courses in private medical institutes, and to require doctors to update their skills, knowledge and attitudes by continuing education.

## 8 LAWS AND POLICIES

The Constitution of India guarantees equal rights to all women, yet the social disadvantages of women do not allow the full realisation and enjoyment of these rights. While several laws exist to prevent specific crimes against women and to limit discrimination, often they are not implemented or the isolated implementation of a law does not create an enabling environment. Patriarchy pervades the police and judicial system. The artificial divide between the public and the private domains in people's lives further reduces women's access to justice. Failing to respect, protect and fulfil the rights of women, the State allows violence against them within and outside the home to continue with impunity.

Health, including mental health, is affected by policies in a large number of areas, from macro-economic and development policies to policies on agriculture, forests, mining and fisheries, to policies regulating drugs and petrochemicals, and to the health and family planning policy. With the onslaught of liberalisation, policies in all these areas are found to benefit multinationals and local elites rather than ordinary people. Aspects of policy and sometimes whole policies are drafted at the behest of international interests without adequate and democratic discussion and with little accountability to the people of India. Often Government departments which enunciate the policies are not aware of or sensitive to their implications on health, not to speak of women's health. So it is essential that all policies go through an audit process from both gender and health points of view.

The mental health sector is driven by law without a State policy at either central or state level. Private practitioners thrive with little or no monitoring. The Mental Health Act is a penal law similar in format and content to other penal laws, such as the Criminal Procedure Code (CPC) and the Beggary Prevention Act. Positive laws formulated from a rights perspective, such as the Persons with Disabilities (PWD) Act, Legal Aid Authority Act and the Human Rights Act, are yet to be implemented in the mental health sector. Even though mental health is a cross-cutting issue, there is barely any linkage between general health, mental health, disability, social justice and empowerment, family and child welfare, and other departments. Standards of clinical practice even within mental hospitals have not been established, which are especially needed for treatments that involve risk, such as ECT. In the mental health sector laws that should protect patients actually permit the widespread use of force and coercive treatment. Civil laws pertaining to marriage, divorce and other kinds of contracts exclude citizenship to people presumed to be of 'unsound mind', and this exclusion works particularly against women.

### A) Health-Related Laws and Policies, Budget and Gender Audit

The National Health Policy 2002 pays scant attention to the health of women, which is considered the ambit of the National Population Policy 2000. This mismatch reflects in the fact that several States in India, with the assistance of an American consultancy firm, have enunciated their own population policies without any State health policy being in place. Some States have announced draft mental health policies without putting in place a public health system that would be the instrument for implementing them. In many areas there are evident contradictions between policies at State level and National level.

The concept of health and gender audit has come into increasing prominence among development economists, social scientists and policy makers in the new millennium. It is perceived as crucial from the point of view of equity, efficiency and transparency. Policy-makers and others both within and outside of Government are coming to accept that gender-bias is not only harmful and costly for women, but it is equally harmful to children, households, communities and society as a whole. If women were assured of equality in nurturance and health-care, employment opportunities and remuneration and in property rights, it would be possible for the country to achieve a better overall health status, more development of capacities, more national output and yet more leisure due to the combined contribution of men and women!

And so our **demands** relating to health-related laws and policies are:

1. To require all development policies and programme implementation to be subjected to periodic health and gender audit in order to assure gender sensitivity and accountability to the people.

2. To spend a minimum 5 percent of GDP on public health, devoting an equitable portion of it to women's health and mental health, setting a balance between the overall health needs of women of all ages and groups in society.
3. To monitor the health needs, facilities, expenditure and services delivery with help of disaggregated data, to enable accurate and effective budgeting of physical and financial resources.
4. To repeal laws that violate women's human rights and to reform laws to improve women's status.
5. To enhance women's access to legal aid, police intervention and judicial remedies in case of violence, rape, extortion and exploitation.
6. To strictly implement and monitor the laws on prenatal sex selection and sex-selective abortions, dowry, domestic violence, kidnappings, molestation and rape.
7. To protect and promote the development of girl children by implementing free and compulsory education, banning child labour and preventing child marriage.
8. To change the laws driving the mental health sector.
9. To strictly implement women's right to maintenance and property after divorce.
10. To permit wide dissemination and use of the Right to Information (RTI) Act with respect to fulfilment of women's rights.

#### **B) Population Policies at National and State Levels**

Most governments manipulate population growth according to the needs of the country's economy or to fulfil political and religious agendas. Women become soft targets of such policies, whether to increase the number of children or to reduce them. Population policies, pro-natalist or anti-natalist, work against the interests of women, the poor, immigrants and minorities.

Despite the liberal pronouncements of India's National Population Policy 2000, women have continued to bear the brunt of population programmes through targets and a range of incentives and disincentives. The latter include restricting employment to those with only two children, differential fees for irrigation for them, limiting Government schemes under the anti-poverty programmes to two-child couples, restricting school admissions to two children per couple, and so forth. The enforced two-child norm acts as an inducement for sex selective abortions. Moreover, evidence shows that the two-child norm for contesting elections to panchayats (local government bodies) discriminates especially against poor, dalit and adivasi women. At the same time, women are bearing the brunt of population control policies through introduction of hazardous contraceptives. Linking contraceptive use to employment, to political participation and to abortion access are some ways in which this coercion acts upon poor women. While we are for women's unequivocal right to contraception and abortion, we are against population control. We also reject the communalisation of the population issue by groups that have exhorted Hindu women to bear more children.

Thus, our **demands** with regard to population policy at national and state levels are:

1. To promote and ensure the right of women to control their own fertility and to decide whether, when and how many children they want.
2. To guarantee all women's right to safe, effective, reversible and user-controlled contraceptives.
3. To ban provider-controlled, harmful and invasive contraceptives in the Indian Family Planning Programme.
4. To abolish the coercive two-child norm policy.
5. To revoke all targeted population control policies.
6. To de-link women's political participation from family size.
7. To abolish the link of coercive population policies with irrigation policy, the Panchayati Raj Act, employment during famines and so on.
8. To increase the involvement of men in family planning and to promote contraceptive methods designed for males.
9. To fully inform and educate people, including adolescents, about fertility regulation method options through development of specific IEC strategies.
10. To prevent denial of access to contraception or abortion to certain groups of women on the ground that 'their numbers' are declining.

## 9 OTHER HEALTH CARE SERVICES AND RELATED SECTORS

The 'assumed' health care services in the Indian Women's Health Charter are the public health services, since the demands of the Charter are mainly directed towards the Government. However, around 80% of all private health expenditure is in the non-government sector, comprising mainly of the private sector. The pharmaceutical and drug industries are also major players in provision of health services. Similarly, the 'non-government organisations' or NGOs are also involved in creation of new alternatives or best practices related to health care. Another assumption that runs through most discourses related to health care delivery is that the practitioners are all from the allopathic stream. Though that may be dominant mode of therapeutic intervention, over one million indigenous healers continue to function throughout the country, 'invisibilised' and marginalised. This section deals with health care services beyond the public sector and which need acknowledgement, regulation and monitoring in terms of rationality of treatment, cost of payment, ethics and social audit, so as to make them more accessible and answerable to women's health concerns.

### A) The Private Health Care Sector

The 'private health sector' in India comprises a large and heterogeneous assortment of actors and institutions. At the base of the pyramid are the 'unqualified' local practitioners frequently referred to as 'quacks' who associate mainly with ayurveda and homoeopathy but use allopathic medicines to a greater or lesser extent. Above that level are the qualified practitioners of the formal allopathic (Western) and non-allopathic medical (Ayurveda, Unani, Homoeopathy) systems who by-and-large practice in individual set-ups. Above them are the private single- and multi-specialty hospitals, nursing homes and maternity homes which employ physicians and other essential staff. At the top of this pyramid are the large corporate sector hospitals. The upper three levels are supported by a network of clinical testing laboratories. The private sector overlaps with the public health services in various ways, receiving visible and invisible subsidies from the public sector, and thus seeing it as a purely 'private' sector is not possible.

Nevertheless it is clear that India has the world's largest and least-regulated medical care industry in the world with hardly any social accountability. Costs vary widely but they tend to be higher in institutions at the upper end of the private care pyramid and also in areas where the public health services are weak. Private health facilities tend to be inequitably concentrated in urban areas and in richer states and regions. The private sector has resisted efforts at cost regulation and monitoring of care. Since it has not been forthcoming with data, statements or comparisons about efficiency and effectiveness are not always possible to make. However, concerned observers and the few existing studies of the private sector indicate a disturbingly high prevalence of unacceptable and irrational practices, as in the private treatment of tuberculosis. The private sector also bears disproportionate responsibility for the disappearance of the girl child through sex-selective abortion. Also, from reports of insiders, there appears to be a high prevalence of financially exploitative practices like 'scalping' and kick-backs for referrals for diagnostic tests and therapeutic procedures.

For years the disappearing breed of 'family doctors' in India have provided care in the spirit of personal care and concern, but with the onslaught of globalisation medical Institutes are mushrooming solely from commercial interest. In the background, through the economic instruments of GATT and TRIPS, profit-driven multi-national interests have managed to force the Government of India to change its model Patent Act of 1970. This has led to sharp increase in drug prices not only in India but in many developing countries which were getting good quality drugs from India at much lower cost.

Over the years the proportion of people accessing the private sector has increased sharply for both out-patient care and in-patient care. The poor, however, continue to rely for in-patient care on the public hospitals. Over the same period, the costs of health care have increased sharply, with medical expenditure emerging as the second leading cause of indebtedness among the poor. Social exclusion and discrimination reduce people's access to costly medical care, and women are more likely to be excluded than men. Similarly dalits and minorities, usually also poor, tend to get filtered out.

Our **demands** with regard to the private health care sector are:

1. To strictly regulate the private sector in terms of both quality of care and standard regimen of costs.
2. To institute an accreditation process for all private sector facilities, including specialty facilities, maternity homes, investigative facilities and pathology laboratories, residential facilities for mentally ill people, and so on.
3. To adhere to the conditions under which private hospitals obtain subsidies from Government, including their obligation to provide free care to a certain proportion of patients, and to make these obligations transparent for scrutiny under the RTI Act.
4. To adhere to ethical medical and surgical practice norms and self-regulation of the medical profession.
5. To make continuing education with regular upgrading of skills mandatory.
6. To provide required care in all emergencies, including emergency obstetric care, irrespective of patients' ability to pay.
7. For the Indian Medical Association (IMA) to take action against any of its members found to be violating the provisions of the PCPNDT Act.
8. To set up norms of practice for doctors and psychiatrists, including addressing the issue of sexual abuse of women patients, students or colleagues.
9. To monitor health care, especially in the private sector, in times of conflict, riots or disasters for incidents of discrimination based on poverty, religion, caste, occupation, HIV status, etc. and to prosecute those responsible for denial of care.

#### **B) The Non-Government Organisation (NGO) Health Sector**

Providing free or low cost health services through hospitals and community medical dispensaries has been an activity of NGOs, also known as 'voluntary' organisations, since the time of independence. The earlier voluntary and charitable organisations in health care were largely affiliated to religious groups or to Gandhian institutions. In the mid-1970s secular NGOs arose dramatically in the area of community health. During the '80s and '90s NGOs emerged in many States of India to work with women on concerns of health and development.

This varied sector ranges from massive 'trust' hospitals actually in the private sector to community-based initiatives involving village level health workers and ordinary people. It encompasses the functions of service delivery, capacity-building (even of government health staff), documentation and research, community mobilisation, and advocacy to pressure the State for better health policies and services. While NGOs are regulated by the Public Trusts Act and Societies Act through the Charity Commissioner's office, direct accountability to people in the local communities where they serve has never been required by law. Even so, this sector has provided space for a number of classic post-independence projects in community health. Thus, the concept of the village-level community health worker (CHW), later accepted by the Government, was developed in this sector. Through the efforts of women CHWs, NGOs have shown that health indices such as neonatal and infant mortality rates (NMR, IMR) and children's nutritional levels can improve through systematic community-level health interventions.

The relationship between health NGOs and the Government has never been smooth. For most of the post-independence period even apolitical or 'non-confrontational' NGOs preferred to work aloof from Government. In their turn Government officials, obliged to meet the primary health requirements of far larger populations, looked down upon NGOs as amateur players with the luxury to 'experiment'. Gradually Government has acknowledged the innovative achievements within this sector, and increasingly we see representatives of NGOs being invited by the Government in policy formulation and at field level the 'handing over' of primary health centres (PHCs) for NGOs to run! Adoption by the public health services of the NGO model of subsidised user fees is another step along the soft road to privatisation.

Now large business houses seeking to establish reputations of 'corporate social responsibility' (CSR) are registering in-house NGOs. In the era of privatisation and liberalisation these are flourishing, especially as the State threatens to pull out of providing the basic services. It is also interesting that most NGOs rarely threaten the interests of the private sector in the area where they work. Since health NGOs work among the poorest, they often compete to serve the same people (mostly women) who would otherwise go to the public health services. The State must provide for universal comprehensive health care services at least at primary level irrespective of ability to pay, and it must not be allowed to give up this responsibility in the name of public-private partnership. However, NGOs have an

important role to play in linking Government health services and the people, in enabling people to assert their health rights and in exploring optimal health care innovations with responsibility and accountability to local communities.

Our **demands** with regard to the NGO health sector are:

1. To compile among themselves the 'best practices' and insights discovered over decades of To assure transparency and accountability to constituent communities, to their staff, and to the sections of the public and health professionals with whom they relate.
2. To be transparent about their funding sources and the use of public money.
3. To reiterate the State obligation towards providing universal health care and refrain from weaning people away from Government health services; to be clearer about their roles in relation to the Government health services, particularly with regard to duplication.
4. To take stands when the State violates health rights, or when irrational, unnecessary or exorbitantly expensive private sector medical care threatens women's well-being; to stand up in the interests of social justice and against discrimination and violence, particularly against women, both in constituent communities and in the organisation.
5. To practice democracy, non-discrimination and gender-sensitivity within the organisation; to ensure employment and growth opportunities for women within the organisation, and to mainstream gender concerns in the organisation's governance as well as in its day to day work.
6. To enable women from marginalised and discriminated sections to fully participate in the functioning and governance of the organisation.
7. To abide by labour laws, to provide fair wages and adequate social security for their employees (maternity benefits, child care support, provident fund and other applicable retirement benefits).
8. To abide by all laws concerning the workplace (child labour, grievance redress, prevention of sexual harassment at the workplace, safety, etc).
9. To follow ethical principles while engaging in interventions, research and clinical trials.
10. To maintain confidentiality of health records of women, especially where the health status may compromise the interests of women (mental health, domestic violence, rape, HIV status etc).
11. community health work, including in the training and work with Community Health Workers (CHWs), the majority of whom have been women.
12. To provide information and education about health, illness and health care, to create mass awareness / public opinion on health and social issues and to create enabling conditions within the household and the community for women to access health care.
13. To advocate for women's right to health care at district, state and national levels.

### **C) The Drugs and Pharmaceutical Industry**

Under pressure from the World Trade Organisation (WTO), pharmaceutical giants, western governments and associated international lobbies, in 2005 the Government of India modified the Indian Patents Act of 1970 that was unique in providing for 'process' patenting. The new regime of 'product' patenting will impact on the Indian drugs and pharmaceuticals industry to raise the costs of essential drugs. There are severe pressures to phase out price control and let the market determine the prices of drugs. At the same time, Indian and foreign pharmaceutical companies are producing unprecedented quantities of unnecessary and expensive food supplements and costly drug formulations that are often useless and sometimes hazardous. By medicalising women's natural states of pregnancy and menopause and capitalising on fears of aging and over-weight, companies are leading women in the upper classes to be over-drugged, whereas poor women and their families are deprived of low-cost essential and life-saving drugs.

Medicines have various effects on women, including on the reproductive system and especially during pregnancy and lactation. They affect the foetus through the mother's blood circulation and the infant by passing through the breast milk. Some effects are latent and visible only after some years, either on the woman or on her child or even on the child's progeny. Moreover, women are targets of provider-centric population control programmes which foist upon them various oral, injectable and implant contraceptives and anti-fertility vaccines. During and after natural menopause women in the post-reproductive phase of life are urged to take hormone 'replacement' therapy, presenting otherwise healthy older women with various risks.

In view of all that is wrong with drugs and the drug industry, our **demands** from the Government are:

1. To recognise affordable access to medicines as a human rights issue, and to supply all essential drugs and pharmaceuticals for use at PHC level, and in case of non-availability to give entitlement for reimbursement.
2. To produce essential drugs and medical supplies in the public sector in order to move towards self-reliance in these areas.
3. To encourage research by drug companies, Indian or multinational, only for neglected diseases and/or diseases of relevance to India.
4. To regulate introduction of new drugs and formulations, to periodically review the list of currently approved and useful drugs, and to systematically weed out unnecessary, hazardous and irrational formulations in all systems of medicine.
5. To explicitly incorporate gender concerns in drug policy-making and in the design, development, manufacture and marketing of drugs.
6. To regulate the promotion, advertisement and marketing of all medications, to promote compulsory use of generic names for all drugs, and to limit the list of OTC drugs.
7. To strictly regulate the promotional activities of drug companies, and to implement clear guidelines in allowing sponsorship of symposia and other scientific meetings,
8. To recognise patients' right to information about ingredients and side effects of medicines in all the medical systems, providing access to information from the Drug Controller General of India.
9. To raise mass awareness about drug hazards relating to pregnancy, lactation and to the specific concerns of women's bodies relating to effects of drugs.
10. To modify the new Patent Act to ensure availability of essential drugs to all, and specifically:
  - a. No product patents on medicines for diseases in national control programmes and that affect large sections of people.
  - b. Ease in obtaining licensing for manufacture of drugs of importance to the people of India, especially when patented drugs are priced at unaffordable levels.
  - c. Transparent decision-making by Government in matters of EMRs, patents, pre-grant oppositions, data exclusivity etc. and use of flexibilities available in WTO/TRIPS and the Doha Agreement, keeping in mind the people's interests.
  - d. No relaxation of laws that minimise 'ever-greening' (lengthening of patent period beyond 20 years) of patents.
  - e. No patents on microorganisms whether genetically engineered or naturally occurring.
17. To regulate the prices of all essential drugs, and to institute a systematic policy of pricing of non-allopathic drugs.
18. To make registration of all clinical trials in India mandatory, with public access to all information in the registry, to regulate clinical trials to drugs required in India based on epidemiological need, and to subject out-sourcing of trials to or from India to prior public scrutiny/periodic monitoring considering the ethics, safety and methodology.
19. To institute a comprehensive policy for research and clinical trials on allopathic and non-allopathic medicines, subjecting all medicines to assessment of safety/efficacy.
20. To encourage research on the gender-related aspects of access, use and affordability of medicines.
21. To act towards eliminating corruption and unethical practices at all levels of drug administration, the drug industry and the medical profession; to regulate unnecessary tests, screening, scans and other misuse of technology and to ban cut-practice (kickbacks to prescribers for ordering such tests and/or for referral to specialists).
22. To develop clear system-wise standards for treatment and to strictly implement the Supreme Court order banning cross-practice between various medical systems.

#### **D) Medical Technology: Mis-Use, Over-Use and Under-Use**

Medical technology is extremely important for alleviation of suffering, curing of diseases and prevention of early deaths. In our country however, we have a situation where the vast majority of people lack access to the most basic therapeutic and diagnostic technologies, while others are subjected to unnecessary and expensive investigations and interventions usually with deleterious and undocumented consequences. Misuse of technology occurs by the most qualified medical practitioners and also by under-qualified personnel from all systems of medicine. This leads to increasing health care costs, often depriving people of the real benefits they would enjoy from other cheaper technologies. The market for medical technologies is not regulated and is driven by commercial concerns of the manufacturers with the logic that 'supply creates its own demand'.

Violations of women's reproductive health by unnecessary Caesarean sections, unwarranted hysterectomies and sex-selective abortions are increasing. Also, in recent times India has emerged as an international hub for 'medical tourism' along with the creation of a new form of international medical research networks. This includes technology transfers, supply of fetal tissue, eggs, embryos for medical research and stockpiling to meet the expanding international demand. We oppose the commodification and commercialisation of body parts in the name of research or therapy, as well as the use or abuse of medical technology unguided by either patient's interests or epidemiological concerns.

A law is needed to monitor invasive research and proliferation of the new invasive assisted reproductive technologies (ARTs) and women need to become aware of the risks.

While condemning these adverse and menacing trends, our **demands** are:

1. To regulate and promote the rational use of diagnostic and therapeutic medical technologies and to provide them in the public sector so that they are universally available, irrespective of ability to pay.
2. To provide continuing education of doctors regarding use of new technology, regulated by the Medical Council of India (MCI), so that doctors in practice are not 'educated' by the medical technology industry alone.
3. To make more resources available for research and development of low-cost technologies that are relevant for women's short- and long-term wellbeing.
4. To monitor the overuse of technologies in the private medical sector in accordance with existing guidelines such as those of the Indian Council of Medical Research.
5. To reverse the glorification of biological birth through invasive medical technology which may be at the cost of women's mental and physical wellbeing, and to advocate options of social parenting, child adoption, or living full lives without raising children.
6. To frame a law to regulate use of invasive reproductive technologies in the private sector, that covers surrogacy, genetic engineering, cloning and intensive ARTs.

#### **E) Indigenous Healing Systems**

Women in India have been 'health care providers' since many generations, and they possess vast experiential and practical knowledge of healing. However the elitist and patriarchal formal medical systems invisibilise this women-centred knowledge. In India, Ayurveda and the Western system alike – both being male-structured and upper caste/class-dominated systems – hold superior and patronising if not outright ridiculing views towards 'traditional folk remedies'. In India the belief systems of most people and particularly of most women resonate with the non-allopathic healing systems. Yet the public health system as it today stands operates within an exclusively allopathic world-view with respect to both health services and disease control. We assert that our people deserve a holistically integrated public health system strengthened by the best aspects of the indigenous systems of medicine, including the local folk healing traditions.

While upholding all people's access to the real benefits of modern medicine and technology, we assert the need to affirm the strengths and incorporate the contributions of indigenous women healers including the midwives known as 'dais' or 'traditional birth attendants' (TBAs). The strengths of the formal indigenous systems like Ayurveda, Siddha and Unani also need to be recognised. It is a fact that considerable deskilling of indigenous practitioners in both the folk and formal systems has occurred due to negative social and economic pressures and government policy neglect. Hence, there is a need for a system of upgrading skills and regulating practices that may best be done through organisations of the healers and practitioners themselves.



Since 2004, there has been a full-fledged Department of AYUSH (Ayurveda, Yoga, Unani, Siddha, Homoeopathy) in the Health Ministry. Since the 10<sup>th</sup> Five Year Plan the Government of India has the stated intention of integrating the AYUSH systems into the public health services. However, serious steps at 'mainstreaming' AYUSH systems in national health programmes are being taken only now through the National Rural Health Mission in the 11<sup>th</sup> Plan period (2007-2012). This effort is beset by problems and contradictions, starting with the domination of allopathy in the public health system. Most AYUSH physicians use allopathic medicines ('cross-practice'). There are, in fact, great practical difficulties in rationally integrating the totally different medical systems and in bringing about co-operation between the respective physicians. Furthermore, acceptance of people's healing traditions and giving them equal status with the formal systems is a new and challenging demand.

In the mental health sector there is a professional move to displace local healers in the name of eradicating superstition. The Supreme Court has issued directives for the closure of traditional healing practices and the construction of mental hospitals. Given the abysmal nature of services provided in the mental hospitals, there is a need to study traditional healing systems in mental health and to encourage those that are pro-women.

The Indian Government needs to resist the current pressures and policies of global institutions such as the World Bank that negate our indigenous legacy of healing.

In view of the vast yet barely known potential of the indigenous healing systems and healers to contribute to primary health care, our **demands** are:

1. To encourage women healers all over the country to recollect their indigenous knowledge and skills, and to document this knowledge systematically.
2. To support and conduct systematic research to build up the evidence base for the use of knowledge and experience from the indigenous healing systems; to limit the patenting of such knowledge to retain community and people's ownership.
3. To insist on the development of ethical guidelines, including the principles of informed consent for patients, and to ensure self-regulation of practice through registered associations of indigenous women healers, local healers in mental health and midwives.
4. To regulate dangerous, life-threatening or anti-woman interventions in the name of indigenous or alternative healing, to prosecute perpetrators who violate the human rights or dignity of their patients and to ensure safety standards in the practice of indigenous healing systems.
5. To recognise genuine indigenous women healers and TBAs through their respective organisations and to equitably compensate them for services to women and people.
6. To recognise the role of women traditional healers and the psychological resources that women use, such as possession and trancing, and not to 'witch hunt' possessed women; to support studies in this area.
7. To enable and provide for development of training and skill-upgrading by registered organisations of indigenous women healers and dais (TBAs).
8. To establish practicable linkages between the services of indigenous healers, TBAs and the relevant health care practitioners, departments and institutions.
9. To promote the appropriate and holistic integration of indigenous healing systems within the public health and mental health system to strengthen PHC services, mainstreaming them in national health programmes and in the National Rural Health Mission (NRHM).
10. To consider women healers in selection for ASHA ('Accredited Social Health Activist') in the NRHM, or those who have backgrounds of traditional healing, and support their use of this knowledge in community health action beyond reproductive health.

## 10 VIOLENCE AGAINST WOMEN: PUBLIC HEALTH AND HUMAN RIGHTS

Violence against women (VAW) is steadily emerging worldwide as a main reason for death and morbidity (illness) in women of reproductive age. In India, death by burning is the major cause of mortality in this age group. Violence against women starts even before birth through sex selective abortions. Marginalised women are more vulnerable to violence, including widows, disabled women, lesbian, bisexual and transgender women, sex-workers as well as any woman who challenges patriarchal powers. Being deserted, raped, paraded naked, hounded as witches are some of the ways in which women suffer unspeakable violence in our society even today. In times of communal or caste conflict, strife, army occupation, insurgency and war, women's bodies become virtual 'battlefields' resulting in brutality, rape, torture and trafficking.

For a married woman, being dependent on husbands and in-laws for health care reduces health care access. Ill-health and its disclosure increases the risk of violence. Thus there is a two-way linkage between violence and health. When she does reach a health centre, notions of family honour and the consequences of speaking out may keep her silent, so a vicious circle is thus set in motion. Often, the health centre is the first and sometimes the only external contact that a woman is able to access after a violent episode. However, health professionals are unable or unwilling to identify family violence as a factor, trivialising it or not asking questions that may detect sexual violence. Moreover, doctors may not be aware of how to preserve evidence in the event of sexual assault, or how to present forensic evidence in a gender-sensitive manner when called to court. In fact, most health professionals avoid being called as expert witnesses. Health professionals themselves have traditional ideas and biases about why violence occurs (related to class, religion, gender, caste, ability, sexuality and so on). Occasionally they have their own unresolved issues that block their sensitivity in such cases. Medical curricula do not include issues related to violence within the home or outside it as a public health issue.

Our **demands** related to violence against women are:

1. To consider violence against women (VAW) as a human rights violation and to address it as a public health issue.
2. To see denial of health care as another form of violence, particularly against marginalised women.
3. To make health professionals aware of the traumatic impact of VAW on women and on children.
4. To include topics like 'gender and medico-legal jurisprudence', 'sexuality, HIV/AIDS and violence' in training and continuing education for doctors, paramedics, social workers and counsellors, police, army and paramilitary forces, and so on.
5. To train medical and paramedical personnel in understanding the total importance of writing legible, accurate and supportive medical reports, including the history of the cause(s) of injuries.
6. To issue accurate and timely medical certificates to survivors of rape.
7. To strictly implement the Protection of Women from Domestic Violence Act (PWDVA), with efforts to increase awareness of the Act among the various stakeholders, such as women, NGOs, medical professionals etc, and to inform panchayat members of laws and policies relating to VAW.
8. To provide women violence survivors with non-judgmental counselling and psychotherapy, play therapy etc. for the effects of physical or sexual abuse or rape, including past incidents of child sexual abuse, adhering to strict confidentiality.
9. To prevent child marriages as well as forced marriages, considering these as human rights violations
10. To provide State protection to persons who wish to choose their partners in defiance of parental or community views.
11. To prevent, investigate, prosecute and adequately punish crimes in the name of 'honour' of family, community, caste, tribe or nation.
12. To prevent and seriously deal with incidents of sexual assault and mass rape during communal conflagrations or in communal retribution and to treat the survivors with sensitivity, disallowing titillating coverage by the media.
13. To impart training to medical professionals to help them deal with survivors of violence, including domestic violence, without prejudice or judgement.

## 11 HEALTH RIGHTS OF WOMEN WITH SPECIAL NEEDS

The Indian Women's Health Charter attempts to spell out the health rights of all Indian women. This section draws attention to the fact that 'women' are not a homogenous category, but that they are distinctly located within structures of class, caste, religion and culture, as well as distinguished by gender and sexual identity, ability status, and so on. Naturally 'one size doesn't fit all!' ... and general or 'neutral' demands usually fall short of reaching out to those with special needs. Thus, to include ALL women within the ambit of health rights, the specific situations and concerns of women with special needs must be addressed.

The human rights of single or marginalised women are more easily violated and their recognition as full citizens (with ration cards, passports, access to credit or loans) is often compromised. Access to health services (including the reproductive and sexual health services) is also constricted by social vulnerability, stigma, fear of backlash, and lack of confidentiality or sensitivity on the part of health care providers. All women suffer greatly in times of disaster or conflict, and disadvantaged women even more so.

Patriarchal families and communities control women, especially 'deviant' women who they perceive as a threat. Crimes of 'honour' are perpetrated with impunity whenever women dare to exercise their option to choose or to leave their sexual partners. Atrocities against women – persecution for alleged 'witch-craft', humiliation by public disrobing – are used to punish women who dare to challenge power structures and to terrorise all women within communities. In times of wars and riots, the bodies of women become the battlefields of warring patriarchies. Women within custodial institutions (remand homes, 'shelters', prisons, mental hospitals) are subject to severe human rights violations with no access to legal redress or justice.

Below, we list the needs and demands of 11 categories of 'special' women. Here we reaffirm all the rights earlier mentioned in this Charter. Moreover, we argue that unless special measures are taken to ensure the health rights of these women, they are at risk of exclusion from full enjoyment of their human rights. Being a signatory of the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), India is committed to removing gender discrimination. CEDAW includes provision for temporary measures of 'positive discrimination' (reservation) for women from disadvantaged backgrounds.

Recognising this difference between 'women', the Indian Women's Health Charter attempts to frame these demands for women with special needs:

### A) Girl Children and Adolescents

Girl children and adolescents are vulnerable physically and psychologically to sexual abuse, denied educational opportunities, early marriage and pregnancy. The concerns of this group encompass the rights to adequate nutrition, minimum of high school education including sexuality education, appropriate health care services, choice of sexual and life-partner, opportunities for all-round development. They also entail the elimination of child labour, discrimination and violence.

Our **demands** in the interests of girl children and adolescents are:

1. To assure equal treatment of girls with boy siblings, and freedom from sex-role stereotyping, humiliation and discriminative deprivation.
2. To promote policies and programmes to meet the health needs of girl adolescents, and to provide opportunities for their optimum physical, mental and intellectual development through education and vocational training, increasing their mobility and decision-making, so that marriage and child-bearing does not remain a sole option.
3. To refuse to compromise on quality or level of education or on mobility for adolescent girls in the name of culture, religion or customary law.
4. To guarantee safety from physical, emotional or sexual abuse within and outside of home by prosecuting violators, whether family members, guardians, teachers, custodians or others.
5. To ensure freedom from discrimination and neglect, under-nutrition, child labour (paid or unpaid), school drop-out, physical or sexual abuse, trafficking and early marriage.
6. To promote the right to equal inheritance as opposed to dowry.
7. To make punishable by law the giving away of minor girls to religious institutions.

8. To assure availability and access to sex education that is positive in attitude without moralism, judgement, homophobia or fear-mongering.
9. To provide counselling for mothers of adolescent girls, to help bridge the information gap about important issues (e.g. menarche, growth in puberty, etc).
10. To involve young people in the design, planning, implementation and evaluation of measures to improve their health.
11. To provide training for adolescents as peer counsellors and health communicators.
12. To provide for and develop safe spaces for adolescent girls at community level, such as clubs, drop-in activity centres, training and productivity centres, etc.
13. To assure non-discrimination in education, job opportunities or marriage, against adolescent girls in vulnerable situations, such as daughters of women in prostitution, girls in violent/alcoholic families, adopted children and of same sex parents, children in remand homes and state institutions, and during disasters.

#### **B) Women of Age\***

All over the world women's longevity is higher than men's. Even in India women who survive the challenges of the reproductive period tend to outlive their male counterparts. Over the next few decades the proportion of aged people in the population will rise and therefore society and the health services need to gear up to the needs and concerns of this group. Aging women are often neglected and even abused by the very people who are supposed to be their carers. Verbal abuse and ridicule, physical assault, isolation, deprivation and starvation, cheating and theft, desertion and destitution are dangers that many aged women in India face. In the health services we need to reaffirm the importance of an integrated approach combining preventive, curative and rehabilitative health care for aging women. Such specific yet comprehensive care should be designed to include periodic check-ups, appropriate treatment, and both physical and psychological rehabilitative measures that aim to preserve functionality as long as possible in life. Aside from provision of adequate care and nursing facilities, attention needs to be given to physical safety, nutritional security, alleviation of pain, and enabling aged women to die with dignity.

On behalf of aging women, our **demands** are:

1. To protect the property rights of elderly women, especially those who are single, widowed, divorced women or living in State or religious institutions.
2. To prosecute persons who abuse aging women, who desert or abandon them at religious places, who forcibly incarcerate them in institutions (including old-age homes) and who deprive them of their rightful property or income.
3. To provide functioning help-lines equipped to counsel and intervene in cases of aging women's health concerns, including discrimination or any form of abuse.
4. To assure freedom from abuse by health care providers, carers and family members.
5. To include specific intervention measures to address health concerns associated with older age, such as osteoporosis, fractures, cancers, arthritis, dementia, urinary incontinence, diabetes and the various forms of elder abuse.
6. To establish geriatric wards in public sector hospitals and provide concessions for geriatric care in private hospitals with identity cards for women as senior citizens.
7. To train and appoint specially qualified personnel to deal with geriatric disorders and provide counselling services attuned to sensitive listening.
8. To provide separate counters for elderly patients in hospitals and dispensaries in order to reduce the waiting period for care.
9. To provide eye and ear check-ups, correctional aids and surgeries free or subsidised.
10. To make available at low cost or on hire equipments that are needed by elderly women (walkers, wheel chairs, bed pans, etc).
11. To design and construct age-friendly public building structures, spaces and transportation facilities with wheel chair ramps and lifts, etc.
12. To provide mental health support, nutritional supplements, and appropriate health insurance coverage for aging persons.

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\* The terms 'aging women', 'aged women', 'women of age', 'elderly women' and 'older women' are used synonymously.

13. To allocate funds at national, state and district levels for implementing health policy and programmes addressing the concerns of elderly people.
14. To design and provide old age homes that are safe, secure and respectful to elderly women, especially for the physically/mentally challenged or destitute.

### C) Single Women\*

The current health policies and the health care system focus on the 'reproductive health' needs of married women and thus, whether by omission or commission, exclude the health needs and rights of single women. Women outside of marriage face discrimination while attempting to access sexual and reproductive health care. They are also more vulnerable to sexual and economic exploitation by health care providers in both public and private sector.

Single women are not a homogenous category. Their health concerns, and the degrees of their marginalisation, vary with class, caste, sexuality, ability as well as on the 'type' of singlehood – never married, widowed, deserted, divorced or remaining single by choice. Similarly, their access to health services is affected according to whether they live within a family or not, such as living alone or in a religious institution, prison, state hospital, shelter or on the street, as well as whether their lifestyle and occupation are accepted by society (night duty, sex-workers, dancers, lesbians etc). Younger single women face strict supervision from natal and marital families and are subject to severe punishment including 'honour' crimes by families and communities for real or perceived sexual digression. Moreover, widows are stigmatised and considered inauspicious, deprived of certain foods colourful clothes, exploited as servants, and constantly under threat of being thrown out of the marital home. Half-widows (wives of missing men) are forced to straddle a double-existence of being both married and widowed. With the denial of their sexuality and any notion of happiness outside marriage, yet vulnerable to sexual abuse from family and community, single women's concerns often stay unaddressed, whether of violence, sexuality or loneliness.

Hence, our **demands** on behalf of single women are:

1. To oppose denial of opportunity to any woman on the basis of singlehood, whether never-married, widowed, divorced, separated or deserted.
2. To enforce equality in inheritance and property rights in the natal or marital family.
3. To provide State-sponsored social security schemes for single women such as higher tax exemption level and subsidised housing allotment, and to consider the special needs of single women while framing all policies.
4. To provide easy access to reproductive and sexual health screening and treatment without moralistic judgment, but with special sensitivity to maintaining confidentiality.
5. To provide for counselling, therapy, and measures for individual and social justice in cases of traumatised single women, especially deserted women, widows, war widows and 'half-widows' (of disappeared men).
6. To prohibit abandonment of widows in religious places, as well as 'giving away' of girls or women, including to religious institutions.
7. To allow vows of celibacy on entering religious institutions to be given only by adult women after informed consent, assuring them the right to reverse these vows.
8. To rule out double sexual standards for men and women especially in employment and inheritance; to ban discriminative and humiliating practices like virginity tests.
9. To assure women's right to choose sexual and marital partners without its curtailment in the name of 'honour' of family, community, caste, culture, religion or nation.
10. In states of India embroiled in long-drawn conflict or under the Armed Forces Special Powers Act (AFSPA), to ensure protection of single women from violence.
11. To provide widows of farmers who have died of suicide with exemption from repayment of loan, income-generating work and education of their children at Government expense.

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\* 'Single' women include women outside of marriage, whether never-married, divorced or abandoned, and whether living unmarried in a relationship or having walked out of a relationship.

#### D) **Women with Disabilities\***

Just like any other category, 'women with disabilities' are not a homogenous group. It includes women who are mentally disabled (with mental illness or intellectual/learning-impairment) as well as women who are visually impaired, hearing-impaired and speech-impaired, and women with physical impairment. They encounter different kinds of barriers and their mobility is restricted in various ways. Further, their multiple disadvantages vary with the extent of disability, poverty, caste, marital status, whether they are childless, and so on. All disabled girls and women are particularly vulnerable to violence, discrimination, stigma and neglect especially within the home. Even though the sexuality of women with disabilities is not recognized or acknowledged, sexual abuse is commonly experienced and more frequently by women with mental or severe physical disabilities. Also common is abuse by physicians and caregivers, including forced sterilisation.

Women with disability experience barriers to availing opportunities for development and realisation of their potential. Thus, rather than merely a physical trait, disability is a socially constructed disorder. It has to be addressed socially by challenging the mindset that justifies the barriers, and by improving access to basic needs and opportunities such as health care, education, gainful employment, improved living and working relationships, respect and non-discrimination at workplaces. Additionally, special access facilities and reservations for disabled women, with promotion of positive images in the media and in society will go a long way to increasing self-esteem, reducing dependence and promoting empowerment of disabled women. In sum, the human rights of disabled women deserve recognition and respect through effective remedial action. Immediate, adequate and appropriate measures to equalise the opportunities for disabled girls and women are imperative.

Thus, on behalf of girls and women with disabilities, our **demands** are:

1. To implement legislative provisions to protect disabled women's human rights in accordance with the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, and to deploy monitoring mechanisms.
2. To make schools and colleges accessible along with all facilities (classrooms, toilets, information) and to provide personal assistance to support disabled girls in schools; to provide specially trained teachers for children with special needs and sensitization programmes for all school teachers.
3. To provide vocational training to women with disabilities and special rehabilitation support for elderly women with disability.
4. To include the concerns of women with disability in all rehabilitation programmes, and provide equal opportunity for vocational development and gainful employment.
5. To make appropriate and locally produced aids and appliances available to support disabled women and girls in their domestic, educational and working lives.
6. To provide early diagnosis, intervention and rehabilitation programmes for infants and children with disabilities.
7. To involve disabled people in genetic counselling of parents expecting a baby with impairment, to help them understand how 'disability' gets socially constructed.
8. To establish the sexual and reproductive rights of women with disabilities to contraception, abortion, safe motherhood and to acceptance of their sexuality.
9. To refuse any demand for compulsory sterilisation or hysterectomy at the time of admission to day-care/day-schools or in Government or private institutions.
10. To provide counseling and peer-support for parents, guardians and caretakers to lead them to understand the greater risk of physical, emotional, financial and sexual abuse that girls and women with disability face in and outside of homes / institutions.
11. To monitor medical, surgical and drug trial interventions on disabled women, especially in the case of institutionalised women.
12. To integrate disability rights issues within reproductive health programmes and to develop specific measure to address the needs of disabled women in rural areas and in urban slum or temporary settlements.

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\* *The terms 'disabled women', 'women with disabilities' and 'women living with disability' are used synonymously.*

13. To ensure disability-access to building environments by provision of proper ramps, wider doorways, accessible toilets with higher seat and support bar, adjustable or lower examination tables, and so on.
14. To involve women with impairment (e.g. hearing, etc.) in the running of clinic services for similarly affected women.
15. To ensure access to information on health and health-care facilities in disabled-friendly communication formats, e.g. by using large print, Braille text or audio/video-tapes, making sure that at least one health team member can use sign language.
16. To include disability issues in course curricula of medical, paramedical, management and development programmes, and in continuing education of health professionals.
17. To include health care services for disabled girls and women in all national health programmes and in disaster management, with social security provisions that deal specifically with the needs of disabled women, especially young disabled mothers.
18. To create more employment opportunities for women with disabilities, prioritising their placement in health and rehabilitation centres as service providers, and giving them priority within the 3 percent reservation for employment to persons with disabilities.
19. To include disabled women in the mainstream movements, including the women's movement, to ensure full participation in developmental activities.

#### E) **Women Workers\***

The health of most workers in India is precarious and unprotected, and for women workers in the unorganised sector (where most women are employed) the concerns are even more serious. Occupations that women are largely engaged in range widely from home-based small industries, domestic labour and agriculture to work in quarries or brick-kilns, road and building construction, rag-picking and so on. Hence, women workers suffer from large variety of health problems, from accidental injuries and disabilities, miscarriages, birth defects in their children, and there are also deaths. Women in the organized sector, including in the Special Economic Zones (SEZ) also suffer from lack of access to laws and from gender-blindness or gender bias during employment and promotion. Women's personal and occupational vulnerabilities are intricately linked, yet employers do not see women's illnesses as their responsibility. Due to inappropriate recording of occupational illnesses, most women never get compensated for them. Since women are largely located in self-employment, piece-rate and home-based work, their collective voice is not heard.

Trade unions being male-dominated have often been insensitive to the special needs and rights of women (for crèches, toilets, transport, etc). Interestingly, under pressure of globalisation, many male workers have lost permanent jobs and their families are now being supported by women in unorganised domestic labour and small-scale home-based occupations. Thus, now the trade unions are discovering the importance of protecting women's rights as workers, who are usually paid less than the men with poorer working conditions and longer hours, affecting their health adversely. Sexual harassment at workplace continues with impunity in all sectors and needs to be addressed urgently.

Women's household work and labour on family farms is unrecognised in financial, social and cultural terms. For it women are given neither wages nor maternity benefits, and the wisdom they apply in decision-making is not considered by the family. Moreover, women do not interact with the market in the way men do and they hardly ever possess the land. It is ironic that women's suicides related to farmlands are not considered in 'farmer suicides' so it results in no State compensation. Eventually even non-wage earning women should be covered by maternity and health benefits. Childcare support – so crucial to release older siblings from babysitting – needs to be provided at community-level. Considering that housework along with childbearing and childrearing is socially productive work, the enabling conditions for ALL women irrespective of current 'work status' need to be put into place.

Thus our encompassing and specific **demands** on behalf of women as workers are:

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\* *'Working women' often refers only to women who work outside of home; here we include women doing housework, bearing and raising children and working on family farms.*

1. To prohibit discrimination against women at employment, permanency or promotion in accordance with the Equal Opportunities of Employment Act with special provision for maintaining continuity of women in employment after marriage or childbirth.
2. To provide for special inclusion of discriminated, marginalised and vulnerable women in employment and livelihood opportunities.
3. To protect women from being forced by economic necessity to enter occupations unsuited to their age, inclination or any special impairment.
4. To strictly implement the principle of 'equal pay for equal work'.
5. To ensure that working conditions are safe and not hazardous to women's health, particularly during pregnancy and lactation, and to assure adequate safety measures to prevent occupational illnesses and accidents.
6. To assure to all women workers, in case of illness or injuries arising from harmful exposure or accidents at the workplace, early recognition and treatment and award of adequate compensation.
7. To follow the Vishakha guidelines on sexual harassment at workplace at all workplaces including the private, informal and NGO sectors.
8. To vastly improve workplace conditions, including adequate lighting, ventilation, drinking water, toilet and crèche facilities.
9. To assure women of gender-specific health entitlements (maternity leave, abortion leave, sterilisation leave, crèches, toilets) in public and private employment.
10. To design a mechanism to grant maternity leave to all women through joint contribution from employers, Government and people (through taxation) .
11. To collect and incorporate data on unorganised work and home-/family-based labour into the labour statistics.
12. To bring the unorganized sector under the purview of labour laws, and to provide health insurance coverage to all unorganised sector workers.
13. To recognise women's suicides related to farmlands and to provide adequate and equitable compensation.
14. To address the triple stigma of 'farmer suicide' widows due of widowhood, unnatural death and indebtedness, topped by the financial burden of loan repayment.
15. To make maternity and other labour benefits universal irrespective of the wage-earning status of women.
16. To provide childcare services and other social supports at community level.
17. To recognise women's property right as applying to homesteads and family farms.

#### **F) Sex Workers\***

The dominant social view towards sex workers, or women in prostitution, has been moralistic and repressive, excluding them from discussions and decisions around policy and legislation regarding their lives and health. The social, emotional and economic exclusion they face exposes them to be policed by family, state and society. The State's policy of 'rehabilitating' sex workers involves interventions such as forced rehabilitation and victim-blaming and often doesn't work. Refusing to believe in them as 'women', society prefers to see them as petty criminals and a public health threat.

Marginalised by this judgmental attitude, sex workers are prevented from realising their health and human rights. Almost all discussion on their health centres around sexually-transmitted infections and is focused on reducing infection of their clients. Their own health concerns beyond RTIs, STIs and HIV/AIDS are more or less ignored. Anticipating discrimination, sex workers do not access the public health care system and fall prey to exploitative private and quack treatment. Other factors restrict their access to health care, like the close watch of brothel keepers and the stigma of HIV infection. Also unaddressed is the violence they face from clients, goons, police, pimps, brothel keepers and 'husbands'. The constant fear of violence, arrest and displacement results in isolation, emotional stress and further vulnerability.

Within themselves sex workers are not a homogenous group. It is important to understand recognise and understand the specific needs of the varying categories of sex

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\* The term 'sex workers' also refers to 'commercial sex workers' or 'women in prostitution'.



workers: formal / informal, bonded / free, brothel / street / non-brothel, migrant / local, child / adult / aging, bi-sexual or transgender.

Thus, our **demands** on behalf of sex workers are:

1. To prevent stigma and ban discrimination against sex workers and their children.
2. To implement strict measures to prevent trafficking, especially entry of minor girls into sex work.
3. To monitor exploitation by pimps and brothel-keepers under the Immoral Trafficking Prevention Act (ITPA), but exempting children of sex workers even if 'living off' their mother's wages from falling under ITPA.
4. To prevent violence against sex workers by the police, local politicians, goons, brothel keepers, pimps and clients, to protect them from illegal detention, extortion, exploitation, beatings and assaults.
5. To provide easy and free access to legal aid, judicial remedies and police intervention in case of violence including rape, extortion and exploitation.
6. To prevent forced evictions and rehabilitation, considering the views of sex workers as central in decision-making about their lives.
7. To recognise that women, men and transgender persons are all involved in sex-trade and that each category has specific health needs.
8. To assure comprehensive health care for sex workers beyond just sexual and reproductive health and consider their issues of occupational health and safety.
9. To sensitise health care providers to respect sex workers' rights without moral judgment, considering their sexual labour as work and not pathology; to acknowledge their need for safe working conditions and their right to comprehensive health care.
10. To maintain confidentiality about all infections including HIV status.
11. To provide preventive care, early detection and treatment of all diseases, including tuberculosis, RTI, STI and HIV-AIDS, with adequate information and easy access.
12. To provide mobile clinics for the floating population of sex workers,
13. To provide night crèche and study facilities for the children of sex workers, with special sensitivity to the timing of work and to equal opportunity for their education.
14. To prohibit the long-term or permanent separation of children from a mother without her consent.
15. To arrange for community kitchens providing adequate and nutritious food.
16. To employ special protective measures like condom provision, violence prevention and restriction of economic exploitation in festive seasons when sex-trade increases.
17. To sensitise Government and all other agencies about the legal rights of sex workers.
18. To respect the rights of sex workers as citizens by providing ration cards and other documents to enable opening of bank accounts and access to low-interest loans.

#### **G) Lesbian, Bisexual and Transgender (LBT) Women\***

Diverse gender identities, sexual orientations and same-sex preferences have existed for centuries among most cultures, irrespective of caste, class, race, religion, and occupation. Indian mythologies reveal the existence of a range of sexual expressions and identities, and ancient sculptures in India depict same-sex eroticism. Transgender people, especially hijras have been accepted in societies of our subcontinent for centuries. Yet people with non-heterosexual preference have been marginalized and suppressed by families and communities, especially after colonial law made same-sex preference punishable and labelled it as 'against the order of nature'.

The non-recognition or suppression of a person's nature and existence not only violates one's fundamental rights, it also leads to stigma and discrimination at all levels and impinges on the mental, physical and social well being of those excluded. Let us accept that there are forms of sexuality and gender identities that do not conform to hetero-normative standards. Recognising the right to sexual and reproductive well-being with full civic and political rights is the beginning of accepting diverse gender and sexual identities as being normal.

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\* 'LBT' is part of the larger category of LGBT (Lesbian, Gay, Bisexual, Transgender).

On behalf of LBT women, our **demands** are:

1. To prevent stigmatisation and ban discrimination of LBT on the basis of gender identity, sexual orientation, sexual preference, health outcomes and occupation.
2. To repeal the Section 377 of the Indian Penal Code (IPC) and similar discriminatory legislations which single out same-sex acts, even between consenting adults.
3. To prevent discrimination at workplace, in housing, in employment, in access to Government schemes for loans and to insurance policies.
4. To assure a non-judgemental, sensitive and confidential approach with illnesses related to the LBT community, especially which increase stigma or marginalisation.
5. To respect the fundamental and human rights of LBT people, including legal rights of child adoption, marriage, divorce, property, inheritance etc. without discrimination.
6. To provide for decent livelihood options through special arrangements in education, training and employment opportunity with special attention for needs of transgender.
7. To provide effective education about adolescent sexuality including gender identities, sexual orientations and preference as well as HIV/AIDS awareness; to reach out to adolescents in school/colleges as well as into communities.
8. To organise special health education programmes for healthcare providers and counsellors to sensitise and train them regarding gender/sexual identities, sexual orientation, and specific health needs of LBT women.
9. To include in all health education programmes accurate information about risks involved in any kind of sexual behaviour or practices; to recognise and accept diversities in gender identity and sexual orientation; not to target certain sexual practices as the principal cause for infectivity.
10. To pay special attention on mental health needs of LBT women, often precipitated by rejection, stigma and discrimination unrecognized by health providers.
11. To provide access to information, prevention, early detection and treatment for cancer (breast, oral, cervical or anal), STIs, HIV /AIDs and other diseases as per specific LBT group/community needs, and to include this in national health policy.
12. To include a 'transgender' category in the Census as well as in all records denoting 'sex/gender' in Government/non-government records in order to recognize the existence of transgender people.
13. To provide for sex reassignment surgeries in public hospitals with reformed legal eligibility criteria for adult transsexuals (e.g. castration being illegal at the moment), and not to force sterilisation as a prerequisite for changing gender status.
14. To provide for mobile clinics for floating population for transgender sex workers.
15. To protect transgender/bisexual people, especially those in sex work, from violence by brothel keepers, pimps, clients and goons; to assure freedom from illegal detention, extortion, exploitation, beatings and assaults from all including police and politicians, and to prosecute and punish the violators.
16. To include transgender issues in anti-discrimination legislation regarding hate crimes.
17. To consider aversive shock and behavioural therapy in attempts to 'convert' lesbian homosexuality and transsexuality to heterosexuality as violence against women.

#### **H) HIV-Positive Women**

HIV/AIDS is not only a health issue but also a developmental issue. Unequal economic development, natural disasters like drought and conflict situations lead to displacement, destitution and increased HIV infectivity. Conversely HIV infectivity results not only in illness and death from AIDS but also brings stigma and destitution for young widows, who are marginalized and further impoverished. The alarming increase in HIV prevalence in India is not limited to the conventional 'high-risk groups'. Social, economic and biological factors put women at higher risk and when infected their low status imposes further violence, neglect and desertion by family and community. Often it falls upon a positive woman, even though sick herself, to look after and arrange for financial support for the dying husband. Fears for her children and of being deserted add to her mental stress and further pull down her health. Thus the health services have a crucial role to play in assuring access to supportive and respectful care.

With respect to the health needs of HIV-positive women our **demands** are:

1. To initiate progressive, people-centred health interventions that aim towards breaking the vicious circle of impoverishment and HIV infectivity.
2. To ensure access to housing, education, health care, and social welfare services for HIV-positive women, including childcare and nutritional support.
3. To provide employment opportunities in public and private sector.
4. To provide for medical insurance coverage for HIV-positive women.
5. To ban the segregation or quarantine of HIV-positive women and their children in prisons, schools, and hospitals or elsewhere.
6. To prevent discrimination in public and private health services, to hold the health care providers accountable for discriminative denial of health services as a violation of human rights, and to prosecute the violators.
7. To refrain from imposing compulsory testing for HIV, especially during antenatal care visits, to make pre- and post-test counselling mandatory even in voluntary testing, and to maintain confidentiality with regard to HIV status.
8. To provide for HIV-testing on a voluntary basis with due respect to confidentiality, and to ensure that health care services are not denied on the basis of the test result.
9. To respect patients' right to confidentiality, privacy, dignity and equal law protection.
10. To promote policies and programmes that ensure harm-reduction in all vulnerable sections, including sex workers, drug users, sexual minorities and street children.
11. To include positive women in decision-making for the design and implementation of HIV/AIDS intervention policies and programmes.
12. To provide for affordable and timely post-exposure prophylactic care for rape survivors and ensure their access to adequate information about HIV/AIDS.
13. To enhance PHC level intervention for HIV and AIDS with allopathic and non-allopathic medicines.
14. To integrate anti-retroviral treatment (ART) clinics within general clinics to reduce the stigma and discrimination of positive people by the community.
15. To ensure easy availability, affordability and sustained supply of quality generic ARV drugs and other essential medicines for HIV positive persons.
16. To respect the rights of positive women to fulfilling sexual life and to having children without interference from bias by health care providers and others.
17. To provide for HIV-positive pregnant women access to full information regarding mother-to-child transmission and affordable treatment, with timely renewed protocols.
18. To stop treating HIV-positive women as objects in prevention of mother-to-child transmission, and to provide them anti-retroviral (ARV) treatment as a right.
19. To give full information on the risks and benefits of the options of infant-feeding by breast or top-feeds, with adequate emphasis on the benefits of exclusive breast-feeding, and to respect the informed choice of HIV-positive mothers.
20. To include nutritional inputs and psycho-social support in health care intervention policy and programmes for people living with HIV/AIDS.
21. To provide full information and appropriate education about HIV/AIDS prevention, transmission and care, and for reducing stigma and discrimination, to all health care providers including traditional healer and traditional birth attendants.
22. To make available adequate counseling, information and education not only to HIV-positive women but to their family members and caretakers.
23. To encourage mass media to impart positive messages and to challenge discriminatory and stigmatising attitudes towards people living with HIV/AIDS.
24. To hold the authorities in both public and private health sector responsible for providing free post-exposure prophylaxis to women workers in health care systems.
25. To ensure Government loans and benefits to women widowed or deserted due to HIV/AIDS in accordance with their reduced economic status, not according to the wealth of their natal/marital family.

**I) Women in Traumatic Situations: Disaster, Conflict, Riots and War**

Disasters, displacement and conflict situations have gendered consequences. Any human-made or natural disaster affects vulnerable people more adversely, and women suffer doubly or triply due their social vulnerabilities. In conflict situations, the targeting of women by physical and sexual assault is a tool to wreak terror, humiliation, retribution and 'ethnic cleansing' or genocide of the 'other' community. Rape aims not only to inflict sexual torture but

also to force pregnancy on women in minority communities, women prisoners and women refugees from armed conflict. The consequences for women survivors, whether physical, emotional, sexual, are grave and affect them for the rest of their lives, including chronic medical problems, psychological damage, life-threatening diseases such as HIV/AIDS, infertility, stigmatisation and/or rejection by families and communities. For those placed lowest in the intersecting hierarchies of caste, class, gender or sexuality, the most extreme forms of violence, discrimination and exploitation are a reality. After most disasters there is an increase in inter-generational and forced marriages and trafficking or stigma for marriageable girls rises.

Special attention needs to be paid to the violation of rights of women whose men-folk are in insurgent groups or other politically proscribed organizations. Similarly, women living in areas of political conflict are subject to violence, terror and control from the armed forces and police as well as from the insurgents. Control over behaviour or imposition of dress codes adds to women's anguish and reduces their access to health care facilities. 'Half-widows' (wives of men who have 'disappeared' in police encounters, riots, conflict situations, wars etc.) and mothers of 'missing' sons (disappeared after arbitrary arrest) suffer the financial, social, legal as well as emotional effects of these crises.

In case of violence against refugee and displaced women, or after communal conflicts, the role of health professional must extend beyond providing emergency medical relief. Medical evidence and intervention assume legitimacy in law and society on account of the skills and knowledge that health professionals represent, who therefore enjoy an acceptability that transcends class or communal boundaries. Hence, if the medical profession takes a position against violence through its members it can become catalytic for deep-rooted social change.

On behalf of women in special situations of trauma and conflict, our **demands** are:

1. To provide access to all basic needs like food, water, sanitation, health care and so forth in camps set up for rescue, relief or military purposes, with assurance of privacy and adequate water and disposal system in toilets and bathing areas.
2. To consider women as individuals, not merely as part of family, at the time of enumerating/evaluating assets, property and compensation amounts.
3. To pay adequate attention to preventing violations of women's human rights that occur during and after disasters and conflicts, such as early/forced or bigamous marriages, trafficking, rape etc. and to work towards guaranteeing freedom from physical and sexual violence against women.
4. To develop and provide special health services for conflict and trauma survivors including counselling, psychiatric care, recanalisation (reversal of tubectomy), adoption, and therapy for Post Traumatic Stress Disorder (PTSD) including yoga, meditation and other healing modalities.
5. To prohibit discrimination in rehabilitation on the basis of caste, religion, ability, marital status and so on, and to prosecute those who discriminate.
6. To provide free and accessible legal aid to assure both individual and social justice.
7. To prosecute perpetrators and to provide adequate compensation to survivors, assuring unconditional and dignified safe return to homes and original occupations.

#### **J) Women Living in Custody of State Institutions**

Women inmates in state institutions such as prisons, remand homes, mental institutions, asylums, juvenile or 'correction' homes, beggars' homes, state orphanages and old age homes are extremely vulnerable by the fact that they are temporarily or permanently incarcerated. Due to loopholes within the system, callousness, outdated laws, moral policing and so on, justice is delayed or denied to many women, and they land up living in institutions far beyond the necessary period with little hope of being released.

Often women inmates suffer abuse or neglect by those very people entrusted with their safety. They are doubly disempowered, on one hand incurring social stigma and discrimination for their incarceration and on the other being at mercy of a de-personalised, often dehumanized institutional system. Frequently abandoned by their families, they are vulnerable to neglect and violence without legal or even medical intervention. Brutal or unethical treatments (punishments, unnecessary surgeries or drugging, sexual harassment and rape, being used as guinea pigs for clinical trials, or for organ or sex trade) can thrive with

impunity within institutions. The trend of reducing resources and increasing staff workloads (especially of Class III and Class IV employees) precludes inmates from receiving adequate clothing, food and care. Therefore, the health and human rights of women in institutions are of utmost importance and need immediate attention.

So on behalf of women living in the custody of institutions, our **demands** are:

1. To treat all women with respect and dignity, assuring protection of their human rights, civil rights (voting, etc.) and legal rights (property and inheritance, legal representation, grievance-redressal, etc).
2. To assure the human rights of inmates to personal security and integrity, specifically guaranteeing the freedom from torture, bodily harm, abuse and humiliation.
3. To withdraw unrestricted control over the lives, minds, bodies and health of incarcerated women from those who run the institutions.
4. To ban corporal punishment and other forms of humiliation, to monitor human rights violations by staff or other inmates within institutions, and to prosecute and punish the perpetrators of violations.
5. To guarantee freedom from trafficking, forced labour and forced prostitution.
6. To provide comprehensive health care for women inmates, including preventive care with periodic physical, pelvic and breast exams, pap smears, ultra-sonography and mammograms, according to a standard well-women protocol, and to provide pre- and post-natal care for women and their newborns in custody.
7. To involve women in arrangements for care of their infants and children; if ever a child has to be separated from the mother, to keep her continually informed and to give her reasonable access to the child.
8. To prevent the presence of a woman inmate's infant or children from being used as a pretext to exert control over her or to torture her.
9. To enable fulfilment of the right of girl children and adolescents to be fostered and adopted into safe, secure and nurturing homes.
10. To assure any woman's right to put up her child for fostering and adoption, but never to physically or emotionally separate a child from an inmate against her wishes.
11. To make available regular health check-ups, early detection and treatment of illnesses, and counselling, assuring the right to second opinion and to the compulsory presence of a woman attendant during medical examination.
12. To assure the right to privacy and confidentiality of medical records.
13. To assure access to health services for any woman throughout the country without discrimination on grounds of her legal situation, including accessible and available trained health care providers, diagnosis and treatment facilities, and care institutions that provide inmates with necessary and prompt care and referrals when required.
14. To protect women inmates from being subjected to unethical and or invasive research including in drug or vaccine trials, or to unnecessary medical or surgical intervention, and to assure the right to informed consent with the right to refuse participation in medical, social science or drug/vaccine/technology trial research.
15. To assure access for institutionalized women, in event of medical violations, to legal advice and grievance-redressal in the presence of a medical board that includes a woman social worker or psychologist as well as representatives from the State Women's Commission and/or other women's organisation(s).
16. To stipulate it as the duty of medical officer to report to authorities where continued imprisonment is likely to injuriously affect woman's health and wellbeing in any way.
17. To provide for correctional aids (spectacles, hearing aids, calipers, wheelchairs etc.) and to make nutritional supplements available whenever required.
18. To provide adequate supply of water for drinking and bathing and of nutritious and wholesome food that is well-prepared and served at appropriate hours.
19. To provide living accommodation that meets all health requirements, with due regard to climatic conditions, safety and hygienic standards, including air quality, minimum floor space, lighting, heating and ventilation, sleeping facility with mosquito nets, and adequate bathing/showering/sanitary installations sufficient for menstrual hygiene.
20. To provide adequate and clean clothing including under garments, and sanitary pads.
21. To make available opportunities for educational, recreational and creative pursuits, including vocational and occupational training.

22. To consider as final, in case of non-criminal incarceration, such as in mental asylum, orphanage, ashramshala or rescue home, a woman's decision about staying or leaving the institution.
23. To provide for availability of a full time counsellor and social worker on the premises.
24. To provide for counselling of families to help them accept and cope with the woman's incarceration and to readjust with her after her release from the institution.
25. To provide for alternative short-stay homes, day-care centres and community-based shelters to help families cope and relieve them from solely looking after the woman.

**K) Women of Religious, Caste and Ethnic Minorities**

Women in the religious, caste and ethnic minorities have special health needs because of the delicate and often volatile situations in which they live. Majority politics as well as minority insecurities affect the daily lives, security, autonomy and well-being of these women. They suffer doubly under the fundamentalism and/or conservatism of both majority and minority communities. Myths, stereotypes, and ignorance in the majority groups about the minorities reduce minority women's access to health care, education, livelihood, mobility and gainful employment. The blind spot, and occasionally the excessive glare, of mass media on minority women's issues, especially those related to sexuality, also precludes the existence of secular spaces for minority women to place their demands.

We see an increase in atrocities against dalit women and the sexualisation of mass violence, whether in wider caste or communal strife situations or to settle scores locally. In an environment dominated by majoritarian politics and hatred, not only is there reduced access to justice or medical intervention for minority survivors, but they also face possibilities of ostracism as women within their own communities.

Therefore, our special **demands** on behalf of minority women are:

1. To guarantee the physical safety of all women in the minority groups, especially in times of strife and riots, and for the State to exercise due diligence wherever violence against minority women is concerned.
2. To protect women's reproductive and sexual rights and to prosecute the violators.
3. To protect internally displaced women from trafficking, violence in relief camps, and early or forced marriages; to enable fulfilment of their right to return to homes and livelihoods unconditionally, with social justice, guarantee from the State that violations will not recur, and apology from the perpetrators.
4. To protect the livelihoods of women, assuring access to health care, to education, jobs and housing for all women without discrimination and stigma through immediate and positive measures.
5. To prevent all discrimination based on caste, culture, religion or tribe, guaranteeing all women equal rights within family and marriage, including the rights related to divorce, adoption, inheritance or land and property ownership and access.
6. To provide for positive discrimination (reservation) for all women who come from discriminated backgrounds.
7. To disallow and delegitimise all trials by caste panchayats or religious bodies taking place outside the secular courts.
8. To restrict media and health providers from promoting and sustaining stereotypes about women of various minority groups by sensitising them to the special and different but equal position of minority women in society.
9. To see that all medical and health interventions are designed with cultural sensitivity, yet but do not essentialise any group or justify human rights violations in the name of religion or culture.

## EPILOGUE

In compiling women's perspectives on health rights and their related demands in the *Indian Women's Health Charter*, we have tried to squarely address the differences that exist between unequally placed women living in diverse situations in India. In this Charter we affirm a spirit of inclusion of ALL women and a will to eliminate all forms of discrimination against them, particularly in matters of health and health care. At the same time we aim towards equality between men and women.

As we give the final touches to the Charter about two weeks before releasing it in the National Health Assembly (II) of the *Jan Swasthya Abhiyan* (People's Health Movement) at Bhopal, we realise that the document is still not 'complete'. Even so we hope that it will help various groups to incorporate women's 'health and development' perspectives within their own advocacy discourses. Rights can only be expanded, and so we hope that the Charter grows over the years, serving as a tool for campaigns and movements to enunciate and advocate for health-related rights and demands.

Now let us make sure that the demands in the Charter truly become more than a wish-list! We need to debate the aspects of the new and unfamiliar demands, to understand them and take them to heart. We need to push Government to adopt these demands of women in spirit and in letter within laws and policies. Likewise, we need to press Government to ensure enabling conditions for all women in India to attain equal health status as well as equal access to comprehensive health care services as part of their basic human rights. In pursuit of these goals, our connection with other movements is crucial.

Today (on International Women's Day), we dedicate this Charter to all women living within India. With sadness we remember the women who have needlessly died from lack of health services or from poverty, neglect and violence. We raise our voices against these denials of health rights as violations of women's human rights. In salute to all women survivors of individual and structural violence, we pledge to fight discrimination, oppression and marginalisation and to move towards peace and justice.

**ACRONYMS:**

(used in the *Indian Women's Health Charter*)

AFSPA	Armed Forces Special Powers Act
AIDS	Acquired Immuno-Deficiency Syndrome (due to HIV virus infection)
APL	Above Poverty Line
ART	Anti-Retroviral Therapy (for HIV); also, Assisted Reproduction Technology
ASHA	Accredited Social Health Activist (in NRHM)
AYUSH	Ayurveda-Yoga-Unani-Siddha-Homeopathy (Department in Ministry of Health & FW)
BNHRA	Bombay Nursing Homes Regulation Act
BPL	Below Poverty Line
CEDAW	UN Convention for Elimination of (All Forms of) Discrimination against Women
CHW	Community Health Worker (village-level)
CSR	Corporate Social Responsibility
CPC	Criminal Procedure Code
ECT	Electro-Convulsive Therapy (electric shock)
EGS	Employment Guarantee Scheme
EIA	Environment Impact Assessment
EMR	Exclusive Marketing Rights (like Patent)
FYP	Five Year Plan (of Government of India)
GATT	General Agreement on Trade & Tariffs
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HRT	Hormonal Replacement Therapy
ICDS	Integrated Child Development Scheme
IEC	Information, Education and Communication
IMA	Indian Medical Association
IMR / NMR	Infant Mortality Rate / Newborn Mortality Rate
IPR	Intellectual Property Rights
IWHM	International Women & Health Meeting
JSA	Jan Swasthya Abhiyan (People's Health Campaign)
LCA	Local Competant Authority
LGBT	Lesbian, Gay, Bisexual, Transgender
LPG	Liberalisation, Privatisation, Globalisation
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate

MoH&FW	Ministry of Health and Family Welfare
MNP	Minimum Needs Programme
NCW	National Commission for Women
NGO	Non-Government Organisation
NHA-II	2 <sup>nd</sup> National Health Assembly (2007)
NPP	National Population Policy
NREGA	National Rural Employment Guarantee Act
NRHM	National Rural Health Mission
PCPNDT	Pre-conception and Pre-natal Diagnostic Techniques (Act)
PDS	Public Distribution System (Ration)
PESA	Panchayat Extension to Scheduled Areas
PHC	Primary Health Care / Centre
PHA	People's Health Assembly
PIL	Public Interest Litigation
PPP	Private-Public Partnership
PRI	Panchayati Raj Institutions (Act)
PTSD	Post-Traumatic Stress Disorder
PWD	Persons with Disability (Act), 1995
PWDVA	Protection of Women from Domestic Violence Act
RTI	Right to Information (Act) also, Reproductive Tract Infection(s)
S. 377	Section 377 of Indian Penal Code, pertaining to sexual acts 'against nature'
SC/ST	Scheduled Caste / Scheduled Tribe
SEZ	Special Economic Zone
SHG	Self-Help Group (Savings & Credit)
SMZ	Special Medical Zone
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant ( Dai)
TFA	Target Free Approach
TRIMS	Trade Related Investment Measures
TRIPS	Trade Related Intellectual Property & Services (Agreement)
VAW	Violence Against Women
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization

**Some Word Meanings (used in the *Indian Women's Health Charter*)**

ability to pay	this refers to the universal right of all persons to basic services like health, education, food security and so on, irrespective of their 'ability to pay'.
comprehensive	all-encompassing; referring to health care it entails all preventive and curative aspects of health (including mental health and occupational health) with gender-sensitivity, non-discrimination and addressing



	health needs throughout the life-span.
custody	the right or responsibility to guard a person (child, adult) especially as granted by a court or by law.
determinants	Factors, as in 'social determinants of health'
disability	Deprivation of access to facilities faced by persons with impaired physical or mental functions
discrimination	bias against or exclusion of any particular person or group.
equity	Equality with justice
erotic	Pertaining to sexual desire, or arousing it.
gender audit	public scrutiny of government allocation and implementation of programmes & schemes in view of benefit to girls and women
holistic	refers to a total integrated view; every part reflects the whole (as used in 'health care')
life-cycle approach	a view that considers the concerns and needs in all the phases of a person's life
panchayat	According to the PRI Act, an elected body of local government at village & block level; however, many castes in India try to control their members through separate traditional 'caste panchayats'.

patent	Exclusive right granted for a limited period of time to produce and market a product
positive people	Persons who are HIV-positive, living with the virus of AIDS
neo-liberalism	Reorganisation of state policies to facilitate strengthening of market, commercialisation of each sector of the economy, withdrawing state-supported services and social security, deregulation in production, exchange & distribution of goods & services, promoting private sector and curbing the public sector.
reproductive health	health relating to reproductive system and behaviour; broadened to include sexual health of both women and men and related concerns throughout the life-cycle; it should be rightly placed in the holistic context of general health.
rights-based approach	current approach to development and health that sees people (and women) as agents in their own / society's development, and holds the State accountable for enabling fulfillment of their rights.
sexual orientation	the private sexual preference of a person for heterosexuality, homosexuality or bisexuality.
stigma	shame or disgrace attached to something regarded as socially unacceptable
universal	inclusive of ALL people, with reference to rights to comprehensive health care, food security (through universal PDS), etc.

Note: Some of the definitions are debatable. We invite further suggestions regarding words and meanings that we use often in our discussions and debates.