ARROW RESOURCE KIT

GENDER, FEMINISMS AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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Gender, Feminisms and Sexual and Reproductive Health and Rights
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CONTENTS

INTRODUCTION

The Asian-Pacific Resource and Research Centre for Women (ARROW) is a non-profit women's NGO based in Kuala Lumpur, Malaysia and has been working since 1993 to champion women's health issues. ARROW aims to achieve this through interlinked strategies of information and communications, knowledge exchange and transfer, evidence generation for advocacy, consistent monitoring of progress towards relevant international commitments made vis-a-vis women's health, capacity building, partnership building for advocacy, engagement at international and regional fora, and enhancing the organizational strength of ARROW and partners. ARROW works with a core set of national partners across Asia and the Pacific, as well as with regional partners from Africa, Middle East and North Africa, Eastern Europe, and Latin America and the Caribbean, and with allied international organisations.

The Kit is a user-friendly and easy to navigate resource. It is presented in simple, non-technical language as far as possible. The Kit tackles the diverse meanings attached to key concepts, explaining why these issues are pertinent, whose issues they are, where they come from and how they can be nuanced for more strategic interventions.

In ARROW's engagement at the national, regional and international levels, staff and partners require a uniform, sound and robust knowledge of key concepts related to gender, feminism and Sexual Reproductive Health and Rights (SRHR). In order to develop this, access to key information resources, in addition to ARROW resources, can help understanding of these concepts and discourse that have developed. In turn advocates can use it to inform their work. The discourse in relation to these concepts is constantly evolving and is dynamic, and as researchers and activists, this dynamism should also inform their work.

The aim of this Resource Kit on Gender, Feminism and Sexual and Reproductive Health and Rights is to help meet these needs. The Kit is a user-friendly and easy to navigate resource. It is presented in simple, non-technical language as far as possible. The Kit tackles the diverse meanings attached to key concepts, explaining why these issues are pertinent, whose issues they are, where they come from and how they can be nuanced for more strategic interventions.

The Resource Kit was conceptualised and written by TK Sundari Ravindran and Renu Khanna and coordinated by the Rural Women's Social Education Centre (RUWSEC), India.

PART 1

Concepts Related to Feminism, Gender and Human Rights

TK Sundari Ravindran

1.1 FEMINISM

1.1.1 What is Feminism? Who are Feminists?

The origins of the term 'feminism' are uncertain. However, we would all agree that the term emerged a few hundred years after the emergence of concern for discrimination against women based on their sex. The term seems to have been widely used in Western Europe and Britain towards the end of the 19th century and early 20th century (Offen 1988, Freedman 2001) to describe women's movements for equal rights in suffrage.

It would be difficult to present a definition of feminism that all feminists would agree with. It would not be incorrect to say that there is no one feminism but many feminisms (Freedman 2001, 1). Because the manifestations of male power and female subordination/discrimination against women takes diverse forms across cultures, societies and historical time, what feminism means is likely to be different across contexts and has been evolving over time.

All the same, there are unifying ideas running through all. Feminisms may be described as a system of ideas that oppose norms and values upholding male privilege—also known as patriarchy—and the subordination of women in family and society. All feminisms call for transformation of social, economic, political and cultural structures that uphold male superiority and aim to reduce and eventually eliminate sex-based discrimination against women (Freedman 2001, 1; Offen 1988, 151). Sections 1.1.2 and 1.1.3 describe some key principles of present day feminism.

Feminism is a concept that encompasses an ideology, analytical frameworks and strategies for socio-political change (Delmar 1986,17-18). Feminism has existed as an intellectual tendency beyond movements by and for women. It has also existed as a strand within various movements—e.g. socialist movements, anti-colonial movements, environmental movements, peace movements—seeking to draw attention to the ways in which the issues of focus may impact differently on women and men (Batliwala and Friedman, 28-29). As an analytical framework, feminism has created a range of analytical tools and methods for better understanding the processes and mechanisms through which women's subordination has been constructed and sustained over centuries (e.g. gender-based division of labour; control over sexuality and reproduction). Feminism has also been influenced by the work of queer scholars to go beyond the gender binary to factor-in diverse gender identities and sexual orientations.

As a strategy for social change, feminism is committed to the transformation of power inequalities between men, and women and other marginalised genders. It assesses all change interventions and progress on the basis of whether the change has advanced the position of women and other marginalised genders. Feminism seeks to give voice and equal participation to all and be based on collective leadership, or at the least, consultative leadership in all attempts to mobilise for social change.

As there are many feminisms, so are there different kinds of feminists, with some common features that help distinguish them from non-feminists. Delmar (1986, 16) describes a feminist as "someone whose central concern and preoccupation lies with the position of women and their struggle for emancipation".

A more elaborate description is offered by Offen (1988). She describes a feminist as "any person, female or male, whose ideas and actions (in so far as they can be documented) show them to meet three criteria:

1. they recognize the validity of women's own interpretations of their lived experience and needs and acknowledge the values women claim publicly as their own (as distinct from an aesthetic ideal of womanhood invented by men) in assessing their status in society relative to men;
2. they exhibit consciousness of, discomfort at, or even anger over institutionalized injustice (or inequity) toward women as a group by men as a group in a given society; and
3. they advocate the elimination of that injustice by challenging, through efforts to alter prevailing ideas and/or social institutions and practices, the coercive power, force, or authority that upholds male prerogatives in that particular culture. (Offen 1988, 152)

Thus, a feminist need not be a woman, and being a woman does not make one a feminist. Further, while feminists oppose the ideology of male superiority and privilege, they are not necessarily anti-men.

If feminists are concerned with women's rights and progress, is the converse true? Would it be accurate to term as 'feminist' everyone who is concerned about women's rights and working towards improving women's position in society? Indeed, no. One does not have to be a feminist to support women's progress. What distinguishes a feminist of any shade from others who may be working for women's rights is a shared social analysis that opposes institutionalized privileging of male authority and systematic discrimination against women throughout their lives.

KEY DEBATES

Equality Versus Difference Between Sexes

A key debate in the feminist movement over more than five decades is that of "equality versus difference". (Scott 1988).

Some sections of feminists represent the differences between women and men as minimal. They view the granting to women of equal rights as granted to men as key to the advancement of women. In their view, highlighting the differences between the sexes could trap women into stereotyped roles, denying them opportunities and resources available to men.

However, others criticize this stance of "knocking on men's doors to be let in". In their view (and in ours), the idea is not to minimize the differences between men and women but rather, to claim that these differences are not of lesser of value. Rather than seeking or demanding a share of the power and privileges enjoyed by men in a hierarchical and male-dominated society, feminists ought to reorder society and its structures "to be in tune also with women's requirements" (Offen 1988, 123). We would claim that women, and for that matter, all human beings, may be different but are equal. Difference does not necessarily mean a lower or higher position in the social hierarchy.

Do All Women Share the Same Experiences?

The assumption of "sisterhood" and solidarity among all women based on their shared experiences of economic, legal, political discrimination by male-dominated social structures has been another source of major tension in the feminist movement of the late twentieth century. The movement, led by white middleclass feminists of the global North, seemed to assume that women constituted a homogenous social class, united in their opposition of men as a class. This was manifested in their framing of various issues as common to all women, irrespective of race, class or nationality.

The emergence of third wave feminism is in part a response to the failure by the mainstream feminist movement to factor-in the diverse meanings of womanhood by context and the varied experiences of women. This resulted in the marginalization of the issues that were of relevance to women of diverse races, classes, sexual orientations, religions, nationalities and so on.

Section 1.1.3 describes in greater detail the positions of these diverse feminisms.

Is Feminism Confined to and Concerned only with Women's Issues?

Some think of feminism as concerned only about equal opportunities for women on par with men, and successful entry into male bastions hitherto denied to women. Feminism does not support the narrow concerns of privileged women who seek equality with men even while themselves being party to subordination of other human beings based on race, class etc.

Twenty-first century feminism is concerned beyond gender equality. It challenges all forms of oppression, and is concerned with development and emancipation issues (Batliwala and Friedman 2014, 28). Present day feminism goes beyond parity between sexes and accepts multiple gender identities; it recognises heterogeneity within the group of women based on their age, race, location, class etc. and seeks gender equality in a transformed society that upholds equality and human rights for all.

1.1.2 Three Waves of Feminism: A Brief History

Maggie Humm and Rebecca Walker identified three different waves of feminism historically. The first wave of feminism is identified with the feminist movements of late 19th and early 20th century. This was an extended period of activism for women's rights in Britain, USA and in Western Europe. The second wave of feminism emerged in the late sixties and early seventies and acquired a global character by the 1980s. The third wave extends from the 1990s and co-exists alongside the second wave in the present day. Even while we talk of "waves" of feminism, it is important to remember that feminist groups continued to exist and work between these waves. What the waves signify are periods of intensive activity when large groups of people were mobilized around the feminist political agenda (New World Encyclopedia 2017).

First Wave Feminism

As already mentioned, sections of women have for several centuries critiqued and written about the unfairness of denial to them of freedoms and resources enjoyed by men. However, it was not until the late nineteenth century that women in the USA, UK and Western Europe began to mobilise to demand an end to this situation, marking the beginning of the first wave of feminism in the Western world.

Although known mainly as a movement for women's right to vote, first wave feminist movement included attempts to promote women's rights within marriage; right to own property; right to education and the right to work outside the home (New World Encyclopedia 2017; Fisher 2013a, 30 April). Women gained entry to colleges and medical schools and into the world of work. By the 1920s women had gained the right to vote, in the UK and in the USA. The latter part of first wave feminism witnessed campaigns for birth control by feminists such as Margaret Sanger and Annie Besant (New World Encyclopedia 2017).

Second Wave Feminism

Second wave feminism is believed to be premised on the sweeping social changes that occurred in the USA, UK and Western Europe during World War II and its aftermath. Women had joined the workforce in large numbers because the men were at war but were relegated to their homes and hearths after the war when the men returned to their previous jobs. However, women had by then discovered that they could do men's jobs. Elsewhere in the world, this was a period of anti-colonial struggles in which significant numbers of elite and middle-class women participated alongside men.

The Civil Rights Movement and the anti-Vietnam war movements in the USA politicized large numbers of young students. Women who had been a part of organisations such as Student National Coordinating Committee (SNCC) and Students for Democratic Society (SDS) felt that their voices were not being heard within these structures, which were dominated by patriarchal norms (Dorey-Stein 2015, September 22). Women's experiences with political activism and their encounter of patriarchal domination even within progressive organisations paved the way for the emergence of second wave feminism. Books such as "The Second Sex" by Simone De Beauvoir, which appeared soon after the end of the second World War in 1947, and the "Feminine Mystique" by Betty Friedan in 1963 made a deep impact on and shaped the politics of second wave feminism.

Second Wave feminism in the West built on the gains made during the first wave and extended it much farther. Women advocated for equal pay and equal opportunities for employment (Fisher 2013b, May 8). It is closely identified with the slogan "The Personal is Political", coined by the feminist activist and author Carol Hanisch (New World Encyclopedia 2017). Women were encouraged to understand their personal lives as representing the sexist power structures of society, to question power inequalities within personal and intimate relationships within the family; and to see the links of their personal subordination to the larger social, economic and political structures (Delmar 1986, 26). Second wave feminism used the language of collectivism rather than individualism; it refuted formal, hierarchical structures and set about creating non-hierarchical structures; it preferred participation by all groups of women over representation of all women by a few.

The availability of the birth control pill in 1960 revolutionised women's thinking about their right to contraception and abortion. Conversations on sex, sexuality and women's right over their bodies appeared centre-stage. Women were not only challenging male control over women's sexuality but asserting women's sexual persona and right to sexual pleasure.

Third Wave Feminism/Post Feminism/ Neoliberal Feminism

Third wave feminism emerged as a response to perceived failures of second wave feminism and continues to co-exist with it. One of the key challenges posed by third wave feminism is the assumption that there is a universal female identity and defining "women's issues" predominantly from the perspective of white-middle-class women from the global North. The challenges began in the US by African American feminists who felt that race issues were side-lined; by women from the global south who identified the absence of an analysis of colonial domination (New World Encyclopedia 2017).

Third wave feminism also includes feminist strands that have emerged from various social movements and in response to specific contexts, for example, eco-feminism and Islamic feminism.

Third wave feminism rejects the notion that there are only two genders and accepts the concept of a gender continuum, with each person, whether male or female, is located somewhere along the continuum. It challenges heteronormativity and acknowledges the existence of diverse sexual orientations. Some groups within this wave of feminism also identify themselves as "sex positive", celebrating sexuality as a positive aspect of life. However, in some instances sex positive groups have taken controversial stances such as support for pornography, sex work and sadomasochism as individual choices on which moral positions should not be taken (Fisher 2013c, 16 May).

Third wave feminism upholds plurality and diversity, and is comfortable with the idea that feminists need not have one unified agenda; or at least one beyond the very general goal of working towards gender, racial, economic and social justice (Encyclopedia Britannica 2017).

Some of the above strands of third wave feminism that are a critique of second wave feminism, are also used as synonymous with post-feminism. Post-feminism is a term that means different things to different people. However, most definitions of post-feminism include the opposition to a monolithic view of women as a homogenous category and the emphasis on gender and sexual diversity—what we have described as third wave feminism. Post-feminism also opposes second wave feminists' rejection of femininity and celebrates women's freedom to choose how to dress and what to consume.

Post-feminism is also described by some feminist scholars as closely related to neoliberal ideology of individualism, free-choice and self-governance, or 'neoliberal feminism'. They are embedded in, and uphold consumerist values, and are focused on the achievements of individual women and not about the conditions of all women (Genz 2006). More discussion on neoliberalism and its impact on feminism follows in Section 1.2.6.

Although each wave of feminism is identified with one major set of issues, there was considerable diversity within each wave in terms of the positions and strategies of different groups of feminists. The next section describes selected ideological strands within feminism across the three waves, and some facets specific to third wave feminism such as post-colonial and Islamic feminism. There is a wide array of feminisms, and it would need an Encyclopedia to describe these comprehensively. We have chosen to focus on a select few that we believe continue to be of great import and could provide guidance on future directions for the feminist movement of the 21st century.

1.1.3 Different Ideological Approaches to Feminism

In this section, we first discuss major ideological strands in first and second wave feminisms, namely liberal feminism, radical feminism and Marxist and Socialist feminisms. We then examine three strands of third wave feminism of particular relevance to the Asia-Pacific Region, namely post-colonial feminism, Islamic feminism and intersectional feminism.

Liberal Feminism

Liberal feminism has existed since the first wave and continues to do so. Liberal feminism seeks equality for women in all institutions of society, including government, law, education, workplace, and religion, and the family and marriage. Its main strategy is to organize for political and legal reforms that give women the same rights as men within these institutions.

Liberal feminism also supports affirmative action legislations that require employers, educational institutions and political bodies to make special attempts to include women (New World Encyclopedia 2017; Tong 1988).

Liberal feminism is seen as concerned mainly with equality in the public sphere, as expressed, for example, in equal access to education, employment, equal pay for equal work and so on. It does engage with the private sphere, with issues such as marriage, women's burden of house work and intimate partner violence, but from the perspective of how these may impede public equality. For example, liberal feminism seeks equality in marriage rather than question the very institution of marriage and the premises on which it is built. In the personal sphere, liberal feminists support the ideal of androgyny where both women and men acquire feminine and masculine traits, and become better human beings (Lewis 2017, 30 September).

Liberal feminism is critiqued mainly for assuming and acting as if true equality is possible in a society that is built on structures that stood on fundamentally unequal values and ways of doing business. Its failure to challenge the existing power structures and willingness to work within the rules that they have laid down may have led to incremental changes and improvements in the lives of some women—mostly from privileged sections of society. Liberal feminism is also critiqued for its lack of class and race analysis and its heteronormative past, but liberal feminists contend that this is no longer true; and that they have overcomes these biases of the past and adapted to newer realities (Tong 1988, Lewis 2017, 30 September).

Radical Feminism

Radical feminism emerged in the 1960s in Europe and North America. The term "radical" is used because it is focused on addressing the root causes of women's oppression, which is patriarchy.

A central tenet of radical feminism is that globally women as a biological class are oppressed by men as a biological class. Radical feminists see women's oppression as closely bound up with women's reproductive power and men's fear and hatred of it. However, they hold that women's subjugation has nothing to do with women's biology, and can be challenged and dismantled. The instruments of oppression are institutional structures that uphold male superiority and reinforce women's inferiority. Some radical feminists have also highlighted the role of male violence against women in the creation and sustenance of women's subordination. While radical feminists recognize the ways in which women are oppressed by class, race or disability, patriarchy is seen as the single most significant and root cause of women's oppression. Radical feminists do not subscribe to collaborating with the patriarchal system in order to win some gains for some women in the interim, but believe in a radical transformation of society and the demise of patriarchy (Radfem Collective 2017, Murphy 2011, 20 July).

Marxist Feminism and Socialist Feminism

These two are largely similar ideological stances with some differences, and it would be fair to say that Socialist feminism has a much larger following than Marxist feminism.

> *Marxist Feminism*

Marxist feminism explains women's oppression as rooted in capitalism and private property. In Family, Private Property and the State" (1884), Engels traced to the origin of private property the widespread social phenomena of the fixation with women's virginity and sexual purity before marriage and violent reprimand for women who transgressed social norms related to female morality. Chastity and fidelity on the part of women was necessary for ensuring that the inheritance of private property-owning men was passed on exclusively to their own children. Engels considered the nuclear family as the institution that made male control possible over women's labour and their sexuality (Tong 1988).

Marxist feminists talk about two types of labour: productive labour and reproductive labour. Productive labour is that which produces goods and services with a monetary value in the capitalist system and is therefore rewarded with a wage. Reproductive labour is in the private sphere and produces all other goods and services, which are necessary for survival: processing raw materials to make them edible, cooking, cleaning, child care, etc. Women are assigned to perform reproductive labour, which is uncompensated and receives no recognition within the capitalist system. Women's uncompensated reproductive labour serves the capitalist system by nurturing the current labour force and producing the next generation of labourers. Because this labour is seen as a natural function of women's roles as wives and mothers, and remains uncompensated, capitalists are able to pay their paid labourers low wages. If not for the unpaid labour of women in the households, workers in the "productive" sector would have to purchase these goods and services for a price and would need higher wages in order to do so (Tong 1988).

One of the limitations of Marxist feminism is its view of women's oppression as a sub- component of class oppression. Marxist feminists take the view that with the overthrow of capitalism and overcoming of class oppression, women will no longer be oppressed because the very basis of their oppression, i.e. capitalism, will be demolished. Experiences from erstwhile socialist countries bear testimony to the persistence of discrimination against women (Tong 1988).

> *Socialist Feminists*

Socialist feminists share with Marxist feminists most of the analysis related to women's oppression and its roots. The differences may be summarized as follows. Unlike Marxist feminism, socialist feminism does not believe that capitalism alone was at the root of women's subordination in society; and unlike radical feminists, neither does it believe that patriarchy alone was responsible (Tong 1988). According to socialist feminists, capitalism is a major factor for the oppression, not only of women, but of other marginalised groups. Conversely, capitalism is only one of many other axes of women's oppression, key among which are racism, patriarchy and imperialism. Socialist feminists stand for the transformation of social, economic and political structures of contemporary society into egalitarian and non-exploitative entities.

They focus a great deal on collaborating with all oppressed groups that suffer as a result of capitalism, patriarchy or any other form of domination (The feminist eZine).

Further, while Marxist feminists use the concept of 'alienation' only with respect to the external workplace and wage-labour, Socialist feminists see women's domestic work also as 'alienating'. Marx describes 'alienated' as the worker who sells his/her labour power to capitalists who owns the means of production, and engages in production of goods and services that are of no import to him/her, and over whose production process s/he has no control. This sense of "no control" is viewed as dehumanizing for the worker. Socialist feminists conceive the woman working within the home without any power to make decisions about what to do and when and how, as similarly alienated (The feminist eZine 2017).

Post-colonial Feminism

Post-colonial feminism is a response to the absence of recognition of patriarchal domination in post-colonial theory; and the tendency of feminists from Europe and America to universalise their issues as issues pertinent to all women. Post-colonial feminism calls for specific attention to the exploitation of post-colonial societies and their women by forces of global capitalism. It rejects the idea of global sisterhood and believes that women in postcolonial societies have to engage in simultaneous struggles for emancipation from patriarchy, imperialism, racism and other forces of oppression (Kamran 2017, 18 April).

Post-colonial feminists take the view that feminism in postcolonial societies is not imported from the Global North, but has evolved organically within their own countries, to challenge the specific forms of women's oppression happening in their own social, economic and cultural milieu. Post-colonial feminists such as Chandra Talpade Mohanty have critiqued Western feminists' tendency to depict women from post-colonial societies as victims devoid of agency, and have urged to evaluate the situation in these societies against the Western feminist norm (Kamran 2017, 18 April).

There are many similarities between post-colonial feminism and Black/intersectional feminism, discussed later in this section.

Intersectional Feminism

Kimberlè Crenshaw coined the term 'intersectionality' in 1989 which recognises women not as a homogenous group but divided by class, race, nationality, ethnicity, ability and sexual orientation (Crenshaw 1989).

Each of us have many identities at the same time, some of which enrich and others oppress us. The multiple oppressions experienced cannot be separated, and while all women may experience patriarchal oppression, not all experience it in the same way: some experience racialised patriarchy,[1] others experience trans-misogyny,[2] which cannot be equated to the experiences of more privileged groups. Intersectionality is about being aware of the multiple systems of power and privilege. It calls for examining the ways in which these multiple systems operate, sometimes reinforcing each other and at other

times colliding and off-setting each other. For example, a wealthy woman living with disability would experience the privilege of wealth and the disadvantages of being a woman and living with a disability. The way these three axes interact and the extent of oppression or privilege that results would depend on the context.

Intersectional feminists critique mainstream feminism's quest for a universal agenda because this may render invisible some unique problems that disproportionately affect a marginalised group. They advocate acknowledging and making space for issues affecting diverse groups of women. Adopting an intersectionality-lens in our practice of feminism is important to the movement because it allows the fight for gender equality to become inclusive.

I would view intersectional feminism not as a specific strand of feminism but rather, as a framework that influences Black feminism, socialist feminism, postcolonial feminism and other feminisms of a similar worldview. A more detailed discussion of intersectionality as a world-view that contemporary feminism would benefit from, is presented in Part 1, pages 12 and 16.

Islamic Feminism

Because the Asia Pacific region has a significant Islamic population and many countries adopting Islamic laws, it is important to discuss how feminists in these countries have sought to deal with this while maintaining their faith in Islam.

Islamic feminism may be seen as feminist discourse and practice located within an Islamic paradigm. The phrase "Islamic feminism' became visible and widely used since the 1990s by feminists in the Arab region. According to Mai Yamani (1996).

"Islamic feminism represents the ideology which describes the discourses and actions of those who uphold women's rights within the context of authentic and well-understood Islam" (Yamani 1996, 1-2). Although the term is of recent origin, there have been notable Islamic feminists who satisfy this definition for the past several centuries.

In the current era, there have emerged many organisations and groups that may be identified as Islamic feminists, although there may be some differences in their issues and strategies. There is a section of feminists for whom Islamic feminism is a strategy within contexts deeply.[1]

Patriarchy differentiates women from men while privileging men. Racism simultaneously differentiates people of colour from whites and privileges whiteness. Racialized patriarchy is an intersection of the two. For example, the sexual exploitation of women of colour who were slaves by their white supervisors or masters. Transmisogyny is an intersection of two forms of oppression that transgender women are subjected to: transphobia and misogyny (http://queerdictionary.blogspot.in/2014/09/definition-of-transmisogyny.html) suspicious of Western feminism. They seek to reinterpret the Quran and question Hadith and Shariah. Another strand of Islamic feminists take the position that Quran guarantees equal rights to women, but that a patriarchal religious order has interpreted it towards subordination of women. Another group takes an intersectional position, challenging the homogenising of all Muslim women, ignoring the enormous national, ethnic, cultural and class-based diversity among this group. This group locates the oppression of Muslim women beyond religion alone and factors-in class, ethnicity, geographic location and numerous other influences on women's status in society (Ahmed-Ghosh 2008).

Areas of concern for Islamic feminists have included the Muslim Family Law (MFL), which they believe have been distorted to become oppressive for women especially in the areas of marriage and divorce, polygyny, custody of children and right to property. While some groups of Islamic feminists have objected to discriminatory MFL in their countries, others seek to reform MFL to remove its discriminatory aspects. There are diverse stances also with respect to dress codes and especially the veil, with some groups calling it a visible symbol of women's subjugation and others supporting women's right to choose whether or not they would wear the veil. Islamic feminists have worked to gain equality in the Mosque and equality in leading prayer, among other issues. Some examples of Islamic feminist organisations are: Sister-hood, Sisters in Islam, Muslim Women's Quest for Equality and Musawah (Ahmed-Ghosh 2008).

Sisters in Islam in Malaysia was formed in 1988. The organisation takes the unique ideological stand that equality of sexes is guaranteed by Islam, and believes in working with the source, i.e., Quran, adopting the human rights framework and informed by the lived realities of women. This stance has helped them pressure the State to reform personal and family laws that were discriminatory to women Sisters in Islam is a pioneer in this area in the Asia-Pacific region, and from it emerged Musawah, which is now

an international feminist organisation that grounds its work on Muslim Family Law (Personal Communication, Rashidah Shuib).

Transnational Feminism

The term 'transnational feminism' is of recent origin. The term was first used by Inderpal Grewal and Caren Kaplan in their 1994 text, entitled Scattered Hegemonies: Postmodernity and Transnational Feminist Practices". Another seminal work on transnational feminism is the 1997 book entitled Feminist Genealogies, Colonial Legacies, Democratic Futures by M. Alexander and Chandra Mohanty (Herr 2014).

Transnational feminism draws on the ideologies underpinning post-colonial, intersectional, Marxist and socialist feminisms to build solidarity across borders. It acknowledges and critiques the role of neoliberal globalisation in women's oppression across all countries, and rejects the unidimensional focus of liberal feminism on gender as the only axis of women's oppression. Anti-globalisation and anti-capitalism are central to the worldview of transnational feminism. Transnational feminists reject terms such as "international" for its emphasis on nation-states and "global" as glossing over the distinct vantage points of women of colour and women from the global South (Herr 2014).

In a recent monograph, Chhachhi and Abeysekara (2014) have challenged the focus of transnational feminist debates on the global North/South and global/local. The monograph talks about the neglect of regional transnational feminist networks and their contribution to activism as well as knowledge production. There are Latin American feminists networks and South-Asian feminist networks, that share the worldview of transnational feminism. An example of transnational feminist activism in Asia is the alliance between the Korean and Japanese women's movements in their campaign on behalf of the victims of 'military sexual slavery' during the Second World War (Piper 2001).

There is a great deal of focus on changing norms and standards under the aegis of the UN system, but not enough action on legal reforms within countries; there is acknowledgement of forces beyond gender that impact SRHR but a failure to integrate intersectional and transnational feminist thinking into the analysis of SRHR issues and to develop an action agenda accordingly.

Where Does the Movement for Sexual and Reproductive Health and Rights Fit In?

From the documentation of various waves and ideological stances of feminism, it appears that the Sexual and reproductive health and rights (SRHR) movement is a part of second and third wave feminisms. Within the SRHR movement, we find strands of liberal, radical and socialist feminisms, and in fact, the same group may take political positions suggestive of all three ideologies. There is a great deal of focus on changing norms and standards under the aegis of the UN system, but not enough action on legal reforms within countries; there is acknowledgement of forces beyond gender that impact SRHR but a failure to integrate intersectional and transnational feminist thinking into the analysis of SRHR issues and to develop an action agenda accordingly. Part 2 on sexual and reproductive health and rights engages with the linkages between feminism and SRHR in some detail.

1.2 GENDER AND HUMAN RIGHTS

1.2.1 Evolution of Gender as a Concept in Feminist Thought

Sex and Gender

Simone De Beauvoir's assertion in The Second Sex (1949) that 'One is not born a woman, one becomes one' was precursor to the concept of 'gender' as used in feminist thinking and analysis since the 1970s. In her 1972 book titled "Sex and Gender", Oakley describes sex and gender as follows:

> *'Sex' is a word that refers to the biological differences between male and female: the visible difference in genitalia, the related difference in procreative function. 'Gender', however, is a matter of culture: it refers to the social classification into 'masculine' and 'feminine'.* (Oakley 1972, 16as quoted in Freedman 2001, 15)

More comprehensive definitions of sex and gender have evolved since then. Box 3 (page 39) gives more widely used definitions of sex, sexuality, and related terms.

When the concept of gender emerged in the 1970s, it marked a major step forward in feminist analysis of women's subordination in society. According to Freedman (2001), it made possible three theoretical advances:

- 'Gender' brought together the many differences between sexes that were socially constructed into one concept
- It drew attention to the relationship between males and females and to the social mechanisms that constructed and reinforced it
- Since attention was no longer limited to biological differences, facets of the relationship between sexes such as hierarchy and power came into focus (Freedman 2001, 16).
- However, it may be noted that there is no equivalent for the word 'gender' in many languages. The term is sometimes used interchangeably with women or sex if not elaborated and clarified. In numerous countries, the concept is explained rather than use the word 'gender', to misconceptions.

Beyond the Binary — Developments in the Understanding of Sex and Gender

The strictly 'binary' definition of sex and gender as 'male' and 'female' has since been challenged, as is the notion that gender alone is socially constructed, whereas sex is a "given" which cannot be altered.

It is now acknowledged that the strict binary division of biological sex into male and female is not borne out by nature. According to Girshick, one in 100 bodies deviate from what we recognise to be strictly "male" or "female" bodies (Girshick 2008). A wide spectrum of sex anatomy exist, which display variations in size and shapes of genitalia, and variations in the combinations of chromosomes, gonad tissues and hormones with which babies are born. What counts as 'male' and 'female' anatomy and as 'intersex' is decided by society. In fact, medical opinion on who is an 'intersex' person appears to vary widely (Intersex Society of North America 2017).

Across different cultures, a person's biological sex and gender identity are assumed to coincide, and the acknowledgement that they could diverge marked an important political advancement. This led to the evolution of the concept of 'gender identity', which refers to "one's sense of oneself as male, female, or transgender" (American Psychological Association 2011).

Judith Butler in her understanding of gender identities, introduced the concept of 'performativity' in which we, within our societal reality, continually create the illusion of gender "through language, gesture, and all manner of symbolic social sign" (Butler 1988, 519). Gender identity therefore need not remain static, and as Butler put it, "One is not simply a body, but one does one's body and one does one's body differently from one's contemporaries and from one's embodied predecessors and successors as well" (Butler 1988, 521). This then gives rise to the notion of Gender Expression. This concept surmises the fact that one's gender identity need not coincide with the way one chooses to express one's gender identity in terms of clothes and behaviour. A person may identify as female and express herself in what is socially understood as expressions of maleness.

Maleness and femaleness are now viewed as a continuum with individuals in a population located all along the continuum. The work of Dvorskyand Hughes on post-genderism takes the concept of gender even further. Gender will soon be seen as a dynamic and fluid characteristic with persons being able to assume different genders at different points in time with the help of technology bypassing biological, psychological and social gendering (Dvorsky and Hughes 2008).

Gender expansiveness is an umbrella term used to signify that a person's gender identity, behaviour or expression goes beyond commonly held definitions pertaining to gender. "An example of gender-expansive is a person who does not identify with being either male or female, or who identifies as a combination of both or who expresses their gender in a different way." (Your Dictionary 2018)

Intersectionality

In Part 1 we mentioned 'intersectional' feminism as the ideology that challenged the perceived hegemony of white middle-class feminism to bring in the vantage points of women of colour. The concept of 'intersectionality' reflects the ideological position of intersectional feminists. It starts from the premises that people have multiple identities and seeks to understand the ways in which patriarchy, class oppression, racism and other systems of discrimination create inequalities among women and men, placing some at a relative advantage or position of power as compared to the others (AWID 2004).

The intersectionality approach holds that:

- "human lives cannot be reduced to single characteristics;
- human experiences cannot be accurately understood by prioritizing any one single factor or constellation of factors;
- social categories/locations, such as 'race'/ethnicity, gender, class, sexuality and ability, are socially constructed, fluid and flexible;
- social locations are inseparable and shaped by interacting and mutually constituting social processes and structures, which, in turn, are shaped by power and
- influenced by both time and place; and
- the promotion of social justice and equity are paramount" (Hankivsky and Cormier 2009, pp.8-9; Hankvisky 2012, pp.1713).

Gender expansiveness is an umbrella term used to signify that a person's gender identity, behaviour or expression goes beyond commonly held definitions pertaining to gender.

The intersectionality approach implies that gender should be considered together with other contextually relevant social categories in any analysis of a situation or policy, and that within- group inequalities among women and men be identified and addressed. It also implies that power relations between men and women may not always favour men, and there may be situations where a subgroup of men (e.g. migrant, person with disability) is less privileged and powerless as compared to a different subgroup of women (e.g. local resident, able-bodied).

These advances in the understanding of sex and gender drawn from "queer" approaches and critical race theory have considerably enriched feminist analysis and conjure up a vision of an ideal society where all forms of gender and intersectional differences would have freedom of expression and enjoy dignity and equality. At the same time, because queer approaches have focused predominantly on sexual and gender diversity since the late 1990s, this has hampered advances in the conceptualisation of women's subordination by patriarchy in every-day life to keep pace with the fast changing social realities that impact on the relationships between and within the groups of women and men.

The next few sub-sections present concepts used to understand various dimensions of gender-based oppression and its converse—gender equality, autonomy and empowerment. These concepts date back to the 1980s and 1990s. Wherever possible, we have tried to extrapolate these concepts to include sex and gender as defined currently.

1.2.2 Concepts Related to the Mechanisms of Gender-based Oppression

A few key inter-related mechanisms have been identified as laying the pathways to gender- based inequalities. These include:

- Gender roles and norms
- Gender-based division of labour
- Access to and control over resources, and
- Access to power and decision-making

Gender Roles and Norms

Gender norms refer to the social and cultural assumptions about the relative value of women and men and girls and boys in society, about what constitutes masculinity and femininity, about women and men's accepted roles and behaviour, their relative power and their rights. Such norms manifest not only in individual and community values and behaviour but in the way that institutions are structured, reflecting the social assumptions about the position and value of men and women in society.

Across most cultures, gender roles and norms are governed by the patriarchal ideology, which upholds male privilege and female subordination as the natural order of society. "Male privilege" bestows on men rights and advantages just because of their sex. These include the right to property, control over women within married relationships and so on. Because male privilege has been the gender norm for centuries, it may be invisible to those who have it. Men may ascribe their superiority to their own merits. Not all men may have access to the same level of privileges. The extent of privileges accessed would depend on the intersection of gender with other axes of power and privilege. For example, rich men would have greater privileges than poorer men. Also, men who closely match society's ideal masculine norm (for e.g. heterosexual, able-bodied, physically powerful) may be more likely to enjoy the most advantages as compared to those who do not (Phillips and Phillips 2009). Male violence against women is one common manifestation of male privilege. Men exercise physical or sexual violence because they believe that women have to obey men, and that they, as men, have the right to discipline women.

Gender-based Division of Labour

This term was formerly referred to as 'sexual division of labour'. With the realisation that the division of labour is socially constructed, the terminology of 'gender-based division of labour' has come to be preferred.

Gender roles and norms define the range of tasks and activities that constitute 'men's work' and 'women's work',respectively. This is what we refer to as gender-based division of labour. Gender-based division of labour is reflected both in the types of employment available to women and men outside the home, and in the work they do within the household.

Within the hetero-normative male-headed household, women typically shoulder a 'triple burden' of work. This includes reproductive work (e.g., household tasks, child-bearing and nurturing; other care work, gathering fuel and fodder); productive work (work for income and subsistence) and community work (e.g., social responsibilities, care work). Young girls are may have to discontinue schooling to support their mothers in childcare and in household tasks.

Men are expected to be breadwinners/income-earners for the family and expected to do little around the household. Sometimes, young boys have to become income-earners because their father is no longer able to be the breadwinner.

As in the household, so in the labour market, women are preferred for some jobs and men for others. Far fewer women are found in managerial and leadership positions than men, while a majority of women are found concentrated in the lower ends of the job market. This is a trend globally, although there may be differences in extent across contexts. According to the Global Gender Gap Report 2017, women constitute only 22% of individuals holding senior managerial positions; the gap in wages between women and men has been widening, although earned incomes have been increasing for both genders (World Economic Forum 2017).

Some may view the gender division of labour as a harmless and practical way of sharing responsibilities. This may be so when women and men actually have a choice as to what they would do—be responsible for unpaid work within the household, or paid work outside. Further, in a society where all necessities have to be bought in the market, the

lack of a cash income makes women dependent on men for their everyday purchases and needs to ensure wellbeing. Women who do not have a man to support them or are in traditionally male-dominated relationships may be in extremely vulnerable situations.

Access to and Control Over Resources

In most societies, gender roles and norms combined with gender-based division of labour have resulted in lower access to and control over resources for women as compared to men. Resources are defined broadly to include information, decision-making, power, educational opportunities, time, income and other economic resources (such as land, the capacity to inherit, or credit), as well as internal resources (such as self-esteem and confidence). Access is having a resource at hand, while control is the ability to define and make binding decisions about the use of a resource.

Women's lack of access to and control over resources gives men the power to control key decisions affecting women's lives.

Power and Decision-making

Gender norms that vest greater value on men and uphold male authority in all institutions of society and provide men with greater access to and control over resources—i.e. patriarchal norms - makes men more powerful than women in most social groups. This may be the power of physical force, of knowledge and skills, of wealth and income, or the power to make decisions because they are in a position of authority. Men often have greater decision-making power over reproduction and sexuality. Male power and control over resources and decisions is institutionalised through the laws and policies of the state, and through the rules and regulations of formal social institutions. Laws in many countries of the world give men greater control over wealth and greater rights in marriage and over children.

Women's lack of access to and control over resources gives men the power to control key decisions affecting women's lives.

1.2.3 Concepts Related to Overcoming Gender-based Oppression

In this sub-section, we describe widely used concepts that describe women's freedom from male oppression. There is a wide range of such concepts, sometimes used with very different meanings.

Gender Equality, Gender Equity and Gender Justice

Gender equality refers to equal chances, irrespective of one's sex, for access to and control over social, economic and political resources (including protection under the law). It is alsoknown as formal equality (WHO 2011).

Gender equity refers to fairness and considers men and women's different needs to achieve gender equality (WHO 2011). Gender equity is sometimes referred to as substantive equality, where the goal is to achieve equal outcomes in terms of life opportunities, by recognizing the diversities within and across different gender identities and catering to these.

When boys and girls have the same right to enrol in school, they enjoy formal equality. However, substantive equality may be achieved when girls are provided with a scholarship to ensure that in circumstances of limited resources, they are not kept back from school to make way for their brothers.

The concept of gender justice seems to have evolved from disenchantment with the failure to achieve 'gender equality' even after several decades of feminist advocacy. There are many different definitions of gender justice that one comes across in published literature, from which one may surmise that gender justice is closer to the concept of gender equity. For example,

Seguino (2008) locates gender justice within Amartya Sen's capabilities framework. For her, gender justice requires that all genders enjoy access to adequate economic resources "in such measure as to ensure that each has the means to acquire the necessary capabilities." (Seguino 2008, 3). As in the case of gender equity, gender justice is also focused on equality of outcomes than of opportunities.

There is considerable controversy surrounding all three concepts. The concept of gender 'equality' is often criticized as representing a liberal feminist position, where the removal of legal discrimination is assumed to allow women the achievement of equal status to men, and women's progress is measured against male norms. However, having the same opportunities at a given point in time may not result in de facto equality between genders because of unequal starting points; because the laws and institutions in society are tilted in favour of males, and because there may be differences in needs by gender. The example of formal versus substantive equality (see page 18, Part 1) would serve to illustrate this point. In contrast, human rights advocates are deeply concerned with the clever use of the terms "gender equity" and "gender justice" by conservative governments to deny the right to non- discrimination and gender equality. A publication by Sida (2016) cites how the government of Turkey used the term 'gender justice' to counter gender equality as "against nature". The publication warns that "Gender equity and other similar concepts may open up for actors that want to move away from the women's human rights agenda. It is important to keep in mind that the use of these concepts may be an indirect support to conservative and repressive actors." (Sida 2016, 2).

Empowerment and Autonomy as Markers of Gender Equality

> *Empowerment:*

Williams et al (1994, p.233-234) in the Oxfam Gender Training Manual, defined empowerment in relation to various forms in which power operated.

- **power over**: This power involves an either/or relationship of domination/subordination. Ultimately, it is based on socially sanctioned threats of violence and intimidation, it requires constant vigilance to maintain, and it invites active and passive resistance;
- **power to:** This power relates to having decision-making authority, power to solve problems and can be creative and enabling;
- **power with:** This power involves people organising with a common purpose or common understanding to achieve collective goals;
- **power within:** This power refers to self- confidence, self- awareness and assertiveness. It relates to how can individuals can recognise, through analysing their experience, how power operates in their lives, and gain the confidence to act to influence and change this.

For feminists, women's empowerment was mainly about 'power-with' and 'power-within', and also about 'power-to', but not about 'power-over'. Empowered women did not seek to control men or other women, but just to have greater control over their own lives and have the possibility of working with other women to achieve their lives' goals.

Kabeer (2001), whose definition is the most widely accepted, defines empowerment as "the expansion of people's ability to make strategic life choices in a context where this ability was previously denied to them. Having the power to decide whether or not one should find employment, or pursue higher studies, are some examples of strategic life-choices. Other feminist definitions of women's empowerment have visualized empowerment as being bottom- up: claimed, not bestowed; enabling greater participation in the affairs of the community in which one lived and worked, and challenging oppression and injustice (Oxaal and Baden 1997).

In the 1970s and 1980s, when the integration of women in development policies and programmes was high on the agenda of some sections of the feminist movement, civil society,and of multilateral UN organisations, 'empowerment' of women was spelt out as the explicit goal of this endeavour. Over time, women's empowerment has been interpreted to mean many different things, to the extent of equating women's credit programmes as 'empowering' for women just because women would now have marginally more access to cash.

Addressing just one dimension of a practical need of women, such as need for credit, does not amount to empowerment. Empowerment happens when the relative power that women wield as compared to men increases, so that women are able to exercise their decisions and choices. While the former is called a practical gender need, the latter is known as a 'strategic gender need'.

> *Autonomy*

Autonomy is "an individual's capacity for self-determination or self-governance" (Internet Encyclopaedia of Philosophy 2017). The achievement of 'autonomy' by women has been a coveted goal on the feminist agenda. However, definitions of women's autonomy range from the sophisticated, nuanced and complex to the simplistic and fuzzy.

An autonomous individual, according to Joel Feinburg, has a distinct self-identity and is self- directed; he/she is not subject to external influences when making decisions and thinks for herself, himself. While this definition of autonomy suggests no role for external influences others such as Dworkin acknowledge that autonomous individuals may be shaped to some extent, by the context and history of their socialization in childhood. Social conditions were seen as influencing, but not determining a person's autonomy, which was seen as dependent on internal psychological states and capacities (Abrams 1999).

Feminist thinkers have critiqued this conceptualization of autonomy as a self-made characteristic of individuals isolated from each other; and reconceived it as influenced by the social environment and personal relationships. Dorothy Meyers, for example, argued that girls and women were conditioned into accepting specific ways of being within a patriarchal society, and hence there was no such thing as absolute autonomy. What women were able to achieve was various forms of partial autonomy—for example, being able to exercise some choices but not others; having some but not all attributes of an autonomous person; or being able to act autonomously in some specific situations or relationships and not in others (Abrams 1999). Baumann (2008) asserts that a person's autonomy cannot be assessed at single points in time and postulates that autonomy is a diachronic property of persons.

In contrast, demographers have often treated autonomy at a rather mundane level, far removed from moral decisions on the course one's life must take. The introduction in Demographic and Health Surveys of indicators of women's autonomy seems to have reduced women's autonomy to a few specific areas of decision-making within their households. These include decisions related to purchase of everyday articles and more valuable assets; ability to spend money on their own; and their freedom for physical mobility. Scales have been developed to quantify women's autonomy based on responses to yes/no questions about these decisions, based on which women are classified as being more or less autonomous. In many of their writings, autonomy is used interchangeably with empowerment (Jejeebhoy 2000).

Interestingly, one of the key sources of women's subordination—control over reproduction and sexuality—features nowhere in these accounts of women's autonomy. There have been very few accounts of women's sexual autonomy and what it entails. Although more has been written about 'reproductive autonomy', this is narrowly conceived as the freedom to make contraceptive choices or seek abortion. The fact that for many women, contraceptive use or abortion is an imperative caused by their lack of sexual autonomy, seems to be nowhere on the radar. Part 2 of this document discusses women's reproductive and sexual and rights and autonomy in detail.

Concepts Used in Assessing the 'Gender-responsiveness 'of Policies, Programmes and Interventions

Approaches to addressing gender in policies and programmes range from ignoring it, to trying to work within the limits imposed by gender discrimination, to challenging it. Over time a common language, consisting of four key concepts, has developed for describing these approaches (Kabeer 1994; Klugman 2001).

1. **Gender-unequal (or gender-biased) policies/ programmes.** These are policies or programmes that explicitly discriminate against women and privilege men. A practice where service providers require a man's consent before a woman can be sterilized is gender-unequal in that it deliberately gives men power over women and denies women's right to self-determination.

2. **Gender-blind policies/programmes.** These policies and programmes do not deliberately discriminate. However, they ignore, or are blind to, the unequal situation of women as compared to men and in doing so, contribute to gender discrimination. For example, when a policy decision is made that health-facility- based palliative care is not cost-effective and institutes home-based-care, the programme puts the burden of care on women who are traditionally the caregivers in a household.

3. **Gender-specific policies/programmes.** Gender-specific policies and programmes recognise differences in gender roles, responsibilities and access to resources, and takes account of these differentials, in an instrumental sense, but do not try to change them. For example, community-based distribution of contraceptives acknowledges women's lack of time and money, and in some settings, restricted mobility. However, it does not necessarily increase women's access to resources or encourage men to use contraception.

4. **Gender-transformative policies/programmes.** Policies and programmes are referred to as 'gender transformative' when they explicitly acknowledge gender differences and seek to change these towards greater gender equality. For example, child health messages that call on fathers to bring children for immunisation seek to transform the gender norm that women are solely responsible for childcare.

The aim is to ensure that no harm is done through gender-unequal or gender-blind health policies and programming. The 'do no harm' approach is also known as being gender-sensitive- when developing policies and programmes. The aim is to advance from this position progressively towards gender-specific to gender-transformative policies and programmes.

Gender-specific and gender-transformative policies and programmes are also classified as 'gender-responsive' (Kabeer 1994, Klugman 2001).

1.2.4 History of the Development of Gender in Policies and Programmes

The previous two sub-sections introduced gender and related concepts used in analysing situations from a gender perspective. These conceptual developments provided feminist scholars and activists the tools to generate the empirical evidence illustrating ways in which women were denied equal opportunities as men. This section continues where we left off in section one on the history of the feminist movement and describes how these conceptual developments and empirical evidence contributed to attention to women's and gender issues in policies and programmes at the level of international multilateral and bilateral organisations as well as national governments.

WID to WAD and GAD

The second wave feminist movement, and the feminist scholarship that emerged alongside the movement, exerted political pressure on national governments in countries with strong movements, and through them, on UN bodies, to address issues of women's equality. Ester Boserup's book "Women's role in economic development", published in 1970, significantly influenced thinking in policy circles. The book provided empirical evidence that "development" processes in the newly independent countries of the South had been blind to women's contributions to the agrarian economy for many centuries and had been male-centred. Many development programmes implemented with considerable funding from bilateral donors and international financial institutions had excluded women from their economic gains and social benefits (Cn2Collins 2013, 19 March; Connelly, Murray Li, MacDonald and Parpart 2000).

Feminists in the US succeeded in getting the US Congress to pass a bill which required USAID to include women in development programmes. This came to be known as the "Women in Development" or WID approach. WID was about ensuring that women were not left out of "development" programmes or programmes of modernisation and technological advancement aimed at increasing productivity and increasing economic growth. The WID approach did not question the capitalist accumulation process nor the patriarchal power structures, it simply wanted women to have a share in the gains (if any), brought about by capitalist development. Women were to be included in development not for reasons of equality with men, but because investing in women was good for economic growth. Another limitation of WID was its focus on women's productive role and neglect of women's reproductive role in the household economy (Cn2Collins 2013, 19 March; Connelly, Murray Li, MacDonald and Parpart 2000).

The Women and Development (WAD) approach was a parallel, though not dominant, strand of thinking that emerged around the same time. Its protagonists were radical feminists critical of the dangers of integrating women into programmes run by patriarchal structures, according to patriarchal norms. The WAD approach upholds women's distinct knowledge, work and capabilities and fought hard to create and maintain women-only spaces and projects to help nurture women's strengths and protect them from patriarchal domination. The WAD approach contributed to enhancing women's capabilities through organisations of their own and in bringing women's concerns into the policy arena. However, WAD has been critiqued for treating women as a homogenous "class' exploited by patriarchy, ignoring the many divides and differences within the group of women by class, race, ethnicity, nationality and so on (Cn2Collins 2013, 19 March; Connelly, Murray Li, MacDonald and Parpart 2000).

The GAD or Gender and Development approach of the 1980s was an outcome of the influence of Marxist critique of global capitalism and its impact on third-world women, and also the rise of "Gender" as a concept to understand women's subordination. The GAD approach was most clearly articulated by DAWN, a network of Southern feminists launched in the Second UN World Conference on Women in Nairobi in 1985, although Western socialist feminists have also contributed to developing this line of thinking. For the first time, the GAD approach postulated that to understand women's subordination, one needed to examine two distinct domains. One was the material conditions of women's lives and their position in the global, national and local economies. The second was the nature of patriarchal authority prevailing in their society at the level of the household, social structures and the state. According to the GAD approach, programmes and policies to meet women's practical needs had also to promote their strategic interests—i.e. the goal of gender equality. Thus, it was important to examine and attempt to transform all attempts to improve women's material conditions and their capabilities to move towards greater gender equality. Empowerment of women and gender equality and a focus on the gender-power inequalities between women and men (rather than a concern only with women) were central tenets of the GAD approach. Gender mainstreaming was a logical policy offshoot of the GAD approach (Cn2Collins 2013, 19 March; Connelly, Murray Li, MacDonald and Parpart 2000).

Gender Mainstreaming

By the early 1990s the limitations of the exclusive focus on women as in the WID approach during the previous decades became clear. Women's programmes and projects within the Women's Bureaus of countries or women's departments of organisations existed as mere "add- ons" while the country or organisation's overall policies and approaches continued with 'business-as-usual'. The gender mainstreaming approach was a response to this realisation. The word "mainstream" indicates that issues of gender inequality should be dealt with in every aspect of organisational structure and programming, rather than as a separate, add-on activity.

According to UN Economic and Social Council (ECOSOC), gender mainstreaming is

> *"...the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate aim is to achieve gender equality."* (UNECOSOC 1997, unpaginated).

Gender mainstreaming calls for initiatives that reduce gender inequalities; it also means that no initiatives are implemented that further exacerbate or perpetuate inequalities.

Gender mainstreaming within the policies and programmes implemented by an organisation is unlikely to happen unless changes are made in overall organisational goals; rules for running the organisation; allocation of resources; and monitoring and evaluation systems (Institute of Development Studies 1997).

Gender mainstreaming therefore is seen as composed of two inter-related but distinct and equally important dimensions. One is 'operational gender mainstreaming' concerned with establishing gender equality in the content of policies, programmes and interventions. The second is 'institutional gender mainstreaming' concerned with bringing about gender equality within the institutional structures that are responsible for formulating, implementing and monitoring and evaluation of gender-mainstreamed policies and programmes.

For over a decade, gender-mainstreaming was a buzz-word in policy circles. A large number of tools were developed to guide the process and capacity-building became a key activity in the area of gender. However, despite increasing visibility and legitimacy of gender equality in policy documents at national and international levels, gender remained a peripheral concern in the everyday routine of the State and social institutions. Substantive gender equality remained elusive.

Three major factors underlie the failure of gender mainstreaming to achieve its original intent of gender equality and justice (adapted from Ravindran and Kelkar-Khambete 2007). These are:

- Confusion about concepts
- Depoliticisation of gender-mainstreaming
- Changes in the global policy environment in the new millennium

Confusion About Concepts:

Mainstreaming had been interpreted to mean that there was no more need for working for women's equality and empowerment and became an excuse to no longer invest on women's projects and programmes.

Gender mainstreaming was also interpreted as bringing-in men's issues on to the agenda, because "gender is about women and men", and attempts were made to start funding men's programmes. This is an erroneous interpretation. True, gender is not only about women; gender is about women in relation to men. Gender is about the unequal relationship between women and men, with women at a disadvantage. Gender mainstreaming is therefore about paying attention to and redressing these inequalities across all policies and programmes, rather than develop specific programmes for women without disturbing the status quo.

Even while gender mainstreaming was touted as an organisational priority, drastic cuts in funding and downsizing of women's bureaus were happening at the same time. Poorly funded women's bureaus occupying a low status within a bureaucracy, had little scope for making the kind of dramatic and fundamental changes that gender mainstreaming called for.

De-politicisation of Gender Mainstreaming:

Gender mainstreaming efforts were often implemented 'top down', as part of programmes funded by bilateral and multilateral donors, in ways that least resembled what feminists had fought long and hard for. Women were no longer on the side-lines of development. Documents of the World Bank, for example, described women as a weapon in the war against poverty. The empowerment of women and girls would lead to economic growth and ultimately, to poverty reduction (Buvinic and King 2007). "Empowerment" was divested of its political content. Poverty was identified with lack of access to the market, and "empowerment" was identified with micro-credit loans, conditional cash transfers and access to markets: in effect, women's integration into the market.

Gender mainstreaming activities implemented in this top-down fashion tended to not be grounded in feminist ideology or informed by social transformation agenda. Routine and mandatory gender-training programmes for staff became mechanical activities of many institutions. Disinterested participants became "gender literate" and smart at integrating politically correct terminology without attempting to transform practice.

In fact, there was no reference in most gender-mainstreaming training workshops to feminist ideology at all, or to the global economic and political forces that underlay the marginalization of women by gender as well as by class, race/ethnicity and other axes of power inequalities.

Gender and feminism came to be separated, and gender mainstreaming simply became a set of tools and activities that sought to just 'add women and stir' (Cornwall, Gideon and Wilson 2008).

Changes in the Global Policy Environment

The global policy environment has become increasingly hostile to justice and equity concerns since the 2000s. With growing uncertainties in the global economy, many donor countries are less willing to commit to development aid overall, and funding for 'gender' is dwindling. The lip service paid to gender issues for more than two and a half decades seems also to have caused donor fatigue with funding for gender. At the same time, conservative national governments are no longer held to account for ignoring issues of equality and social justice.

Having critiqued the failure of gender mainstreaming overall, it would be important to place on record some of its impact. Institutions—especially international governmental and non- governmental organisations and private foundations introduced gender equality policies in the work-place. There were small increases in the recruitment of women, some improvements in workplace infrastructure to meet women's practical needs such as separate toilets; and introduction of gender-specific policies such as flexitime, breastfeeding breaks, and sexual harassment committees. At the same time, training by NGOs have tended to be more grounded, with some attempts to be linked to the feminist ideology and drawing on what was useful from the GAD approach.

It may be time to move on from gender mainstreaming to explicitly addressing issues of gender equity, rights and justice. The focus should shift from 'integration' of gender issues into existing agendas, to reframing the agenda in a way that promotes gender and social equity. For example, rather than make sure that women's interests do not get

excluded from the health sector reform agenda, the attempt would be to transform the agenda to make it equity-oriented. Further, gender inequity should be located within the context of global forces of economic exploitation under neoliberalism, and of inequities by caste, class, ethnicity and so on. The creation of demand for gender equity through political mobilisation must be seen as necessary ground work.

1.2.5 Framing Gender Equality as a Human Rights Issue

Another strand in the development of feminist theorizing and activism was the recognition that human rights principles of equality and non-discrimination provided powerful tools to advance the gender equality agenda. Although some sections of feminists critiqued (and continue to critique) International Human Rights Instruments as androcentric and ethnocentric[3] (Nash 2002), there was a strong push from other sections within the feminist movement to mainstream gender issues within the Human Rights world. According to Goonesekere, a feminist human rights activist from Sri Lanka, a rights-based approach to gender equality "allows legitimate claims to be articulated with a moral authority which other approaches lack. It is a language that is recognized by the powerful, and which stimulates deep chords of response in many." (Goonesekere). The articulation of gender equality as a human right to equality and non-discrimination already recognised by and committed to by governments may be seen as a major strategic advancement. It transformed gender issues, originally framed as "concerns" or "demands" of yet another population group which governments may or may not choose to act on, into legal entitlements that they were duty-bound to respect and were accountable for internationally through Human Rights Treaty Bodies.

The "Convention on the Elimination of All Forms of Discrimination Against Women" (CEDAW), which was adopted by the UN General Assembly in 1979, marked a major milestone in the advancement of gender equality globally. The Convention articulated the nature and meaning of sex-based discrimination and laid out State obligations to eliminate discrimination and achieve substantive equality. Its 16 substantive articles cover women's civil and political rights and economic, social and cultural rights. The Convention also pays specific attention to specific phenomena such as trafficking, and to the potential violations of women's human rights within marriage and the family. The CEDAW Committee, which began its work in 1982, remains a key accountability mechanism defending gender equality globally. The second half of the 1980s witnessed a growing interest among sections of the feminist movement, which had by now achieved a global character with leadership across all continents, in mainstreaming gender issues in UN Conferences and in using UN mechanisms for advancing gender equality. The Commission on the Status of Women process which requires periodic reporting by state-parties on action taken to advance the status of women; and large global and inter-regional forums have provided the space to negotiate for transforming terminology to be more inclusive (for example of SOGI issues) and for the introduction or revision of numerous laws and policies such as laws related to child marriage, child sexual abuse, marital rape. Feminist groups and civil society organisations have played a key role in pressuring governments through alternative reports prepared by civil society for CEDAW.

A further leap forward came with the UN Conference on Human Rights in Vienna in 1993, during which women's rights groups mobilized strongly around the slogan "Women's rights are Human Rights". Women's groups working on issues of Violence Against Women organized tribunals that focused on VAW, an issue neglected by the mainstream Human Rights movement as belonging to the private sphere. The Vienna Declaration and Programme of Action stated that "the human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights" (para. 18) and placed particularly heavy emphasis on eliminating all forms of gender-based violence. The Programme of Action also stated unequivocally that practices that were harmful to women shall not be upheld in the name of cultural rights: "the eradication of any conflicts which may arise between the rights of women and the harmful effects of certain traditional or customary practices, cultural prejudices and religious extremism" (para. 38) (UN General Assembly 1993).

The International Conference on Population and Development (ICPD) in Cairo, held in 1994, a year after the Vienna Conference built on the foundations laid by the Vienna Declaration. The Beijing fourth world conference on Women in 1995 further advanced the Cairo agenda. These are elaborated at considerable length in Part 2.

1.2.6 Neoliberalism and Gender: The Evaporation of Equity and Justice in the Capitalist Melting Pot

The feminist movement is at cross-roads in the twenty-first century. There is soul-searching in various quarters about the wisdom of pursuing gender-mainstreaming within national and international structures actively pursuing neoliberal agendas.

Neoliberalism is an economic theory and an ideological conviction that proposes that human well-being is best advanced through maximizing economic freedom for individuals, within an institutional framework characterized by private property rights, free markets and free trade. The role of the state was to create and preserve an institutional framework appropriate to such practices (Harvey 2005, 2). After a period of state-supported capitalism in the post-war period, there has been a steady ascent since the 1980s of neoliberal economic policies and ideology at a global scale. The main tenets of neoliberal globalisation have included: promoting the 'free' market with no restrictions imposed by the government (on what is produced and distributed, in what quantities at what price); cutting public expenditure for social services; and reducing the role of the state in the production and distribution of goods and services. Neoliberalism fosters the ideology of meritocracy, where individuals are held responsible for their own welfare and well-being. Striving to reach upwards has become a moral obligation: you were either a striver or a skiver. If you cannot draw on your inherited privileges, you simply had to work harder to catch up. Your poverty was of your own making: your lack of talent and efforts, i.e. "merit". Clearly, this is not the most supportive setting for the promotion of an equity and social justice agenda.

The institutionalization of gender equity within State structures entrenched in neoliberal economic and political ideology distorts and makes a mockery of the feminists' radical agenda for women's emancipation within a broader agenda of equity and social justice for all. Neoliberalism has given rise to post- feminisms that celebrate individual advancement—the successful woman entrepreneur whose success may be built on the economic exploitation of other women—over social solidarity. Under neo-liberal, 'post-feminism', self-help and self-reliance have replaced collective justice and solidarity. Post-feminism, unlike feminism, is not critical of economism but embraces money as a means to "empowerment". Concepts of empowerment and autonomy have been turned on their head. Women who are "empowered" are those who have been given access to the capabilities of being employed, earning money and spending money to acquire goods and services within a consumerist society. As aptly described by Nina Powers, "if the contemporary portrayal of womankind is to be believed, contemporary female achievement would culminate in the ownership of expensive handbags, a vibrator, a job, a flat and a man—probably in that order" (Power 2009, 1). The transformation of social structures that produce women's subordination is not on the agenda anymore.

Writing about the portrayal of empowered women in reality TV in the USA (and in many LMIC television shows as well), Omer (2017, 3 November) writes about how, besides crass consumerism, the "empowered" woman is also portrayed as being selfish, aggressive, degrading other women, scandalizing and shaming other women over their personal lives and at the same time "wealthy, glamorous, and successful in her ambition". It is all about self-actualisation" and everyone around is a potential means or victim for her quest for power translated in economic terms. This powerful and extremely negative portrayal of the empowered woman in reality shows and in television soap operas has made a mockery of feminist struggles for women's empowerment as freedom from oppression and the autonomy to realise one's potential.

In its efforts to renew and survive, neoliberalism has co-opted the feminist agenda and turned it to support its own ends, quite successfully. Fraser's powerful essay (Fraser 2013, 13 October) identifies three major feminist critiques that have been subverted to suit neoliberal ends.

The first is the feminist critique of the 'family wage' which cast men in the role of bread-winners and excluded women from the paid-labour force. The push for women's participation in the paid-labour force has helped neoliberalism access a vast pool of labourers whose employment is characterized by low wages, long hours of work and decreased job-security. Thus, "neoliberalism harnessed the dream of women's emancipation to the engine of capitalist accumulation". This is not to deny that work outside the home and the opportunity to earn an income has been emancipatory for many women. The point is that one set of freedoms have been gained at the cost of another.

The second is the feminist critique of the focus on economic and political oppression of other progressive movements to the exclusion of injustices in the personal sphere. Neoliberalism has promoted the exclusive pursuit of injustices in the personal sphere—e.g. intimate partner violence, heteronormativity[4] and transphobia[5]—to the exclusion of political and economic injustices. Fraser argues that a critique of political economy gradually disappeared from the feminist agenda just when it was most needed—during the period of ascendance of neoliberal ideology.

The third is the feminist critique of welfare-state paternalism. The many welfare policies implemented in post-war Britain and in Europe, including the National Health Service and Social Insurance schemes were critiqued by feminist scholars of the 1980s as casting women in the role of housewives whose presence in the paid-labour force was likely to be transient. Child-support schemes for single mothers in Britain, Europe and the US were critiqued as being sexist and infantilising women. Neoliberalism has found this a convenient argument to justify the withdrawal of child care, social welfare and other social services so essential for gender equality (Fraser 2013).

At the same time, a character-change is being forced upon old-time feminist civil society organisations advocating for women's rights or offering a range of services based on donor and government grants. With the rise of the contracts and commissioning culture where organisations have to 'bid' for funds competition between groups is accentuated, destroying the solidarities that feminists had worked so hard at building with other CSOs. The "short-termist, box-ticking culture of neoliberalism" (Gupta 2012) with an emphasis on targets and "measurable" achievements have begun to destroy the integrity of work informed by feminist values and requiring persistent, long term efforts. Those who do not measure up to the neoliberal standards are soon out of business. This is discussed in greater detail in Part 3.

The need of the hour is to stop and take stock rather than race forward to grab whatever opportunities are offered to us within the neoliberal frame. Are we happy with gender equality for some at the cost of social justice for all?

1.3 GENDER-BASED INEQUALITIES IN HEALTH AND FEMINIST ENGAGEMENT WITH GENDER AND (WOMEN'S) HEALTH ISSUES

1.3.1 Gender-based Inequalities in Health

Women and men are biologically different, and this results in differences in health risks, conditions and needs. One of the key differences is women's role in biological reproduction, which exposes them to a whole set of additional health risks. The socially constructed differences between women/girls and men/boys through the mechanisms of gender roles and norms and gender-based division of labour result in differential exposure to risk of illness and differential vulnerability. For example, social norms may discourage the imparting of information on puberty to girls, resulting in fear and myths about menstruation and improper menstrual hygiene practices. Women may be exposed to respiratory infections through exposure to cooking fuels whereas men may be at risk of the same through exposure to dust and chemicals at work. Gender differences in access to and control over resources and power and decision-making often result in differential access to timely and appropriate health care and in differential social and economic consequences of illness, usually to the disadvantage of girls and women.

In many instances, both biological and social factors interact to contribute to avoidable morbidity and mortality on a large scale. For example, while women's greater risk of cardio- vascular diseases after menopause and atypical presentation of symptoms are biological, the representation of cardiological problems as mainly a male problem in most medical text books, as well as women's limited access to health care may result in considerable delays in diagnosis and treatment. While girls and women are usually more negatively affected by gender-based differences, the social construction of masculinity can adversely affect the health of boys and men, as in the case of higher morbidity and mortality related to violence and injuries. Gender is thus a factor affecting health conditions, health behaviours, utilization of health care services and health outcomes.

While a gender equity agenda is a difficult undertaking in any sector, the health sector faces some specific challenges (Ravindran and Kelkar-Khambete 2007). One, because there are biological differences between women and men in health needs and experiences, there is a tendency to attribute all male-female differences to biology. The consequence is that maternal health programmes are believed to be an adequate response to addressing differences in health between sexes. The need for examining gender issues in all health problems as well as in delivery of health care services remains unrecognised. Two, while the disadvantages experienced by women in sectors like education, employment or political participation are evident from available data; the case of health is more complex. Women outlive men in most countries of the world, and for many health conditions, male mortality exceeds female mortality. Many policy makers and programme managers therefore remain unconvinced of any gender-based inequalities in health, and of the need for gender mainstreaming. Other dimensions of gender inequality in health -such as in morbidity, access to health care and in social and economic consequences of ill health —are seldom examined. Three, health sectors in many countries are informed by a bio-medical approach to health and disease under the leadership of health professionals who may not see the relevance of understanding the social dimensions and determinants of health. Health care providers tend to see themselves as technical persons who solve a problem presented to them and engaged in the important task of 'saving lives' and may believe themselves to be free from any gender (or other social) biases. The failure of pre-service curriculum for healthcare providers to integrate gender concerns and to develop skills to recognise and respond to the consequences of gender-based discrimination contributes to such gender-blindness. Four,—and this issue is addressed in greater detail in Part 2—discussion on inequalities in health premised on male control over women's sexual and reproductive decisions are politically very sensitive and seem to challenge the very core of patriarchal power. For example, women's right to use contraception irrespective of her husband's objection may be viewed as destabilising the institution of the family. Last, and a related point —is that a vast majority of governments and religious institutions as well as health facilities and health care providers, refuse to concede women's right to terminate an unwanted pregnancy on various grounds.

1.3.2 Tools for Gender Analysis in Health

Gender Analysis has been defined as analysis focused on the relative distribution across genders of "resources, opportunities, constraints and power in a given context." (Sida 2015).The purpose of gender analysis is to develop responses to remedy inequalities by gender in achieving their full human potential.

There are only a few known tools used in gender-analysis of health. One is the gender-analysis matrix (GAM) used for identifying whether there are gender-based inequalities in a health situation or condition and examining the underlying determinants of these inequalities. The second is the 'gender-responsiveness' scale used to assess the extent of gender bias in a policy, programme or intervention and to move these towards greater gender-equality (WHO 2011). The Gender Analysis Matrix (GAM) for health, now associated with the World Health Organization draws on various tools that were in existence and used widely in gender-training during the 1980s and 1990s. The GAM has biological factors and various mechanisms of gender-based oppression as columns and various health-related outcomes as rows (Table 1). Each cell in the matrix represents a query about the impact of biology or gender on a health-related outcome. For example, the second cell on the first row, i.e. intersection of sociological factors and risk factors and vulnerability represents the question: Are risk factors and vulnerability to this particular health condition influenced by gender roles and norms or gender-based division of labour? Suppose we are conducting this gender analysis with reference to road traffic accidents. Then we would look for evidence to this effect and find that men are at greater risk, because of the identification of masculinity with risky behaviours on the road; as well as because men are more likely to be drivers because of gender-based division of labour.

The need for examining gender issues in all health problems as well as in delivery of health care services remains unrecognised.

TABLE 1: THE WHO GENDER ANALYSIS MATRIX

FACTORS THAT INFLUENCE HEALTH OUTCOMES:

HEALTH-RELATED CONSIDERATIONS	GENDER-RELATED CONSIDERATIONS		
	Biological Factors	**Sociological Factors** (includes gender roles and norms and gender-based division of labour)	**Access to and Control Over Resources and Decision-making**
Risk Factors and Vulnerability			
Access and Use of Health Services			
Health-seeking Behaviour			
Experience in Health Care Settings			
Health and Social Outcomes and Consequences			

SOURCE: WHO 2011

The second is the Gender-Responsiveness Assessment Scale (WHO 2011). This scale is based on Kabeer's concepts related to gender-responsiveness of policies and programmes described earlier in this chapter (p.20). It categorises policies and programmes on the basis of their gender responsiveness into various levels, ranging from gender-unequal or gender-biased to gender-transformative.

Both the gender analysis tool and gender responsiveness scale have complementary functions. Gender analysis would be used to examine whether and in what ways biological and gender differences between women and men contribute to differential risks and vulnerabilities, health seeking and health and social outcomes. Once the underlying factors have been identified, then steps may be taken to address these in the policy or programme concerned. For example, a tuberculosis control programme adopted an active case-finding strategy in place of passive case-finding when gender analysis revealed that because of lack of time and money the proportion of women coming to health facilities was disproportionately low. This is an example of moving from a gender-blind to a gender-specific programme, or 'gender-mainstreaming' the tuberculosis control programme.

A recent article shows evidence of advancement in the conceptualisation of gender analysis of health conditions. In the article, which examined whether sex or gender influenced the outcome after an acute coronary syndrome in the young, Pelletier et al (2016) have used a scale that rates both women and men on the extent of traditionally male or female roles performed. The study found that independent of whether the patient was biologically male or female, feminine roles and personality traits were associated with higher rates of recurrent Acute Coronary Syndrome as well as Major Adverse Coronary Events compared with masculine characteristics.

While Hankvisky and colleagues have made significant theoretical contributions to the analysis of health using an intersectional lens, the application of intersectional analysis of health-related outcomes is in its infancy. In terms of research from LMICs, three studies published from India have applied quantitative techniques to assess the combined effect of class and gender on use of health care services; and caste, geographic location/class and gender on nutritional and immunisation status, respectively (Sen and Iyer 2011; Joe 2015; Mukhopadhyay 2015). A similar number of qualitative studies using an intersectional lens have been published from East Africa, all related to masculinity and HIV (Larson, George, Morgan and Poteat 2016).

Both these are promising advances in gender analysis of health and need much wider attention and application. But we badly need similar innovations in terms of going beyond the gender- binary and heteronormativity. That is where the next steps need to be taken urgently.

1.3.3 Feminist Engagement with Gender and (Women's) Health Issues

In this section, we provide a brief overview of feminist engagement with gender and health issues. Because much of this has been in relation to sexual and reproductive health and rights, a more detailed description and discussion of the same is presented in Part 2.

As outlined in Sec. 1.1.3 one major concern of second wave feminism was patriarchal control over women's sexuality and reproduction and also the medicalisation of birth by the medical establishment. There were demands by the movement for changes in legislation, policies, programmes and services affecting women's health. Women's health centres were established in many countries of the North and also in some countries of the South. Grassroots activism to promote women's control over their fertility and sexuality, to demystify medical knowledge and to advocate for women-centred policies and programmes was widespread in many developing countries. While the focus was on abortion among feminist groups of the North, the major issue for women of the South—especially from India, Bangladesh and Indonesia—was repressive Population Control programmes of the State.

An International Women's Health Movement emerged in the early 1980s, providing further impetus to women's health advocacy. One outcome of advocacy was the development of women's health policies in some countries. Brazil was the first country to create a comprehensive women's policy, in 1983. The Australian National Women's Policy was formulated in 1988, the Colombian 'Health for Women, Women for Health' policy in 1992. Efforts were also made in South Africa in 1994, to develop a women's health policy agenda. In all instances, the policies have gone beyond sexual and reproductive health concerns to address violence against women, occupational health and mental health. They have also drawn attention to health needs of women and girls in all age groups. The fate of these policies varied. In Brazil and in Australia, the policies were successfully implemented for several years, till they gradually merged with gender mainstreaming attempts. In Columbia, the policy suffered from limited political and financial commitment and was never implemented. In South Africa, various components of the women's health policy agenda were successfully integrated into new policies: for example, a policy was implemented for the prevention of domestic violence against women, another on Choice of Termination of Pregnancy, and so on (Ravindran 2002).

If one were to take stock of the achievements of feminist engagement, the findings presented for gender mainstreaming overall also apply for the health sector. The few examples of gender- mainstreamed health interventions are at the micro-level, with limited impact. Much of the available experience in mainstreaming on gender issues in health are focused on reproductive health and HIV/AIDS. The record in terms of institutional mainstreaming is disheartening, because of the apparent tendency to "appear to do much" rather than making fundamental changes. Institutions seem to have superficially gone through the motions of adopting a gender policy and creating a few structures, without investing any more into making these actually work. A survey of 140 of the world's most influential global health organisations found that just over half (55%) of the organisations had explicitly committed to gender equality; only 40% mentioned gender in their programmes and strategies; and an abysmal one- third disaggregated their programme data by sex. Sixty nine percent of the 140 organisations was headed by a man and 80% of the board chairs were men (Global Health 50/50 2018). The recurring story has been one of having to run to stay in place and of being pushed several steps backward for each step advanced. The lack of funding for grassroots organisations providing feminist-health services, limited resources and institutional support for feminist knowledge creation, and the major shift in feminist energies towards influencing the UN and other international agencies has left a void within countries in terms of creative engagement and mobilisation of young people to take the feminist agenda forward in health.

ENDNOTES FOR PART 1:

1 Patriarchy differentiates women from men while privileging men. Racism simultaneously differentiates people of colour from whites and privileges whiteness. Racialized patriarchy is an intersection of the two. For example, the sexual exploitation of women of colour who were slaves by their white supervisors or masters.
2 Transmisogyny is an intersection of two forms of oppression that transgender women are subjected to: transphobia and misogyny (http://queerdictionary.blogspot.in/2014/09/definition-of-transmisogyny.html).
3 Dominated by or emphasizing a male-centred and white-person centred perspective.
4 Heteronormativity is the belief that sexual attraction and relationships between opposite sexes are the natural order of things, and that attraction between people of the same sex is not normal.
5 Transphobia is the dislike of or prejudice against transsexual or transgender people.

PART 2

International Discourse on Sexual and Reproductive Health and Rights

Renu Khanna

This part of the resource kit deals with, as the title suggests, the international discourse on sexual and reproductive health and rights. Throughout the contents we try and reflect what was happening as part of the 'official' global processes as well as the civil society discourse.

In the first section of this Part, we first describe the evolution of the terms sexual and reproductive health and rights, through the history of the women's movement globally and then through the ICPD and the Beijing Conferences and the five yearly reviews of the ICPD. The second section looks at the global processes: ICPD Beyond 2014, the MDGs process and the Post 2015 Development Agenda or the Sustainable Development Goals, to see what aspects of SRHR each was highlighting and how these processes were interacting with each other.

Part 2 will examine the various components and concepts within SRHR as they emerged. Amongst these are: Life Cycle Approach with attention of Adolescents and Young People's SRHR issues, SHR issues of LGBTQ, older women's sexuality and SRHR needs, Men and SRHR, Health systems and SRHR including Universal Health Coverage/Care.

2.1 HISTORY OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

In Part 1 we discussed how gender equality is a human rights issue and a feminist perspective on human rights. In this section, we go onto the history of sexual and reproductive rights. We first give an overview of the history of the evolution of the terms Reproductive Health and Reproductive Rights through the struggles of the women's movements in different countries, regions as well as globally, and also the landmark UN conferences on population and development in 1994 and women in 1995. The next section will describe the official genesis of Reproductive Health and Reproductive Rights, and how these were defined. The concepts of Sexual Health and Sexual Rights as they emerged in official spaces will be dealt with next. The discussion will then move onto the review processes of the ICPD and what each five-year review yielded. And the final part of this section will deal with the Millennium Development Goals and how these treated SRHR. This will then lead to discussions about how SRHR are reflected in Sustainable Development Goals.

2.1.1 History of Women's Movements and Reproductive Health and Reproductive Rights

The global history of the recognition of sexual and reproductive health and rights as important components of human rights and entitlements of women and men emerged somewhere in the mid 1960s. Women's movements worldwide began to examine patriarchal values, institutions and ideologies in creating and reinforcing women's poor health. They engaged with concerns of sexuality, power and sexual violence, and brought domestic violence out of the private sphere into the arena of public debate. Women's right to safe abortion was one of the key issues around which mobilization took place in many Northern countries. Another major concern of the various women's health movements was the medicalisation of women's bodies. Women's health advocates sought to demystify and reclaim knowledge about their bodies and about healing.

In the early 1970s the Boston Women's Health Book Collective came out with their trail blazing 'Our Bodies, Ourselves' which was widely distributed, translated into other languages, and updated as women fed back their health concerns to the collective. Similar books, focusing on women's bodies, on self-help and on how to develop skills, especially in gynaecological examination and treatment, were widely produced around the world. Women's aim was to take back control of their bodies from the medical profession who, through language, medical hierarchy and, often, arrogance, excluded women from knowing how their bodies functioned and what was being done to them.

The 1980s may be seen as marking the emergence of an international women's health movement which integrated the agendas of the Northern as well as Southern countries. In 1977 the first International Women's Health Meeting (IWHM) was organised in Rome attended by women from Europe (Estrada-Claudio 2006). By 1981 when the Third IWHM was organised in Geneva the attendance expanded to 500 women from 35 countries across the world.

Linkages were drawn between structural adjustment, debts and declining health of people and women. Population control policies were challenged. Feminists opposed the rights violations inherent in the population control policies of several countries. They made a clear distinction between women's right to control their fertility and state imposed population control. Discussions at the next IWHM in 1984 made clear that reproductive issues affect all women, and while there were many similarities, there were also differences between the many groups of women across the globe and within their communities. It became clear that global solidarity was essential. Women's Global Network of Reproductive Rights (WGNRR) was formed within this revolutionary context. The term Reproductive Rights seems to have emerged at this time.

WGNRR notes (WGNRR n.d.)

> *'the International Contraception, Abortion and Sterilisation Campaign (ICASC) held the fourth International Women and Health Meeting (IWHM) in 1984, which was themed, "No to Population Control... Women Decide!"*
>
> *The grave import and urgency of the myriad issues faced by women and the danger to the realisation of their rights saw the formation of several important networks that still exist today, such as the Latin American Women and Health Network, and Women Living Under Muslim Laws.... bringing together reproductive rights advocates and activists and ensuring that these pressing issues were given a strong, collective voice of advocacy.'*

Feminists in the global south were identifying their own issues. For example, the FINRAGGE (Feminist International Network of Reproductive and Genetic Engineering) conference in Bangladesh organised in partnership with UBINIG,[6] in 1989, was an important event for South Asian feminists. For example, there was international recognition of the SRHR issues that the feminists in the region were confronted with: unethical trials of Norplant, prenatal sex detection, coercive family planning policies, to name a few. The Comilla Declaration, an outcome document of the UBINIG Conference, traversing a range of recommendations and demands to uphold the integrity and dignity of women, preserve diversity of life, and unite globally against dehumanising technologies, is referred to by a section of the women's health movement in South Asia, even today (FINNRAGE-UBINIG 1989).

The global women's movement in different ways also began articulating what then came to be termed as the reproductive health approach. The reproductive health approach (WHO 2001)

- gives high priority to quality of care in its many dimensions
- pays attention to the needs not only of married women but also unmarried women, men, adolescents, and people beyond their reproductive years
- aims at the provision of integrated reproductive health services within the context of primary health care, rather than vertical reproductive health services, or, within that, only contraceptive services
- promotes the right to choice and aims to create conditions that would enable choice (for example providing information in an accessible form)
- encourages male responsibility in family planning and in women's reproductive health
- focuses on issues of infertility as well as fertility control, so that women and men have greater choices about reproduction.

Feminist Influences in Global Conferences

During the 1990s, the international women's health movement began to engage with and influence major conferences of the United Nations such as the World Conference on Human Rights, Vienna, 1993, the International Conference on Population and Development, Cairo 1994. Maturing feminists began realising that action of the streets was not enough—they had to seriously find their place at the negotiating tables and begin influencing the development agendas. Many feminists entered their national governments and UN organisations in positions of power to engage on behalf of women of their constituencies.

As a result of these concerted efforts, the Declaration that emerged from the UN Conference on Environment and Development held in Rio de Janeiro in 1992 (Rio Declaration) stressed the centrality of women to the twin issues of environment and development. It called for women's participation in environmental management, economic and political decision-making; and for equality to women, especially in access to natural resources.

In the World Conference on Human Rights, Vienna, 1993 feminists took the slogan "Women's Rights are Human Rights". This Conference affirmed the universality of women's human rights, and refuted arguments of cultural relativism, whereby discrimination against women is often upheld under the guise of preserving culture and tradition.

Women's health advocates, with their years of strategising, both within their own countries as well collectively, succeeded in getting the language of reproductive health and rights firmly established in the International Conference on Population and Development (ICPD), at Cairo in 1994. This Conference is the most significant landmark in the history of sexual and reproductive health and rights. The Programme of Action (POA) of the ICPD emphasised the centrality of gender equality and women's empowerment if reproductive health and rights were to be achieved by the vast majority of the world's women. With its strong focus on Empowerment of Women; Reproductive Health and Rights, and Population and Development, the Cairo conference had women's health at its centre. This conference brought together government and international body officials, voluntary and non-aligned groups, academics and representatives of women's organisations to address questions of reproduction, population and health.

The issue of women's reproductive rights led to major struggles as women's demands for access to contraception and abortion were met with some disagreement, largely stemming from religious conservatives, including the Holy Catholic See and several predominantly Islamic nations. The women's groups decided to let go of smaller battles in order to win the war. Sexual rights was forgone and sexual health and was subsumed under Reproductive Health. Thus, despite the disagreements, there was major consensus on the general principles of gender equity, equality and empowerment of women and it was these principles that were fore fronted in the Programme of Action. The conference delegates also achieved consensus on the following four qualitative and quantitative goals:

- Universal education;
- Reduction of infant and child mortality;
- Reduction of maternal mortality;
- Access to reproductive and sexual health services, including family planning.

UN Conferences and Women's Human Rights

Prior to the 1990s, there had been several UN conferences on population but they did not have a focus on rights. There had also been several UN conferences on women, but they had not focused on human rights, or on issues concerning reproduction and sexuality. The first world Conference on Human Rights, which took place in Tehran in the 1960s, made a mention of the right to determine the number and spacing of one's children. In 1993, the second world Conference on Human Rights, which took place in Vienna, set the stage for what happened first in Cairo and then in Beijing. It affirmed that women's rights are human rights; that the eradication of all forms of discrimination on the basis of sex should be a priority for governments; and, finally, that women have a right to the enjoyment of the highest standard of physical and mental health throughout the life cycle, and that this includes a right to accessible, adequate health care and to a wide range of family planning services. The first time a comprehensive framework for realizing reproductive rights was set out at the international governmental level was in Cairo in 1994. It emphasized the link between population and development, and meeting the needs of individuals. This was a departure from the focus on abstract demographic targets, and it affirmed the focus on reproductive rights (WHO 2001).

The momentum of women's organising continued beyond the ICPD to prepare for the Fourth World Conference on Women (FWCW), to be held in Beijing in 1995. Again attended by a wide range of both government and non-statutory sector organizations, the outcome of this conference, the Beijing Platform for Action, was an agenda for women's empowerment. It dealt with removing the obstacles to women's public participation in all spheres of public and private lives through a full and equal share in economic, social, cultural and political decision-making. The Beijing Platform for Action once again affirmed that governments irrespective of their political, economic and cultural systems were responsible for the promotion and protection of women's human rights. It was in the Beijing Conference that the term Sexual Rights found official acceptance. However, women's rights to control their sexuality was circumscribed by a heteronormative framing (Article 96 Platform of Action – Equal relationships between women and men in matters of sexual relations and reproduction...) recognising that women deserve equality and respect within hetero sexual relationships.

These hard-won achievements in the ICPD and the Beijing Conference came at a price. During ICPD negotiations, weaker language regarding abortion were accepted as compromises, sexual rights were sacrificed to safeguard other gains, and adolescent sexual and reproductive health provisions were limited to disease and pregnancy prevention. In Beijing the next year, much of the ICPD language on abortion was replicated and as stated above the paragraph on women's rights to control their sexuality was limited by a heteronormative framing.

In September 2000, building upon a decade of major United Nations conferences and summits, world leaders came together at United Nations Headquarters in New York to adopt the United Nations Millennium Declaration. In doing so they committed their nations to a new global partnership to reduce extreme poverty and set out a series of time-bound targets—with a deadline of 2015—that have become known as the Millennium Development Goals. The eight Millennium Development Goals (MDGs)—which ranged from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015—formed a blueprint agreed to by all the world's countries and all the world's leading development institutions. Some MDGs were directly related to health and some were seen as lateral to health.

Health Goals

- Stopping the spread of HIV/AIDS
- Reduce child mortality
- Improve maternal health
- Combating HIV/AIDS, malaria, TB and other diseases

Non-health Goals

- Reducing extreme poverty by half
- Achieve universal primary education
- Ensure environmental sustainability
- Develop global partnerships in development

The MDGs were seen by many feminists as a setback in the struggle for sexual and reproductive health and rights. They felt that sexual and reproductive health or rights do not feature among these goals. (See Section 2.1.4 for further critiques of MDGs).

2.1.2 Genesis of Reproductive Health as a Human Right

As indicated above, the International Conference on Population and Development (ICPD) in 1994 was celebrated as a turning point for women's health. It resulted in Reproductive Health and Reproductive Rights gaining international acceptance. The ICPD brought to international recognition two important guiding principles of RH: 1) that empowering women and improving their status are important ends in themselves and essential for achieving sustainable development; and 2) reproductive rights are inextricable from basic human rights.

The ICPD definition of reproductive health (RH) went beyond merely reproduction and viewed RH as three interconnected domains of universal rights, women's empowerment, and health service provision. (UN 1994) ICPD promoted a universal understanding that RH is a basic human right to be fulfilled by all governments. Secondly, RH seeks to address the underlying causes of gender inequality and inequity to promote women's empowerment.

Thirdly, the provision of universal access, utilisation, and quality of RH services addresses issues of reproductive ill-health, and possibly death. The three concepts of rights, women's empowerment and equality, and services must work in unison in order for individuals to achieve healthy reproductive and sexual lives.

The first over-arching principle that RH is premised on is a rights-based approach. This means that everyone is entitled to the rights and freedoms set out by the Universal Declaration of Human Rights, which includes the right to health and education without distinction based on race, sex, religion, etc. The implication of the recognition of Reproductive Rights as internationally protected human rights is that member states must comply with international human rights principles and standards. States have an obligation to respect, protect and fulfill universal reproductive rights by formulating suitable policies, programmes and laws, to uphold the right for couples and individuals to decide if, when, and how many children they would like to have, as well as access to information to enable them to make these choices; the right to attain the highest standard of reproductive health; and the right to make RH decisions without discrimination, coercion or violence ("Beijing Declaration and Platform for Action", 1995).

Definitions

Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant ("Beijing Declaration and Platform for Action" 1995).

Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government—and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed." ("Beijing Declaration and Platform for Action" 1995; UN, 1994)

States' Obligations for Reproductive Health and Reproductive Rights

States' obligation to respect, protect, and fulfill human rights should guide the development of laws and policies, as well as practices. The obligation to respect requires that states do not act in a way that interferes with individuals' enjoyment of their rights, either directly or indirectly. As such, states should not limit access to contraceptives, withhold or misrepresent health-related information, or utilize coercive medical practices. The obligation to protect demands that states take measures to prevent third parties from interfering with human rights and impose sanctions on those who violate others' human rights. Treaty monitoring bodies have elucidated that in order to do so, states should adopt legislation to ensure equal access to health care, ensure that health services from private providers comply with human rights standards, and take measures to protect individuals from harmful traditional practices. The obligation to fulfill requires states to adopt legislative, budgetary, administrative, and judicial measures towards the full realization of human rights. (UNFPA 2013)

Reproductive Rights refer to the sense of entitlement that individuals have to make their own autonomous reproductive decisions and the recognition that there are socio economic conditions which enable such decisions to be made (ARROW 1995). 'Without a rights component, the term 'reproductive health' may become the Emperor's new clothes' as cautioned by a women's global network DAWN (cited in ARROW, 1995).

Empowerment Approach for RH

The second concept of RH, women's empowerment, is based on the fact that social norms, values, and laws create an environment that influences the extent of women's equality and power within in a society. Broadly, this means: addressing issues of gender inequality and empowering women; ensuring males participate in decisions and understand their responsibilities; eliminating all forms of discrimination against the girl child (e.g. female genital cutting, forced early marriages); and accessing universal education. This second arena of RH addresses how social and sexual behaviours and relationships affect healthy and satisfying sex lives or how they can create ill-health. RH does not affect women alone and must not be solely promoted as a women's issue. Men also have reproductive health needs in addition to the fact that the involvement of men is an essential part of protecting women's reproductive health (more about this in Section 2.6).

Promoting women's empowerment and addressing issues of equality and equity, should not be limited to viewing only men-women relationships, but also relationships between the individual and wider community. Attitudes and norms surrounding sexuality and gender carry profound meanings in every society/culture. The dynamics of knowledge, power and decision-making in sexual relationships, between service providers and clients, and between community leaders and citizens, all affect an individual's reproductive and sexual health status.

Service Provisioning for RH

The final concept of RH deals with service provision. This includes the ability of public and private service providers to provide a variety of quality RH services, and also addressing the barriers that may prevent an individual from accessing and utilising these services. This would include: ensuring information dissemination on services and contraceptive methods and safe sex; affordability, confidentiality, convenience, treatment of service providers, and availability of supplies.

BOX 1: INTERNATIONAL HUMAN RIGHTS PRINCIPLES

AUTONOMY

Autonomy is a central component of the rights to life, privacy, and liberty, amongst others, and includes individuals' rights to make informed decisions about their bodies, to determine the number and spacing of their children, and to be free from coercion, discrimination and violence. For example, a key component of the ICPD Programme of Action was the recognition that compelling individuals to carry out states' coercive population-based laws, policies, or practices constitutes a human rights violation and should be abolished.

NON-DISCRIMINATION AND EQUALITY

The rights to non-discrimination and equality lie at the core of almost every international human rights treaty and are guaranteed protections in the exercise of all other rights. International human rights law expressly proscribes discrimination on the basis of,inter alia, sex, race, ethnicity, language, religion, disability, and economic status. Treaty monitoring bodies have recognized additional grounds of discrimination on the basis of age, actual or perceived sexual orientation and gender identity, marital status, health status (including HIV status), and pregnancy. To effectuate the right to equality, states should take "all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men." The gender dynamic that underlies sexual and reproductive health and rights demands that non-discrimination and equality are duly emphasized in the realization of these rights. Women who are also of a vulnerable or marginalized group may face multiple forms of discrimination, further imperiling their achievement of development outcomes and human rights, including the right to health. The right to non-discrimination requires states to eradicate discriminatory policies and practices, and take affirmative measures to ensure that everyone is afforded the same rights in law and in practice. In addition to eradicating formal discrimination in laws and policies, states must also eradicate substantive discrimination including by adopting measures to address the conditions and attitudes that perpetuate discrimination. Policies and

practices that place undue onus on women in order to access comprehensive reproductive health care, such as spousal authorizations, constitute discrimination and must be eradicated. Furthermore, states must take measures to combat the social and cultural beliefs that contribute to the diminished status of women worldwide and that have a negative impact on their sexual and reproductive health.

ACCOUNTABILITY

The ICPD Programme of Action recognizes that enhanced accountability to all populations, particularly underserved and marginalized populations, is essential within reproductive health programming. Accountability is critical for ensuring that policies and programs are properly implemented, preventing human rights violations, and providing remedies when violations occur. Measures to enhance accountability should be incorporated into laws and policies; such measures include ensuring oversight, allocating appropriate budgets for initiatives, and clearly defining the roles of government ministries and the rights and duties of health care providers. Formal accountability mechanisms are essential in identifying individual and systematic human rights violations and ensuring access to justice for those who claim their rights have been violated. Examples of formal accountability mechanisms include a functioning judicial system with the authority to adjudicate sexual and reproductive rights violations, and national human rights institutions, including human rights ombudspersons.

States also should ensure that their populations are aware of their rights. Through government-produced public awareness campaigns, people should learn of a state's obligation to protect those rights and thus be enabled to assert them.

PARTICIPATION AND EMPOWERMENT

The ICPD Programme of Action recognizes that the effective realization of sexual and reproductive health and reproductive rights requires empowering all sectors of society—including women, in particular—and incorporating their meaningful participation into the design of policies. The specific needs of women are better addressed by ensuring their meaningful participation in devising and implementing sexual and reproductive health programs and services. This participatory process also empowers individuals, including women, and civil society to assert their rights and report violations when they occur and enhances accountability for the implementation of laws and policies. Further measures to empower women must also be taken in order to elevate their social, economic and political status worldwide, such as guaranteeing their right to education and providing them with equal employment opportunities. Such measures will empower women to exercise their sexual and reproductive health and rights and overcome the stigma attached to the exercise of these rights.

Source: UNFPA, 2013.

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Historical Overview of Sexual Health and Sexual Rights

Although sexuality is central to many health conditions —including 'family planning programmes' that have been a focus of many countries' governments since the 1950s— it failed to receive any serious attention until the HIV pandemic broke out and 'sexual ill-health' became a major concern. As mentioned above, in the ICPD POA, for politically strategic reasons, sexual health was never clearly mentioned, but was subsumed under the relatively more acceptable term reproductive health—Paragraph 7.2 ... 'Reproductive health therefore implies that people are able to have a satisfying and safe sex life'. The POA also did not specifically define sexual rights. It did however include many paragraphs that could allude to sexual rights.

It emphasized the right to SRH services and information regardless of age and marital status. The section on Human Sexuality and Gender relations (Paras 7.34 and 7.35) talks about violence against women, harmful practices to control women's sexuality, and high risk sexual behaviour by their partners that puts women at risk—all these build an argument for sexual rights without naming the concept.

Since sexual rights are closely linked to reproductive rights —human reproduction generally requires sexual activity —it has become common to refer to this group of rights and services as 'SRHR' since the ICPD and the FWCW. This was also a result of the political convenience mentioned above. But it is important to disconnect sexual activity and reproduction. The box below clarifies how 'sexual' and 'reproductive'—often conflated—are connected yet different.

The Fourth World Conference on Women (FWCW) in 1995 elaborated on the ICPD commitments, by highlighting the angle of women's right to bodily integrity and to be free of coercion - 'The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality including sexual and reproductive health, free of coercion, discrimination and violence' ("Beijing Declaration and Platform for Action" 1995).

It was the public health imperative of the HIV pandemic that provided the impetus to organisations like WHO to seriously address Sexual Health issues in the 1990s. WHO convened a technical consultation in January 2002 to define terms related to Sexuality and develop a perspective for working on Sexual Health. The Consultation was convened in partnership with the World Association of Sexology (now renamed as World Association of Sexual Health). From the report of the consultation, it appears that the subject of sexuality continued to remain controversial. Although the Consultation was organized in 2002, the report was published more than four years later. And even in that report there appear to be caveats—the WHO qualifies the definitions as 'Working' Definitions and distances itself from the definitions by stating that 'the definitions do not represent the official position of WHO'! And even in 2017 the same Working Definitions appear on the WHO website!

BOX 2: UNPACKING SRHR

Sexual rights create the conditions, which enable individuals to determine whether to connect sexual activity with desired reproductive ends. They reinforce people's right to engage in a range of non-reproductive sexual practices (some of which are illegal in many countries, for example anal sex).

People have sexual relations from adolescence into old age. As long as they are having sexual relations, they have sexual health needs—related to information, education, services, and protection from sexually transmitted diseases, and to problems of sexual function. (Actually even if they are not having sexual relations, they need information and education on sexuality. Our comment.)

The term "sexual rights" includes the right to sexual health irrespective of one's reproductive status. Sexual rights include the full range of protections across rights, over and above health concerns alone.

Source: WHO, 2001.

BOX 3: WORKING DEFINITIONS

SEX

Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean "sexual activity", but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.

SEXUALITY

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

SEXUAL HEALTH

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

SEXUAL RIGHTS

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

Source: WHO, 2006.

BOX 4: SEXUAL RIGHTS

Beijing Declaration and Platform for Action, 1995: "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."

The Montevideo Consensus on Population and Development, adopted by the governments of Latin America and the Caribbean defines sexual rights as follows (UN, 2013): "the right to a safe and full sex life, as well as the right to take free, informed, voluntary and responsible decisions on their sexuality, sexual orientation and gender identity, without coercion, discrimination or violence, and that guarantee the right to information and the means necessary for their sexual health and reproductive health".

Apart from the Sexual Rights listed above, many other organisations and groups have subsequently developed their own charters and declarations of Sexual Rights. WAS formulated its declaration in 1997, which was revised in 1999 and again in 2014 (World Association for Sexual Health 2014).

IPPF, in 2008, concluded a two year process in which a high level panel engaged to develop the IPPF Declaration of Sexual Rights (IPPF 2008). In 2006, in response to well-documented patterns of abuse, a distinguished group of international human rights experts met in Yogyakarta, Indonesia to outline a set of international principles relating to sexual orientation and gender identity. The result was the 'Yogyakarta Principles: a universal guide to human rights' which affirm binding international legal standards with which all States must comply ("The Yogyakarta Principles – Yogyakartaprinciples.Org" n.d.).

The point to be emphasised is that the world view on Sexuality and Sexual Health has been changing over the last two decades to reinforce the notion of 'positive sexuality' and sexual well-being as contrasted to sexual ill health.

Sex Positive Movement

The sex-positive movement is a social movement, which promotes and embraces sexuality with few limits beyond an emphasis on safe sex and the importance of consent.

"Being sex positive is all about embracing that sexuality is a very important part of who you are, irrespective of your age and irrespective of the social construct," says Dr. Michael Krychman, certified sexual counselor and sexual-medicine gynecologist (Zar Rachel 2013). "It means maintaining a healthy attitude towards sex—or lack thereof—and valuing it given your individual needs." Sex positivity also embraces the idea of being sexually educated and staying safe.

Sex-positivity is *"the cultural philosophy that understands sexuality as a potentially positive force in one's life, and it can, of course, be contrasted with sex-negativity, which sees sex as problematic, disruptive, dangerous. Sex-positivity allows for and in fact celebrates sexual diversity, differing desires and relationships structures, and individual choices based on consent"* – Carol Queen (McCracken 2016).

Another definition is:

> Sex-positivity is *"an attitude towards human sexuality that regards all consensual sexual activities as fundamentally healthy and pleasurable, and encourages sexual pleasure and experimentation. The sex-positive movement is a social and philosophical movement that advocates these attitudes."* – Allena Gabosch (McCracken 2016)

There is also a critique of the 'sex positive' concept. Fabello (Fabello 2014) says that sex positivity can tend towards creating new expectations of women as sexually liberated, resulting in a new form of sexism. She argues that sex positivity should be practiced with some critical analysis. She reminds us that while we may think that we are making empowered decisions, just how autonomous are they? To what extent are they influenced by our socialisation and the prevailing social norms? And so is one's sex positive act a reaction to, a rebellion against the prevailing social norms? Or is it a conscious critically analysed perspective? While a particular sexual act (e.g. use of power), is pleasurable for one woman, and therefore falls into the category of sex positive, it may actually be degrading for many other women and maybe amounting to rape. She states that sex positivity 'boils down to 1) not making moral judgments, 2) respecting everyone's personal preferences, and 3) encouraging people to be active agents in discovering what does (and doesn't) make them tick,' but in the real world where there are oppressive structures operating in myriads of ways, things are not black or white, there are grey areas and fine lines and therefore sex positivity demands that it be accompanied with critical analysis. (Some of this will be discussed in further detail towards the end of this document.)

Social Construction of Sexuality

Social construction theory understands sexuality as being produced through social, economic, cultural and gender power relations. Sexuality is constructed by society in complex ways. 'It is a result of diverse social practices, of social definitions and self-definitions, of struggles between those who have the power to define and regulate, and those who resist. Sexuality is not a given, it is a product of negotiation, struggle and human agency' (Weeks 2003).

In this section with saw how, almost tortuously, the concepts of Sexual Rights and Sexual Health gained some legitimacy and acceptance through the various international

conferences and mobilising. The concept of Sexual Rights whose seeds were sown in the ICPD and whose buds emerged in the Beijing FWCW, continues to evolve. In the next section we will examine how the ICPD agenda continued to be monitored.

2.1.3 Five-Year Reviews of the ICPD Agenda

The ICPD goal was as follows:

> *All countries should strive to make accessible, through the primary healthcare system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015.*

Progress towards the ICPD agenda was reviewed every five years, through national, regional and global events called **ICPD+5, ICPD+10, ICPD+15**. Each of these events included country level field enquiries on the basis of which a high level UN meeting was organized. NGO Forums, Youth Forums and Parliamentarians' Forums were also organized.

The first official review in 1999, **ICPD+5** was held in the Hague Netherlands. In the 21st Special Session of the UN General Assembly Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development were adopted. These Key Actions, as they became known, focused particularly on certain areas of the Programme of Action, expanding the recommendation on what should be done to achieve its implementation within the 20-year time frame. (UNFPA 2010) The first review presented in the UN General Assembly observed there were serious financial constraints that hindered the implementation of the ICPD POA. The report also pointed out that there were socio-economic constraints like cultural factors that perpetuated gender inequalities and violence against women (UN 1999).

ICPD+10 in 2004 once again reviewed progress through country-level activities and a series of regional gatherings, technical meetings and a commemorative session of the General Assembly. An NGO Global Roundtable was held in London, and a meeting of parliamentarians was also convened. The results of the global inquiry on countries' progress were published by UNFPA in a report titled Investing in People: National Progress in Implementing the ICPD Programme of Action.

Civil society analysis 10 years after the ICPD indicated that little had changed on the ground to improve women's lives. The implementation of the ICPD agenda was slow in countries. There was a gap between the stated agenda and the implementation. Required resources for ICPD implementation were yet to be fully mobilised by national governments; and there was a large gap in committed resources from international donor agencies (ARROW 2005). Governments were not able to implement majority of the actions that they had promised. Preventable maternal deaths had decreased only slightly, deaths from unsafe abortions continued. Violence against women, HIV transmission both for men and women was still increasing. Unmet need for contraceptives continued to be high. Screening for cervical and other reproductive cancers was still not being done.

ARROW's 8 country review report showed that despite high level rhetoric at the national, regional and global levels, the promised reproductive health services were non existent on the ground. Contraceptive services were still not satisfactory in terms of availability and quality. Young peoples' SRHR programmes were a non starter in many countries in terms of information provision, access to contraceptives and other services. Although some countries had legislated new abortion laws, there was a growing realisation that liberal abortion laws do not necessarily guarantee women's access to safe abortion services. Many a times, the health facilities are not equipped to provide the abortion services, or the health care providers are not trained enough. The budgetary allocations for training of health care providers and the actual services are also deficient. Another major obstacle is the attitude of health care providers (HCPs) towards abortion itself, it has been seen that the HCPs deny abortion on the basis of their religious background. Hence, though legally allowed, actually abortion services are grossly unavailable for women.

ICPD had promised gender sensitive services for women, men, across their life stages. The 10 year review showed that governments had not initiated serious gender training of health providers. If training was done, there was no follow through and follow up. Disrespect and lack of care continued as before, compounded by staff shortages and continued lack of resources. In India we saw that 'Male Involvement' was reduced to promoting vasectomies, and, although the government announced officially the 'target free approach to family planning', in practice targets and incentives continued! The initial euphoria of the post ICPD

era within the women's health movement that resulted in setting up Healthwatch, an organisation to monitor the implementation of the ICPD promises, slowly fizzled out as it became apparent that business was continuing as usual.

ARROW's 8 country review report identified many barriers for expanded reproductive rights and reproductive health services. Amongst these were weakened public health systems partly due to structural adjustment programmes of the 1980s and partly due to the health systems reforms of the late 1980s and 1990s. The health systems reforms in fact turned out to be quite anti SRHR with their emphasis on expansion of user fees, public private partnerships that promoted profit motives and introduction of cost effective measures for priority setting. All these especially impacted on controversial SRHR services like access to safe abortions, or low priority services like infertility (high priority from women's point of view) and marginalised groups like the adolescents and older women with their long term reproductive morbidities.

In 2009, **ICPD+15**, the third five-year review was carried out under UNFPA's leadership. Again a commemorative event at the General Assembly and a series of meetings were held at global and regional levels. As before, many country-level activities were also undertaken to review progress and discuss challenges.

But the third review was different from the earlier two. In the face of increasing right wing conservatism across the globe, and especially in the US, UNFPA and civil society organisations decided to lie low. The fear was that there might be a backlash and a roll back on the sexual and reproductive health and rights agenda. Thus there was no global survey carried out, there was no global intergovernmental meeting, these were held only at regional levels. There was no new political outcome document for revised actions to implement the ICPD POA, regional meetings and civil society action were subdued. The financial and economic crisis that began in 2009 affected the global social development priorities as well as the ICPD+15 review process itself. (UNFPA 2010) The ICPD+15 resulted in a few shifts in emphasis and priorities. For example, there was a move to 'reposition family planning' and secure reproductive commodities, shift in emphasis towards the MDGs' agenda of Child Mortality and Maternal Mortality, women's education and so on.

The **ICPD+20** global report revealed (UN 2015) some important improvements in SRHR indicators. The annual number of maternal deaths decreased by 47% worldwide between 1990 and 2010 and there was a 10% increase in contraceptive prevalence rate globally. However, the extent to which such figures represented ground realities was debated. Although the WHO reported that there was a 40% increase in STI incidence, a weak database did not allow for clear intervention strategies. And while conversation on young people's SRHR had gained traction, survey data showed little improvement.

ARROW's 8 country review report identified many barriers for expanded reproductive rights and reproductive health services. Amongst these were weakened public health systems partly due to structural adjustment programmes of the 1980s and partly due to the health systems reforms of the late 1980s and 1990s.

On the specific questions of rights, there were some definite gains in the form of resolutions on SRHR being taken up in international human rights treaty monitoring bodies. But once again statistics and data did not reflect much improvement. For instance, 40% of women continued to live in countries where abortion was severely restricted, and comprehensive sexuality education continued to not be prioritised in a large proportion of countries. As such, sexual and reproductive rights did not seem to have achieved much more beyond getting heard and recognised in some forums. The comprehensive sexual and reproductive health agenda had been reduced to a fraction of what it was supposed to be. Only family planning and maternal health had gained attention, and not reproductive health. There was a backlash against some of the gains made in the 1990s. The abortion laws for example, had suffered in Eastern Europe and Central Asia indicating a right-wing threat to sexual and gender rights.

Donors support which was high post 1994 moved away from SRHR. While there was some increase in funding for HIV and maternal health, it was inadequate. Increasingly, funding was going to mega projects and mega conferences, and to INGOs for providing technical support to

governments. Local NGOs were being forced to focus on quantifiable targets and outcomes to survive, a challenge because SRHR as a field is not conducive to dramatic and demonstrable changes. As a result, long-term grassroots work on SRHR in many countries began to suffer. Within the SRHR movement, there began a siloisation of issues into 'RH', 'HIV' etc. The earlier inclusive, collective analysis of the field of SRHR went missing, with national SRHR agendas often being set by INGOs and donors.

The feminist analysis felt that it is important to centre-stage neo-liberal globalisation that was fuelling inequality. Although poverty has decreased, inequality has increased by all measures and 53% of all gains in global income have gone to the top 5% of earners between 1988 and 2008 (UN 2015). Today we are confronted with recurrent multiple crises, agriculture is under severe attack, and there is a roll back of investment in social security even as costs and insecurity of employment rise. All these factors have a gender impact with women's lives, livelihoods and health being disproportionately affected. Also, this scenario leads to increasing fundamentalism as people consolidate ethnic identities and find scapegoats in other groups to make sense of their losses in the world. Further, with the increasing marketisation of health services, decreasing public expenditure on health, public private partnerships and WTO policies, universal access to SRHR can seem like a distant dream.

Girard (Girard 2015) noted that as the 20th anniversary of ICPD loomed closer, SRHR advocates and supportive governments began to be concerned about the 'unfinished business of Cairo'. Despite some early progress seen in the +5 review, another analysis highlighted that four issues needed consideration for the ICPD Beyond 2014 agenda: 1) the right to integrated and quality SRHR services, education and information, including comprehensive sexuality education (CSE), for adolescents, particularly adolescent girls; 2) access to safe and legal abortion as part and parcel of that; 3) international recognition of sexual rights, and 4) condemnation of discrimination, abuse and violence on the basis of sexual orientation and gender identity.

At the juncture of the millennium, on one hand the reproductive health agenda was being furthered through the ICPD process, and on the other hand, the world was discussing broader development agenda which was later termed as the Millennium Development Goals.

2.1.4 MDGs and SRHR – Feminist Critiques

The overall critique of the MDGs agenda was that it was top-down and North-led in its design. Although the MDGs were conceived of as global goals, they ended up being imposed on states in a one size-fits-all manner as national planning targets. In many aid-dependent countries the MDGs replaced the national priority-setting processes and, fostered more "accountability" to donors than to citizens in their own countries (Yamin and Lander 2015).

Women's groups and feminists across the world strongly criticized the Millennium Development Goals for their siloed approach (DAWN 2012). They were also deeply concerned about the regression seen in the MDG agenda in terms of addressing women's rights and sexual and reproductive health and rights. They felt that even though SRHR related directly or indirectly to all eight MDGs, political opponents of these rights and services, including the Bush administration in the US, contributed to sidelining of the SRHR agenda during the MDGs' initial years. Of the eight MDGs, only the third goal explicitly refers to "gender". Women's health advocates felt that all the gains of the ICPD and the FWCW were lost in the MDGs. The MDGs reduced women's health, empowerment and rights to the single MDG 5—reduction of maternal mortality. The ICPD goal of universal access to reproductive health found no mention in the MDGs until women's health advocates' and UNFPA advocacy, over a period of at least two years, resulted in a supplementary target being added to MDG 5, Target 5B Universal access to reproductive health. This was in 2007 when the MDGs' process was almost midway. Feminists felt that SRHR was depoliticised and narrowed down to technocratic interventions for maternal health, and managerialist, rather than transformative approaches for women's empowerment (Yamin and Lander 2015). The failure to address entrenched gender power relations that underlie gender-based violence, abortion rights, sexual health and rights, including gender identity and sexual orientation, or the needs and rights of young people, were considered critical omissions under the MDGs.

Most of the gender-based critiques emphasised that despite the growing recognition of the importance of gender, the gender dimension was not made explicit in the MDGs. This omission was most obvious in the targets and indicators outlined by the UN Secretary General. The proponents of the need for a gender perspective felt that gender equality

should have been central to all the MDGs. A feminist critique of MDGS further highlighted that intersectionalities (how women's various identities play out and how different women are impacted on differently), was ignored.

2.2 'ICPD BEYOND 2014', 'POST-2015 DEVELOPMENT AGENDA', 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT (SDGS)

This section deals with the present moment—the era of the Sustainable Development Goals and the processes that led upto these Goals and how the SRHR agenda is treated within SDGs, and what monitoring and accountability opportunities exist for civil society groups. In 2013, there were at least three processes going on at the global level. The first was the ICPD review process through the ICPD+20 meetings. The second was related to the MDGs and was termed as the 'Post-2015 Development Agenda'. And the third was the process of developing the SDGs agenda. The salient issues that emerged in each of these are highlighted in the following sections.

2.2.1 ICPD Beyond 2014 Review Process

The UN General Assembly (resolution 65/234) mandated an 'operational review' of the implementation of the ICPD Programme of Action Beyond 2014. This review included a Global Survey, global meetings on specific themes, and regional conferences on population and development. In 2013, five regional conferences and three thematic meetings - youth, human rights, and women's health were organised. A meeting on the Indicators Framework concluded this series. The inputs from these meetings and the Global Survey resulted in a report ' Framework of Actions for the follow-up to the Programme of Action of the ICPD Beyond 2014. The Global Survey report pointed out progress in several areas: reduction in the rates of new infection for HIV in any countries, an overall 50% reduction in maternal mortality, and increases in the use of modern contraception. The report pointed out that despite some gains in the 20 years of ICPD, these gains would be lost if the inequalities in the countries affecting the poorest and most marginalised, were not tackled. The Framework of Actions was launched by the UN Secretary-General in February, 2014, just prior to the 47th session of the Commission on Population and Development. The commission acknowledged that 'the data-rich report strongly reinforces the ground-breaking focus of the Cairo Programme of Action on human rights and individual dignity as drivers of development'. It went further to warn that ignoring equality, women's health and the human rights of all people, including the large youth population, could derail progress (UN 2015).

The Experts' Meeting on Women's Health convened as a part of the ICPD Beyond 2014 Review process, (Germain et al. 2015) highlighted that despite significant progress on some aspects of SRHR for some people in LMICs during the 20 years of ICPD implementation, three major gaps required priority attention:

- Inequalities in access to SRH services, education and information.
- Quality of SRH services – these fall short of both human rights and public health standards, as well as, medical ethics standards often.
- Accountability mechanisms – these either do not exist or are not used to track progress, or to prevent and redress inequalities and poor quality of services in most countries.

2.2.2 High Level Task Force

A High Level Task Force for the ICPD, of 25 eminent persons, was set up in 2012 to push for the unfulfilled ICPD agenda to be taken beyond 2014 (20 years after ICPD) and 2015 (post the MDGs).

> *The High-Level Task Force for the ICPD was mandated from 2012-2016 to provide a bold, authoritative voice to advance sexual and reproductive health and rights, gender equality and the human rights of women and girls, and the rights and participation of young people, through the ICPD Beyond 2014, Post-2015 Development Agenda and related UN processes, such as the Beijing+20 review.* (High Level Task Force for ICPD n.d.)

The priorities identified by the High Level Task Force for the post 2015 development agenda stated that Sexual and Reproductive Health and Rights, empowerment of women and gender equality, and rights and empowerment

of adolescents and youth have to be placed at the heart of sustainable development. Sexual and Reproductive Health and Rights are essential elements of human dignity and human development and a core basis for social and economic progress. And this calls for addressing issues such as maternal mortality and morbidity, family planning, HIV, STIs and ANC. Universal access to quality comprehensive sexual and reproductive health information and services throughout the life cycle must be ensured in the post 2015 period. The HLTF also suggested that national legislations to affirm fundamental human rights and sexual and reproductive rights should be considered. They emphasized empowerment of women and girls—increased political participation, leadership and decision making, employment and livelihood opportunities. Recognition of violence against women and girls as an urgent issue to be addressed, was another priority that the HLTF specified. Another area of emphasis was Accountability. Disaggregation of data to reflect inequalities and diversities should be ensured. Participation of the 'affected groups' in policy making and programme formulation should also be ensured. (Force et al. 2015)

2.2.3 2030 Development Agenda (SDGs)

Some of the lacunae of the MDGS process—like being top down and imposed—were consciously addressed by the SDGs process. Unlike the MDGs, which were focused on social issues, the SDGs set out targets across all three dimensions—social, economic and environmental—of sustainable development. Furthermore, while the MDGs were targeted at developing countries, the SDGs are applicable to all countries. Over a three year period the UN organized many discussions and meetings, solicited inputs even from the general public including through online consultations. The process was sought to be transparent and consultative. An Open Working Group was mandated by the UN (outcome document of the United Nations Conference on Sustainable Development, titled "The Future We Want: Outcome Document Adopted at Rio+20") to develop a set of sustainable development goalsand targets. This Open Working Group submitted the proposal "Open Working Group Proposal for Sustainable Development Goals" to the General Assembly in 2014 and proposed a set of 17 goals and 169 targets to be achieved by 2030. And in September 2015, UN Member States adopted the post 2015 development agenda at the UN Sustainable Development Summit. The outcome document of the process is titled 'Transforming Our World: The 2030 Agenda for Sustainable Development', and lays out the vision, principles, the Goals and Targets, as well as the means of implementation and follow up of the implementation.

2.2.4 Civil Society Perspectives

As mentioned above, in 2013, there were at least three processes going on at the global level. The first was the ICPD review process through the ICPD+20 meetings. The second was related to the MDGs and was termed as the 'Post - 2015 Development Agenda'. And the third was the process of developing the SDGs agenda. Some analysts have noted (Yamin and Lander 2015) that the three processes ran parallel, divorced from each other. The Post 2015 discussions, Yamin stated, were uninformed by the ICPD+20 reviews and left out the ICPD agenda of SRHR. She argued that SRHR was a perfect example of the urgent need to link the three processes.

> *...it is striking that, as of this writing in February 2013, the lessons learned from ICPD are still not being fully integrated into consultations taking place for post-2015—and, conversely, that the ICPD review is not being considered in light of the lessons from the MDGs and the other processes under way now.*

> *.....SRHR are fundamental to redressing structural forms of gender discrimination and inequality and are crucial across many of the issues central to post-2015 discussions, such as health, poverty, migration, climate change and environmental sustainability, population dynamics, food security, and access to resources. Yet, precisely because taking SRHR seriously challenges power structures that perpetuate patterns of inequality, violence, and suffering—especially among women—they are deeply contested and are often deliberately marginalized in global discussions where voices are combined and dissonance is minimized.*

Outside of inter- governmental and UN processes described above, feminist groups across the globe felt that transformative agenda needed to be pursued for moving beyond ICPD and health MDGs. There were growing concerns about the fragmentation of SRHR work in the field and the absence of a collective critique of where it is heading. In 2010, Reproductive Health Matters and ARROW organized a meeting Repoliticising Sexual and Reproductive Health and Rights. Several feminists working in the field of health noted that health care provision was being privatised. They felt concerned about the backlash against many of

the gains made since the 1990s, and that the agenda was getting more conservative in response. They expressed that human rights were being challenged, especially in relation to sexuality and gender identity. Progressive donors had changed their agendas. Smaller NGOs, often the innovators, were being defunded. Attention to sexual health was being limited mainly to surviving sex, and attention to reproductive health was being narrowed to surviving pregnancy. They noted that despite there existing dozens of networks in the field, there was no common agenda. NGOs were being forced to focus on and quantify targets and outcomes. And sexual and reproductive health and rights was in danger of disappearing from governmental and inter-governmental agendas. The meeting ended with a call for launching an initiative for repoliticising sexual and reproductive health and rights and formulating a transformative agenda.

ARROW developed a series of thematic advocacy briefs as well as an Asia-Pacific regional advocacy brief on SRHR for the Post 2015 Women's Coalition. The briefs were used for advocacy during the United Nations General Assembly special session on ICPD Beyond 2014 and for advocacy intervention afterwards as well. (Post 2015 Women's Coalition n.d.)

2.2.5 SRHR in SDGs

In addition to the 17 SDGs and the Targets that were adopted in 2015, a roadmap for the development of an indicators' framework was endorsed by the United Nations Statistical Commission in March 2016 and national governments needed to either adopt these indicators or modify them and finalise them in 2016. Civil society groups working on SRHR issues - Guttmacher Institute, ARROW, PMNCH - worked out SRHR indicators and several national groups mobilized to suggest suitable indicators in their own countries (CommonHealth advocacy brief, unpublished) The framework for these indicators followed some of the priorities listed by the High Level Task Force—viz. that the indicators adopted by countries should be able to:

a. monitor universal access to SRHR information and services, without discrimination and at all levels of health facilities,
b. monitor status of laws, policies and regulations pertaining to SRHR,
c. provide disaggregated data to reflect inequities and diversities,
d. monitor quality of services and informed choice (Jyothirmai 2015)

The indicators for the Gender Equality Goal are by and large quite sound, incorporating some on measuring violence against women and girls. The indicators for SRHR seem to be limited to contraceptive access for women between 15 and 49 years, adolescent birth rate, coverage of health services including reproductive health services, MMR, births attended by skilled attendants. It is unclear how exactly SRHR will be worked out in relation to education, transport, economic and other goals. And in relation to the social determinants of sexual and reproductive health and rights. How will the language of sexual rights be incorporated? Will we continue using language like 'family planning' which excludes many groups including adolescents, who actually need contraceptive services? What about clear language around decriminalising and legalising abortions? What about transgender health? And decriminalisation of sex work?

Financing for SRHR in the Post-2015 Development Agenda (IPPF 2010)

The Post-15 agenda discussions also deliberated on the means of implementation and financing for this ambitious global sustainable development agenda. Global partnerships were emphasized and resources for this agenda were sought from domestic public resources, domestic and international private business and finance, international development cooperation, international trade. Increased health financing especially for women and children was emphasised and Global Financing Facility was created for the targets related to women's, children's, adolescents' and reproductive health, in consonance with the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). The US government, Japan, Norway, Canada and Bill and Melinda Gates Foundation made commitments towards the GFF.

According to IPPF, the total cost of sexual and reproductive health care is annually around US$39.2 billion (IPPF 2015). The total represents more than a doubling of the current costs of these services, but amounts to only US$25 per woman of reproductive age annually, or US$7 per person in the developing world (Singh, Darroch, and Ashford 2014). UNFPA and the Netherlands Interdisciplinary Demographic Institute (NIDI) estimate that almost US$70 billion is needed to fully fund the ICPD costed package in 2015 (based on projected estimates made in 2009 ("Financial Resource Flows for Population Activities In" 2010). Out-of-pocket payments make up the lion's share of the costs of SRHR services, with those in developing countries paying

US$ 35,876 million for services. Out-of-pocket payments obviously have a disproportionately negative impact on the poorest and most vulnerable people who may be prevented from accessing services.

To ensure that access to these services is universal, there will need to be increased funding. SRHR services will need to be made a priority for both domestic and international budgets and funding. Governments must be called upon to spend 5% of their GDP on health and to ensure internal consistency in their budgets and spending so that health inequities are addressed.

2.2.6 Other Global Commitments and Accountability Fora

Some of the other global commitments that can be used to push the SRHR agenda are the Every Woman, Every Child initiatives such as the Global Strategy for Women's, Children's and Adolescents' Health, FP 2020, Eliminating Preventable Maternal Mortality. Brief descriptions of each are given in the following sections.

FP 2020

In July of 2012, the Bill & Melinda Gates Foundation and the United Kingdom's Department of International Development hosted the London Summit on Family Planning, bringing together the leaders of 150 countries, international agencies, civil society organisations, foundations, the research and development community, and the private sector for the purpose of realising a vision, that all women and girls should have access to contraceptives and services no matter where they live or what their social or economic circumstances.

Out of this summit resulted FP 2020—a global partnership that purports to support the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have. It works with governments, civil society, multi-lateral organisations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020.

Many countries pledged action as part of FP 2020. And these pledges at the national as well as the global levels can be used by feminist groups to demand quality, rights based contraceptive services and information for women and girls in their countries.

The Global Strategy for Women's, Children's and Adolescents' Health (UN 2016)

The Global Strategy is an update on the earlier strategy for women's and children's health from 2010 to 2015 and has added Adolescents as a critical group whose health also needs focus. The strategy is based on the understanding that the survival, health and well-being of women, children and adolescents are essential to ending extreme poverty, promoting development and resilience, and achieving the SDGs. The Global Strategy document tells us that 'More than 7,000 individuals and organizations informed the drafting process through a global consultation supported by Every Woman Every Child. The World Health Assembly 2015 and consultative regional meetings hosted by the Governments of India, South Africa and the United Arab Emirates were important occasions for consultation. Several partners developed technical papers that provided a strong evidence base for the Global Strategy. Many stakeholders also participated in public consultations organized by The Partnership for Maternal, Newborn & Child Health (the Partnership)'.

The Strategy starts with an economic argument. It argues that there can be 'High returns from investing in women's, children's and adolescents' health'

- At least a 10-fold return on investments in the health and nutrition of women, children and adolescents through better educational attainments, workforce participation and social contributions
- At least US$100 billion in demographic dividends from investments in early childhood and adolescent health and development.

It goes onto mention the central role of human rights in what is being proposed. And that gender equality is a precursor to realizing the right to health. Importantly it emphasizes multi sector action for realizing the objectives of the Strategy—Survive, Thrive and Transform. And it also defines roles for diverse stakeholders ranging from Parliamentarians and Legislators, Health care providers, Business, Academics, Media, Communities, Civil Society Actors and many others.

Many of the international conferences are not by any means feminist in nature. Their agendas are influenced by organisations who tend towards neo liberalism, by philanthrocapitalism. What is heartening is that there is an effort by southern feminists to constantly engage with these complex processes, to push the boundaries and question the rhetoric.

Accountability Fora

There are several accountability mechanisms that can be used to monitors SRHR progress in countries as well as globally. The Independent Accountability Panel invites and receives submissions that are (can be) included in the State of Women's, Children's and Adolescents' Health annual report.

The United Nations Commission on Information and Accountability for Women's and Children's Health (CoIA) has specified what Civil Society Organizations can do (WHO Commission on Information & Accountability for Women's and Children's and Health 2011).

- Support the work plan to implement the Commission's recommendations.
- Convene a coalition of partners convened to develop a plan for assisting countries in strengthening health information management systems.
- Ensure transparent reporting of commitments etc.

Feminists have been using the CEDAW process quite successfully to press for accountability action within their countries. The Shadow Reports to complement the government reports, exceptional reports on domestic issues affecting women (e.g. Gujarat sexual violence against women (2010), Armed Forces Special Protection Act in India), attendance at the NGO Forum, the caucuses at the annual Committee for Status of Women meetings, to take up issues from their countries, are some of the avenues within the CEDAW process used by feminists. A classic example is the compensation awarded to her mother and daughter, in the case of Alyneda Silva Pimentel, a 28-year-old Afro-Brazilian woman, who died of complications resulting from pregnancy after her local health centre misdiagnosed her symptoms and delayed providing her with emergency care. Although the process took over nine years, the results made history and gave much inspiration to women striving in these arenas.

The Universal Periodic Review process of the Human Rights Council is yet another mechanism that feminists have been using to improve the human rights situation in their countries. The good aspect of all these international efforts at demanding accountability is that they entail collective efforts across national, regional and global boundaries and have the potential for promoting global solidarity.

In one sense many of the global processes described above, appear quite progressive. It has, however, also to be recognised that some of the seemingly progressive forces, may have other sides to them. Many of the international conferences like, for example, Women Deliver or the Asia Pacific Reproductive and Sexual Health Conferences, are not by any means feminist in nature. Their agendas are influenced by organisations who tend towards neo liberalism, by philanthrocapitalism. While the rhetoric is political and seemingly progressive, the question to be asked is 'where actually is the power? And how is it playing out?' What is heartening is that there is an effort by southern feminists to constantly engage with these complex processes, to push the boundaries and question the rhetoric, and negotiate for the agendas and issues of marginalised women.

2.2.7 Conclusion

Many of us, women's health advocates in the global south, through our community based practice as well as women's health clinics and self help groups, realized that national health programmes had to cater to women's and girls' health needs beyond their reproductive life span. Women leaders made a strong push for the Life Cycle/ Span Approach to be included in the PoA in the pre-ICPD advocacy processes. In several sections the ICPD Programme of Action refers to a Life Cycle Approach. With its mandate on Population issues, in addition to migrants and displaced populations, it focuses on population groups in different life stages, viz., on children, young people and the elderly. Additionally, with respect to Reproductive Health, one of the objectives of the PoA is "to meet the changing reproductive health needs over the life cycle. (UN 1994)

2.3 Life Cycle/Span Approach

2.3.1 Introduction

Many of us, women's health advocates in the global south, through our community based practice as well as women's health clinics and self help groups, realized that national health programmes had to cater to women's and girls' health needs beyond their reproductive life span. Women leaders made a strong push for the Life Cycle/ Span Approach to be included in the PoA in the pre-ICPD advocacy processes. In several sections the ICPD Programme of Action refers to a Life Cycle Approach. With its mandate on Population issues, in addition to migrants and displaced populations, it focuses on population groups in different life stages, viz., on children, young people and the elderly. Additionally, with respect to Reproductive Health, one of the objectives of the PoA is "to meet the changing reproductive health needs over the life cycle. (UN 1994)

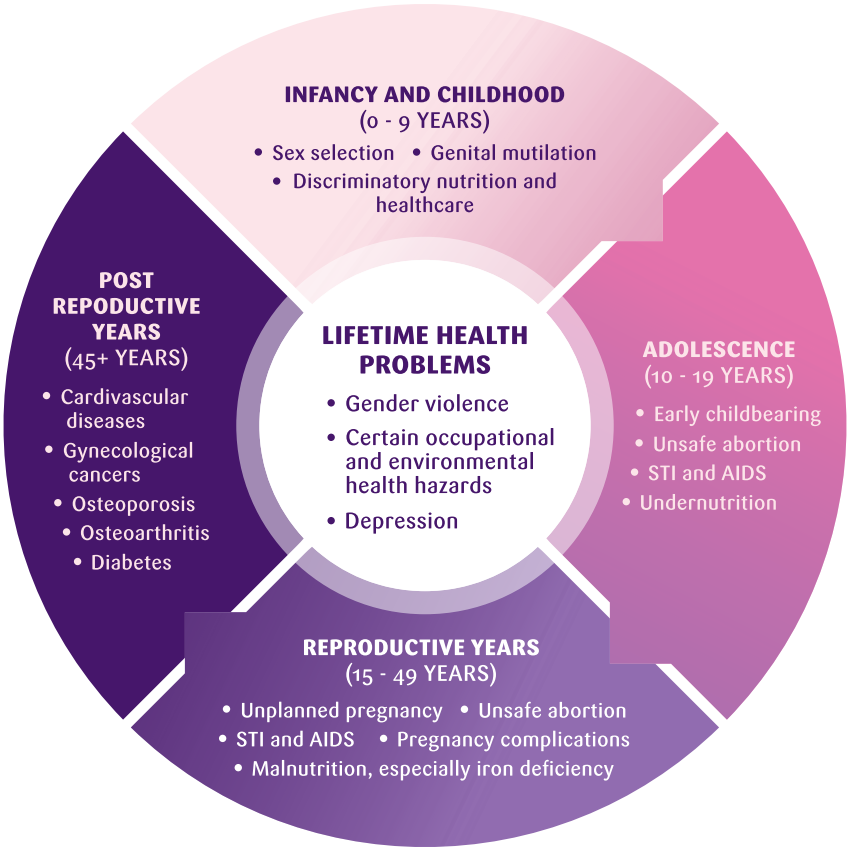
BOX 6: A LIFE CYCLE APPROACH TO REPRODUCTIVE HEALTH

- Anticipates and meets women's health needs from infancy through old age.
- Emphasizes health-seeking behaviour and appropriate services to meet women's health needs throughout their lives.
- Recognizes the right of all women to make informed decisions about their health.

SOURCE: (Family Care International Organisation 2001)

FIGURE 1: LIFE CYCLE APPROACH TO WOMEN'S HEALTH

SOURCE: Family Care International Organisation, 2001.



The Life Cycle Approach and the Reproductive Health Approach described earlier were both drivers for the demand that health systems address women's health issues beyond the narrow maternal and child health programmes. And although the earlier discourse spoke about the life cycle approach to reproductive health, many of us came to realise that we had to press for a life span approach to reproductive and sexual health and rights, and for all groups—women, men, girls and boys.

Figure 1 shows that women and girls have special health needs throughout their lives. The consequences of unaddressed health needs in the earlier life stages, exacerbate adverse health conditions in later life stages. For example, unaddressed anaemia and malnutrition in adolescence leads to maternal morbidities in reproductive age and in later life stages. The implication is that the health systems should recognize and address women's health problems throughout the different stages of their lives, by implementing special programmes for adolescents and women.

2.3.2 Young People's SRHR

A review done by ARROW during the ICPD+20 process gives some startling estimates pointing out that there is need to consider SRHR in relation to a number of aspects that affect young people—educational, health, access to a broad range of services, overcoming poverty.

> *UN estimates in 2012 showed that 43% of the world's population was people under 25 and roughly 88% of adolescents live in developing countries. Of the 620 million young people in the labor force, almost 13% were unemployed in 2009, which is the highest number ever. Many girls and boys enter adolescence in a malnourished state of health. About 16 million adolescent girls give birth every year globally and in any given year at least 20% of adolescents suffer from mental illnesses such as depression or anxiety.* Approximately, 430 young people die from interpersonal violence every day. While 40% of men and 38% of women have accurate knowledge about HIV transmission, an estimated 40% of new HIV infections occur in young people age 15-24 (ARROW n.d.).

The importance of young people's reproductive health began to be recognized in the 1980s. In 1989, WHO, UNICEF and UNFPA brought out a joint statement 'The reproductive health of adolescents: a strategy for action'. The statement acknowledged that adolescent health needed attention especially in developing countries where four out of five of the world's young people lived and where more than half the population was under the age of 25. The statement went on to state that a principal barrier to promotion of good adolescent reproductive health are a widespread lack of effective policies and programmes and the failure to involve young people in any existing promotional activities. Following this, the ICPD was the first forum where governments accepted that they needed to develop policies and programmes to address adolescent Reproductive Health. In this section, we first examine what the ICPD POA has to say about adolescent reproductive and sexual health and then go on to examine how the discussions and debates developed over the 20 years of the ICPD.

Young people, girls, children are mentioned frequently in the POA. The Principles section states that the human rights of women and the girl child are inalienable, integral and indivisible part of universal human rights. The right to education especially for women and girls and children's right to protection and to be safe from sexual abuse are emphasised. Investment in skill development of women and girls to promote their participation in economic spheres finds a mention. The chapter on Gender Equality, Equity and Empowerment of Women has an entire section on the Girl Child, drawing attention to son preference in many societies and the resultant sex selection and sex determination, in addition to general neglect of the girl child.

The POA exhorts governments to ensure that the rights of the girl child are protected and promoted. The chapter on Population Growth and Structure has a section on children and youth and once again emphasises strongly the rights of adolescents and youth to opportunities, participation and access to education, counselling and high quality reproductive health services. It warns against early marriages and high risk child bearing. Elements of youth friendly services—confidentiality, privacy, support of parents—are reflected in the POA. (UN 1994)

One important point that has emerged over the years is that adolescents are not a homogenous group. The term "adolescence" has been defined as including those aged between 10 and 19, and "youth" as those between 15 and 24; "young people" is a term that covers both age groups, i.e. those between the ages of 10 and 24. Within Adolescents there are the very young adolescents—10 to 14 year old. Adolescents are also different by way of

their marital status, educational status—school going, out of school, their location—rural, urban. These—and other differences—result in different sexual and reproductive health needs and issues, which have to be taken account while formulating adolescents SRHR programmes.

BOX 7: DEFINITION OF ADOLESCENCE (Curtis 2015)

"Adolescence" is a dynamically evolving theoretical construct informed through physiologic, psychosocial, temporal and cultural lenses. This critical developmental period is conventionally understood as the years between the onset of puberty and the establishment of social independence The most commonly used chronologic definition of adolescence includes the ages of 10-18, but may incorporate a span of 9 to 26 years depending on the source.

Early adolescence is the first stage and occurs from ages 10 to 14. Puberty usually begins during this stage.

Middle adolescence is the second stage and occurs from ages 15 to 17. By this time, puberty has passed. Teens in this stage are extremely concerned with how they look, and they think others are concerned, too.

Late adolescence, ages eighteen to twenty. By late adolescence, many youngsters have come to appreciate subtleties of situations and ideas, and to project into the future. Their capacity to solve complex problems and to sense what others are thinking has sharpened considerably. But because they are still relatively inexperienced in life, even older teens apply these newfound skills erratically and therefore may act without thinking.

So what are the most pressing issues faced by adolescent girls and boys?

Traditional and Harmful Practices

Young women, who may not have full agency over decisions concerning their bodies and sexualities, find themselves caught between the burden of harmful traditional practices and the dangers of newly emergent practices such as gang harassment and human trafficking. (Thanenthiran 2014). These traditional cultural values affect various aspects of adolescent girls' health and well being, as described in subsequent sections and constitute violation of their fundamental human rights.

Child Marriage, Early Marriage, Forced Marriage

Child marriage is any marriage where either one or both the spouses are under 18 years of age. The term is often referred to as "early" and/or "forced" marriage since children that young are not able to give informed consent. Forced marriage is also defined as as the union of two persons at least one of whom has not given their full and free consent to the marriage. Forced marriages are a result of varying degrees of coercion or deception and can range from emotional pressure by family to abduction and imprisonment.

The right to 'free and full' consent to a marriage is recognized in the Universal Declaration of Human Rights —with the recognition that consent cannot be 'free and full' when one of the parties involved is not sufficiently mature to make an informed decision about a life partner. Child marriage is not considered as a direct violation in the Convention on the Rights of the Child. However it is frequently addressed by the Committee on the Rights of the Child because it is linked to other rights—such as the right to express their views freely, the right to protection from all forms of abuse, and the right to be protected from harmful traditional practices. (UNICEF 2005)

Each year 15 million girls are married before the age of 18 across the globe. ("Girls Not Brides- Understanding the Scale of Child Marriage" 2014) Child marriage is considered as a form of violence against women and girls because, at a meta level, it prevents girls from reaching their full potential and well being and therefore is a violation of their basic human rights. Child brides are also especially vulnerable to sexual and emotional abuse, because of their disempowerment and isolation due to age, and status in the marital family. Child marriage is a result of gender inequality, and a belief that girls are inferior to boys, poverty (girls are considered a burden that should be passed onto another family as soon as possible), lack of education, cultural practices and beliefs (the notion of purity, chastity and honour of the family), and insecurity.

Child marriage is largely considered as a Child Protection issue and a Reproductive and Sexual Health and Rights issue. However looking at Child Marriage from multiple

perspectives can help foster alliances across different constituencies to address the issue.

- **Gender Perspective –** is concerned with the girl as well as the boy. It considers the differential consequences of Child/Early Marriage from the girl's as well as the boy's point of view. Strategies to address the issue include not only empowerment of girls, but also sensitization of boys to issues of the burden of early responsibility for caring for a family, the right to create your own life and future before taking on the responsibility of a family, issues of dowry and its exploitative nature, power relations that subjugate a new young wife in an alien household and family, caring sexuality, consent, and so on. A gender perspective would look at the dimensions of masculinity in relation to child marriage.
- **Adolescent Sexual and Reproductive Rights –** emphasizes young people's right to age appropriate comprehensive sexuality education, right to choice, right to youth friendly services including information and counselling, right to reproductive self determination, right to freedom from discrimination and violence. A broader Adolescent Rights' perspective would also look at adolescents' right to development and how child marriage violates this right.
- **Feminist Perspective –** would argue against the patriarchal connotation in the use of the word 'child' in 'child marriage', as well as the protectionist stance versus a self determination perspective within the 'evolving capacities' framework.[7] Feminist—as well as a gender perspective—also questions the entire notion of the inevitability of 'marriage' especially for girls—marriage as the ultimate destiny for all girls/women! A critical feminist critique of child marriage is from the perspective of control of a girl's sexuality, the fear of her losing her chastity and virginity pushes society—through parents—to promote child marriages.
- **Human Rights Perspective –** would emphasise the right to equality, right to self determination, right to participation, right to equal opportunities and development, right to health and education.

The idea of looking at Child Marriage through the lens of multiple perspectives is not only to engage in a theoretical exercise but also to create common ground and agreed upon principles that can guide the work. The strategies that are then developed are based on these principles and uphold the common values. By doing this, solidarity is created on the issue and a larger constituency is then engaged in this task. (Khanna Renu cited in Sudarshan and Nandi 2018)

Female Genital Mutilation

The ICPD Programme of Action called for the total elimination of Female Genital Mutilation (FGM), defined as the partial or total removal of the female genitalia or other injury to the female genital organs for non-medical reasons. (UN 1994)

An estimated 200 million girls and women alive today are believed to have been subjected to FGM; but rates of FGM are increasing, a reflection of global population growth. Girls and women who have undergone FGM live predominately in sub-Saharan Africa and some Arab States, but FGM is also practiced in select countries in Asia, Eastern Europe, and Latin America. It is also practiced among migrant populations throughout Europe, North America, Australia, and New Zealand. (UNFPA 2017)

BOX 8: REASONS GIVEN FOR PRACTICING FGM

> **Psychosexual Reasons:** FGM is carried out as a way to control women's sexuality, which is sometimes said to be insatiable if parts of the genitalia, especially the clitoris, are not removed. It is thought to ensure virginity before marriage and fidelity afterward, and to increase male sexual pleasure.

> **Sociological and Cultural Reasons:** FGM is seen as part of a girl's initiation into womanhood and as an intrinsic part of a community's cultural heritage. Sometimes myths about female genitalia (e.g., that an uncut clitoris will grow to the size of a penis, or that FGM will enhance fertility or promote child survival) perpetuate the practice.

> **Hygiene and Aesthetic Reasons:** In some communities, the external female genitalia are considered dirty and ugly and are removed, ostensibly to promote hygiene and aesthetic appeal. Religious reasons: Although FGM is not endorsed by either Islam or by Christianity, supposed religious doctrine is often used to justifythe practice.

> **Socio-economic Factors:** Inw many communities, FGM is a prerequisite for marriage. Where women are largely dependent on men, economic necessity can be a major driver of the procedure. FGM sometimes is a prerequisite for the right to inherit. It may also be a major income source for practitioners.

SOURCE: UNFPA 2017

Apart from the reasons mentioned above, there are strong cultural and religious reasons given that FGM maintains the girls' purity. However the patriarchal aspects oflack of women's/girls' control over their own bodies, right to bodily integrity have been highlighted by many feminists.

There has been a lot of debate around the language—Female Genital Circumcision, Female Genital Mutilation, Female Genital Cutting, Female Genital Manipulation. The term Female Genital Circumcision has been rejected because what is done to girls and women is nothing like male circumcision. The health implications of the two are completely different—while male circumcision reduces HIV transmission, FGM can increase the risk of HIV transmission. Female Genital Mutilation is a term used by women's rights and human rights organisations to emphasise the gravity of what is done to girls and women in the name of tradition and culture. In the 1990s the term Female Genital Cutting was introduced by 'insider' women's organisations who were (and continue) working to stop this practice within their communities. Tostan, a group in West Africa states on its website

> *.... the term "cutting" allows them (the communities who are giving up the practice) to accomplish more than the others because it is less judgmental and value-laden. As a result, the term is more effective for engaging groups in dialog around this practice, and eventually bringing about its end.*

The website portrays the complexity of the situation—

> *... it is love*—because not cutting your daughter risks her *entire future. As explained by a former cutter-turned-Tostan advocate, OureyeSall, in communities where FGC is practiced, an uncut girl is ostracized. Community members will not eat food cooked by a woman who is not cut, will not accept water from her, will not even sit with her. She will have difficulty getting married. An uncut woman is viewed as unclean and therefore unable to participate fully in the community. With these social pressures, if a family chooses not to cut their daughter, they have risked severely damaging her social status. To imply that parents are actually "mutilating" their daughters through a decision made with love and concern for her well-being is unfair to them and risks alienating and offending them rather than convincing them to abandon the practice.*
> (Gillespie Gannon 2015)

Malnutrition and Anaemia

During adolescence, weight gain equivalent to 40% of final adult weight and height gain equivalent to 15% of adult height happens thus there is ahigher need of nutrient dense food. However, there is a difference between the nutritional needs of boys and girls of the same age group as the period of physical maturation is different for both.

UNICEF in 2012 published that in 11 out of 64 countries, over a quarter of adolescent girls were underweight, and in 21 out of 41 countries, more than one third of adolescent girls were anaemic (UNICEF 2011). We know that there are intergenerational effects of undernutrition in adolescent girls. Improving the nutritional wellbeing of adolescent girls in South Asia is essential to achieve the global nutrition targets for 2025: to reduce the number of children under 5 years who are stunted by 40% and the number of women of reproductive age with anaemia by 50%. However, feminists have been asserting that an instrumentalist view of adolescent girls—as future mothers—is a violation of their human rights. Girls need to be well nourished for their own sakes. Well nourished adolescent girls would have better learning outcomes, delay their marriage and first pregnancy, increase their life choices, earn income, and advance the socioeconomic development of South Asian countries.

A high rate of iron deficiency anaemia is reported among adolescents in the South East Asian Region. There is, however, a great disparity within the Region. There are disparities between rural and urban areas as well as in school going and non-school going adolescents. It was also observed that socio-economic status determined the occurrence of anaemia among adolescents. Boys are as much prone to anaemia as girls in some countries. Irrespective of the severity, the prevalence of anaemia ranges between 12-100% in the Region. Boys are prone to suffering from anaemia because of the sharp increase in the iron requirements which decreases after the growth spurt and sexual maturation, whereas for girls, additional iron is required throughout reproductive period as there is monthly loss during menstruation.

Adolescent Pregnancies

Key facts (WHO 2018)

- Every year, an estimated 21 million girls aged 15 to 19 years, and 2 million girls aged under 15 years become pregnant in developing regions.
- Approximately 16 million girls aged 15 to 19 years and 2.5 million girls under 16 years give birth each year in developing regions.
- Complications during pregnancy and childbirth are the leading cause of death for 15 to 19 year-old girls globally.
- Every year, some 3.9 million girls aged 15 to 19 years undergo unsafe abortions.
- Adolescent mothers (ages 10 to 19 years) face higher risks of eclampsia, puerperal endometritis, and systemic infections than women aged 20 to 24 years, and babies born to adolescent mothers face higher risks of low birth weight, preterm delivery, and severe neonatal conditions than those born to women aged 20 to 24 years.
- The global adolescent birth rate has declined from 65 births per 1000 women in 1990 to 47 births per 1000 women in 2015. Despite this overall progress, because the global population of adolescents continues to grow, projections indicate the number of adolescent pregnancies will increase globally by 2030, with the greatest proportional increases in West and Central Africa and Eastern and Southern Africa.

Unsafe Abortions Among Adolescents

A recent report by Guttmacher institute (Guttmacher Institute 2016) states that in 2008 (the most recent estimate available), about 3.2 million adolescent women in developing regions underwent unsafe abortions, an annual rate of about 16 unsafe abortions per 1,000 women aged 15 to 19. The global rate masks a variation between geographic regions. Africa and Latin America and the Caribbean, with many countries having restrictive abortion laws, had very high unsafe abortion rates: 26 unsafe abortions per 1,000 adolescent women in Africa and 25 per 1,000 in Latin America and the Caribbean. In Asia, where many countries have liberal abortion laws, the unsafe abortion rate in 2008 was nine per 1,000 adolescents. It is possible that this rate masks the unreported and unsafe abortions increasingly happening among adolescents.

The table below shows that there is a lot of variation in abortion rates and in the proportion of adolescent pregnancies that end in abortion, in countries where reasonably accurate data is available. Ethiopia has the lowest abortion rate and Kenya and Mexico have the highest rates. Ethiopia (with a high adolescent birthrate, 79 births per 1,000 adolescent women) also has the lowest proportion of teen pregnancies that end in abortion, while Mexico (with a lower teen birthrate of 67 births per 1,000) has by far the highest.

TABLE 2: ADULT ABORTION IN FIVE DEVELOPING COUNTRIES

COUNTRY AND YEAR		NUMBER OF ABORTIONS TO WOMEN AGED 15 - 19	RATE PER 1,000 WOMEN AGED 15 - 19	% OF PREGNANCIES TO WOMEN AGED 15 - 19 THAT END IN ABORTION
BURKINA FASO	2008	23,630	30	16
ETHIOPIA	2008	46,860	11	9
KENYA	2012	76,760	38	22
MALAWI	2009	14,040	21	14
MEXICO	2009	230,180	44	34

SOURCE: Sedgh G et al., Adolescent pregnancy, birth, and abortion rates across countries: levels and recent trends, Journal of Adolescent Health, 2015, 56(2):223-230. www.guttmacher.org

BOX 9: RECOGNIZING ADOLESCENTS' 'EVOLVING CAPACITIES'

The Convention on the Rights of the Child details governments' responsibility to guarantee the rights of all children up to age 18, including the right to privacy (Article 16), and to information "regardless of frontiers" (Article 13). The Convention also acknowledges that children's ability to make important decisions, including decisions about their health, increases with age and experience. Article 5 calls on governments to respect the rights and duties of parents, legal guardians and extended families or communities (if empowered by local custom) to guide and direct children in the exercise of their rights "in a manner consistent with the evolving capacities of the child".

The ICPD similarly noted the need to balance the responsibilities and rights of parents or guardians with the "evolving capacities" of "adolescents" (a term not in the Convention but used throughout the ICPD Programme of Action).

The concept of "evolving capacities" also implies increasing autonomy. Policies "that treat competent adults as if they are children," argue Rebecca Cook and Bernard Dickens, "can become demeaning and insulting." Laws ostensibly designed to protect adolescents, for example by denying them access to contraception without parental consent, can jeopardize their health and may also violate the Convention and other human rights treaties

SOURCE: Barzelatto and United Nations Population Fund, 2003.

Studies show that in comparison with older women, adolescents have a greater tendency to seek abortions from untrained providers or to self-induce (Woog etal 2015). As a result, adolescents may end up making multiple attempts to end their pregnancies, instead of having one safe, effective procedure. Studies from India and Ghana show that adolescents have second-trimester abortions (instead of first-trimester abortions) more often than older women. This is because adolescents typically take longer than older women to recognize their pregnancies, locate providers and find a way to pay for the procedure. In India, in recent months, there have been a spate of cases where legal MTPs have been denied to sexually abused/raped young girls, by health providers and these cases have had to seek legal recourse to what should be routine as allowed under the MTP Act of 1972.

Barriers to abortion and post abortion care include restrictive laws. In countries where abortion is legal other barriers emerge: restrictions for adolescent girls, such as requiring parental notification or consent, or unnecessary requirements like mandatory waiting periods, mandatory counselling, third-party authorization, and medically unnecessary tests (WHO 2018) In India, the recent POCSO (Protection of Children Against Sexual Offences) Act defines a child as below 18 years, and deems criminal any sexual activity below the age of 18 for girls. Mandatory reporting is required if a girl under 18 seeks abortion, thereby violating her right to confidentiality. Adolescents cite a desire to keep the pregnancy secret (because of stigma associated with abortion, pregnancy and sexual activity among unmarried women) and trouble locating safe providers, as well as cost, as their main reasons for self-inducing or seeking abortions from untrained providers—even in countries where abortion is legal and widely available). (Guttmacher Institute 2016)

Adolescents and Contraceptive Use

Global estimates by Guttmacher show that in 2012, 52 million never married women, most of whom are adolescents and young women aged 15-24 in the developing world, were sexually active and in need of contraceptives. Another Guttmacher report noted that there is a steady long-term trend towards increased levels of sexual activity among this group, due to many reasons - declining age of menarche, rising age at marriage and changing societal values. (ARROW n.d.) Earlier estimates cited in the World Population Report of 2003, estimated that in Latin America and the Caribbean an average of 35% of sexually active teens over age 15 used FP, in sub-Saharan Africa fewer than one fifth did so (UNFPA 2003).

Sexually active unmarried young people do not have easy access to contraceptives because of programme biases and providers' attitudes. Programme designers remain blind to the fact that young people all across the globe, are sexually active at early ages and require sexual and reproductive health information appropriate to their contexts.

BOX 10: WHAT MAKES HEALTH SERVICES YOUTH-FRIENDLY?

> **Service Providers:**
- Specially trained staff.
- Respect for young people.
- Privacy and confidentiality honoured.
- Adequate time for client-provider interaction.
- Peer counsellors available.

> **Health Facilities:**
- Separate space or special times set aside.
- Convenient hours and location.
- Adequate space and sufficient privacy.
- Comfortable surroundings.

> **Programme Design:**
- Youth involved in design, service outreach and delivery, and continuing feedback.
- Drop-in clients welcomed or appointments arranged rapidly.
- No overcrowding and short waiting times.
- Affordable fees.
- Publicity and recruitment that inform and reassure youth.
- Boys and young men welcomed and served.
- Wide range of services available.
- Necessary referrals available.

> **Other Possible Characteristics:**
- Educational material available on site to take.
- Group discussions available.
- Delay of pelvic examination and blood tests possible.
- Altenative ways to access information, counselling and services

SOURCE: UNFPA 2003.

BOX 11: DEFINITION OF SEXUALITY EDUCATION

Sexuality education is defined as education about all matters relating to sexuality and its expression. Sexuality education covers the same topics as sex education, but also includes issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and the social pressures to be sexually active and it provides information about SRH services. It may also include training in communication and decision making skills.

Comprehensive Sexuality Education and Life Skills Education

There is a prevailing belief that if we teach young people about sexuality, it will encourage them to start having sex early. The evidence, however, shows that sex education either has no effect or young people delay sex for longer and when they do start, they are more likely to protect themselves from pregnancy and STIs and HIV (Cullin 2003 cited in (Training Manual for Adolescent Sexuality" 2013)).

There is evidence that there is a high demand for sexuality education yet the provision in many countries both to in school and out of school children is not satisfactory. The curricula in many countries is not adequate—language and concepts are compromised, the translation of the national curriculum at the local levels is compromised, there are problems in transacting the curriculum with the adolescents. According to the ARROW review for the ICPD+20 of comprehensive sexuality education, in countries reviewed in Latin America and the Caribbean, contraception was included only in the secondary and tertiary levels in most countries.

Evidence also indicated that school curricula include limited information on reproductive health. In addition, teachers usually overlook this information during classes either out of embarrassment or unpreparedness. (ARROW n.d.)

2.3.3 Conclusion

It appears that most countries do not want to face the fact that adolescent girls are sexual beings. Health programmes for girls are comfortable to address issues like nutrition and menstrual hygiene, look at girls as future mothers, and not as human beings in their own rights. Issues such access to age appropriate sexuality education, contraceptive services or safe abortion services, are not within the radar of programme planners in many countries.

There is evidence that there is a high demand for sexuality education yet the provision in many countries both to in school and out of school children is not satisfactory.

2.4 OLDER WOMEN'S HEALTH

The PoA states in Chapter 7 that older women and men have distinct reproductive and sexual health needs that are often inadequately addressed. Unfortunately, even twenty years after ICPD, policy and programmes, and also research, have failed to adequately attend to their needs. As life expectancy increases and there are more older women than men in the world (older women make up much more than half the older population anywhere in the world (Basu Alaka 2016), women's health needs beyond their child bearing years are completely invisible in the health research agenda as well as in health programming.

Older women in developing countries suffer from cumulative malnutrition, osteoporosis, arthritis, and other such conditions. Many older women in developing countries also complain about uterine prolapses resulting from hard physical labour and frequent child bearing in their younger days. Other non-reproductive tract illnesses triggered by hormonal changes associated with post-menopause, mental health issues, reproductive cancers, all go to make up poor reproductive health in older women.

Older women's health issues, particularly reproductive and sexual health issues and needs, go unnoticed, unaddressed and are deprioritised, because many times they may not acknowledge their condition, or want to draw attention to their needs. Many more older women than men are left single, are widows because of their biological advantage. Older women more than older men, are thus likely to have lesser economic resources, are more likely to be socially isolated and abandoned than men. These women are considered unproductive, more so than men. Older women's health suffers from a double jeopardy—they are especially vulnerable because of their location at the intersections of ageism and sexism. (Calasanti 2005)

There is growing evidence that older people are sexually active, with older men and women continuing to enjoy sex into their 80s. Sexual activity in older people goes beyond coital activity and has important bearing on their overall mental wellbeing. Research has been limited to clinical/medical aspects to do with male erectile dysfunction and pharmaceutical products to address this. There is a dearth of literature on the positive aspects of sexuality, sexual and post-reproductive health and rights of older people, especially older women. Similarly, research on the sexuality of older gay, lesbian, bisexual, transgender and intersex (LGBTI) individuals is scant, reflecting the hetero-normative and heterosexist biases in societies. (Heidari 2016)

Thus, from a rights perspective it is important to emphasise that sexual and reproductive health and rights of older women are an important issue to be addressed in research and programming agendas. Older women's participation in programme design would help to customize health programmes for them. Mechanisms should be put in place to enable their involvement in planning, designing and implementation of health policies and programmes. The perspective of service delivery and providers should be based on a realisation that older people have contributed enough to society and that now society needs to look after them with empathy and respect, and uphold their dignity as seniors.

Women's health needs beyond their child bearing years are completely invisible in the health research agenda as well as in health programming. Older women's health issues and needs go unnoticed, unaddressed and are deprioritised because many times they may not acknowledge their condition , or want to draw attention to their needs.

2.5 SRH ISSUES OF PERSONS WITH DIVERSE SEXUAL ORIENTATION AND GENDER IDENTITIES

Some SRH issues like provision of safe abortion services, provision of sexuality education to adolescents, services for women suffering sexual violence remain controversial in many countries. One such controversial issue is also recognition of people with diverse sexualities like gay, lesbian and intersex people and their SRH needs. The reasons for these controversies are the contradictions between these and cultural, social, religious values, norms and beliefs.

A recent systematic review of studies indicates that LGBT people are more susceptible to health problems, such as abuse of alcohol, tobacco and illicit drugs, obesity, unprotected sex, mental disorders, Sexually Transmitted Diseases (STDs) as HIV/AIDS, bullying, and cervical and breast cancer, as well as violent behavior (Alencar Albuquerque et al. 2016)The review also points out that the situation is further complicated because of the poor access to health care and the discriminatory practices of health care providers stemming from homophobia. Studies in South Africa (Lynch et al. 2016) confirm some of the underlying drivers of discrimination against sexual and gender minorities, and denial of their SRHR. In addition to the discriminatory and heterosexist attitudes internalised by health care providers because of the prevailing patriarchal norms, the design, management and provision of health services are all structured through a heteronormative lens which act as a deterrent for LGBT persons seeking SRH care. The intimate partner—and sometimes even public violence (including sexual violence) that LGBT persons experience, remains unacknowledged by the health systems, who do not have specific protocols to address these issues, thereby adding another layer of violence and compounding its effects. The study identifies a fourth factor in denial of SRHR as that of silences around transgender and sexual minority women's health.

The Box 12 further exemplifies the ways in which health systems are blind to the needs of sexual minorities. This is an excerpt from a policy brief from India and illustrates the range of SRH needs of sexual minorities that health programmes in India overlook.

BOX 12: SEXUAL AND GENDER DIVERSITY — WHAT DO WE MEAN?

A same-sex orientation can manifest itself in three ways: attraction, behaviour and/or identity. But not all people with a same sex attraction and/or behaviour want to or can identify as homosexual (lesbian, gay) or as bisexual and be open about this. In this case people are often categorized as MSM (men who have sex with men) or WSW (women who have sex with women).

Beside variances in sexual orientation, people can vary in their gender identity. Sometimes their felt gender identity does not correspond with the gender/sex (male or female) assigned at birth. Some of these people wish to live in the other gender role, in expression only, or also physically through a bodily transition to the other gender with hormones and/or surgery.

We speak of transgender people, or when surgery is done transsexual people, to refer to this gender variances. Transgender people can have every sexual orientation, and hence can identify either as heterosexual, lesbian, gay or bisexual, but also as transgender or queer, or without any such label. (Rutgers n.d.)

Cisgender is a term that describes a person whose sexual expression and identity correlates with his or her sex assigned at birth and is considered as the opposite of Transgender.

SOGIE—Sexual Orientation and Gender Identity and Expression—is another term which is being used increasingly. This is explained above.

BOX 13: SRH NEEDS OF PERSONS WITH DIVERSE SEXUAL ORIENTATION AND GENDER IDENTITIES (Chakrapani 2011)

The two government programmes—Reproductive and Child Health (RCH)-II and the National Rural Health Mission (NRHM) are silent about the needs of sexual minorities. Nowhere in the RCH-II/NRHM documents and training modules one can find terms related to sexual minorities such as MSM or Hijras or transgender people.

a) Health needs of MSM,Hijra and transgender populations are not articulated: These populations may be at risk of STIs and HIV if they have unprotected sex with men and women. While any type of STI can be contracted, certain STIs are more likely to be contracted through certain unprotected sexual practices. For example, the risk of getting hepatitis B virus infection is high with unprotected anal sex and that for hepatitis A virus infection with unprotected oral-anal sex (anilingus). Hepatitis B infection may later evolve into a chronic disease affecting the liver and also may lead to liver cancer. Similarly, some strains of the human papilloma virus that cause anal-genital warts may lead to anal cancer. Also, societal prejudice and discrimination have been linked to increased prevalence of mental health disorders among sexual minorities.

b) Health needs of lesbian/bisexual women and female-to-male transgender people are nowhere addressed: Lesbian and bisexual women face the same health issues as that of other women but also have specific health information and service needs. These include: Information on the health risks associated with certain sexual practices with women and men (STIs and HIV); information on cancer screening such as mammography (breast cancer screening) and pap smear (identification of precancerous lesions in the cervix); support for problematic use of alcohol, drug use, and smoking/tobacco use; support for mental health issues; and support services for intimate partner (same-sex or other-sex partner) violence. Some of the health needs related to female-to-male transgender people include: Information and services in relation to gender transition —masculinising procedures and sex change operation; pre- and post-gender transition counselling and support; and support for mental health issues.

c) SRH needs of same-sex attracted and transgender adolescents are not addressed: As same- sex attracted males grow up, some proportion of them may exhibit mannerisms and behaviours that would be labelled by the society as 'feminine'. Thus, they face ridicule and teasing from their neighbours, school friends and relatives. Similar issues may be faced by other sexual minorities as they grow up. Currently there is a complete lack of correct and supportive information about same-sex sexuality or transgender issues in popular media or even from health care providers.

d) Need for standards of care for gender transition procedures (including sex change operation) for transgender people: Only one state in India, Tamil Nadu, has initiated free sexual reassignment surgery (SRS) in government hospitals—that too, only for Hijras and male-to-female TG people. No support from the government is available for feminising procedures(such as female hormonal treatment and electrolysis for facial hair removal). The government is silent on providing services such as free SRS and masculinising procedures for female-to-male transgender people.

e) Lack of legal recognition of same-sex marriage and marriage between transgender persons and men/women: All citizens including sexual minorities have the right to marry their partner of choice and to have legal recognition of that marriage. Even in the absence of legal recognition, some same-sex attracted people are getting 'married' to same-sex partners and some proportion of Hijras and TG persons get 'married' to their regular Panthi partners.

f) Ambiguity in legal recognition of gender identity of transgender people and Hijras and its relation to access to health services: Lack of legal recognition of the gender identity of transgender people (male-to-female and female-to-male) is a key barrier to exercising their rights related to marriage with a man/woman (where their 'trans' gender identity and not biological sex is primary), child adoption, inheritance, wills and trusts, employment, and access to public and private health services, and access to and use of social welfare and health insurance schemes.

Studies have documented that the *Hijras* felt humiliated on having to stand in a queue for males at hospitals and were laughed at by the co-patients in the queue. Also, *Hijras* have no say in deciding in which ward—male or female—they can stay as in-patients in hospitals. Theseexperiences prevent Hijras from ever visiting government hospitals or repeating visits.

g) Marital counselling issues of couples in mixed sexual orientation marriages are not addressed: There is a huge unmet need for counselling support that should address a range of SRH-related topics of sexual minorities. Sometimes, same-sex or both-sex attracted men and TG persons may get married to women attributing family compulsions and other reasons for getting married to a woman. Some proportion of these married same-sex attracted men and TG persons may complain of sexual dysfunction with their wife and may not know how to deal with the issues they face. Men with a bisexual orientation and MSM or TG persons living with HIV may have a dilemma with regard to whether or not to get married and whether or how to disclose their sexuality and/or HIV status before marriage. Some proportion of lesbians and bisexual women may be compelled or expected by their family members to get married to a man. Heterosexual spouses of sexual minority individuals may also require support in terms of how to deal with their situation, and take informed decisions.

h) Need to impart adequate knowledge on family planning options for married MSM and TG persons: Many married MSM and TG persons are largely unaware of the wide range of family planning options available for them and their spouses. Similar to heterosexual males, married MSM and TG persons do not want to undergo vasectomy due to a variety of reasons. Thus, it is important to educate married MSM and TG persons, just like heterosexual married men, about the need to take responsibility for family planning as well as remove any misconceptions about vasectomy.

Health Sector reforms aimed at achieving universal access to health care and 'leaving no one behind' as the SDGs promise, need to take care of each of the above to ensure the SRH needs of LGBTQI groups are satisfied.

While respectful SRH care provision is non-negotiable, we also need to ensure that human rights and sexual rights of all these groups are upheld. The annual report of the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) states that 72 countries still have laws criminalizing homosexuality, some even with death penalty. Advocacy on the implementation of Yogjakarta Principles needs to be strengthened within all countries. An inclusive approach to sexuality that affirms the right to non-confirming sexualities needs to be fostered. Anti-discriminatory laws need to be brought in. Affirmative sexuality, a framework that acknowledges freedom from coercion, violence and discrimination and affirms positive sexual rights—right to sexual expression, pleasure, fulfilment and wellbeing as well as broader sexual freedom —need to become part of everyday discourse.

Several organisations are engaged in ensuring that the SDG indicators include those related to SOGIE issues. (Majeedullah, Wied, and Mills 2016)

2.6 MEN AND SRHR

In many patriarchal societies, rigid gender norms and harmful perceptions of what it means to be a man, have far reaching consequences on health and well-being of both men and women. Patriarchal norms of control of women's sexuality and reproduction are the basis of all structures of society. Men are the main decision makers in all domains of public and private life. They wield their power to control when a woman should marry or how many children she will bear. Decision to abort an unwanted pregnancy is denied to women in many countries. Many men are also responsible for sexual violence against women, even against women and girls in their own families. The implications of gender on men's own health, too, are well recognised. A series of WHO fact sheets describe the how construction of masculinity in many societies, can lead to higher incidence of deaths among men due to road traffic accidents, violence and conflict. (WHO 2002)

It is therefore important to recognize the value of including men because, men have a stake in the health of their families/households and men's involvement (as well as women's) is required to address gendered constraints to health seeking. Chapter IV Section C of the ICPD Programme of Action calls for an understanding of men's and women's joint responsibilities so that they become equal partners in public and private lives, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour.

However, patriarchy has benefited men and very few men have challenged the unequal privileges that men gain in the current gender order. This makes it extremely challenging to work with men for gender equality.

Perspective of Working with Men

What does 'working with men' actually mean? The fundamental question is 'Working with men' for what? We believe that working with men has to go beyond 'Male Involvement' as it is currently understood and practiced. Post ICPD in many countries' programmatic contexts, male involvement has been reduced to increasing distribution of condoms and vasectomies. The larger perspective of working with men to promote gender equality and gender justice is not in the consciousness of policy makers and programme designers. We would like to propose that men need to be engaged in the overarching struggle for gender justice and gender equality. While this is in itself an important human right principle, research has also shown that men living in highly gender equal societies have better quality of life than men in less gender equal societies (Holter 2014). Additionally, working with men and boys for promoting gender equality would reduce violence against women and result in better health outcomes.

Benefits of Working with Men

Researchers and activists working with men on gender equality and violence prevention programmes, have noted several achievements (Flood 2015).WHO's review in 2007 examined 15 interventions involving men and/or boys in preventing and reducing violence (Flood 2015). Of these, four were judged as effective, seven as promising, and four as unclear. Another review in 2011 of 65 studies found change in boys' and young men's attitudes towards rape and other forms of violence against women, and other gender-related attitudes, following specific interventions. This review also concludes that well designed interventions can bring about a change in behaviours related to both sexual and non-sexual violence, although there is room for better evidence generation. Flood also points out that data and evidence concerns notwithstanding, the issue has caught the imagination of policy makers and violence prevention programmers, as well as of 'men' who are mobilizing and creating alliances with women's groups for gender equality.

A WHO-led Systematic Review on identifying effective programmes to engage men for improved Maternal and Neonatal Health outcomes (Tokhi et al. 2018) shows that Male Intervention programmes reported several positive outcomes: 1) increased skilled birth attendant and 2) facility births, 3) improvements in Ante Natal and Post -Partum Care and breastfeeding, and 4) care-seeking for complications or illnesses in women and new-borns. Other studies showed: women experience less pain in labour and delivery (WHO 2007); involving men can lead to greater use of post-partum contraception (Varkey et al. 2004); improved couple communication and increased emotional support and reduced workload for pregnant women (Sahip and Molzan Turan 2007).

Strategies for Working with Men

Programmes have addressed men in different roles: as 'Partners'—typically as husbands and partners in caring for children, as 'Change Agents'—men in influential positions, as role models and champions for gender justice, and as 'Clients'—addressing men's own SRH needs. Table 3 explains this further.

Engaging men as equal partners includes addressing gender inequality and unfair gender roles, openness on issues of sexuality and tackling negative features of masculinity. Men as agents of change would imply that they publically encourage living out of transformative masculinities, through their own example. And they are actively engaged in increasing utilisation of SRH services. Addressing men as clients would mean that they utilise health services for their SRH issues.

Men's own sexual and reproductive health needs have never been seriously considered by policy makers and programme designers. Adolescent boys have several concerns around their awakening sexuality like 'nightfall', masturbation, size of penis and so on. It is important that men are seen as individuals with male-specific sexual and reproductive health needs. Other male SRH concerns are medical male circumcision (MMC); male-specific STI symptoms; male-specific family planning needs, male infertility; erectile

TABLE 3: APPROACHES TO INVOLVING MEN IN SEXUAL AND REPRODUCTIVE HEALTH

APPROACH	PURPOSE AND ASSUMPTIONS	PROGRAMMATIC IMPLICATIONS
TRADITIONAL FAMILY PLANNING FOR WOMEN	> Increase contraceptive prevalence; reduce fertility. > Inclusion of men is not necessary from an efficiency standpoint.	> Contraceptive delivery to women, in the context of maternal and child health
1994 Cairo International Conference on Population and Development		
MEN AS CLIENTS	> Address men's reproductive health needs.	> Extend same range of reproductive health services to men as to women. > Employ male health workers.
MEN AS PARTNERS	> Men have a central role to play in supporting women's health.	> Recruit men to support women's health, e.g., teach husbands about danger signs in labor, how to develop transportation plans, the benefits of family planning for women's health.
MEN AS AGENTS OF POSITIVE CHANGE	> Promote gender equity as a means of improving men's and women's health and as an end in itself. > Addressing inequity requires full participation and cooperation of men.	> Paradigm shift in how programmes are structured and service are delivered, whatever they are. > Broader range of activities, working with men as sexual partners, fathers, and community members.

SOURCE: MenEngage, n.d.

dysfunction; and prostate and testicular cancers. Addressing individual SRH concerns will improve men's health outcomes; in addition, promoting and encouraging men to address their own sexual and reproductive health is also good for women's health outcomes.

Sonke Gender Justice Network in Africa states (Pascoe et al. 2012)

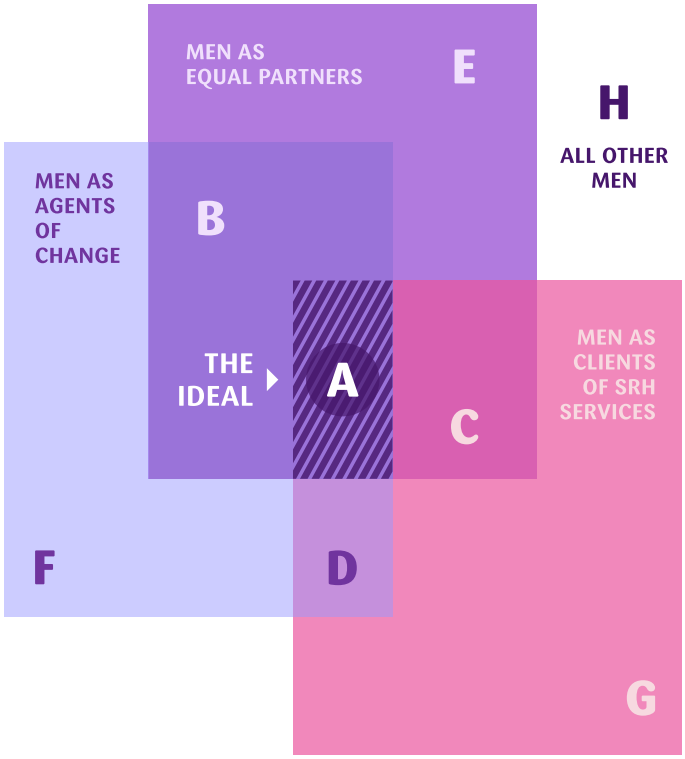
> *"While continuing to ensure women have access to SRH and their needs are met, if men are not equal partners, clients of SRH services, and agents of change, the result is limited in terms of successful and gender equal SRH that can benefit both men and women"*

Sonke's model of male involvement in SRHR emphasises that programmes should address men in all their three roles —as partners, clients and change agents—and that any one component in isolation will have limited effectiveness in addressing gender inequality and improving SRH for men and women. The Figure below illustrates this principle.

Men who are responsible partners and who have satisfactorily sought treatment for their own male health issues, can become champions for change towards gender equity.

FIGURE 2:
MODEL FOR MALE INVOLVEMENT IN SRHR

SOURCE: Street and Town, 2011.



Male Involvement: Some Critiques

Many feminists have raised several arguments against working with men. The most common is—our agenda of attaining equality for women is far from being achieved—do we want to divert our attention now to Male Involvement and working with men? Another argument is that resources for women's organising for their rights are severely limited. If we draw attention to working with men for gender equality, there is a danger of the limited resources being diverted away from feminist organising to the work with men, perpetuating the existing social order of lack of resources for women's issues and controlled by women. Yet another argument is that there is a danger of increasing men's control over women by asking them to be supportive partners. For instance, as was cited in a study, there was a negative side to 'support' from husbands—this sometimes took the form of pressure on them to adopt healthy behaviours and for the woman to think only of the baby rather than her own needs/wants (Sahip and Molzan Turan 2007).

> *My husband paid a lot of attention to this issue. He would say, "You need to eat this, not for your benefit, but for the baby's benefit."*
>
> *My husband would prepare me food packets to take to work, as if preparing a packed lunch for a child. Asking, "Did you get your apple? Did you get your sandwich?" He would put the packet in my hand as I was going to work. He learned it here [husbands' education sessions in ANC Clinics in a health facility], he's a know-it-all. I want to give the baby meatballs; he doesn't want me to, since he knows it all. Sometimes I wish that he hadn't gone to the course.* (Sahip and Molzan Turan 2007)

In the context of HIV and MCH services, women fear violence and abandonment from men if the partners attend the ANC clinics and find out positive test results. Negative Male Involvement and Participation (as contrasted with Positive Male Involvement) can lead to increased violence and control over women (Ditekemena et al. 2012)

Necessary Principles for Male Involvement Programmes

Groups and networks working with men on gender equality have learnt that it is important to do this work in consultation and collaboration with feminist organisations. Forum for Engaging Men in India have consciously invited feminists on their advisory board and openedthemselves up for scrutiny periodically. The line between 'support' and patriarchal 'control' and 'protection' is very fineand men's groups must build checks and balances to see that they do not cross the line.

Health programmes like MCH, SRH and health sector response to GBV must make mandatory women's permission and consent before inviting men as partners. These programmes must also be designed with women's participation. IEC campaigns and key messages for men must first be pilot tested with women.

2.7 SRHR, GENDER AND HEALTH SYSTEMS

SRHR as we have stated above comprises of two key concepts—the right to make deciions on reproduction and sexuality free from discrimination, violence and coercion and the right to the highest attainable standards of sexual and reproductive health care. In this section we look at what the implications of these are for health systems in countries—what are the issues that health systems need to be accountable for especially keeping the relevant SDGs in focus.

2.7.1 SDG Targets Related to SRHR and Implications for Health Systems

Specific targets of SDGs 3 (on Health) and SDG 5 (on Gender Equality) are directly related to SRHR especially if we define Gender the way that we have—as a non-binary fluid concept that accommodates diverse gender identities. The SDG targets having a bearing on SRHR are listed in Table 4.

TABLE 4: SDG TARGETS DIRECTLY RELATED TO SRHR	
SDG 3	
3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.
3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
SDG 5	
5.2	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.
5.6	Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

In this section we examine each of the above to assess the implications for health systems in the Asia Pacific region.

Reducing Maternal Mortality Ratio

Maternal Mortality Ratio (MMR) is a critical indicator not only of women's health but is also considered an important indicator of their status in a particular society, and the level of investment made in women's well being. MMR is calculated as the number of maternal deaths in a given time period per 100000 live births in the same time period. Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Reducing Maternal Mortality Ratio entails provision of comprehensive maternal health services—high quality ante natal care (including screening for malnutrition, anaemia, STIs, HIV, education of women and families about high risk symptoms), skilled birth attendance during delivery, emergency obstetric care, good quality post partum care. High quality maternal health services have to be within easy access for all groups of women. Health systems in most countries have to gear up to ensure that these services are available. Adequate number of functional health facilities, competent and caring service providers, supplies and equipment including assured blood supply, all need to be available and accessible for all groups of women. Health systems also need to work along with other public systems to ensure that roads and transport, food and nutritional security and other determinants of maternal health are available. Accountability and grievance redress mechanisms must be in place and regularly monitored for effectiveness. Maternal Death Reviews must be systematically done to learn what went wrong and how could the death have been prevented. These reviews must be done along with community participation because family and community perspectives can contribute different dimensions of preventable causes. Action taken reports after the Maternal Death Reviews must be made public as a demonstration of accountability.

Skilled Birth Attendance

There has been an international policy focus on institutional deliveries in developing countries with incentives like conditional cash transfers. However, with supply side gaps, health facilities in many countries are not yet adequately prepared to receive the increased number of women in labour presenting themselves at their doorsteps. The assumption that all deliveries within institutions are safe deliveries has been belied. Safe deliveries must be ensured

wherever they occur, whether within institutions or at home (if terrains are difficult and access is an issue), or in transit. For quality normal deliveries, countries must invest in a cadre of professional midwives. Traditional midwives are a resource with high credibility in many communities—this resource must not be lost. Traditional midwives should also be trained to provide psychological and spiritual support to pregnant and post-natal women. Labour room abuse and violence is prevalent in many contexts and is recognised as a problem. Respectful care must also be included within the purview of skilled birth attendance and must be considered as an important indicator.

Emergency Obstetric Care (EmOC)

The standard for EmOC facilities according to the latest 2009 guidelines (WHO 2009) is that for every 500,000 people there should be four facilities offering basic care and one facility offering comprehensive essential obstetric care.This is a standard that countries in our region need to aspire towards. A survey conducted in Kenya, Malawi, Sierra Leone, Nigeria, Bangladesh and

India between 2009 and 2011 showed that fewer than 23.1% of facilities aiming to provide CEOC were able to offer the nine required signal functions of CEOC and only 2.3% of healthfacilities expected to provide BEOC provided all seven signal functions. The population based Caesarean Section rate was estimated to be less than 2% as against the minimum recommended level of 5% indicating that essential emergency life saving caesarean sections are not happening. (Ameh et al. 2012) Factors contributing to the non functional status were: out of pocket expenditure by women and their families,[8] non functional referral systems, distance, lack of transportation, inequitable distribution of facilities, inadequate human resources, lack of blood transfusion facilities (ARROW 2016). The inequitable distribution of skilled medical professionals and their unavailability in remote areas is an intractable problem facing many countries. Health human resource policies have to be designed in a way that availability of skilled personnel is ensured in areas where the vulnerabilities are the greatest. Task shifting may also need to be considered to train nurses, midwives to handle certain aspects of EmOC.

Post Partum Care

Although Post-Partum Care is critical to prevent both maternal and neo natal deaths it has not been given due attention in MDGs and SDGs or in the ICPD PoA. And in most developing countries this aspect of maternal health care continues to be weak (ARROW 2016). Well executed Post-Partum Care within the first 48 hours after delivery can prevent post-partum haemorrhage, (most common direct cause of maternal deaths) and sepsis. This aspect of maternal health needs to be strengthened by health systems in most countries.

Contraception

Contraceptive services are a contentious issue in many countries in the Asia Pacific region. There are different reasons for this—religious ideologies that do not permit use of contraceptives, historic population control mindsets and policies, patriarchal mindsets and norms. Some of these factors also influence the way important indicators have been defined. For example, the WHO definition of Contraceptive Prevalence Rate "is the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time." This includes only heterosexual and married women. Similarly Unmet Need for family planning, a very important indicator because it factors in women's reproductive desires—expressed as a percentage of women of reproductive age who are married, in a union, or are sexually active but are not using any method of contraception despite not wanting any children —is calculated based on samples of married heterosexual women only, excluding unmarried and single women. This may not give an accurate picture of the actual Unmet Need in the country. Also Unmet Need figures may be distorted because women are accepting particular methods because of government policies and resultant provider bias and not based on their free choice. Contraceptive programmes are also primarily focused on pregnancy prevention and not improving reproductive health status per se, which would imply a push towards barrier methods to prevent STIs. Health systems within countries also need to be cognizant of how the different indicators are playing out in their contexts. An example is Malaysia where the TFR is actually low (2.1) but the percentage of women using modern contraceptive methods is only 32. Unmet Need is high and actually rising due to non use of modern contraceptive methods by young single women resulting in out of wedlock babies—almost 10% between 2006 and 2010 (ARROW 2016).

All of the above has important implications for health systems, both at the macro level of definition and calculation of indicators, as well as designing of delivery of contraceptive services.

Abortion

Abortion is another contentious issue in many countries. In the Philippines and Sri Lanka abortion is restricted on all grounds, except when it is to save the life of the woman. Many countries criminalise induced abortions, for example, Lao PDR and Bangladesh. However, Bangladesh has succeeded in bringing about legal changes in the Penal Code to allow menstrual regulation, a procedure for early evacuation of the uterus. In India while the Medical Termination Act of 1972 makes provision of induced abortions legal under certain conditions, the Indian Penal Code Section 312 makes abortion criminal—and the prevailing general understanding both amongst women and providers is that abortion is criminal. Access to safe abortions in India has been further restricted due to the skewed sex ratio in favour of boys and the Prevention of Pre Conception Pre Natal Diagnostics Act which has resulted in providers being discouraged to perform even non sex selective termination of pregnancies. Even in countries where abortion is legal, for example, Malaysia, Nepal, Mongolia, China, India, access may not be easy - many women and girls do not have the information that abortion is legal or that the husband's permission is not required, or there are religious forces discouraging women from accessing these services. All of these issues result in women going for unsafe abortions which often result in long term reproductive morbidities and even loss of life.

Health systems therefore need to ensure that women and girls have access to safe abortion services, provided with confidentiality, and without any discrimination and stigma.

Even in countries where abortion is legal, access may not be easy—many women and girls do not have the information that abortion is legal or that the husband's permission is not required, or there are religious forces discouraging women from accessing these services.

2.7.2 Universal Health Coverage and Universal Access to Reproductive and Sexual Health (Ravindran 2012)

There is a widespread belief that universal health coverage will ensure that health care services will reach all. The term is understood differently by different people. Universal health coverage means that "financing and organisational arrangements are sufficient to cover the entire population, removing ability to pay as a barrier to accessing health services and protecting people from financial risks." UHC thus consists of health financing measures to remove financial barriers for those wanting to access health care services. UHC has three dimensions that have to be expanded—one, an essential package of health services that has to be progressively expanded; two, increasing the population groups that will be covered by financial protection schemes, until health care becomes truly 'universal'; and three, increasing financial protection until the out-of-pocket expenditures for households reduces to zero.

There are several reasons why women get excluded from the financial protection schemes, which are mainly insurance based. Firstly, very few women are in the organised sector where compulsory deduction of insurance premium from the salary is matched by employers' contribution to form part of what is called a Social Insurance scheme. These contributions become part of 'risk pooling' and provide a safety net at times of an individual's health crisis—costs of health care are met out of these cumulative contributions, resulting in reduced out-of –pocket expenditure. The second kind of insurance available to people in the unorganised sector is through the Community Based Health Insurance or the Micro Finance Schemes. In these, women from vulnerable sections pay very small premiums for small health covers. However, women and those without ready access to even these small amounts of cash often find themselves excluded from these schemes.

Social Protection Schemes like vouchers and fee waivers for targeted populations and Conditional Cash Transfers for encouraging behaviour change (like availing institutional deliveries and completing ante natal care or immunisation schedules), are other ways of removing financial barriers and providing financial incentives. However, while they have improved access for some women, each of these have

their weaknesses. Social Protection Schemes addressing only targeted groups, leave out other women—for example, those just above the poverty line—who may still not have access to resources to be able to pay for services. Evaluations of Conditional Cash Transfer schemes have shown that among the excluded the poorest are often disproportionately higher]. Many times it is those who do not have the necessary documentation. Most of the schemes and Essential Services Packages are focused on maternal health services thus leaving out adolescent girls and older women and their SRH needs.

The point therefore to be made is that Universal Coverage does not necessarily ensure 'universal access to SRH'. Universal access to reproductive health is understood as 'information and services are "available, accessible, and acceptable" to meet the different needs of all individuals' (ARROW 2016). Simply stated, universal access implies the ability of those who need healthcare to obtain it. It has also been defined as "the absence of geographic, financial, organizational, socio-cultural and gender-based barriers to care." The concept of Universal Access thus includes Universal Coverage which removes the financial barriers that prevent individuals from accessing services. It also means that other barriers that prevent people from accessing services—like discriminatory behaviour of providers, acceptability of services and quality from the users' perspectives—are also addressed by health systems.

Health systems thus need to:

- Address issues that directly impact on the SDGs' commitments – improving quality of Maternal Health services and its determinants, including strengthening of EMoC, contraceptive services and other reproductive and sexual health services.
- Following from the above, plan the Essential Services Packages keeping in mind SRHR needs of diverse populations – including safe abortion services, adolescent friendly services including information and counselling.
- Ensure that all health care provision is free from discrimination and that patient- provider interaction is respectful and compassionate. Set up community monitoring systems including grievance redressal mechanisms.
- Restructure and reorganise health service provision to meet the location and timing issues of different groups.
- Pay special attention to health insurance and financial protection needs of especially the most marginalised groups. Streamline and simplify the procedures so that these do not become barriers.
- Health systems also need to ensure that they respond effectively to survivors of gender based violence including sexual violence.

In addition to all of the above, Universal Access to Sexual and Reproductive Rights entails going beyond the health system. Laws and policies that prevent child and early and forced marriages, violence against women, discrimination of people with different gender identities and sexual orientations and programmes to ensure the proper implementation of these laws and policies will go a long way to achieving universal access to sexual and reproductive rights.

> *..... universal access should mean that all groups in the community could access any of these services. However, groups such as young people, unmarried women, LGBTIQ persons, sex workers, and migrants continue to face innumerable barriers, which stem from systemic bias, provider attitudes, discrimination, and stigma when trying to access services. Universal access should also mean that men and boys were also equally targeted for information and services, but male participation in contraception remains negligible over the last 30 years.* (Thanenthiran 2017)

ENDNOTES FOR PART 2:

6 UBINIG is a community led and community based policy and action research organization formed in 1984 to support people's initiatives to take command over their own lives and livelihood. http://ubinig.org/index.php/home/showMain/english.

7 The concept of 'evolving capacities' in the Child Rights Convention seeks to strike a balance based on capacity – between parental responsibility for protecting the child and the rights of the child to autonomy and decision-making.

8 In India, despite the JananiShishuSurakshaKaryakram, a programme started by the Government of India in 2011, to provide free ante natal, intranatal and post natal services to women (and to babies upto one year) in government health facilities, there are national reports stating that families do incur out of pocket expenditure even for public sector deliveries. [NSSO. Key Indicators of social consumption in India, health: NSSO 71st Round (January-June 2014). National Sample Survey Organization, Ministry of Statistics and Programme Implementation, Government of India, New Delhi; 2015].

PART 3

Challenges to SRHR in the Current Context

TK Sundari Ravindran

3.1 GLOBAL AND NATIONAL INFLUENCES ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

3.1.1 Neo-liberal Globalization and Its Influences on Sexual and Reproductive Health

Neo-liberal globalisation is not only a set of economic rules and practices that uphold the free market. It is an ideology that seeks to bring all human action into the domain of the market. Neoliberal ideology holds that the market is the ideal mechanism through which all human needs can be met in an efficient and fair manner. The ideology permeates our ways of understanding the world and our relationships with people around us. Neoliberal ideology has given rise to a world view, wherein people assert their freedoms by buying and consuming whatever they choose to and interact with each other as competitors or as people engaged in transactions wherein everything has a price tag. In the words of Nancy Scheper-Hughes, "...(markets) by their nature, [...] (are) indiscriminate, promiscuous and inclined to reduce everything, including human beings, their labour, their bodies, and their sexual and reproductive capacities to the status of commodities, things that can be bought, sold, traded, and stolen" (Scheper-Hughes 2002, 43).

In this section, we illustrate the direct and indirect influences of neoliberal globalization on sexual and reproductive health by considering a few illustrative examples. For illustrating the direct influences, we examine two issues: the objectification and commodification of women's bodies; and trafficking for sex-work. Indirect influences of neoliberal globalization on sexual and reproductive health and rights are illustrated through examining its influence on aspects such as widening economic inequalities, resulting in precarious livelihoods, displacement and distress-led migration; and climate change and food crises.

Objectification and Commodification of the (Female) Body

The term 'objectification' of the body refers to considering the body as something to be looked at, evaluated, enjoyed or derided. Objectification results in valuing a person for his/her physical appearance and good looks and sexual attractiveness. While objectification of the female body has existed perhaps as long as patriarchy has, it has taken specific forms in the neoliberal era.

Neoliberal ideology emphasises individual choice and personal responsibility in achieving success and status in society. The neoliberal subject is entrepreneurial and self-optimising. Within this context, the human body, especially the female body, is recast as a site of identity and empowerment through self-fashioning and personal choice (Phipps 2014). The cosmetic industrial complex, through the power of advertisements and media images, has created people and especially women who are always dissatisfied with their bodies and appearance.

Women's constant striving to achieve body perfection may be seen as an act of "entrepreneurial self-work", making the most of one's body as the capital one possesses, to be able to compete better in the social and economic market place. (Conor 2004). The result of such striving would be a socially ideal body, which would lead to empowerment, "a better job, better husband, and a better life" (Essig 2011, 35). This is done by consuming a wide range of cosmetic and fashion products.

The cosmetic industry provides women with the tool of make-up to transform their bodies into socially desired forms. The way make-up is advertised can have a significant impact on a woman's self-esteem.

Plastic or cosmetic surgery is another tool available to women to achieve the ideal body. Cosmetic surgery has emerged as a major industry not only in the Global North but also in countries like Brazil, and South Korea in the Asia-Pacific region. In the context of USA, where women are reported to be incurring heavy debts in order to pay for cosmetic surgery, Essig (2011) holds neoliberal globalisation responsible for this phenomenon through pathways other than the objectification of the body. According to her, the growth of the cosmetic surgery industry needs to be understood within the context of economic insecurities created by neoliberal globalisation; deregulation of

medicine which has permitted the growth of a non-essential branch of medicine; and the availability of credit from banks through the use of credit cards and liberal loans (Essig 2011, 33).

The use of digital media to transform one's life into a series of images and put it out for constant display may be seen as yet another form of objectification of the body. The purpose of displaying selfies and details of one's life in the digital media is often to be desired and admired by others—not only by those who we know, but by a much wider social circle, which amounts to "thingification" of the body—making ourselves into commodities for others' consumption, according to Marcie Bianco(2016). The race to build a social-media presence and competing with each other for getting the most number of 'likes', often has deleterious effect on the emotional well-being and self-worth of teenagers, according to Sales (2016).

A more recent development that appears to have much potential for emotional damage is the proliferation of mobile phone-based "Beauty Apps" such as Golden Beauty Meter, Instaglam, Modiface and Beauty Mirror. These are meant to "analyse, rate, evaluate, monitor or enhance" one's appearance (Elias and Gill 2017). This state of being alienates us from others and from ourselves and is at odds with the goals of feminism which is defined by self-respect and respect for others (Bianco 2016).

A core element of objectification of the body is sexual objectification. Sexual objectification refers to a situation wherein "a person is reduced to and/or treated solely as a body or a collection of body parts for sexual use; when sexual parts and/or functions are separated out from the rest of the person." (Calogero 2012, 574). Sexual objectification plays out most obviously in two arenas: (1) actual interpersonal encounters and (2) media encounters. Sexual harassment, sexual violence and rape are examples of sexual objectification of the female body in inter-personal encounters. Sexually objectified media portrayal usually takes the form of focusing on women's bodies and body parts as targets of television programmes and commercials, cartoons and music videos, music lyrics, magazines and newspapers, cartoons and animation, and bill boards, to mention just a few. One of the consequences of living in a context where sexual objectification is pervasive is self-objectification of their bodies by women themselves. Girls and women come to see themselves as sexualised objects, contributing to the sexist ideology that maintains the status-quo in terms of gender-power inequalities. Neoliberal ideology casts this as representative of women's sexual liberation and freedom.

The Growth of the Sex industry

Prostitution and sexual exploitation have existed perhaps for as long as patriarchy has. However, the world has witnessed historically unprecedented growth in the 'sex industry' alongside the rise of neoliberal globalisation since the last three decades of the twentieth century. 'Sex industry' includes all transactions where sexual access to the bodies of women and girls is obtained through exchange of cash or goods, such as prostitution, pornography, stripping and other sexual services.[9] Since 1970s, prostitution has been industrialised, normalised and widely diffused globally (Barry 1995, 122).

In South-East Asia for example, a 1998 report by the International Labour Organization (ILO), estimated that the sex industry accounted for 2 to 14% of the worth of economies in the Philippines, Malaysia, Thailand and Indonesia (Lim 1988). Around the same time, the sex industry in South Korea was estimated to be worth 4.4% of the GDP, more than the contribution of agriculture, forestry and fishing sectors (Hurt 2005). Unfortunately, more recent estimates are not available.

It is not possible to understand the factors underlying the large -scale growth of the sex industry without referring back to the ideology of neoliberal globalisation. A key driver of neoliberal globalisation is the consumerist culture, where consumption no longer serves the satisfaction of a need but as an end in itself. Profit maximisation calls for maximisation of consumption, and consumption may be maximised by stimulating irrational desires. Neoliberal ideology unconditionally defends desire and appetite as "freedom" and "choice". Free market ideology has recast the idea of sexual freedom as equivalent to the freedom to consume sexual services of various hues, as and when desired. Sexual gratification through commercial transaction has come of age within this context and exists in myriad forms beyond prostitution (Jeffrey 2009).

There is industrialisation and mass production of access to women's bodies transcending national borders. Sex tourism has become an integral part of the tourist industry in many countries, including in Asia. Internet has made it easy to access pornography, and the adult entertainment

industry has grown, both virtual and real. Sexual services are advertised on the internet, and smart phones make it possible to access sex workers wherever they are located. The sex industry is a multi-billion- dollar global industry that benefits not only those directly involved. A wide range of related businesses thrive because of the sex industry. For example, sex tourism benefits hotels and airlines, taxi drivers who transport clients to strip-clubs, alcohol and tobacco companies who supply their goods to strip clubs and other places where sexual services are provided. The virtual sex industry likewise provides employment opportunities to many. Sex industry also follows the setting-up of military bases and of foreign companies that employ expatriate labour, which creates a demand for sexual services (Jeffreys 2009).

Economic crises and instability and limited employment opportunities in many countries have led many women to seek alternative sources of livelihood, including through migration to urban areas and to other countries. The sex industry offers these women a potential source of livelihood. On the demand side, one review reported that at least 9% of men reported paying for sexual services during the 12 months preceding the survey, and that during 1990–2000, the demand for sexual services doubled in the United Kingdom. With a significant proportion of adults in many countries spending many years of their lives alone, the demand for sexual services is expected to increase (Ward and Aral 2006).

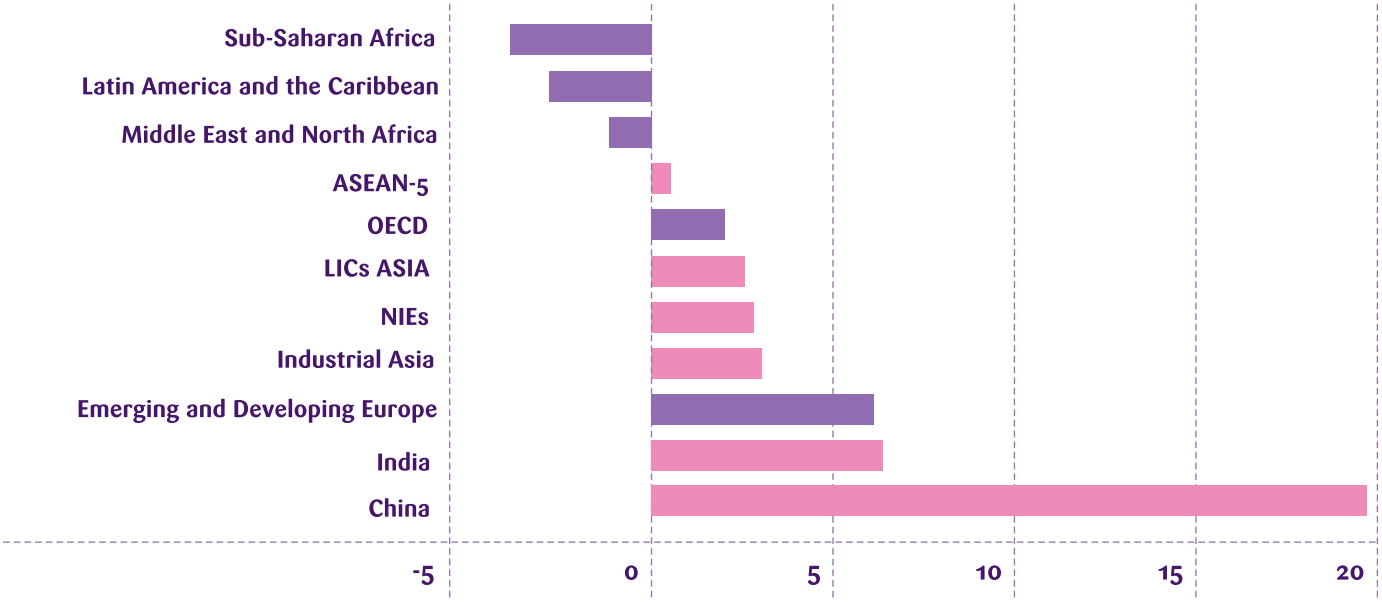
Providing sexual services impacts of the sexual and reproductive health of female sex workers in many ways. They are at high risk of sexually transmitted infections; could contract HPV infection, which would increase risk of cervical cancer, unintended pregnancies, and risk of physical and psychological violence (Slabbert et al., 2017). A meta-analysis of 102 previously published studies covering 50 countries found that HIV prevalence among female sex workers was 14 times that of other women in the same countries (Baral et al., 2012).The criminalisation of sex work in many countries creates formidable barriers to health care access to many female sex workers. Even where sex work is legal, stigma and discrimination could still make seeking health care an onerous task.

Economic Inequalities, Migration, and Climate Change

Neoliberal globalisation has resulted in increasing economic inequalities within countries. Before the 1990s, most Asian countries had succeeded in reducing economic inequalities. Post 1990s, there has been a sharp increase in economic inequalities except in three countries with conscious policy interventions: Thailand, and to a smaller extent, Malaysia and the Philippines (see Figure 3).

FIGURE 3: CHANGES IN INCOME INEQUALITIES SINCE THE 1990s
(Selected Countries and Regions)

Net Gini Index in Gini points; change since 1990; average across the region



SOURCE: Jain-Chandra 2016, 9, Figure 5. SWIID Version 5.0; IMF, WEO database; and IMF staff calculations.

Cuts in public expenditure including for social welfare and subsidies to agricultural sector, a key feature of neoliberal economic policies, has led to the displacement of small and marginal farmers, often followed by distress-led migration from rural to urban areas. Women, more than men, bear the brunt of residing in urban slums with poor infrastructure, and being cut-off from traditional social support mechanisms. ´Lack of public investment in basic amenities (water supply, sanitation) and infrastructure (roads, transportation) greatly increasing women's work burden. Increasing cost of food because of crises in international food markets result in food insecurity. These take a higher toll on women than men because of their role in procuring and preparing food.

At the same time, the opening of Special Economic Zones in peri-urban and urban settings has also brought greater employment opportunities for women, although poorly paid and insecure. Sex industry is another source of employment for young women. Women in many Asian countries are also migrating to other countries as workers usually in the care industry—jobs that are economically insecure and may also place women at risk of sexual exploitation, as indicated by numerous reports.

Widening inequalities cause fissures in the social fabric. Religious, caste and ethnic conflicts have become common place in many countries, alongside intolerance of sexual, mental and physical diversity. Unemployment for men and increased job opportunities for women, and the resulting "threatened masculinities" may be causing increase in social and inter-personal violence, especially against women and those with non-conforming gender and sexual identities. Hunger, hazardous living and working conditions, poor social support and threat of social and inter-personal violence, all imply poor overall health, including sexual and reproductive health.

Rural to urban migration is a double-edged sword in terms of sexual and reproductive health. The heightened possibility of risky sexual behaviour by male migrants and higher prevalence of STIs and HIV among them is well-documented. Their insecure work contracts may make it difficult for them to seek health care, even though these may be available and accessible in the urban setting. A study from India noted that women migrants living in urban slums experienced relatively poorer reproductive health outcomes, possibly because of increased domestic workload with no adult women in the household to give a helping hand; poor water supply and sanitation contributing to poorer menstrual and genital hygiene and poor nutrition because of having to depend exclusively on food purchased from the market (Unnithan-Kumar and Ally 2015).

Women migrating to other countries as care workers experience violations of their sexual and reproductive rights in many ways. International women migrants in the Asia-Pacific region migrating to Malaysia, Singapore, Taiwan and all Gulf Cooperation Council (GCC) countries have to undergo testing for pregnancy, HIV and other STIs before they depart, and almost every year or each time their contract is renewed. Women who get pregnant or are diagnosed with STIs may face deportation. Access to sexual and reproductive health services are constrained by language barriers, unfamiliarity with the health care systems and high costs in case of not having insurance coverage or for conditions not covered by their insurance (Marin 2013). An ethnographic study of Filipina migrant workers in Taiwan documents how a care worker taking care of an elderly couple, with the man suffering from cancer and the woman in need of full- time care, chose not to seek timely care when she developed symptoms of breast cancer, and to not undergo surgery in order to not disrupt her care-giving. Her daughter's survival back in Philippines, and her own survival depended on the worker's income as migrant care-giver in Taiwan (Liu 2015).

Neoliberal economic policies are also responsible for one of the major threats to the wellbeing of humankind, namely, climate-change. Neoliberal economic policies have fuelled the indiscriminate exploitation of natural resources, the use of fossil fuels and the unwillingness to compromise profits in order to prevent air, water and soil pollution; secondly, the consumer culture that encourages wasteful and conspicuous consumption, among others (Gratrex 2017).

Climate change will have detrimental impact on sexual and reproductive health and rights by worsening the inequalities in access to resources that underlie poor sexual and reproductive health but also by widening gender-power inequalities and by strengthening the position of population-control lobbyists who blame women and their uncontrolled fertility for the crisis of climate change.

The following table (Table 5) by ARROW (2014) summarises some of the myriad pathways through which the effect of climate change will be to erode gender equality and sexual and reproductive health and rights.

TABLE 5: SOME EXAMPLES OF HOW CLIMATE CHANGE IMPACTS WOMEN AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

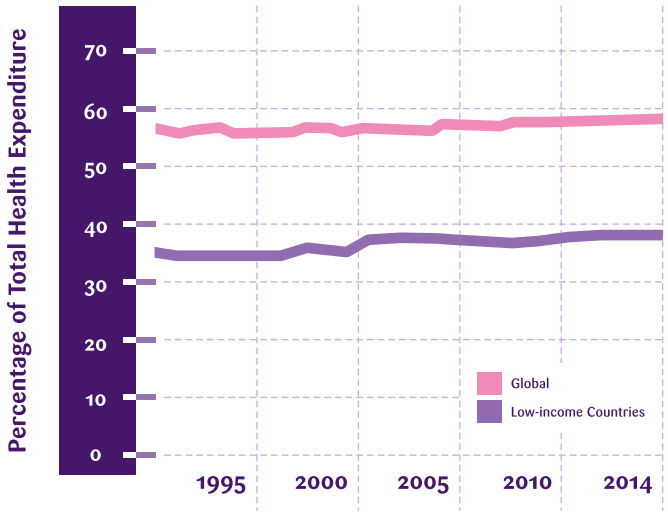
CLIMATE CHANGE IMPACT	GENDER EQUALITY	SEXUAL AND REPRODUCTIVE HEALTH
EXTREME WEATHER EVENTS	> Lack of access to educationand information about extreme weather eventsRestricted ability to respond due to restrictions on women's mobility > Lack of survival skills, such as swimming and tree climbing, often taught to boys and men, not girls and women. > Women's exclusion from planning and disaster recovery decision-making. > Increase in household expenses.	> Access to SRH services constrained. > SRH services excluded as priorities from disaster recovery. > Increased health risks with pregnancy and childbirth > Gynaecological problems due to unhygienic water use.
DROUGHT	> Increased women and girls work burden and time spent gathering water, food and fuel due to availability of water and other resources. > For girls, increasing task may affect their capacity to attend school is at risk. > Loss of land tenure for women with restricted access to land.	> With women traveling further distances to collectfuel and water, increased risk of sexual violence. > Water-logging prevents women from accessing sexual and reproductive health care and services.
FOOD SECURITY	> Increased hunger and calorie reduction for women. > Malnutrition and micronutrient deficiencies. > Compromised food safety .	> Low weights births, increase in miscarriage, perinatal mortality.
HEALTH	> Increased burdened of care for women caregivers, both in households and as careworkers. > Limited access to health services. > Increase in infectious, water borne or vector-borne diseases.	> Maternal malaria increases the risk to spontaneous abortion, premature delivery, stillbirth and low birth weight. > Some evidence of relationship between pre-eclampsia and increased incidence during climatic conditions. > Saline contamination of drinking water linked to pre-eclampsia, eclampsia and hypertension among women.
MIGRATION	> The priorities of migrant and displaced women are not prioritised. > Increased violence a the fastest growing economy in Asia t the household level.	> Trafficking and exploitation Loss of access to services due to migrant status.
CONFLICT	> Internal displacement due to conflict over resources Violence against women.	> Limited access to sexual and reproductive health services and supplies. > Limited access to post- exposure prophylaxis, counselling and STD and STI testing, abortion services in cases of sexual violence.
ECONOMIC IMPACT	> Loss and reduction of livelihoods and assets. > Limited resilience and coping mechanisms. > Feminisation of Poverty especially in urban and peri-urban areas.	

Neoliberal Economic Policies and Universal Access to Sexual and Reproductive Hhealth Services

On the one hand, neoliberal economic policies have increased risk factors for poor sexual and reproductive health. On the other, availability of affordable sexual and reproductive health services is rendered a moot possibility by low and stagnating public expenditure on health, another feature of neoliberal economic policies. As seen in figure 2, the proportion of government expenditure in total health expenditure has remained lower than the global average for low-income countries during 1995-2014 (WHO 2017).

FIGURE 4: GOVERNMENT EXPENDITURE ON HEALTH AS A PERCENTAGE OF TOTAL HEALTH EXPENDITURE, 1995 – 2014

SOURCE: WHO 2017.



This has implications for the availability of sexual and reproductive health services. Except for maternal health and family planning, most sexual and reproductive health services have even before ICPD been concentrated in the private- for--profit sector. To move anywhere near equitable access to care even for maternal health and family planning, there is need for massive public investment in sexual and reproductive health, not stagnating or reducing investment. There appears to be limited scope for making claims for additional sexual and reproductive health services that are publicly funded.

Privatisation in the delivery of sexual and reproductive health services has expanded significantly in the post ICPD era. This has taken the form of contracting in and contracting out of clinical and non-clinical services and the creation and promotion of social franchises of private provider networks. In an attempt to make private provider networks financially viable, the USAID has established a "Development Credit Authority," which offers partial credit guarantees to banks which gave loans to private provider networks (Fonn and Ravindran 2011).

Donor money diverted into bolstering the private sector means less donor funding for the public sector in health and worsens the resource crunch brought about by declining public investment in health. Demoralised staff leave the public sector to join the private sector, setting in motion a downward spiral of poor quality public sector health services. Contrary to claims, market creation efforts do not 'free up' resources that can be used for the poor. The reality is one of shrinking resources; when patient load falls, fewer resources are allocated to the public sector, resulting in its steady deterioration and decline. Studies show that the private sector in health in many middle- and low-income countries may not be much better than the public sector (if at all), in terms of efficiency and quality of care (Fonn and Ravindran 2011). Seeking care for sexual and reproductive health needs implies high levels of out-of-pocket spending.

Women from low-income groups have often to make the choice between incurring catastrophic health expenditure or remaining with their sexual and reproductive health needs unmet.

3.1.2 Global Politics of SRH in an Era of Conservatism

In this section, we look at the many formidable challenges for the advancement of sexual and reproductive health and rights that have emerged in the 23 years since the International Conference on Population and Development in 1994. These include the strengthening of conservative global and regional forces that are waging ideological warfare against the values of gender equality and human rights upheld in the Cairo consensus; changes in the international development aid scenario which have impacted on funding for sexual and reproductive health and rights programmes; and the weakened presence globally and nationally of feminist sexual and reproductive health and rights groups. These factors are interlinked and mutually reinforce each other.

The Strengthening of Conservative Global and Regional Forces Against Gender Equality and Sexual and Reproductive Rights

The years since the ICPD in 1994 have been tumultuous for the SRHR agenda. Part 2 of this manual has described the tenuous nature of the Cairo consensus, the setback to the SRHR agenda with the MDGs and the return of hope following the inclusion of SRHR explicitly in the SDG agenda. This section elaborates on the strengthening of conservative forces post ICPD both in the international arena, and in national politics within several countries.

Strengthening of Conservative Forces Post ICPD

The world is witnessing unprecedented strengthening of anti-gender, anti-egalitarian conservative forces in practically every continent. The protection of tradition is often linked to the protection of family and private property.

Following the ICPD in 1994 and the World Women's Conference in Beijing in 1995, the Vatican mounted a counter-offensive against 'gender-ideology' promoted by a small elite, which it held responsible for attempting to impose western values of gender equality and reproductive rights on traditional societies. This rhetoric is being widely used by conservative forces against SRHR and women's rights and LGBTQ rights organisations. 'Gender ideology' becomes a useful target to channel the anger and frustration resulting from being left behind in an increasingly unequal society (Zacharenko 2016). The Vatican has been working hard to undermine the Cairo consensus on SRHR through its presence in UN forums and its consistent opposition to the use of condoms and contraceptive and safe abortion services. Conferences such as the International Conference on the Family, held in Doha with the support of the government of Qatar in 2014 is an example of how Islamic conservatism acts to derail the feminist agenda.

Well organised conservative groups opposed to sexual and reproductive health and rights are a feature of the European Union in recent decades. They are diverse in nature and may include religious institutions, civil society organisations, citizens' initiatives and political parties.

Through the skilful use of social media and grassroots mobilisation, they have been very effective in organising against marriage equality, safe and legal abortion and comprehensive sexuality education. Many of these groups are linked to like-minded counterparts in the USA who play and mentoring role and provide support with strategising and funding (Hodžić and Bijelić, .2014). Conservative 'anti-choice' activism in Eastern and Central Europe and Russia is similarly aimed at rolling back of abortion rights and against gay marriage (Wichterich 2015).

The growing influence of the US Christian Right in Africa to curtail sexual and reproductive rights is well-documented in a study by Kaoma (2012). Organisations have been set up in many African countries to influence laws and policies. The East African Centre for Law and Justice's (EACLJ) in Kenya and the African Centre for Law and Justice (ACLJ) in Zimbabwe, for example, have been set up by the US-based Centre for Law and Justice, to lobby African parliaments to adhere by Christian values when framing laws. The Catholic Human Life International has affiliates in many sub-Saharan African countries, which campaign against contraception, LGBT rights and monitor violation of anti-abortion laws (Kaoma 2012).

Faced with increasing economic inequalities, country after country in Asia is witnessing the rise of religious fundamentalism and hatred towards minority groups. This is discussed in greater detail in the next Section 3.1.3.

The Mexico City Policy or the Global Gag Rule

Mexico City Policy was first announced by the Reagan administration at the International Conference on Population and Development held in Mexico City in 1984. According to this policy, also referred to as the "Global Gag Rule" (GGR), a condition for foreign non- governmental organisations (NGOs) to receive US government funding was that they certify that they will not utilise non-US funding from any source that not allowed for performing, advising on, or endorsing abortion as a method of family planning. Exceptions were made for abortions performed in cases of rape, incest, and when the woman's life was in danger.

The Policy has since been in place whenever the US President was from the Republican party, for example during 2001-2008 when George W. Bush was the President. It was rescinded during the Clinton Administration (1993-2000) and the Obama's administration, (2009-2016). In January 2017, the Trump administration reintroduced the Global Gag rule in a dramatically expanded form, wherein the conditionality applies not only to family planning assistance but to all global health assistance provided. According to one estimate, this expanded Global Gag Rule Under President Trump will apply to nearly nine billion

dollars in funding, whereas previous iterations of the GGR applied to a much more modest amount of US$600 million (Center for Reproductive Rights 2018). Further, if the funding loss is not made good by alternative sources, then Trump's global gag rule could result in 6.5 million unintended pregnancies, 2.2 million abortions, 2.1 million unsafe abortions, 21,700 maternal deaths between 2017-2020 (Marie Stopes International 2017).

A study in Nepal, of the effects of the GGR imposed during the George W. Bush era provides a glimpse into the extent of damage caused to accessing contraceptive and abortion services. For example, the Family Planning Association of Nepal lost direct funding of US$ 100,000 received through Engender Health because it could not abide by the terms of Global Gag Rule. It also lost US$400,000 worth of contraceptive supplies. Doctors had to be laid off from clinics, and fee- for-services had to be introduced. The Marie-Stopes Institute (MSI) had to discontinue mobile clinics providing reproductive health services to remote areas and the services of Community Health Workers had to be discontinued. In all instances, it was the poorest and most—marginalised women who were most affected (Population Action International 2006).

Other Changes in the Scenario of International Development Aid (IDA) for SRHR

As seen above, the Global Gag Rule is not only an ideological attack on SRHR, but severely limits the availability of donor funding available for sexual and reproductive health in low and middle- income countries. There have been a number of other changes in the IDA scenario, including the focus on HIV funding, the dependence of multilateral agencies on bilateral donor funding, the weakening of funding availability to civil society organisations and women's rights organisations and the major upset to the funding status quo with the entry of powerful private foundations into the SRHR funding scenario.

Skewing of the Limited Funding by International Donors Towards HIV/AIDS and Away from Comprehensive SRH Services

At the ICPD in 1994, the international community made a commitment to finance one third of the cost of providing comprehensive sexual and reproductive health services in low and middle-income countries. According to estimates made in 1994, about 5-7 billion US dollars in donor aid would be required between 2000 and 2015 for this purpose. However, the estimates did not include treatment for HIV and services for reproductive cancers. Revised estimates peg the total amount required at about US$70 billion in 2015, of which about US$23 billion would have to come from the international community (UNFPA 2014).

Although falling far short of this amount, donor aid for four major components of the ICPD Programme of Action—HIV/AIDS and STIs; family planning; reproductive health; and basic research—steadily increased from less than US$2 billion (current) to US$12 billion (current) in 2011. However, 70% of this amount was for HIV/AIDs and other STIs. About 22% was for "reproductive health" —essentially nothing more than traditional maternal and child health services, and 8% was directed towards family planning programmes. Thus, at a time when public expenditures in health were declining at the national level, donor funding was getting skewed towards funding HIV/AIDS programmes, marginally supporting MCH and FP, with little available for other neglected areas such as abortion, adolescent sexual and reproductive health, gynaecological morbidities, infertility and reproductive cancers (UNFPA 2014).

Development Assistance by Key SRHR Donor Countries Directed Towards Multilateral Agencies and LMIC Governments

Much of the development assistance for SRHR in the post-ICPD years has been from seven European countries. These are Denmark, Finland, Germany, Netherlands, Norway, Sweden and the United Kingdom, usually referred to as "like-minded European donors". They have staunchly supported financial support for both, the traditional areas of SRH such as contraception and maternal health as well as newer areas such as safe abortion and young people's sexual and reproductive health. A series of studies commissioned by the Packard Foundation in 2011 on the nature of ODA for SRHR from these seven countries found some disturbing trends.

Close to 50% of the health-ODA from these countries was for general health, 34% was earmarked for HIV/AIDS programmes and only 17.5% was earmarked for SRHR-specific programmes. Of the limited SRHR ear-marked assistance, more than three-quarters was provided to United Nations Population Fund, and about 14% to the International Planned Parenthood Federation. Country assistance usually took the form of support to government-led programmes, resulting in very little funding available for civil society organisations (Seims 2011).

Donor Funding for Women's Rights and SRHR Organisations Being Directed Towards Civil Society Organisations in Their own Countries

According to a report by the OECD's Development Assistance Committee (DAC), it provided about US$35.5 billion in development assistance for gender equality in 2014, and of this 28% or nearly US$10 billion went to civil society organisations. One may presume that some part of this funding was for CSO work on SRHR, given the close interlinkages between work on gender equality and that on SRHR. The report also notes that most (92%) of the CSO funding went to international NGOs based in donor countries, and only 8% was received directly by women's rights organisations in low and middle- income countries (OECD 2016).

New Players in Private Foundation-funding for SRHR Changing the Rules of the Game

The entry of the Bill and Melinda Gates Foundation as an SRHR funder has marked a major shift in the funding scenario for SRHR. The Gates Foundation is by far the largest global health funder, and its engagement with SRH issues beyond HIV is less than a decade old. However, given the huge funds at its disposal, the Gates Foundation wields enormous powers to change funding priorities in the SRHR field. The Foundation has largely been concerned with maternal and child health and more recently, family planning. It also invests on policy advocacy and product development in contraception.

Increasing global conservatism, the global gag rule and other changes in the international funding scenario for SRHR has significant consequences for country-level work for promoting SRHR and for SRH funding available to women's rights and SRHR organisations at the national level in most countries, especially in LMICs. This is explored further in the next section.

3.1.3 Challenges to SRHR at the National Level

This section focuses on specific challenges to SRHR at the national level, including the rise of religious fundamentalism, shrinking spaces for civil society alongside the rise of right wing politics and the weakening of women's rights and SRHR organisations at the national level. All of these are influenced by the global rise of neoconservatism and neoliberal economic policies, discussed in earlier sections.

Religious Fundamentalism and SRHR

As seen in Europe and the USA, the misuse of religion for political power, or 'religious fundamentalism' has posed a formidable challenge to advancing sexual and reproductive health and rights and gender equality in many Asian countries, across all religions. Sexuality is a taboo subject, and young people are denied access to comprehensive sexuality education. Diversity in gender identity and sexual orientation is attacked as being against religion and culture, violating the human rights of persons. Equality in marriage is opposed as detrimental to the sanctity of the family, and marital rape and genital mutilation are condoned in the name of culture and religion. Women's right to fertility control is seriously restricted by rendering abortion criminal, and often results in avoidable morbidity and even mortality from unsafe abortion (ARROW 2014).

For example, in India politicians from the Hindu nationalist Bharatiya Janata Party or BJP have for nearly two decades consistently opposed comprehensive sexuality education in schools. Recent years have seen an increase in killings associated with inter-caste and inter-religious marriages (Ram Prakash, Balasubramanian and Narasimhan 2017). In other countries, the rise of political Islam has resulted in the use of *Shari'ah* (system of Islamic laws) to impose strict controls over women's sexuality, mobility, dress code and enforcing women's subordinate gender role. In Pakistan, instances have been reported from Swat, of opposition by mainstream Islamists to contraception and sex education as vulgar and against culture. With the services of Lady Health Workers no longer available because of their persecution and threats of violence, maternal health and family planning services were unavailable to women in the community (Ud Din, Mumtaz and Ataullahjan 2012). Access to contraception and safe abortion services have for long been denied to women in the Philippines, despite the presence of strong feminist SRHR organisations.

Shrinking Civil Society Spaces

Many countries of the global South, including in Asia, are also witnessing a crack-down on freedom of association by civil society groups and shrinking of civil society space, usually in the guise of protecting national security. According to "The State of Civil Society Report of 2015" a typical typology of repression of civil society includes: the introduction or more intensive application of laws that limit freedoms of assembly, association and expression, including anti-terrorism laws; the tightening of registration

requirements, which consume civil society energy and resources in compliance, and which proscribe some activities, or give governments powers to make some types of CSOs illegal; controls on the receipt of funding for CSOs, most usually funding from foreign sources, and related rhetoric that paints CSOs receiving such funding as agents of foreign powers; and verbal and physical attacks by politicians and other powerful figures that can escalate to detention, imprisonment and assassination (CIVICUS 2015, 78).

In his report published in January 2015, Maina Kiai, UN Special Rapporteur on the rights of freedom of peaceful assembly and of association, observed that governments treated businesses favourably while reining in the freedoms of civil society organisations (UN 2015).

The attack on CSOs assumes increased ferocity in the case of organisations and individuals working for women's rights and rights of LGBTQI, who often caught between government's restrictions on the one hand and intolerance of religious fundamentalists on the other. This was the case in Egypt post-2011, regardless of which government was in power (CIVICUS 2015, 84). In countries where homosexuality is criminalised, as in Kenya till 2015, LGBTQI organisations were not allowed to register as CSOs. In Russia, a law against propaganda for homosexuality combined with a law against foreign funding for CSOs have together been used to clamp down on LGBTQI activism (CIVICUS 2015, 108).

Shrinking Donor Funding for National NGOs, Changes in Donor Culture, Weakening of Feminist Voices

The many changes in the architecture for donor funding of CSOs in LMICs in general, and of SRHR and women's rights organisations in particular, have resulted in the fragmentation, weakening or even wipe-out of feminist SRHR organisations.

To begin with, there is very limited SRHR-specific funding in ODA, and only a small fraction of this goes to CSOs from the Global North as well as the Global South. Secondly, a miniscule fraction of funding for CSOs is received by SRHR organisations in LMICs.

Private funding for SRHR is increasingly from large private Foundations funded by individuals of great wealth, who have successfully changed the ways in which funding is solicited and disbursed, and ways of monitoring and assessing achievements and outcomes.

For example, rather than CSOs approaching donors with proposals that reflect locally identified priorities, agendas are increasingly pre-determined by donors who then solicit proposals for specific initiatives from identified organisations or issue a call for competitive bidding from organisations that satisfy specific criteria. Funding is often short-term, and project-specific, with core-funding rarely provided (Kuhnert 2014). In an effort to minimize overhead costs and make grant-administration more efficient, large-scale funding to organisations with capacity for "fund-absorption" are preferred, over small-scale grassroots organisations. International NGOs who set up shop in LMICs often become funding intermediaries channelling donor funding as well as providing "technical support" to grassroots organisations. Intermediary CSOs struggle under the burden of managerialism imposed by the donor, with a range of internal and external reviews and assessments and elaborate accounting procedures. Achievements are assessed on the basis of quantifiable outputs and outcomes while processes such as community participation take a back seat (Roberts et al., 2005).

> *"...many of our donors are suffering from 'logframitis'. They want us to package the long-term and systemic change we are passionate about into neat little fundable projects that fit their programme and timelines. They work through complex chains of 'fundermediaries' who channel ever-smaller chunks of money with ever-larger relative reporting requirements."* (CIVICUS 2015, 6).

Caught between a situation where civil society's access to foreign funding is increasingly restricted and where there is little domestic funding available especially for SRHR from a feminist perspective, feminist SRHR organisations in LMICs that were once vibrant and active are under pressure to either rework their agendas to align with donors' priorities or resign themselves to a precarious existence. Grassroots SRHR groups as independent entities have been almost wiped out, and exist, if at all, only as "partners" of larger CSOs whether national or international. Agenda-setting in SRHR is more often than not, in the hands of international NGOs operating in LMICs.

TK Sundari Ravindran

3.2 SOME CONTENTIOUS ISSUES

The feminist movement is diverse, and there are many issues on which we do not see eye to eye with each other. This section presents and discusses selected issues that have remained controversial within the feminist health movement: pornography and sex work, marriage and motherhood and abortion and contraceptive technologies.

3.2.1 The Rights and Wrongs of Pornography

There has perhaps been no issue as contentious in the feminist movement, especially in the USA but through its global influence, of the feminist movement worldwide, as pornography. Unresolved controversies on matters related to sex and sexuality between different groups of feminists in the West have subsequently been referred to as "sex wars", indicating their deeply divisive nature. Positions continue to remain diametrically opposite to each other and hardened for and against pornography (and sex work) among some groups of feminists to the extent that no constructive dialogue has been possible on the issue.

But this was not always the case. In the 1970s, second wave feminists sought to challenge sexism in all its forms and strove for equality in all aspects of life, including sexual and reproductive. Women's right to sexual pleasure and fulfilment on their own terms was deemed an integral part of women's autonomy and agency.

The publication of Kate Millet's Sexual Politics in 1970 and of Susan Brownmiller's "Against Our Will" in 1975, linked the maintenance of patriarchy to sexual control of women by men through coercive means. Pornography emerged as "the" feminist issue of the 1980s, with widely varying positions taken by the anti-pornography feminists (mostly of the radical feminist genre) and 'sex- positive' feminists (mostly drawn from the liberal feminist genre), with the socialist feminists opposed to anti-pornography stance but not quite aligned with the 'sex-positive' position.

According to the Oxford English Dictionary, pornography refers to "printed or visual material containing the explicit description or display of sexual organs or activity, intended to stimulate sexual excitement." Anti-pornography feminists recast the very definition of pornography as the cruel and degrading depiction of women. Their view, as contained in the works of Andrea Dworkin and Susan Griffin, may be summarised as follows:

a) Male sexuality is cruel, aggressive and exploitative.
b) Pornography reinforces the idea that male sexual pleasure is derived from humiliating women. It teaches men how to deploy male sexuality with the penis as their weapon
c) All pornography is sadistic with sexist and racist overtones.

Anti-pornography feminists have sought to fight pornography with state-regulations and censorship (Dworkin 1979; Griffin 1981).

In contrast, sex-positive feminists believe that far greater damage is done by opposing and restricting production of pornography, and these include

a) Anti-pornography positions mitigate against women's sexual freedom and sexual exploration by making a blanket distinction against acceptable and non-acceptable sexual behaviours.
b) Anti-pornographic stances are judgemental of individual sexual fantasies and practices and interfere with individual freedoms by labelling them as degrading. This could result in the judgement, marginalisation or even criminalisation of sexual cultures and practices that do not conform to what is deemed "normal" and "acceptable".
c) Inviting state regulation of sexual representation is dangerous and could be a slippery slope that paves the way for state interference in individual privacy in other domains. This may result in discrimination against non-normative sexualities (Purcell 2009).

The demonising by anti-pornography feminists of male sexuality and casting women as victims of male sexual aggression is far from reality. These may be characteristics of pornography, but not of everyday sexual conduct between men and women. Pornography is but one manifestation of sexism, and to focus exclusively on it obscures the negative consequences of deeply entrenched sexism in all social institutions, from the family and work place to legal and political structures. Nor is sexualised

portrayal of women exclusive to pornography. Objectification of women's bodies in advertising and in the media are also sexist and degrading and important to challenge.

Anti-pornography stances have led to some misguided political positions that could be counter- productive. For example, there is danger of getting subsumed in public perception with the conservative right- wing opposition to pornography. Further, censorship and state-regulation, as "sex-positive" feminists rightly point out, is deeply problematic. At the same time, it is important to recognise that there may be aspects of pornography that are illegal —those which portray sex between an adult and a child, or those that are involve violence or coercion on any of the actors in the pornographic material. As feminists, we have to oppose unacceptable and illegal depictions of individuals in a sexual act.

The conflation by sex positive feminists of sexual liberation with pornographyis also disturbing. Sexual liberation is far removed from commodification of sex. Further, some argue that because many women choose to go into pornography of their own volition, to oppose pornography would be to disrespect these women. This argument is somewhat illogical. Let us take the example of women who work in sweat shops of their own volition. This does not mean that sweat shops are not exploiting women's labour nor does criticism of sweat shops imply disrespect for the women.

Pornography is problematic not because it is immoral but because it promotes a view of the body—usually the female body—as an object that satisfies a need. It strips sex of its human elements—of caring, intimacy, love, communication —and portrays it a physical act between two bodies, not two human beings who respect each other and are in an equal relationship, sans context and meaning. As with any kind of meaningless consumption in this consumerist society, there is boredom with the usual depictions of sex and a continued search for more and more titillating and hard-core pornography.

More importantly, as socialist feminists point out, neither the anti-pornography or the sex- positive stances look at the material circumstances that have led to the mass production and ever-increasing consumption of pornography in multiple forms. From its hesitant beginnings in the 1950s and 1960s with Play Boy and Pent House magazines with nude centre-spreads, pornography today is a multi-billion- dollar industry. The coming of the internet has brought pornography within everyone's reach and expanded its reach to become a truly global industry. The logic of capitalist economy is to produce goods and services for which there is effective demand and would yield a profit. The growth of the sex industry, of which pornography is a component, has to be seen within this context. Writing about sexuality under capitalism, McGregor (1989) says that in a capitalist society, human labour is bought and sold according to market forces. In order to survive, a worker has to engage in any kind of work that would result in an income and is often unable to choose to only to engage in work that is creative and fulfilling. This leads to a profound sense of alienation, which affects all their relationships and most importantly, intimate relationships. People seek to fill the void created by alienation in their lives through acquisition and consumption, which brings some excitement, albeit temporary. The consumption of pornography has to be seen within this context. There may be other factors which influence the demand for pornography which may vary across contexts—e.g. strict sexual segregation and lack of access to sex education. The pornography industry is catering to this demand, as well as contributing to further expanding the demand (McGregor 1989).

Thus, pornography is only a symptom of a greater social malaise affecting human relationships under neoliberal globalisation. This is not to say that we sit back and wait for the revolution after which all the problems will go away. Our starting points could be depictions of female and male sexuality that are about respectful and caring relationships between people; which celebrate exploration of sexuality and view it as pleasurable and nurturing, not about performance and achievement or power and control. Comprehensive sexuality education, respect for sexual diversity and for variations in sexual preferences within mutually consensual adult relationships are values we would uphold.

Saunders (1990) argues that socialist feminists have the theoretical framework to examine pornography but have yet to produce a comprehensive analysis using this framework. She outlines areas for further exploration: a) examine pornography as patriarchal ideology and the various ways that its sexist messages affect human wellbeing b) look into the evidence on the relationship between coercive pornography and sexual abuse c) explore the political economy of pornography: drivers of its production, distribution and consumption.

Such an understanding would go a long way towards identifying ways in which to respond to the sexual politics of pornography.

3.2.2 Making Sense of the Campaigns for "Equal Marriages"

On the one hand feminists regard marriage as a patriarchal institution. And yet, campaigns the fight for "marriage equality"—the right of same-sex couples to marry—has occupied centre stage within the LGBTQ movement over the past few decades. How do we make sense of these contradictory stances? This section presents the feminist critique of marriage as an institution followed by the history of the campaign for equality in marriage. It examines arguments in support of gay marriages from a socialist feminist perspective.

Feminists have for long critiqued the institution of marriage for its role in reproducing unequal gender relations through the gender-based division of labour, with women as care-givers and men as bread-winners. Women's subordinate status within marriage is reinforced by law and religion, and in the workplace, among others. The idea that one's wedding day is the most important day in one's life, and that to be chosen as a wife is the goal of life is instilled in girls from an early age. Both women and men are socialised into the idea that the correct way to live and raise children is within the parameters of a legal marriage and the nuclear family (Barker 2012).

There have been profound changes in the institution during the course of the twentieth century, with marriage no longer a precondition for sexual intimacy, and childbearing not the central purpose of marriage. The influence of the feminist movement has made gender relationships within marriage relatively more egalitarian, at least in some contexts.

However, marriage is unlikely to be egalitarian as an institution, as long as capitalist economies benefit and rely on the unpaid caregiving role of one or more members of the family to take care of the present generation of workers and to nurture and raise the future generation. The wages paid do not have to factor-in the cost of care-labour, and the neoliberal state does not consequently have to subsidise the provision of such care. When women enter the paid work- force, they continue to bear the double burden of unpaid domestic work as well as paid labour (Boyd 2013).

A second aspect of the critique is that while marriage is portrayed as the ultimate goal of couples who are in love and would like to commit themselves to the relationship, it serves an important regulatory and economic purpose. This is well illustrated in a judgement related to same-sex marriage in the USA.

> *"The State's interest in licensing marriages is regulatory in nature. The regulatory purpose of the licensing scheme is to create public records for the orderly allocation of benefits, imposition of obligations, and distribution of property through inheritance. Thus, a marriage license merely acts as a trigger for state-conferred benefits. In granting a marriage license, the State is not espousing certain morals, lifestyles, or relationships, but only identifying those persons entitled to the benefits of the marital status."* (Case 2010, 1205, citing a judgement by Justice Denise Johnson in the case of Baker vs. Vermont)

Marriage rights first featured on the agenda of the lesbian and gay movement in 1987 and soon came to occupy centre-stage in the movement's attention. During the 1970s and 80s, lesbians constituted a significant part of the feminist movement and had critiqued marriage as a patriarchal institution. Following attempts to legalise same-sex marriages in Hawaii in 1990s, the lesbian and gay movement mobilised around the issue of "marriage equality" for several decades and have achieved some significant victories in many countries of the world, the latest of which was the judgement by the US Supreme Court in 2015 of the constitutionality of same-sex marriages. (Green 2015, 26 June).

The recognition of the rights of same-sex couples to marry is a significant step forward in the history of sexual rights. Same sex-marriages have made it possible for lesbians and gay persons to enjoy legal rights previously denied to them, such as the right to raise children, inherit property, have the right to benefit from spousal insurance coverage and be recognised as the next of kin of their sexual partner. "Marriage equality" may also be viewed as another step forward in the transformation of marriage into an inclusive institution, with the potential for ushering in new and more democratic ways of relating to each other (Bilger 2015, 29 June).

Even while acknowledging these positive aspects, one cannot but feel unsettled at the renewed valorisation of marriage as 'the' institution that legitimises a relationship. As Boyd (2013) observes that

> *"By embracing marriage, homosexuals remind others that it is, or should be, the norm for committed couples. It is the best place to experience love, sex and companionship together. It is the best place to raise children. Marriage's "till death do us part" pledge of permanence gives people the security they need to give themselves fully to the other.* (Boyd 2013, 273)

For example, when Ireland voted in favour of legalising same-sex marriages, its Prime Minister Enda Kenny remarked that "This decision makes every citizen equal and I believe it will strengthen the institution of marriage (Murphy 2015, 25 May).

By side-lining the critique against marriage, the fight for marriage equality may represent a step backward in the history of the feminist movement. Card (1996) argues that because the institution of marriage is basically unjust, lesbians and gays should not fight for the right to marry "just as white women should not have fought for the (equal) right to be slave-owners".

Marriage, whether same-sex or heterosexual, serves to support neoliberal policies of making families responsible for individual welfare and absolving the state of this responsibility.In fact, an important decision by the Supreme Court of Canada mentions that same sex partners should

have the same spousal support obligations towards each other as opposite sex couples, and further stated explicitly that a main purpose of spousal support law was to alleviate the burden on the public purse by shifting the obligation to provide support for needy persons from the state to family members." (Boyd 2013).

Another major critique of the focus on gay marriages by the movement is that this has detracted attention from the everyday struggles for existence of a large number of gay people from socially and economically marginalised groups —many of whom may never marry so as to not lose welfare benefits. Marriage will not solve many of the economic and social issues of the LGBT community, just as it won't alleviate poverty of straight couples. It is unfortunate that marriage rights are presented as the route to health care access and economic stability for same-sex couples (Kandaswamy 2010) rather than making claims for these as individual rights of all people.

As long as marriage remains the only route to gaining legal and economic rights and privileges for same-sex couples, same-sex marriages will be a legitimate demand. The way forward would be to focus in the short-term, on improving legal rights of same-sex couples and at the same time engaging in a long-term struggle to "ensure equality and dignity for all, including those who do not enter traditional relationships that offer economic entitlements (Boyd 2013).

3.2.3 Feminist Debates Around Selective Abortions

The right to safe abortion services is central to women's effective control over their reproduction. Women could never be equal with men unless governments made abortion services legal, safe accessible and affordable to all women. It is for this reason that feminists the world over have advocated for abortion rights from the very early days of the second wave of the feminist movement in the 1960s. Despite this, 42% of women of reproductive age in 2017 lived in the 125 countries where abortion is highly restricted -prohibited altogether, or allowed only to save a woman's life or protect her health (Singh et al 2018).Advocacy for liberalising abortion laws have met with success in many countries over the past few decades, but the progress is not linear. Many countries of Eastern Europe and Central Asia which had liberal abortion laws under the pre-1990s socialist regime have regressed to restrictive laws.

A greater cause for concern is the emergence of fissures within feminist ranks on whether women's right to abortion can be unequivocally upheld at all times. Two such debates are discussed here. One is sex-selective abortion of female foetuses and the second is selective abortion of defective foetuses.

Sex-selective Abortions (SSA)

Sex-selective abortions appear to have been first discovered in the early 1980s by a feminist group in Mumbai, India, which found evidence on the use of prenatal diagnostic techniques such as amniocentesis, chorionic villi sampling and subsequently, ultrasonography for sex-determination, followed by pregnancy-termination if the foetus was female. The phenomenon was soon reported to

be prevalent in China, South Korea and Vietnam. The issue of SSA garnered international attention with the publication in 1990 by the Nobel laureate Amartya Sen titled "More than 100 million women are missing" in New York Review of Books. More recently in 2015, UK witnessed a campaign to "Stop Gendercide" among its immigrant populations.

The pervasive son-preference in India, China and other Asian settings, and among immigrant populations from these countries, coupled with the widespread availability of prenatal diagnostic techniques are believed to have contributed to the misuse of these techniques for sex-determination and selective abortion of the female foetus. The situation worsened in contexts of state-sponsored population control programmes such as those in China and India, enforcing the one and two child norms, respectively. Sex detection tests followed by selective abortion of the female foetus made it possible to reconcile the pressure to bear sons with that to have a small family. Sex-selective abortion of the female foetus is a manifestation of the deep-rooted undervaluation and rejection of female children. It would be difficult to identify as a feminist and not oppose such a practice.

In the early years after the discovery of SSA, Indian feminists strongly opposed the practice. Several Indian feminist and civil society groups led a campaign and succeeded in 1994 in achieving the enactment of a national law prohibiting the use of pre-natal diagnostic techniques for sex-determination, later (2003) amended to extend its scope to include pre-conception sex selection as well. Feminists and civil society fought hard to ensure that this law was implemented, and that sex-determination did not happen. Sex-selective abortion of female foetuses was framed as a form of "Violence Against Women" and public opinion was effectively mobilised against it, with considerable support from the media. It was only several years later, when the success of the campaign began to be manifested in the form of refusal by providers to provide second trimester abortions and even first trimester abortions became difficult to obtain, that deep divisions began to appear within the feminist movement in India. In India, and elsewhere, these divides deepened when anti-abortion groups infiltrated and even took over campaigns against SSA in some instances (Lee 2015, 17 February).

Sex-selective abortion of the female foetus is a manifestation of the deep-rooted undervaluation and rejection of female children. It would be difficult to identify as a feminist and not oppose such a practice.

Drawing on India's experiences, the question before the feminist movement is whether we can on the one hand, uphold a woman's right to terminate an unwanted pregnancy, and on the other, oppose pregnancy terminations in a specific instance, i.e. when the foetus is female. Here are some arguments from both sides and from some who seek to create common ground.

Those who hold that sex-selective abortions should be made illegal argue that women who terminate a pregnancy because the foetus is female, most often do so under coercion or pressure, and against their free will. Therefore, legislation prohibiting sex-selective abortions would help such women to not have to undergo an abortion against their will. According to this view, even when a woman claims to have chosen SSA of her own free will, she is acting under the pressure of social norms that undervalue girl children and undervalue women who bear too many girl children. The supporters of campaigns to outlaw SSA believe that such a ban will send an important message to the public—that, it is wrong to discriminate against female foetuses. They deride feminists who uphold women's right to abortion under all circumstances, because in their view this amounts to supporting sex-selection and working against the interests of womankind overall.

Those who uphold women's right to safe abortion under all circumstances have the following arguments to offer. First, that if we are pro-choice, then it means supporting even those choices that we may not agree with, such as sex-selective abortions (Furedi 2013, 16 September). Second, that we are on a slippery slope when we start opposing some kinds of abortions while supporting others. "The minute you allow one or more of the reasons a woman gives to be contested, you open the door for any and every reason she has to be contested. The foetus and its characteristics are not the issue. The issue is the woman and whether you agree that carrying a pregnancy to term, giving birth and motherhood should always be her autonomous choice" (Berer 2008, 8 May). In other words, whether or not sex-selective abortion is acceptable is not

an issue to engage with, because it side-tracks the main concern of women's bodily autonomy and right to choose.

Selective Abortions for Foetal Abnormality

In recent decades, feminists from the disability rights movement have challenged the morality of routine prenatal screening for detection of foetal anomalies followed by abortion when the results are positive. According to some disability rights activists, their discomfort with selective abortions on grounds of foetal anomaly is rooted in the abuses perpetrated on persons with disabilities in early to mid-twentieth century under the influence of eugenic ideology.

Some key reasons for opposition by disability rights activists to selective abortions for foetal anomalies are as follows. One, genetic screening followed by prenatal testing has become routine practice and is a growing multimillion dollar industry. More and more tests are being made available for prenatal detection of potential foetal impairments. While these tests can only predict foetal impairments as a probability and not as a certainty, medical professionals tend to recommend to parents that they abort the pregnancy to eliminate any chance of having a child with a disability. Not only is this not informed choice by the woman concerned or her partner, but in many instances, women are acting under pressure from the community as well as from medical professionals. Two, selective abortions communicated to those living with disabilities the social message that a person with impairment was not worthy of living. Disability may therefore be seen as 'a form of social oppression experienced by people with impairments or people perceived to be different from an idealised norm of what "being human" means' (Fletcher1998). Persons with disabilities have a right to be born and to expect from society the creation of an environment conducive to a life of dignity and autonomy for everyone.

Other disability-rights feminists prefer not to have to choose between disability justice and women's right to abortion, which would mean pitting inherent human worth against bodily autonomy. They uphold the right of all women to terminate an unwanted pregnancy and to carry a wanted pregnancy to term. They are against the compulsory abortion or sterilisation of women living with physical or mental disabilities. At the same time, they demand that women be allowed to make an informed choice about whether or not they will be able to parent a child with a specific kind of disability. This implies that full and complete information be given to women on the predictive value of the prenatal test results and on the implications of parenting a child born with disabilities. Some have suggested that potential parents be given the opportunity to be counselled by persons living with disabilities in order to appreciate what it would mean to parent a disabled child, and what the child may feel about his/her life (Neumeir 2017, 11 April).

It is worth noting that whether or not all foetuses with abnormalities are aborted or carried to term would not make a great difference to the situation of persons living with disabilities, because genetic anomalies account for a very small proportion of disabilities overall. A more urgent priority is to advocate for and work towards a society that upholds the 'inherent worth, well-being and autonomy' of all persons, irrespective of their abilities.

Selective abortions communicated to those living with disabilities the social message that a person with impairment was not worthy of living. Persons with disabilities have a right to be born and to expect from society the creation of an environment conducive to a life of dignity and autonomy for everyone.

3.2.4 Contraceptive Technologies — Liberating for Women Under All Circumstances?

The struggle for control over sexuality and reproduction lie at the heart of feminist campaigns across the world. While campaigns for birth control existed since the late 19th century, it was the innovation of the oral contraceptive pill and its availability since 1961 that marked the definitive break-through in terms of giving women the means to effectively prevent pregnancy. It opened up hitherto unavailable opportunities to women, and removed one major hurdle to their participation in higher education and in the labour force. It has also enabled women and men to engage in sexual relations without the Damocles sword of an unwanted pregnancy hanging over their heads, and prevented avoidable mortality and morbidity related to high-order and unwanted pregnancies.

It may therefore seem surprising that, within the feminist movement, the issue of contraceptive technologies could at all be contentious. In this section we present positions within the feminist movement about the availability of 'modern' or artificial contraceptive technologies as not necessarily in the interest of women. Some of these positions are against artificial contraceptives in all circumstances while others are oppositions to specific technologies or specific ways in which contraceptive technologies are being used.

Arguments Against Use of Any Artificial Method of Contraception

One of the arguments against artificial methods of contraception is that by removing the threat of pregnancy they make women's bodies available for sex to men at all times, and also contribute to an excessively sexualised culture. Women have become objects with whom men can "have a good time" without taking any responsibility for the consequences of having sex. Women are expected to take responsibility for preventing pregnancy and are blamed if they fail to do so. Artificial contraceptives are also seen as responsible for the rise of the 'hook-up' culture of casual and mindless sex, removing from sexual relationships the beauty of intimacy and mutual caring (Bennett 2013).

The second major argument is that artificial contraceptives, especially hormonal contraceptives, are a means through which technology enables corporations to exploit women's bodies. Corporations that produce contraceptives profit from the sale of hormonal contraceptives that need to be used every day (oral contraceptive pills) or every few months (injectable contraceptives). Other corporations profit indirectly, from their savings on maternity benefits and insurance coverage, for example. Women workers are given the same treatment as men workers, without making any allowances for their role in biological reproduction (Bennett 2013).

Within population control programmes, contraceptive methods are no longer tools that women may choose to use as and when they wish, as part of their decision related to whether, when and how many children to have.

Arguments Against Use of Hormonal Contraception

Some feminist groups oppose hormonal contraceptives in particular, for several reasons. The first and most predominant concern is related to the safety of hormonal contraceptives. The estrogen-progestin combined contraceptive pill has been documented to carry several health risks, ranging from increased risk of breast and liver cancer to stroke and blood-clotting in the presence of risk factors such as obesity and smoking. A related concern is that it is women alone who bear this burden entirely. In contrast, natural methods such as rhythm method involve periodic abstinence, which is a shared responsibility. In addition to the health risks posed by the hormones in injectable contraceptives, feminists in some low and middle-income countries have been concerned with the increased risk of HIV transmission, as shown by many research studies.

Another argument against all hormonal contraceptives is that to date, all of these are targeted at women, thus making women bear the entire burden for preventing pregnancies. In contrast, use of the rhythm method calls for periodic abstinence, for which both men and women have to share responsibility.

Contraceptives as a Weapon for "Population Control"

In many low and middle-income countries especially in Asia, the opposition by feminist groups to some modern contraceptive methods is rooted in the context of state-sponsored population control programs. Within population control programmes, contraceptive methods are no longer tools that women may choose to use as and when they wish, as part of their decision related to whether, when and how many children to have. Modern methods of contraception, many of which are health-provider-controlled, are used by the State as a means to reduce population growth rates.

Population control programmes have been strongest in Asian countries such as China, India, Indonesia and Bangladesh. These are also countries experiencing major violations of women's reproductive rights, which take the form of policies and legislations that deny maternity benefits or access to poverty-reduction schemes to women and/or households with more than a specific number of

children; provide incentives and disincentives for adoption of any or a specific method of contraception; set targets for health care providers on the number of contraceptive users to recruit; and even engage in coercive female or male sterilisation; or insertion of intra-uterine contraceptive devices without women's consent.

Within such a context, the introduction of provider-controlled methods of contraception such as the injectable, have the potential for being misused. In India, there has been a long-standing opposition to including in the National Family Welfare Programme, Depo-Provera, the injectable contraceptive.

Where do We Stand in All of This?

How do we understand and make sense of the opposition by some feminists to artificial contraceptives described here?

At the outset, we would like to acknowledge that the availability of artificial contraceptives is indeed a double-edged sword. It holds immense liberatory potential for women and to humankind overall, but at the same time could become detrimental to women's interests and to their wellbeing, in specific contexts. However, what we disagree with is targeting and opposing the technology rather than the contextual factors that make the technology counter-productive. Objectification and commodification of women's bodies is a feature of neoliberal globalisation working in cahoots with patriarchy, as discussed in the previous section. State- control over women's reproduction is also a feature of a neoliberal state trying to restrain the widening economic inequalities from rupturing the social fabric. If we start opposing technologies because of who controls them, we may be throwing the baby out with the bathwater.

At the same time, what is evident is that there are no magic bullets against neoliberal globalisation or patriarchy. No technology can resolve the problems created by patriarchy and neoliberal globalisation, whether it is birth control pills or washing machines. We need to wrest control of contraceptive technologies away from the state and keep up the struggle against patriarchy and neoliberal globalisation for the multitude of ways in which the two collude to disempower women from the most marginalised sections of society.

3.2.5 Gender-based Violence and Intersecting Violences

In this section we first describe various dimensions of commonest forms of gender based violence. And then go on to look at other forms of gender violence namely by caste, sexual orientation and gender identity.

Definitions

There are several definitions of Violence against Women. The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." (United Nations 1993)

Intimate partner violence refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours (WHO 2017).

Sexual violence is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object."

'Battering' refers to a severe and escalating form of partner violence characterized by multiple forms of abuse, terrorization and threats, and increasingly possessive and controlling behaviour on the part of the abuser.

Domestic violence means "all acts of physical, sexual, psychological or economic violence within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim." The two main forms of domestic violence are intimate partner violence between current or former spouses or partners and inter-generational violence, which typically occurs between parents and children (Article 3 Istanbul Convention and Explanatory Report).

BOX 14: GENDER DIMENSIONS OF VIOLENCE AGAINST WOMEN

- **Gender-based violence mainly affects women and girls.**
- **Women and men experience violence in different contexts:** while men are more likely to die as a result of armed conflict, violence by strangers and suicide, women are more likely to die at the hands of somebody they know, including intimate partners.
- **In many societies, prevailing attitudes subordinate women to men and entitle men to use violence to control women.** These attitudes serve to justify, tolerate or condone violence against women.
- **Women survivors of violence face specific barriers when seeking access to support services.** This is because women have fewer resources and options to access justice, care and support, as a result of discrimination and their lower position in society

SOURCE: World Health Organization 2012.

There are several debates around the terms like Gender Based Violence. It is important to note that GBV is a structural problem that is deeply embedded in unequal power relationships between men and women. Such violence is perpetuated by harmful social and cultural expectations about gender roles typically associated with being a woman or being a man, a girl or a boy. GBV is a mechanism for enforcing and sustaining gender inequality. Women and girls who are subjected to violence receive the message that they are worth less than others and that they do not have control over their own lives and bodies. This has direct consequences with respect to their health, employment and participation in social and political life (L. Kelly 2005).

It is important to note that GBV also includes violence perpetrated against men and boys. For instance, boys may become subjected to sexual abuse by family members or trafficked for the purpose of sexual exploitation. There are also instances where men have become survivors of domestic violence—by partners or children (Bloom 2008).

In some settings, sexual violence against males may even be more prevalent compared to females, for example, in prisons and the armed forces (WHO 2003). Nevertheless, as highlighted earlier, because of the unequal distribution of power between men and women, women and girls constitute the vast majority of persons affected by GBV, with the majority of perpetrators being male.

Some Facts: Violence against Women — Intimate Partner and Sexual Violence Against Women

- Global estimates published by WHO indicate that about 1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.
- The prevalence estimates of intimate partner violence range from 23.2% in high-income countries and 24.6% in the WHO Western Pacific region to 37% in the WHO Eastern Mediterranean region, and 37.7% in the WHO South-East Asia region.
- Most of this violence is intimate partner violence. Worldwide, almost one third (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner in their lifetime.
- Globally, as many as 38% of murders of women are committed by a male intimate partner.
- Violence can negatively affect women's physical, mental, sexual, and reproductive health, and may increase the risk of acquiring HIV in some settings.
- Men are more likely to perpetrate violence if they have low low education, a history of child maltreatment, exposure to domestic violence against their mothers, harmful use of alcohol, unequal gender norms including attitudes accepting of violence, and a sense of entitlement over women.
- Women are more likely to experience intimate partner violence if they have low education, exposure to mothers being abused by a partner, abuse during childhood, and attitudes accepting violence, male privilege, and women's subordinate status.
- There is evidence that advocacy and empowerment counselling interventions, as well as home visitation are promising in preventing or reducing intimate partner violence against women.
- Situations of conflict, post conflict and displacement may exacerbate existing violence, such as by intimate partners, as well as and non-partner sexual violence, and may also lead to new forms of violence against women. (WHO 2017)

Why Don't Women Leave Violent Partners?

This question is frequently asked. Evidence suggests that most abused women are not passive victims—they often adopt strategies to maximize their safety and that of their children. Heise and colleagues (1999) argue that a woman's apparent inaction may in fact be the result of a calculation about how to protect herself and her children (Heise, L., Ellsberg, M. and Gottemoeller 1999) Women may stay in violent relationships, because of:

- fear of retaliation;
- lack of alternative means of economic support;
- concern for their children;
- lack of support from family and friends;
- stigma or fear of losing custody of children associated with divorce; and
- love and the hope that the partner will change.

Despite these barriers, many abused women eventually do leave their partners, often after multiple attempts and years of violence. In the WHO multi-country study, 19-51% of women who had ever been physically abused by their partner had left home for at least one night, and 8-21% had left two to five times (Garcia-Moreno, Claudia, Janson Henrica, Ellsberg Mary, Heise Lori 2005). Factors associated with a woman leaving an abusive partner permanently appear to include an escalation in violence severity; a realization that her partner will not change; and the recognition that the violence is affecting her children.

Intersecting Violences

CAWN – Central America Women's Network in its 2010 report (CAWN 2010) highlight the concept of intersecting violences. The report reflects on the various definitions of VAW and GBV using the intersectional lens and points out the limitations and specificities. The concepts in this report can offer us useful tools to analyse the structural nature of gender based violence in the Asia Pacific region.

In Part 1 we discussed intersectionality. Crenshaw defines intersectionality as expressing a "complex system of multiple, simultaneous structure of oppression. Intersectional subordination is often the consequence of one burden interacting with existing vulnerabilities to create a new dimension of disempowerment" (Crenshaw 1991) Yakin Ertürk, the former UN Rapporteur on VAW, uses the concept of intersectionality in her 2005 report on Guatemala when she states 'Women's exposure to violence is related to their position in the multiple systems of inequality and shows a tendency to increase as these systems intersect, creating layers of discrimination and exclusion for different groups of women'.

Debates around Definitions

The authors of the CAWN Report trace the debates around the term "gender-based violence"(GBV). They point out that scholars object to equating GBV with VAW - the reality is that women and girls constitute the vast majority of GBV victims and men the majority of perpetrators. They advocate that the unambiguous use of the term "violence against women" would expose governments' failure to address power inequalities between men and women in both the public and private spheres. The report clarifies that GBV and VAW are not synonymous and that the UN Declaration on the Elimination of Violence against Women (1993) approaches VAW as a "sub-category" of GBV. Other scholars cited in the report stress the relevance of "gendered violence" in their reflection on masculinities (e.g. Jacobson et al. 2000 cited in CAWN 2010)). Marcela Lagarde's use of the term "gender-based violence against women" highlights the significance of gender difference in the set of sexual, social, economic, judicial, political and cultural factors which determine men's domination of women.

Male scholars cited in the report (Andrés Montero 2004) offer their insights based on how masculinities act to perpetuate violence against women. Montero refers to male-based violence *(violencia de géneromasculino)* to specify that it is violence against women perpetrated exclusively by men; while Bonino Méndez speaks of "masculine VAW" (Luis Bonino Méndez 1998) and Patrick Welsh (2010) writes of machista violence against women and "intrageneric violence" to problematise the social construction of masculine identity as embedded in relations of domination and violence.

Lesbian women's organisations such as Cattrachas in Honduras, argue that the term "gender- based violence" masks heterosexism, by assuming that there are only two genders—masculine and feminine. The term "gender-based violence" invisibilises that neither of the two genders illustrate the lesbian existence or give a full account of the heterosexist oppression experienced by lesbian women, an oppression intensified by the dominant notion of the family as a nuclear and heterosexual institution. Cattrachasuses "genders" and "violences" to embrace

the plurality of gender realities informing VAW in Central America. These violences, they insist, are the product of both patriarchal ideology and heterosexist supremacy.

Scholars and researchers working with indigenous and Afro-descendant women in Central America also suggest that violence should be referred to in the plural, since indigenous people and Afro descendant women have historically endured intersecting violences both as individuals and collectively, as peoples (IximuleuChnab'jul 2008: 12(CAWN 2010)). They state that a feminist standpoint should incorporate gender along with race, sexuality as variables driving these intersecting violences.

Intersecting Violences in the Asia Pacific Region

Caste Based Violence Against Women

Positioned at the bottom of caste, class and gender hierarchies, Dalit women experience endemic gender-and-caste discrimination and violence. Their socio-economic vulnerability and lack of political voice, when combined with the dominant risk factors of being Dalit and female, increase their exposure to potentially violent situations ('Violence against Dalit Women' 2015) Caste-based discrimination exists in many countries across the world including in Nepal, Bangladesh, Pakistan and Sri Lanka. Violence against Dalit women and girls is used as a tool by the dominant communities to shame the Dalit communities. Prominent forms of violence on Dalit women and girls that are reported are rapes, gang rapes, murder, mass attacks in most caste-affected countries in South Asia. While certain patterns and forms of caste-based violence against Dalit women are similar in the caste-affected countries, certain others are more prominent in some of these countries. "Stripping and parading naked and forced temple prostitution in India are forms of violence against Dalit women particular to India. Forced conversion of Dalit girls in Pakistan is a pattern of violence against Dalit women which is unique in that given context", analyses ManjulaPradeep, a leading Dalit feminist in India ("CASTE-BASED VIOLENCE AGAINST WOMEN THE ROLE OF THE UN IN COMBATTING CASTE-BASED VIOLENCE AND DISCRIMINATION" 2014). The challenges faced by Dalit women in Nepal including poverty, violence, rape, caste-based slavery and forced prostitution (Durga Sob, President of the Feminist Dalit Organisation in Nepal, ibid).

Although all women in India face discrimination and sexual intimidation, Special Rapporteur on violence against women, Ms. Yakin Ertürk (2009) pointed out that the human rights of Dalit women are violated in peculiar and extreme forms. *"Dalit women are confronted with discrimination, exclusion and violence to a larger extent than men. Land and property issues in particular, tend to cause or be at the root of conflicts over which Dalit women have faced eviction, harassment, physical abuse and assault. Dalit women are often denied access to or are evicted from their land by dominant castes, especially if it borders land belonging to such castes. They are thus forced to live in the outskirts of villages, often on barren land. Reportedly, on many occasions, cases of violence against Dalit women are not registered, and adequate procedures are not taken by the police."* (United Nations 2009)

Religious and philosophical sanctions compound the travails of dalit women by promoting a climate of impunity against atrocities committed on them, despite the presence of progressive legislative measures.

Caste based gender violence also takes the form of honour killings and femicide in countries like India. Upper caste girls choosing to marry lower caste men or men from other religions face the wrath of their families and communities. Women's bodies are the ultimate sites where the bodily injuries are inflicted by male hegemonic power and male privilege and masculinities rise up to protect the honour of the community, to eliminate the body defiled by the action of the girl.

Gender-based Violence Against People with Diverse Gender Identities and Sexual Orientations (SOGIE)

International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) reports that those who challenge sexual or gender norms often confront violence in the "private" sphere of the family. Fear of rejection within the family and the community, results in people leading double lives, making them vulnerable to all kinds of blackmail and extortion. DédéOetomo, Chair of the Asia Pacific Coalition on Male Sexual Health, states, "The family unit is arguably the greatest influence on the lives of LGBTI people, yet acceptance by families is limited by strong cultural pressures." (SIDA 2014). Violence against LGBTI persons is often based on non-conforming gender identity or sexuality. Lesbians with masculine expression and

transgender persons are at risk of being raped. Health care workers and police who are supposed to help are both ignorant about and biased against nonconforming sexuality or gender identity, often subjecting victims to additional harassment. Queer and transgender persons and other gender non-conforming people and communities face hostility, discrimination and abuse in most places.

Lack of reliable data makes it difficult to assess the levels of oppression that LGBTI persons face in various countries in the region. In Cambodia, there are reports of attacks in public places resulting from homophobia. In Laos, it is difficult to assess the current situation of LGBTI citizens, as the government does not encourage surveys on human rights. Several countries in the region still criminalise same-sex relations. The penal codes of Brunei, India, Malaysia, Myanmar and Singapore (section 377) are remnants from their colonial histories.

Gender-based Violence and Ageing Women

This is another area of intersecting violences.

A review of literature on feminist perspective on elderly abuse(Nerenberg 2002)concludes that there have not been any systematic attempts to develop a feminist analysis of elder abuse. Several reasons are offered to understand this —that because elder abuse is also perpetrated by women on other women, and this contradicts the understanding of violence against women (that this results from gender based power inequalities), older women's abuse has been neglected. Also ageist attitudes within the women's movement have led to the neglect of this agenda. It is suggested that the traditional response to elder abuse—essentially a political problem—has remained individualised or private. Discrimination and disadvantage due to gender as well as age combine to compromise older women's ability to achieve or maintain self-sufficiency and push them towards isolation and marginalisation.

In recent years some amount of literature is emerging on the issue, largely from organisations like Helpage, or social policy groups concerned about the elderly. A common refrain in much of this literature is that there is a lack of data on the prevalence of elder abuse, primarily because surveys are not set up to capture this information. More research, debate and analysis is needed to analyse the economic, social and political status of elderly women as well as to see how ageism and sexism contribute to their abuse.

3.2.6 Motherhood

The feminist analysis on Motherhood has evolved through the historical waves described in Part 1. Neyer and Bernardi (2011) present a succinct historical analysis of motherhood as a contested feminist concept. They state that this is an issue that split the feminist movement down the centre. On the one hand some feminists posited motherhood as a common experience that had the potential to bring half of humanity together and could serve to unite them to claim rights for women related to motherhood. Other feminists expressed that motherhood denied women rights to equality. They rejected motherhood on the grounds that it perpetuated women's insubordination. Simone de Beauvoir was one of the early proponents of this viewpoint(Beauvoir 1949). She pointed out that right from childhood, women are made to see motherhood as the essence of their lives and fulfilment of their destiny. Such pervasive socialisation shapes women's desire to 'choose' motherhood. Other feminists like Adrienne Rich (Of Woman Born) agree with her position and maintained that maternity was a means to relegate women to an inferior social and economic status. Patriarchal construction of womanhood, they felt, projected childbearing and motherhood as the core of a woman's nature. The origins of this argument lie around the biological features, essentialising women's bodies. Feminists in the United Kingdom, North America, and Europe began to challenge the overemphasis on fertility, and refuting the assumption of motherhood as innate to women.

They insisted that the link between childbearing and childrearing is socially manipulative and serves to exclude women from other productive roles ("Motherhood and Maternity – Feminist Critiques" n.d.)These feminists pointed out that linking maternity with women's 'nature' conflates biological and social motherhood, whereas a distinction between biological and social motherhood is critical—social motherhood to be understood as all care work done by women including rearing of children. Failure to distinguish between the two, only serves to perpetuate the idealisation of 'mother's natural love' which is the basis of the woman's 'natural' responsibility to care for children, thereby legitimising women's subordination (Neyer and Bernardi 2011b).

Radical, Marxist and colonial feminist discourse linked motherhood to patriarchy, capitalism and colonialism. For example, production, a concept central to capitalism,

excluded biological and social motherhood. These were seen as 'reproduction'. Feminists, on the other hand, stated that biological and social motherhood were specific forms of production that complemented and maintained modes of capitalist, patriarchal and colonial production and the hierarchical power structures inherent in them. They argued that relegation of women and motherhood to the unproductive sphere of reproduction allowed men control over women's lives, their reproduction, children and work and allowed them to exploit women for private, economic, political, demographic, nationalistic and other purposes (Neyer and Bernardi 2011a) If women became mothers within these systems, they had to comply with the rules which exploited their maternity. Choosing not to have children was seen as a way of resisting these exploitative systems.

Linking maternity to gender, racial, economic and social structures also challenged the notion of motherhood as one universal concept. It was recognised that motherhood was experienced differently by different classes and categories of women—single mothers, step mothers, mothers of different ethnic, racial and national backgrounds. (In fact, certain women in many of our societies are still not allowed motherhood—sex workers, women living with disabilities or with HIV, are clear examples). These women faced additional discrimination and exploitation. They were denied the legal and welfare measures available to 'normal' mothers—married, white, national women.

The ideal family, which is considered as the norm, is one in which the mother is a heterosexual, white female who is wife to a wage-earning white-male father and who is responsible for the care of her biological children. The 'good' mother in this ideal family is the primary caregiver, remaining within the feminine private sphere and leaving the public world of work, the masculine, to the man. The 'good' mother is responsible for the physical care of her children and their emotional and moral development. As a natural mother her duty is to guide future generations to be successful in all their roles—as individuals, workers, and citizens. It is against this ideal of the 'good' mother that racialized images of the 'bad' mother are constructed (Thompson 2006).

Deficiency in mothering is an ideological construct of minority African American motherhood that developed in the US. Minority women, including African-American women and other women of colour, are frequently presented in these discussions as 'bad' mothers, women whose patterns of mothering deviate in significant ways from those of 'good' mothers in ideal families.The main point of deviation was that they 'abandoned their families' while they went out to earn. Enslaved African American women who were forced to sell their labour, and the migrant Latina women, within the capitalist framework, were breaking the rules by being in male spaces and away from their families. Against the idealized criteria of the public/private split these women are immediately found to be deficient both as workers and as mothers (Thompson 2016).

Post modern, post structuralist feminist approaches thus began to conceive that just as there was no fixed category of women, there was no fixed category of 'mothers'.

Being a mother began to be seen as one of the many identities of women and equal to other identities. This then opened up the possibility of diversity of self defined notions of motherhood, of positive identification with maternity. Motherhood therefore did not imply insubordination. Rather, there was a possibility of agency and choice associated the concept. For example, Adrienne Rich made a distinction between motherhood as a patriarchal institution and mothering as a woman's potential relationship to her powers of reproduction and children. Post structural feminists no longer rebuffed motherhood to overcome power structures. They in fact sought the means to overcome power structures to allow for motherhood. They sought to change systems and structures to facilitate parenthood—not simply motherhood—and to reach equality, as highlighted by other feminist literature on welfare state, citizenship and social rights. The postmodern, post structuralist discourse allowed for the notion of 'motherhoods' to embrace the plurality of experiences.

Within the changing economic contexts, women looked for ways to combine wage work and care work (Boyer 2014).

Eugenics and Motherhood, Motherhood and Race

Patriarchy has also valorised Motherhood as a responsibility towards building a nation or perpetuating a race. Instances of this could be seen in the US history from the Reconstruction through the Progressive Era—African-American and white women were urged to view motherhood as a national racial imperative. Similarly, feminists from South Africa point out how nationalist and patriarchal causes appropriated the African-woman as-

mother. The African mother has been projected as one with qualities of nurturance, protectiveness, and altruism, qualities that are believed to make them morally and culturally superior to Western women ("Motherhood and Maternity – Feminist Critiques" n.d.)

In the current divisive politics in many countries in South Asia (for example, India), right wing political forces are urging women of different communities, to 'go forth and multiply' lest their community be overtaken by other groups.

Liberating Motherhood

Acknowledging that mothers are at a higher risk of poverty, financial mercy of the partner and therefore vulnerable, feminists like Vanessa Olorenshaw (Olorenshaw Vanessa 2016) sought to find creative ways to protect, support and empower women who wanted to care for their children, who did not want to be liberated from caring for their children. They suggested that women needed to be viewed beyond the binaries—women trapped by markets as workers, or women as unpaid carers. The terms of engagement had to change from Motherhood vs Feminism to Motherhood and Feminism. They spoke about 'mothering on our own terms', 'liberating motherhood from patriarchal, neoliberal, capitalist constraints' so that mothers can enjoy economic autonomy and self-determination. Some of the creative solutions that emerged were—fathers as equal if not primary care givers, cooperative day care arrangements, extended families, family–friendly work arrangements such as, parenting in workplaces, flexible work force, cooperative housing ("Motherhood AND Feminism" 2012).

Motherhood in the Era of Assisted Reproductive Technologies (ARTs)

How have ARTs impacted the notions of motherhood? The last four decades since the emergence of ARTs have seen many debates and controversies (Neyer and Bernardi 2011a). There is a section of feminists who welcomed ARTs because they promised possibilities of motherhood and parenthood to groups who were deprived of these experiences—women unable to conceive, men and women with health problems who could not bear their own children, gays, lesbians, transsexuals, single women, women beyond menopause. Others felt that ARTs expanded women's reproductive choices—women would not have to worry about their biological clocks and could decide to have children at their own pace. Women (and commissioning parents) could also have 'designer' babies—choose the sex of the baby, the desired physical, and other, characteristics. Early feminist arguments also supported ARTs because these would free women from the 'tyranny of biology' and provide an alternative to the oppressive structures of the biological family (Firestone 1970).

The terms of engagement had to change from Motherhood vs Feminism to Motherhood and Feminism. They spoke about 'mothering on our own terms', 'liberating motherhood from patriarchal, neoliberal, capitalist constraints' so that mothers can enjoy economic autonomy and self-determination.

On the other hand, feminists opposing ARTs pointed out that ARTs resulted in devaluing motherhood and women (FINNRAGE-UBINIG 1989). ARTs disembodied women and made biological motherhood redundant and placed reproduction of human beings and humanity in the hands of medicine and technology. Fracturing of motherhood was the result—ARTs reduced motherhood to biological motherhood, depriving the biological mother of social motherhood, of caring for the child. Reproductive technologies contributed to further deconstruction of biological motherhood—mothers became ovarian mothers, or uterine mothers, depending on which part of their reproductive system was being used.

While on the one hand, liberal and post-modern feminists acknowledged that ARTs afforded women with infertility new opportunities to experience motherhood, a counter argument was that—are ARTs becoming an instrument of patriarchy and promoting the ideal of biological motherhood as a woman's destiny? Are ARTs creating a new pressure for women to experience motherhood at all costs? Are ARTs also creating a eugenics obligation towards families and society?

Surrogacy and reproductive technologies resulted in creating further cleavages amongst women, unequal relationships of power between those who could pay to hire wombs or ovaries—the social mothers—and those who offered their reproductive labour often at much lower costs than the value of services provided, the biological mothers. Surrogacy has also been compared to prostitution because

the woman's body, or part of it, is traded for money. Parallels are also drawn between trafficking and surrogacy in that human eggs and surrogate mothers are being trafficked. ARTs are considered to strengthen the economic and racial exploitation of the poor women who sell their reproductive labour and the better off men and women who hire them.

Legally too the surrogates have no rights over the eggs or the offspring once born. In fact even during pregnancy they have to surrender all control over their bodies—the embryo has all the rights!

3.2.7 Technologies, Women's Bodies, and Feminist Perspectives

There have been many debates around Technologies and Women's Bodies in feminist literature. While on the one hand, in principle, there is an appreciation of women's right to the benefits of scientific progress, feminist have expressed much concern about how scientific and technological developments, neo liberal contexts and patriarchal structures and mindsets have combined to play out on women's bodies. These technologies have resulted in fragmentation of women's bodies and medicalisation of normal physiological processes like pregnancy, premenstrual syndrome and menopause—these are increasingly viewed as diseases that need to be treated with medical cures. Feminists have raised ethical and moral issues. We will try and highlight some of the debates in this section.

Reading through the literature, we find that the technologies around women's bodies, mainly around reproduction, can be categorised into a) Contraceptives, b) Hormone Replacement Therapy, c) Assisted Reproductive Technologies, d) Fertility Preservation. There is another interesting category that emerges i.e.the 'beauty technologies' involving cosmetic surgeries.

Contraceptive Technologies

This topic has been discussed in an earlier section. Here, we are looking at Contraceptives through the lens of Technologies.

Temporary and permanent methods of birth control —Intrauterine devices, oral pills, surgical sterilisation procedures have been reproductive technologies that have to an extent liberated women from the burden of unintended pregnancies. The issues that feminists have raised are around new reproductive technologies—their safety, and the ways they have been tested. Long acting contraceptives like the injectables and Norplant have been tested in countries like India without informed consent of women, and without adequate follow up. In a seminal article, Anita Hardon(1994) highlighted that the way contraceptives are developed, tested and distributed have resulted in controlling women's fertility and harming their health rather than meeting their reproductive needs(Hardon 1994). Many technologies depend on medical personnel for administration and removal thereby reducing women's control over their own bodies and increasing the potential for abuse. Feminists have long argued for technology which is appropriate, safe and under women's control. Others have said that evaluation of the comparative safety of different contraceptive methods has to take into consideration three important attributes of method: effectiveness, non-contraceptive health benefits, and the health hazards associated with use (Fathalla M.F. 1987).

An example of the way contraceptive technology was abused was the unethical use of Quinacrine, a sclerosing agent and an anti-malarial, as a non-surgical, a chemical sterilisation method. In India, following the protests and sustained action by feminist groups, the Supreme Court delivered a judgement in 1998, in response to a Public Interest Litigation, banning the use of Quinacrine for sterilisations. Safety of Quinacrine had not been established. The short term effect of this method of sterilization was that it was highly painful and was known to cause extreme body ache, dizziness, painful periods, irregular bleedings, etc. There was evidence that it resulted in ectopic pregnancies and could trigger cancer. (Rao 2006)

Another consistent demand that feminists have been making is for more participation by men in fertility regulation. Male contraceptive methods like vasectomy, withdrawal, and condoms account for at least 30% of total contraceptive usage in the world today (Wu 1996). More sustained research efforts are required for male methods for contraception. Researchers have been publishing on the issue of male contraception. The point being made is that while young men are willing to participate in family planning by taking full control of their fertility, research on male contraceptives has been tough because of the complicated male reproductive system (Tulsiani and Abou-Haila 2014). It appears that it is easier to control the monthly ovulation of women than to regulate the millions of spermatozoa produced in men

every day. Wu also points out that there is an increasing gap between fundamental research on regulation of sperms and the lack of clinical application because of low public funding priority afforded to male reproduction and the unwillingness of the pharmaceutical industry to invest in male reproductive research and development (Wu 1996).

Medicalising of Menopause and Hormone Replacement Therapy

There is a very interesting story around how menopause came to be termed as a 'deficiency disease'. A prominent Brooklyn gynaecologist, Robert A. Wilson and head of the Wilson Foundation, in the 1960s became a crusader for the use of estrogento prevent breast and genital cancer and 'problems of ageing' (Harris 2013). The Wilson Foundation was supported by multi million dollar grants from the pharmaceutical industry! And the Foundation's mandate seemed to be to promote estrogens. Wilson projected menopause as a hormone deficiency disease similar to diabetes and thyroid dysfunction and advocated for large scale routine administration of Estrogen Replacement Therapy (ERT). 'A year later, Robert Wilson published another article in the Journal of the American Geriatrics Society (1963), with his wife Thelma Wilson. In this article he advocated that women be given estrogens from "puberty to the grave" (Wilson & Wilson, 1963, p. 347). Wilson then published Feminine Forever (1966), claiming HRT/HT as life saving for all women' (Harris 2013). Wilson's use of sexist images of women's bodies to show women that they could look younger and beautiful also contributed to women's decisions to medicate themselves. All of this led to the widespread acceptance of the disease model of menopause, obliterating all other dimensions of the phenomenon such as the mind, body interactions and the role of the context. The biomedical paradigm thus led to devaluing ageing women.

Medicalisation and pathologisation of menopause resulted in search for solutions in terms of medicines. Diethylstilbestrol (DES) was used for regulation of menopause, or what was called 'hormonalization' of women. DES as a 'treatment' for menopause was disputed medically. It was also supposed to be a medicine prescribed to pregnant women to prevent miscarriages. And it resulted in teratrogenic effects - girls born of those pregnancies were found to be at greater risk of vaginal and cervical cancer and the boys at greater risk of genital abnormalities (Harris 2013) and increasing mothers' risks of breast cancer.

Other effects of Hormone Replacement Therapy (estrogen plus progestin HRT) began to emerge, for example, endometrial cancer. But pharmaceutical industry continued to find new reasons to promote HRT—ostopenia or low bone density became the next reason for prescribing HRT to menopausal women. (Krieger et al. 2005) questioned all of this—why, for four decades, since the mid-1960s, were millions of women prescribed powerful pharmacological agents already shown, three decades earlier, to be carcinogenic? Authors point to the political clout of big pharmaceutical companies who had access to women through their physicians, and researchers who were cultivated and nurtured through sponsorships to conferences, funding of training and research. Pharmaceutical industry also sponsored ethnographic research on opinion leaders to promote the acceptance of the notion of menopause as a deficiency disease treatable by HRT. And as the population aged, the market expanded, with women who did not want to look old and ugly or want to experience loss of sexuality. While these were the class of women who could afford the HRT and the beauty treatments to prevent and counter anti aging, they set the standards and aspirations for others less fortunate working class women.

All of this led to the widespread acceptance of the disease model of menopause, obliterating all other dimensions of the phenomenon such as the mind, body interactions and the role of the context.

Assisted Reproductive Technologies

Assisted Reproductive Technologies of ARTs were a response to Infertility. Historically, till the 1970s infertility was seen as a psychosomatic problem not amenable to medical intervention. However, the current medical literature defines infertility in a clinical manner, a result of proximate causes like pelvic scarring, endometriosis, low sperm count and the like. Infertility is also attributed to the postponement of childbearing until the thirties and to sexually transmitted diseases, which cause pelvic scarring (Khatamee 1988, cited in Strickler 1992). Medical literature generally fails to discuss non biological dimensions of infertility—effects on the marriage, family relationships, career, or other aspects of everyday life. The consequences of infertility are guilt, shame and loss of self esteem amongst women, of not being able to live upto the societal

prescription of being a biological mother. Within the family it may lead to psychological abuse, torture, physical violence and even desertion. The blame of infertility is invariably on women, with men's abilities never being questioned. The changes in how infertility is approached is probably due to technological advances which have made medical treatment possible, and to obstetricians in search of new markets for their service (Scritchfield 1989 cited in Strickler 1992). The response to infertility is medical intervention with the goal of pregnancy—the goal of infertility specialists is to enable couples to have their own biological children. Socially oriented alternatives like adoption that can provide a new life to abandoned babies and be a more ecologically and psychologically sound solution, are not the suggested solution for infertility any more.

IVF or in vitro fertilisation and IUI or intrauterine insemination are now being emphasised, while the earlier infertility treatment would seek to address the immediate cause of the problem (for example, removing adhesions). IVF entails laproscopic procedures to collect matured oocytes (eggs) from a woman's ovary, fertilising them in a test-tube with a collected sperm specimen and inserting the resulting embryo(s) into the woman's uterus. Note that the old technology of laproscopy came to be used not only for sterilisation but also for advanced procedures like egg extraction. In IUI or artificial insemination, a catheter is used to place sperm directly into the uterus near the egg at the time of ovulation. The sperm first goes through a laboratory procedure to remove sluggish sperm and retain only fast-moving sperm in order to increase the number of sperm that reach the egg, which increases the chances of conceiving. This procedure is often combined with one or more fertility drugs. The cost of IUI method is much lower than IVF. The point however is how much of this information is actually given to the women and families in ways that can help them to make informed decisions.

Harvesting of the ova (denotes a very mechanical approach towards ART procedures) entails repeated cycles of hormonal treatments for the woman with super-ovulation drugs invented to produce more eggs than usual. This treatment can cause hormonal imbalances over a long time and harm women's bodies in unforeseen ways (Strickler 1992).

IVF has been hotly debated amongst many different constituencies. The Catholic Church referring to the discarding of unused embryos, called this a 'sophisticated form of abortion' (Kalinowska 2017)Secular critics were also concerned about the moral status of the embryo —since it has the potential to become a human being. Secular critics were divided into three categories—full protectionists—'the early embryo created through IVF is a human with potential future sentience whom it is wrong to 'kill' ', modified protectionists—'the early embryo does not have moral status but that the more developed zygote or fetus does', and non–protectionists—'a human does not have moral status before birth'(Kalinowska 2017). The USA Ethics Advisory Board stated that IVF was only permissible for married couples—'a man had to be involved. Clearly, the concern over the coercion of women was there, but so was the importance of her being bound to and protected by men: her husband, the researchers, and the government Ethics Board' (Kalinowska 2017). Other critics of IVF felt that the procedure is a wasteful use of taxpayer money with uncertain results of around a ten percent success rate on the first round. Ova trafficking and commercial trade in ova also became a concern. In 2002 there were reports in some women's magazines that women students were selling their oocyte to infertility patients for around USD 3000 (Kalinowska 2017). In India a popular Bollywood film Vicky Donor visibilised the eugenics aspects of commercial sperm 'donation' (?) as a basis of a physician's roaring infertility treatment practice. Feminist also pointed out the dichotomy around those who sell their eggs being regarded as criminals or compared with sex workers while non-commercial egg donor being considered almost sacred (Paik 2006 cited in (Leem and Park 2008)).

Feminists are concerned about the gender power relations surrounding a woman's decision to seek solutions for infertility and undergo IVF. What happens within herself (not being able to live upto the standards of an 'ideal woman', a biological mother), within her relationship with her husband/partner and her family/families (the lack of sympathy and blame is perhaps greater from the husband's family), and the consequent pressures, are of concern to feminists.

And also the gender power dynamics vis a vis the medical system which perhaps accentuate her already vulnerable situation. Feminist proponents of IVF/IUI view the technology as a tool that 'gives women further control over their reproductive capacity: women have the ultimate power over whether a child will be born, whether if it will be genetically theirs, and whether the relevant risks are worth this child's birth' (Kalinowska 2017). Feminist critics of IVF/IUI worry whether women are really making 'informed choices'—are women informed and aware

of the associated risks of IVF/IUI—the physical pain of laparoscopy, the uncertainty of the results, and the time and money spent for undergoing at least two two-week IVF/IUI cycles? They cite concerns about the murky consent procedures and the stance of 'IVF as the only hope for their problem' (Kalinowska 2017).

The discussions and debates on IVF are further complicated by the phenomenon of Surrogacy, in which wombs are hired to gestate the embryo resulting from IVF. Commercial surrogacy the surrogate mother receives compensation for carrying the child and often there will be a mediating party, a surrogacy agency that deals with all the practical arrangements for the commissioning couple) has been banned in many countries while altruistic surrogacy (pre- established bond between the surrogate mother and the expecting couple) is allowed. One viewpoint is that women and their wombs are not commodities to be hired and purchased for gestational purposes - like the oocytes' debate. Other opinions are – 'Surrogacy is like prostitution', it is a 'form of alienated labour', 'it turns babies into commodities', 'aren't there enough babies in the world needing adoption?', 'surrogacy is for the wealthy', 'it exploits third women and makes powerless women into baby producing machines' ( ), surrogacy promotes 'fertility tourism'. Several ethical issues have been raised about the identity and the relationship of the baby with the gestational mother, the commissioning parents, what happens to the baby if the parents divorce (as happened in the case of baby Manji, Box 14, (Darnovsky 2009) and so on. The section on Motherhood also discusses the implications of ARTs on the concept of Motherhood.

So the right to choose of Yuki and Ikufumi was fulfilled in this case. They chose to use technology and the option of Assisted Reproduction and Surrogacy to overcome their infertility. The surrogate's right to exercise her reproductive right over her body, through her decision to rent her uterus, is also seen in this case. However, the complications of divorce were not foreseen at the time of drafting the contract and several legal and ethical issues arose.

BOX 14: BABY MANJI

Japanese couple Ikufumi and Yuki Yamada travelled to India in late 2007 to discuss with fertility specialist Dr. Nayna Patel their desire to hire a surrogate mother to bear a child for them. The doctor arranged a surrogacy contract with Pritiben Mehta, a married Indian woman with children. Dr. Patel supervised the creation of an embryo from Ikufumi Yamada's sperm and an egg harvested from an anonymous Indian woman. The embryo was then implanted into Mehta's womb.

In June 2008, the Yamadas divorced, and a month later Baby Manji was born to the surrogate mother. Although Ikufami wanted to raise the child, his ex-wife did not. Suddenly, Baby Manji had three mothers—the intended mother who had contracted for the surrogacy, the egg donor, and the gestational surrogate—yet legally she had none.

The surrogacy contract did not cover a situation such as this. Nor did any existing laws help to clarify the matter. Both the parentage and the nationality of Baby Manji were impossible to determine under existing definitions of family and citizenship under Indian and Japanese law. The situation soon grew into a legal and diplomatic crisis. The case of Baby Manji illustrates the complexity and challenges faced by institutions in the face of emerging technologies.

SOURCE: Points n.d.

Fertility Preservation

The removal, cryopreservation and subsequent storage of reproductive materials for future use is termed as Fertility preservation (FP). A related term is New Reproductive Technologies (NRT) which includes stem cell preservation and umbilical cord preservation. The aim of all these technologies is to provide an option for future genetic reproduction. The FP technologies emerged in the context of cancer treatments which sometimes result in infertility. While many FP technologies continue to be experimental, some technologies are becoming available to healthy women who decide to have babies later in life as a guard against age-related infertility. These FP technologies are expanding women's reproductive options and benefitting individual women by satisfying their desires for genetically-related children. But these technologies pose numerous physical, emotional and financial risks to women. It is therefore necessary to do a feminist examination of choice for the ethical provision of FP technologies within patriarchal contexts.

In her thesis on a feminist ethical analysis of Fertility preservation, Petropanagos (Petropanagos 2013)speaks about two oppressive social biases: namely, pronatalism and biologism. Both these she feels unduly influence women's reproductive choices. She defines pronatalism as 'a coercive social bias, which grounds women's identities on their reproductive roles and mandates that women bear men's genetic children'. Biologism, on the other hand she says is 'a coercive social bias that privileges genetic relationships within families over non-genetic relationships, and grounds familial and individual identity on genetic heritage'. Biologism according to her can help to explain why some patients pursue risky FP technologies despite the availability of other reproductive and family-building options—biologism coerces some people to choose assisted reproduction over adoption. Through her dissertation she shows that a feminist analysis of choices around are Fertility Preservation is fundamental to ethical provision of FP technologies.

'Beauty' Technologies

In an interesting paper based in Korea, (Leem and Park 2008) the authors state 'Women's bodies are visible not only in the field of reproductive technologies but also in that of beauty technologies. Korea is known as 'the kingdom of cosmetic surgery' as well as 'the kingdom of the infertility clinic.' They note the growth of cosmetic

surgery industry and dermatology in Korea. They point to the fact that women's bodies have been fragmented and objectified through the development of cosmetic technologies. Cosmetic surgery views women's bodies as 'a set of components such as eyes, noses, lips, chins, breasts, legs, and hips, which can be altered with a knife'. Also in cosmetic dermatology, women's skin is 'a set of biochemical substances such as collagen, melanin, and haemoglobin, which can be regenerated through light-tissue interaction'. Cosmetic technologies are projected and marketed as ways to improve their 'appearance capital', or symbolic/physical capital for self-esteem, and gains in the marriage market, employment and other areas of women's lives. The pressure on women to undergo painful expensive and repeated beauty interventions to maintain an image result in risks accompanying surgery or laser operations are 'compensated for by their outcomes—beautiful bodies, which make women better commodities'.

Feminist Perspectives

Feminists highlight the dichotomies between victim and choice, between objectification and agency, and between anti-technology and pro-technology. They point out that choices or decisions are always made in situations that can never be free from all structural or ideological constraints. The point has been made that 'because biomedical technologies were able to visualize, measure, and literally fragment their bodies, those women could exercise their power to dispose of their material bodies'. Thus, women exercised their agency through the use of reproductive technologies, within contexts that objectified them (Leem and Park 2008) Feminists have opposed objectification of women's bodies - bodies are biological objects, one aspect of women's wholeness. Biotechnologies including reproductive and cosmetic technologies, which are very much a part of women's social context, have both fragmented and reconstructed women's bodies. This has resulted in their bodies becoming ever more visible, but in ways that their bodies as social entities, became disguised. 'In the public domain, women as a social minority have not yet gained their autonomy while their bodies are used as scientific materials, national resources, and capitalistic goods' (Leem and Park 2008).

As stated above, feminists have criticised the increasing medicalisation and commodification of reproduction. Reproductive technologies they feel are a form of medical interference with women's bodies. They see a qualitative difference between infertility treatment, which 'needs to be recognized as an issue of self-determination' (Rothman 1989 cited in Strickler 1992) and include psycho social and gender aspects, and the new procreative technologies, which threaten women's role in procreation (Corea 1985, Rothman 1989 cited in Strickler 1992). While appreciating that IVF can help some women who are unable to conceive, feminists assert that this technology harms women as a collective group, as a class, more than it helps them. Conception through IVF and surrogacy transfers reproductive control from women to physicians. Women lose control over conception, as well as gestation and IVF pregnancies are very closely monitored by physicians, and are more likely to be delivered by Caesarian section (Cohen, Mayaux and Guihard-Moscato 1988 cited in Strickler Jennifer 1992). While the individual women who undergo the procedure may appreciate the availability of medical resources to fulfil their reproductive aspirations, the concern is all of this will legitimise increasing medical involvement in

'natural' pregnancies—the potential routinisation of in vitro fertilisation, following the examples of Caesarean section, ultrasound and foetal monitoring, all of which started out as responses to particular conditions and have become routine procedures (Rothman 1984 cited in Strickler Jennifer 1992).

Jennifer Strickler (1992) cites Robyn Rowland:

> *For feminists, these new techniques mean rethinking our attitudes toward motherhood, pregnancy, and most important, the relationship between an individual's right to exercise choice with respect to motherhood and the necessity for women to ensure that those individual choices do not disadvantage women as a social group . . . Increased technological intervention into the processes by which women conceive is increasing the male-dominated medical profession's control of procreation and will lead inevitably to greater social control of women by men* (1987:513,524).

Feminists define the problem not as a woman's inability to bear children (this is an individual and not a social problem) but as a structural problem which reinforce the necessity of childbearing as a fulfilment of womanhood as prescribed by society on one hand, and physicians' increasing power over facilitating and managing procreation, on the other. Feminists state that Reproductive Technologies are a product of the male reality. They embody typical male values of objectification, domination and exercise male power over women (Strickler 1992).

Feminist are concerned about enhancing women's control over their own lives and their bodies and increasing their autonomy through widening their choices. Motherhood as a concept is contentious as far as feminists are concerned but they do agree that technologies that are related to motherhood define it narrowly and transfer the control from the woman to the physician.

Conclusion

In this section we saw how patriarchy, neo liberal capitalist contexts, medical advancements interact to perpetuate notions of biological motherhood, of women as objects, to fragment women's bodies, increase the control of medical powers over women's lives and their bodies. Increasing choices for individual women leads to harm the interests of women as a social class. In the next final section, we carry our analysis forward—applying a feminist lens to create a framework that can help us to examine certain contentious issues like sex work, pornography, cosmetic surgery, motherhood and assisted reproductive technologies, to name a few.

3.2.8 Prostitution or Sex Work

Prostitution or Sex Work is often referred to as the 'oldest profession'. And continues to be an emotive subject. Modern sex work has been categorised in many ways—street based, brothel based or as escorts. Sex workers are also categorised into many types—those engaged as a street-based prostitute, stripper, escort, pornographic actor, as a masseur in a massage parlour, therapeutic sexual surrogate for physically challenged clients, or any other type of sex

work including phone sex. While the gender diversity amongst sex workers is recognised, much of the feminist discourse around sex work centres on female sex workers. A study in the UK based on data from more than 27,000 individuals advertising commercial sex services online ("Debates around Sex Industry Based on 'Sexist Stereotypes', Says Report |" 2015) shows that more than one in three escorts self-identify as male or trans, less than half of escorts self identify as straight, their ages range from 18 to 91 years, two-thirds of escorts advertise to women, 40% advertise to disabled clients.

History of Prostitution Across Cultures

As the 'oldest profession' prostitution—and its varied forms—has existed across several cultures and across the earliest time periods. In ancient Greek and Roman cultures, emperors and nobility nurtured women as entertainers. Women were also present in ancient temples as serving the deities and the priests. In many contexts they were considered as pillars of society (D. Kelly 2014).

Although in those earliest years, Devadasis enjoyed high respect and social standing, in effect with the passage of time, Devadasis became temple prostitutes and ended up as beggars once their utility as temple handmaidens was outlived. The Devadasi system has been outlawed since 1924 by the British Government and subsequently by several state laws (Srinivasan 1985). Auletrides in Greece, Courtesans in Northern India, *Geishas* in Japan were another category of women entertainers and hostesses. Auletrides were flute, harp and lyre players and dancers in ancient Greece. They were also jugglers, fencers and acrobats who performed in religious ceremonies and

festivals. Sometimes they were reserved for private parties for their sexual talents. Courtesans and *Tawaifs* in the Mughal era were similarly performing artists in Northern India. They were accomplished in poetry, music and dance and enjoyed the patronage of princes and kings. They could also have formal relationships with their patrons but were not their wives. Wives and Courtesans could co-exist. *Geishas* in Japan were hostesses who entertained through their music and dance. *Oiran* in Japan were highest ranked prostitutes. *Ganikas* in India enjoyed high standing and were considered as good luck charms who brought prosperity and enjoyed a place of honour in royal courts and were protected by state laws. They were known for their sexual talents and performing arts (Kelly 2014).

There was also state sponsored prostitution. As early as 100 BC, Ying Chi in China were prostitutes recruited to accompany the armies. Government run brothels deployed widows of soldiers killed in wars to provide sexual services to the soldiers. 'Comfort women' of Korea in World War II were similarly recruited for 'comfort stations' for Japanese soldiers. Between 1932 an 1945, as many as 200,000 women were shipped to Japanese brothels for Japanese military. Girls as old as 11 years were forced to serve between 50 and 100 soldiers a day. Many died. By the end of the war, about 25 to 30% survived to tell their stories. The Japanese government apologised for the horrors inflicted on Chinese, Korean, Filipina, and Taiwanese women by the Imperialist army (Goldfarb 2018).

Some Definitions and Clarity of Terms

Prostitution and Sex Work.

Different positions have been taken around Sex Work. There are the abolitionists who argue that prostitution is always exploitative sexual slavery and that all prostitution is a result of trafficking. Most women are forced into prostitution by coercion or economic need. They are driven to it by structural violence, and systemic ways in which social structures harm or disadvantage individuals. Abolitionist feminists hold that sex work often amounts to bought rape and that prostitution is degrading to women. They become objects or merchandise to be bought, sold and abused. Abolitionists further believe that prostitution is morally wrong and sex as a financial transaction devalues normal human relationships, marriage and the family. They continue to use the term prostitution, refusing to accord this profession the status of 'work'. Their position is that keeping sex trade illegal is key to safeguarding the sanctity of society's basic values.

Sex Work was a term coined by sex workers themselves. Carol Leigh (AKA 'the Scarlet Harlot') who first used the term 'sex worker' in the late 80s, writing 'the usage of the term 'sex work' marks the beginning of a movement...It acknowledges the work we do rather than defines us by our status.' Since then, numerous sex worker rights groups have campaigned to replace 'prostitute' with 'sex worker' (Lister 2017).

Sex Work and Trafficking.

Sex work is commonly conflated with trafficking. The UN Protocol on Trafficking 2000, called the Palermo Protocol (UNODC n.d.) defines trafficking as 'recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.' There are three important dimensions in this definition: the criminal act of recruiting, harbouring etc; the use of force or threat to achieve consent; and the goal—sexual exploitation, forced labour, slavery etc. Sex work, on the other hand, maintain a group of "sex-positive" or "sex-radical" feminists (Ahmed 2011), is sex performed as work by consenting adults who are exercising their sexual liberation and self- determination—it is a personal choice and not a violation of human rights (Ahmed 2011).

There is another confusion that needs to be sorted out—the one between trafficking and migration (George, Ray, and U Vindhya 2010). Migration is movement of individuals in search of work. Migration could be driven by external factors—conflict/drought/social exclusion etc. This need of work is at times exploited by traffickers and agents. Thus there seems to be a continuum with migration at one end and shades of trafficking at the other. While migration is voluntary and free from any kind of coercion, trafficking as stated above is a crime because of the inherent abuse and violations. Measures to curb trafficking many a times have the potential of violating people's right to freedom of mobility.

Positions Around Sex Work

As stated above, abolitionists argue that prostitution is exploitation, sexual slavery, morally wrong, and should be illegal. Patriarchy is the source of women's oppression. Pateman argues that in historical societies men had ownership over their wives. As an extension of this, 'while men no longer have complete ownership of women in our society, prostitution provides a way for men to exercise ownership over women's bodies temporarily' (Pateman 1999).

Over time abolitionist feminists were joined by evangelical Christians and neo-conservatives with a goal to abolish prostitution. This alliance came to be termed as neo-abolitionists (Ahmed 2011; George, Ray, and U Vindhya 2010).

By the 1980s two new movements emerged to challenge abolitionist feminism. First, sex workers began to organise in several countries and also globally (Ahmed 2011). Women in prostitution began to speak out publicly and form their own interest groups, leading to prostitution movements in various countries. As a result in 1985 there was a World Charter for Prostitutes Rights, the first of its kind. Second, within the feminist groups, there was a shift in thinking about sexuality. These "sex-positive" or "sex-radical" feminists stated that sex is a taboo subject in most societies and women are not supposed to be sexually assertive. These feminists emphasised that just like the right to control our reproduction, the right to control our sexuality is essential to feminism. Following from this logic, they posited that sex workers need not be considered as exploited slaves or projected as victims. Women's agency and power, sex workers' ability to consent must be considered. 'When it is accepted in society that human beings are sexual, and when we are allowed to express and explore our sexuality and sexual desires, sex work will begin to be treated with respect in society'.[10] This line of thinking initiated a split within the feminists, the two groups espousing distinctly different sets of values on sex work. This second group opposing the abolitionists held that view that sex work could be legalised with regulation—their position came to be termed as regulationists and later as other actors joined their ranks, as neo regulationists.

Ahmed points out that the new and radical framing of sex work led to sex-positive feminists becoming allies of sex workers. Feminists and sex workers together started creating an intellectual and practical base for legal reforms governing sex work and they started pushing for decriminalisation of sex work.

Another difference between the abolition feminists and the sex positive feminists was that the former remain focused on female sex workers, and the latter recognised and responded to the needs of a more diverse group of sex workers.

Abolitionist feminists hold that sex work often amounts to bought rape and that prostitution is degrading to women, morally wrong, and sex as a financial transaction devalues normal human relationships. "Sex-positive" or "sex-radical" feminists emphasised that just like the right to control our reproduction, the right to control our sexuality is essential to feminism. They posited that sex workers need not be considered as exploited slaves or projected as victims.

Understanding the Range of Legal Regimes Related to Sex Work

As seen above, feminists typically embrace three positions related to sex work—abolition through criminalisation, legalisation with regulation, and decriminalisation.

The abolitionists advocate for criminalization of all forms of sex work. Criminalisation also comes under two categories—partial and full. According to Ahmed (2011) 'a full criminalization legal regime would include criminal sanctions for sex workers, clients, living off of the earnings of a sex worker, and others involved in the act of soliciting or selling sex.' This is also termed as the prohibitionist approach—criminalisation of all actors and acts would result in abolition of the prostitution. Full criminalisation is supported by conservative or right-leaning individuals and organizations, as well as some abolitionist feminists. Partial criminalisation entails criminalizing the client and others who profit from the sexual exploitation of victims, including those who live off the earnings of the sex worker and not the sex workers themselves. The idea is to stop the demand for sex rather than the supply. Partial criminalisation has been opposed by sex-positive feminists and sex workers on the grounds that it will push sex work underground and into unsafe locations. They argue that sex workers face a danger of exploitation only because of the criminalization and stigmatization of sex work.

Criminalisation also results in them being deprived of the much needed services. Sweden is the best known example of an alternative to full prohibition of prostitution—it criminalises the purchase of sex and makes it punishable by imprisonment. Sex workers in Sweden however state that they face stigmatization and marginalisation (Taylor 2015).

Legalisation and regulation of sex work includes several dimensions: that sex workers register with the government and police, fulfil requirements mandated to protect health —their own as well as clients', practice their profession in designated locations like red light areas that can be controlled by the police and urban authorities in terms of licensing and special taxes (Ahmed 2011). Legalising and regulating prostitution make it safer for sex workers. According to Alexander, prostitution needs the same occupational safety and health regulations offered to workers in other labour industries (Alexander 1998). Sex workers need protection from exploitation by their managers. They ask for: limits on the proportion of their income that managers can take, for workers' benefits like health insurance and sick days, for "clean, safe places to work with the absolute right to refuse to engage in unsafe sex practices" (Alexander, 2007, cited in (Bell 2009)). Sex workers also need protection by law enforcement officers, to enforce laws against physical and sexual assault, kidnapping, extortion and fraud.

Legalisation can thus provide them a protection against the pimps, agents and traffickers who exploit them. Prostitutes feel safer going to the police if they no longer fear prosecution.

Decriminalization abolishes all laws against sex work, including those against pimps and purchasing of sex. Advocates for decriminalization believe it empowers sex workers—they have the freedom to advertise, determine their clients, work in safe environments, and report violence perpetrated against them. Sex worker unions, and sex positive feminists argue that decriminalization gives sex workers the conditions to collectivize, mobilize, and change unsafe work environments. Further sex-positive feminists state that sex workers are the best allies in efforts against trafficking because sex workers have immediate access to trafficked women (Ahmed 2011) [Ahmed]. New Zealand and New South Wales in Australia are among the few countries/locations in the world where sex work has been decriminalised. In 2015 Amnesty International called for decriminalisation of all consensual sex work around the world. The resolution stated that by legalising prostitution, the human rights of those working in the industry would be protected ("AMNESTY INTERNATIONAL POLICY ON STATE OBLIGATIONS TO RESPECT, PROTECT AND FULFIL THE HUMAN RIGHTS OF SEX WORKERS" 2016).

Sex worker unions, and sex positive feminists argue that decriminalization gives sex workers the conditions to collectivize, mobilize, and change unsafe work environments. Sex-positive feminists further state that sex workers are the best allies in efforts against trafficking because sex workers have immediate access to trafficked women.

Sex Workers' Voice and Participation

As briefly referred to above, an important part of the history and debates around sex work, is the emergence of sex workers' unions and collectives. Ahmed traces that the 1985 World Charter for Prostitutes' Rights, a product of two World Whores Congresses held in 1985 and 1986, called for a decriminalization of "all aspects of adult prostitution resulting from individual decision." Till the 1990s the sex worker movements of the developing countries were not represented in the global sex workers' forums. In 1991 the global movement began to include sex workers from developing countries with inclusion of sex workers from Suriname and Colombia.

The HIV pandemic brought new struggles for the sex worker movements and new feminist organising. The public health discourse of 'sex workers as vectors', was countered by the health and human rights movements that included sex positive feminists and sex workers' unions. From being the 'targets' of often punitive HIV prevention and control measures, the role of sex workers shifted and they became key participants in the design and implementation of health programmes. The early HIV prevention programmes were based on the abolition approach and attempted to rehabilitate prostitutes. Resistance to this kind of a model from various quarters including brothel owners led to actions such as promoting safety of sex workers and clients through collectives and unions of sex workers. Some examples from India are SANGRAM in Maharashtra and Durbar Mahila Samanvay Committee (DMSC) in Kolkata, powerful collectives of powerful sex workers who

changed the discourse around HIV prevention and control by challenging the state and the local law enforcement agencies to assert their rights to safely practice their profession (George, Ray, and U Vindhya 2010)

Sex workers collectives also played an important role in identifying trafficking and supporting survivors. DMSC asserted that trafficked women should not be viewed as passive victims who are manipulated by others, but as human agents who can fight to gain control of their lives. DMSC's position is that the solution to trafficking is actually the political struggle of the rights of sex workers including the right to self-determination [Jana cited in George et al. 2007].

Sex workers' organisations point out that they are against children being in sex work, or in any other kind of work. They are categorical in their position that they do not support women being forced into sex work even if it is a caste-based occupation, as in India. They maintain that just as women have the right to opt to earn a living as a sex worker, they also have a right to refuse to do so. [Ghatak, Achinta. Sex, work and autonomy. In (Chakravarty 2014).]

But the struggle for sex workers to be heard and taken seriously is constant. Melissa Gira Grant points out that Sweden's prostitution law that criminalised clients was undertaken without any meaningful consultation with sex workers. She contrasts this with New Zealand's decriminalisation of sex work that was advanced by sex workers themselves. The sex workers also subsequently participated in the evaluation of the implementation and were largely satisfied. Pointing to the constant backlash, she gives another example of Canada. The supreme court in Canada agreed to hear a case that could result in decriminalising prostitution but declined to hear testimonies from sex workers' advocacy organisation (Grant 2014).

Health Needs of Sex Workers' STIs Including HIV Infection

Sex workers have a greater risk of getting sexually transmitted infections (STIs) and HIV than other women. The increased risk is because sex work means that she must have sex with many different men each day. While she may want to protect herself by using condoms and other safer sex practices, her clients, the men who pay her can may demand vaginal or anal sex but refuse to use condoms. They may even become violent if she refuses unsafe sex practices. Some sex workers may be addicted to drugs. Their need for drugs may make them more willing to exchange unsafe sex for money or drugs, and less able to take care of themselves.

As with any woman, if a sex worker gets an STI, it may lead to infertility or cervical cancer. STIs like herpes, syphilis, gonorrhea, or chlamydia greatly increase her chance of also becoming infected with HIV. These risks are even more serious for young girls. Since their genitals are not fully grown, they can be damaged more easily during sex.

Many sex workers do not have good information about STIs, or about how to treat or prevent them. Information and health services are often not available to sex workers because of people's prejudice against them. When sex workers do go to a health center for help, they may be treated badly or refused services.

BOX 15: SEX WORKERS BEING BLAMED FOR HIV/AIDS

Sex workers want to practice safer sex. But HIV and AIDS may not seem like the most important problem they face. They often have more immediate, daily problems—such as bad treatment by the police, low wages, dirty and expensive hotels, difficult or violent men, and problems with keeping clean, getting enough to eat, and taking care of their children. If a sex worker does become infected with HIV, she may have no choice but to continue selling sex to survive. As one sex worker says:

> *"Those who blame us do so on full stomachs. I should feed myself and my children adequately. My children should go to school. To say that AIDS kills without giving me a well-paid job is like saying I should die of hunger. To me, that is the only way to survive."*

SOURCE: Sex Workers 2017.

Stereotypes of sex workers as transmitters of HIV and STIs has resulted in mandatory and forced testing of sex workers for STIs and HIV as a public health measure. This is a violation of sex workers' human rights, their right to privacy, dignity, bodily integrity, autonomy, and non- discrimination. Mandatory testing also amounts to

exercising control over sex workers and their health, in a most repressive and degrading manner. Sex workers are further stigmatised because of coercive testing as 'vectors of disease'. Many times the results are not kept anonymous and shared with managers, third parties and families, and are used as blackmail to deter sex workers from disclosing violence or other human rights violations (Understanding sex workers' right to health: impact of criminalisation and violence (ICRSE 2017).

Sex Workers and Pregnancy

Sex workers may or may not want to become pregnant. They have rights to contraception and to safe maternity just like other women. Sex workers should be provided suitable contraceptives if they do not want pregnancies. And if they have an unwanted pregnancy, they should be able to get abortions on demand. And if they do decide to become pregnant they should receive the full range of quality ante natal care, safe childbirth services and post natal services, without any discrimination.

Violence Against Sex Workers

Sex workers face violence from many quarters—from clients if they resist unsafe sex as mentioned, from brothel owners, from pimps and agents as well as from the police who are actually supposed to be provide protection. The violence can range from beating and battering to sexual violence including rape. Violence against sex workers is a result of 'hostile social environments, repressive sex work and related policies, criminalisation, stigma and discrimination, marginalisation, social exclusion and lack of safe work places and spaces. Furthermore, sex workers are often affected by intersecting structural inequalities and injustices, for example transphobia, poverty, racism and lack of access to safe housing' (ICRSE 2017 pg 16).

Sex Work and Mental Health

Criminalisation, violence and stigma affect sex workers' well being and mental health. Sexual abuse in adolescence and childhood can result in post traumatic stress disorder, depression and suicidal tendency (Odabaşı et al. 2012). Sex workers as a group have been pathologised in an attempt to 'explain' why some women become sex workers. For example, one explanation is that women who have suffered childhood violence and sexual abuse, later on in life tend towards a life of selling sex. Generalising findings of research based on specially vulnerable groups of women, deprives sex workers as a group of their agency and is harmful to their mental health (ICRSE 2017). Worsening working and living conditions, increasing right wing conservativism and decreasing state protection can worsen mental health of sex workers. To conclude, sex workers' health needs go beyond sexual health. Their reproductive and sexual health rights need to be recognised—sex workers like any other group of women need a full range of reproductive health services. Their health needs should be viewed through the occupational health lens to identify what are the implications of their work on their health. Violence as a health issue and their need for mental health services need to be recognised.

Male and Transgender Sex Workers

There is not too much research available on the lives and experiences of male and transgender sex workers. However, a few available studies indicate several interesting and different facts. One is that male sex workers rarely identify as sex workers—they use local terms to identify themselves and mostly offer sex to men (Baral et al. 2015). Male sex workers often enter sex work for reasons very different from those of female sex workers—mostly linked to the commercial gay scene and drug and alcohol use. In consonance with the above, only a small proportion of male sex workers have female clients (Balfour and Allen 2014). A new public health context to understand male sex work (Minichiello, Scott, and Callander 2015) examines emerging trends in globalisation and technology that, they say, are contributing to the normalisation of male sex work and reshaping the context within which the male sex industry operates. Male sex work is getting more and more organised through the internet. Masculinity and male bodies are being represented in increasingly eroticised cultural forms and through art and films changing the popular thinking about male sexuality and masculinity. New information technologies are creating a fluidity of sexualities beyond the sexual dichotomy of heterosexual/homosexual. The phenomenon of complex sexual networks resulting from male sex work and its consequences on sexual health of male and female partners, is well known. All this requires new approaches and public health responses to addressing the consequences of unsafe sexual practices.

The complexities of transgender sex work with all their gender identities—cisgender, transgender female sex work, transgender male sex worker—and the accompanying

degrees of stigma, are another area that need to be uncovered. A study with 21 cisgender male and transgender female sex workers in Cape Town, South Africa suggests that the social identities owned or imposed upon sex workers contribute to their experience of exclusion. Cisgender male sex workers emerged as the most vulnerable group, expressing shame and internalised stigma related to identities, because they perceived themselves as 'less than masculine'. Many transgender female sex workers on the other hand, described their identities using positive and empowered language (Samudzi and Mannell 2016).

Government policies have focussed their attention on women in sex work. From the above discussion it is clear that male and transgender sex workers also need to be included in policy planning. It is important to understand the links between gender identities and social exclusion while creating effective health interventions for both cisgender men and transgender women in sex work. Policies and programmes also need to recognise the opportunities afforded by cyber technologies to reach out to sex workers and clients with information and education and safe and respectful ways of engaging in sexual activity.

Diverse Actors and Complex Positions

As can be seen from the above sections, Prostitution and Sex Work has remained an explosive issue over the longest time. There have been a range of actors and many different positions. There have been the abolitionist feminists, conservative right wing religious persons, the anti-trafficking constituency, the sex positive feminists, public health experts, human rights votaries, the business interests (brothel owners, pimps, pornography industry), the arms of the state (the legislating and law enforcement machinery), the sex workers themselves. And among the sex workers, it is important to remember, are sex workers with diverse characteristics. Queer sex work community point out that much of the normative discourse around sex work is constructed around heterosex, often without any attention to sex work in and by queer communities. This has resulted in invisibilising queerness in the context of sex work [Being, doing and thinking 'queer' in debates about commercial sex | Nicola Smith and Katy Pilcher – Academia.edu]. Queer activists argue for an intersectional approach to sex work organising.

The literature surveyed indicates that many of these actors were active in the highest bodies like UNAIDS, UNFPA, Office of the High Commissioner of Human Rights and other committees related to trafficking and sex work [Ahmed]. The hard work of sex worker advocacy organisations to get sex work decriminalised and some tenuous successes towards this end, many times were short lived—the abolitionists within these institutions would reorganise and challenge such decisions!

And so the struggle for sex workers' rights continues in many countries. They continue to raise their voices and counter the stigmatisation and violence that they encounter.

In the next final section, we carry our analysis forward—applying a feminist lens to create a framework that can help us to examine certain contentious issues like sex work, pornography, cosmetic surgery, motherhood and assisted reproductive technologies, to name a few.

3.3 A FRAMEWORK FOR ANALYSING WOMEN'S 'CHOICES'

3.3.1 Meanings of Autonomy

In Part 1 we explored some interpretations of Autonomy. We go further and build on those interpretations in order to foreground a proposed framework for analyzing women's reproductive and sexual choices.

Autonomy is understood by feminists 'as self-government or self-direction. Being autonomous is acting on motives, reasons, or values that are one's own' (Stoljar 2015). Autonomy thus includes a process of critical self reflection as well as developing certain values, attitudes and competencies that enable self governance. Exercising control over one's circumstances, choosing from amongst a range of options to develop one's life course, is implicit within the concept of autonomy. Early feminist writings critiqued the notion of autonomy that they thought was based on an individualistic concept of personhood, of self sufficiency, independent of and unaffected by social relationships, a 'masculine' notion of autonomy(Dryden n.d.). Autonomy was reconceptualised from a feminist

perspective as 'relational autonomy' arguing that human beings/women exist within social relationships, in contexts that can be severely oppressive. How they negotiate these is a marker of their autonomy. 'Autonomy provides not only an emancipatory ideal for those who cope with systemic abuse, degradation, domination, or other forms of oppression but also a lens for illuminating philosophical issues surrounding women's desires, choices, and identities' (Veltman and Piper 2014).

Authors in the edited volume mentioned above offer some fascinating insights into autonomy. Marina Oshana (Chapter 7) states that 'autonomy requires authority over certain choices, a lack of domination and exploitation in social relationships, and enough economic security to maintain control over important aspects of our lives'. She feels that economic security is essential for a person to 'maintain control over fundamental choices, such as choices concerning family or life partners'. Natalie

Stoljar (Chapter 11) focuses on autonomy and adaptation to oppressive social circumstances. She argues that all adaptive preferences, per se may not be incompatible with autonomy. Exercise of agency and self determination itself within oppressive contexts can constitute autonomy even though it may not upturn unequal gender relations. On the other hand, some cases of adaptive choices, are of concern to feminists because they fail to 'satisfy criteria contained in both proceduralist and substantive theories of autonomy' and are thus autonomy undermining. Anita Superson (Chapter 14), explores bodily autonomy in relation to debates and controversies around abortion. Superson extends her arguments around the right to bodily autonomy and abortion to other issues like rape, 'female genital manipulation', and woman battering.

Choices—even the so called 'autonomous choices'—as we know are not made in a vacuum—we argue that it is fundamental to analyse the conditions under which women make choices, and the specifics of the economic, political and social contexts in which women make their choices.

Agency

Another related feminist concept or a lens of analysis is 'agency' as opposed to victimhood. Women in most challenging situations, as victims of oppressive social and patriarchal structures, are rendered vulnerable and could be perceived as victims. Yet many women resist their oppression, many times in most subversive and unidentifiable ways. This resistance requires a discerning gaze and analysis—how are women exercising their agency in that particular context to deal with their reality, to survive if not thrive? Agency as it has emerged in feminist accounts of women's self-determination, 'manifests itself in various forms of self-definition and self-direction, through collective action as well as individual self-reflection, and being directed toward cultural and political, as well as individual targets'. (Abrams 1999)

> *Agency is never freedom from discursive constitution of self but the capacity to recognize that constitution and to resist, subvert and change the discourses themselves through which one is being constituted. It is the freedom to recognize multiple readings such that no discursive practice, or positioning within it by powerful others, can capture and control one's identity. And agency is never autonomy in the sense of being an individual standing outside social structure and process. Autonomy becomes instead the recognition that power and force presume sub-cultural counter-power and counter-force and that such sub-cultures can create new life forms, which disrupt the hegemonic forms, even potentially replacing them.* (Ryan, 1989 cited in Davies 2000)

We draw upon some of these understandings of Autonomy and Agency to develop a framework for analyzing and understanding what stand to take in a specific situation, and how to interpret women's 'choices'. Choices—even the so called 'autonomous choices'—as we know are not made in a vacuum—we argue that it is fundamental to analyse the conditions under which women make choices, and the specifics of the economic, political and social contexts in which women make their choices.

Which Feminisms?

One important component of our framework to analyse women's choices is a feminist lens. We draw upon our understanding of socialist feminism and intersectional feminism mentioned in Part 1:

> *Socialist feminists stand for the transformation of social, economic and political structures of contemporary society into egalitarian and non-exploitative entities. They focus a great deal on collaborating with all oppressed groups that suffer as a result of capitalism, patriarchy or any other form of domination.*
>
> *Intersectionality enables one to observe power, where it collides, interlocks and intersects ....Intersectional feminists.....advocate acknowledging and making space for issues affecting diverse marginalized groups of women. Adopting an intersectionality-lens in our practice of feminism is important to the movement because it allows the fight for gender equality to become inclusive.*

As mentioned in the definition of Socialist Feminism, an analysis of how Patriarchy operates in a particular situation and how Neoliberal economic and political ideology influences the context within women take decisions, would be an integral part of our framework of analysis.

Feminist Notion of Rights

While early feminists have espoused right to equality as fundamental, the evolving feminist critique of human rights holds that equality as 'sameness' does not reflect the differences between men and women. Feminists hold that the first generation of human rights, coded in the Universal Declaration of Human Rights and the International Covenant of Civil and Political Rights were androcentric. They did not account for men's and women's qualitatively different experiences in the public sphere. And they did not apply to the private sphere, like the family, where possible violence against women is a violation of their human rights but not recognized as such in the early Covenants. Classical human rights in the UDHR promoted liberalism in the sense that they talked of individual freedom and liberty, protecting and promoting individual civil and political rights, in very Western or Northern terms.The individual nature of rights detracted from the universal because the gender neutrality of human rights devalued or neglected women's concerns and interests (Nash 2002). The concept of group or collective rights emerged much later when the Declaration on the Rights of Indigenous People drew attention to the need for cultures to be protected against forced assimilation and homogenization tendencies of the nation states and the forces of globalization. However, even within the concept of Collective Rights, women's rights as a subordinate group were not given any importance because women were not considered to be an appropriate sort of group for which self-determination was important or even necessary. It was only with the framing of the CEDAW that human rights of women as a social class were recognized. And it is CEDAW that is an initial reference point for many feminists when analyzing human rights violations of women.

> *The Convention has been used to argue against discrimination against women in human rights declarations themselves, challenging the androcentric exclusion of women from the humanity they construct. In addition, it has far reaching implications for gender relations as such.* (Nash 2002)

And so we would like to propose the following when applying the rights' lens to analyzing any issue that concerns women.

1. An understanding of equality that is not based on 'sameness' or 'difference' but 'deconstructive equality'. Deconstructive equality '....does not require ignoring sexual differences. On the contrary, it requires ongoing transformation of all aspects of sex, gender and sexuality in the name of equal treatment for all individuals regardless of their personal sexual characteristics, biography or choices' (Abrams 1999).
2. A concept of rights that includes not only individual rights of individual women, but also strives to see how an action or situation or issue would impact on the collective rights of women as a social group, how would it affect the subordination of women as a collectivity, how would it address their disadvantage.
3. And finally an additional reference point would be CEDAW and what followed CEDAW – how do these address the issue being analysed?

3.3.2 Applying the Framework

In this section we apply the above framework and discuss some examples of women exercising choice.

A woman deciding to go for cosmetic surgery is exercising her autonomy. Using the lens of patriarchy, we would analyse that women would want to go for cosmetic surgery to 'look good', 'look sexy', fit into the socially prescribed notions of beauty and sexiness and thereby enhance their self worth. As stated earlier, this amounts to objectification of women's bodies and devalues their personhood. The pervasive neoliberal ideology exacerbates the situation in multiple ways—with the advertising industry promoting 'sexy' images of women, with health industry profiteering through commodification of health. And the analysis from the rights' lens proposed above, would point to her exercising her individual right, but this action not really contributing to collective rights of women to transform their subordinate position and achieve gender equality. From the perspective of an intersectional analysis we would ask—who are the women who can go for cosmetic surgery? Obviously those with resources, who can afford the expensive procedures and have time at their disposal. And this situation coexists with another where there are huge sections of women who cannot access life saving surgeries, and medical treatments! So from the perspective of social justice and equity, a system in which cosmetic surgery is allowed to flourish is quite unacceptable. And yet, it would not be fair to judge the woman who opts for cosmetic surgery without knowing her context, her reasons, her compulsions—this action may be her act of subversion, her 'adaptive preference'.

Pornography and Women. As mentioned earlier, early feminists sought equality in all aspects of life, including sexual and reproductive and women's right to sexual pleasure and fulfilment was considered an essential aspect of women's autonomy. Sex positive feminists espoused the idea of women's sexual freedom, including exploration of sexual fantasies through pornography. Another group of feminists feel that pornography too objectifies women's bodies and devalues women's personhood by reducing the female body to an object of titillation and sexual gratification. They go further to draw a parallel between coercive pornography and sexual abuse. In the neoliberal globalised context, pornography thrives as a part of the growing sex industry, accessible in myriads of new and innovative ways on social media and the internet. Production of pornography has become an industry in itself. And so while sexual liberation for women is an important part of sexual rights, as stated in the earlier section, sexuality and sexual pleasure needs to be depicted in ways that are respectful of women and promote caring and intimacy in sexual relationships and thus promote sexual well being.

A woman deciding to go for Assisted Reproductive Technologies to fulfill her desire for biological motherhood. Our analysis would begin from a feminist critique of Motherhood itself. Patriarchy has essentialised women and their bodies to fulfill the reproductive function. All women are destined to be mothers within the patriarchal framework. Any woman who fails to become a mother for any reason—even voluntary—is a lesser being, an unfulfilled woman! Feminists rejected motherhood because it denied women's rights to equality in public spaces, keeping them home bound in caring roles, and thus perpetuated their insubordination. Neoliberal ideologies work in conjunction with Patriarchy to play upon the notion of Motherhood to promote Assisted Reproductive Technologies. Recent decades have seen an emergence of an entire industrial complex around motherhood, beginning from advertising for 'perfect and custom made babies', to hotels for reproductive tourists and hostels for surrogates, to laboratories and hospitals for the required procedures. Motherhood through ARTs has become another thriving industry, with its globalised tentacles offering eggs, oocytes, and babies at much lower costs in countries like India.

An intersectional perspective would examine who are the demand side parties and who are the supply side parties. The demand for ARTs generally comes from those who have the resources, (maybe not so much for those who want altruistic surrogacy, which might be within the family, but even then money is required for the expensive procedures), and in most instances from other developed countries. The supply side comprises of the clinics and doctors as well as the donors and the surrogates. In most instances the donors are poor people selling oocytes and semen, and surrogates are struggling women renting their wombs to be able to invest for the future of their families. As mentioned earlier Surrogacy and reproductive technologies create unequal relationships of power between those who can pay to hire wombs or ovaries and those who offered their reproductive labour often at much lower costs than the

value of services provided. Another aspect of the demand side is also that those wanting babies through ARTs could be same sex partners, single persons, transsexuals.

And so again, in this entire analysis around ARTs, there is no right or wrong—individuals makes their choices because of their circumstances and because of their individual desires and aspirations. How can these choices be executed under conditions that prevent exploitation and balance power relations, is what needs to be kept in mind.

3.3.3 Conclusion

In the section above, we recognize that women—people—make choices. They exercise their agency. It is important to analyse these decisions from multiples perspectives as illustrated above. We need to ask: How would patriarchy influence this decision? What is the feminist perspective/s on this 'choice'? How does the neoliberal political and economic ideaology play out in relation to this issue? What would an intersectional perspective contribute to the analysis of this issue? What would a rights' analysis as described above contribute? Even if the pieces of analysis yield contradictory viewpoints, our stands on these issues would be informed and nuanced.

ENDNOTES FOR PART 3:

9 Though access to the bodies of boys and men are similarly obtained, our focus is on women and girls who constitute an overwhelming majority whose bodies are the object of commercial sexual exploitation.

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