Strengthening Alliances for Sexual and Reproductive Health and Rights

New Delhi, India

8-9 December 2014

Organized by SAHAJ, Baroda, and Rural Women's Social Education Centre, Tamil Nadu

In collaboration with CREA and CommonHealth

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Introduction

CommonHealth, in collaboration with RUWSEC, SAHAJ, and CREA, organized a two-day consultation titled *'Strengthening Alliances for Sexual and Reproductive Health and Rights'* on 8th and 9th December 2014 in New Delhi. The consultation was held in USI Premises, Rao Tula Ram Marg, and attended by 47 participants, representing over 22 NGOs and networks from across the country. In view of the prevailing national and international context for sexual and reproductive freedoms, a need was felt to generate dialogue amongst different coalitions, networks, campaigns and interest groups, on contemporary macro-economic and political challenges that are adversely impacting health and rights. Other objectives were to educate ourselves about each other's work and to collectively strategize about how to support each other, and to use opportunities like the ongoing reviews of the ICPD and MDGs towards advancing a more comprehensive approach to SRHR. With this rationale, this two-day consultation was organised as a reflective space for dialogue and deliberation.

Aims and Objectives

The aim of the consultation was to bring together diverse and often neglected constituencies from within the broad field of SRHR to collectively take stock of the contemporary context of SRHR, reflect on their own work and its inter-connections with each other's work, and strengthen alliances for SRHR. Given the prevailing discourse of 'repositioning family planning', the consultation also discussed a rights-based approach to contraceptive information and services.

The specific objectives of the meeting were:

- To reflect on the current social, economic and political influences acting on health and human rights in general, and on SRHR in particular
- To enable participants representing a range of issues within SRHR to share their experiences and learn from each other's work, especially regarding the inter-connections as well as conflicts between the various facets of SRHR that otherwise tend to be operationalised in silos
- Toexplore the possibilities of enhanced collaboration between participants, and the creation of mechanisms that can support each other's issues, towards an inclusive and unified agenda for SRHR in India
- To present and solicit feedback on an advocacy kit developed by SAHAJ for a rights-based approach to contraceptive information and services

Participants and Agenda

The consultation was attended by participants from over 22 organisations and networks from across India. Apart from representatives of non-governmental organisations and civil society coalitions and networks, this included academics, researchers, members of community based organisations, and independent activists. They brought with them

expertise in different dimensions of SRHR, including abortion, family planning, two child norm, young people's rights, mental health, legal advocacy, HIV, sex work, surrogacy, sexual violence, LGBTQI rights, disability, working with men, etc. Many participants represented more than one constituency and had expertise in more than one area.

Annexure 1 gives a list of participants. Annexure 2 details the consultation agenda.

Day one opened with a rationale for the consultation, a round of introductions, presentation of the agenda and meeting objectives. This was followed by nine sessions over two days, with the first session being an introductory context-setting and the last session a concluding discussion. Each of the other sessions had a thematic focus on a particular aspect of SRHR. The chair for each session would introduce the panel, the speakers would present for roughly twenty minutes each followed by a discussion in which the floor was open for questions and comments, and the panel would be wrapped up by the chair summarising the conversation and offering concluding remarks. While this was the dominant format, the number of speakers at each panel varied, and some panels were more discussion-oriented. The concluding session on day two served as both, a summary of key points from the consultation, as well as a discussion on the way forward for a more collaborative and inclusive SRHR agenda in India.

Day One: 8th December 2014

Session One

Introduction and Context

Sexual and Reproductive Health and Rights: The Global Scenario

The Introductory session on Day One opened with TK Sundari Ravindran's presentation on the global scenario of sexual and reproductive health and rights (SRHR). Chiefly, this presentation focused on the gains and gaps in SRHR internationally, highlighted macro-economic and political factors influencing universal access to SRHR, and discussed thoughts on the way forward for the SRHR movement.

Data on SRHR is a mixed bag of gains and gaps. Findings from the ICPD+ 20 global report reveal important figures such as a 47% decline in maternal mortality and a10% increase in contraceptive prevalence rate globally. However, the extent to which such figures represent ground realities has been debated. Also, although the WHO reports that there is a 40% increase in STI incidence, a weak database does not allow for clear intervention strategies. And while conversation on young people's SRHR has gained traction, survey data shows little improvement.

On the specific questions of rights, there have been some definite gains in the form of resolutions on SRHR being taken up in international human rights treaty monitoring bodies, but statistics leave much to be desired. For instance, 40% of women live in countries where abortion is severely restricted, and comprehensive sexuality education continues to not be prioritised in a large proportion of countries. As such, sexual and reproductive rights do not seem to have achieved much more than getting heard and recognised in some forums.

In terms of global politics, the comprehensive sexual and reproductive health agenda has been reduced to a fraction of what it was supposed to be. What has got attention is what was supposed to get attention, i.e. family planning and maternal health, and not reproductive health. Additionally, there has been backlash against some of the gains made in the 1990s. For instance, laws have gone backwards in terms of access to abortion in Eastern Europe and Central Asia. Further, there is a right-wing threat to human rights more generally, and to sexual and gender rights in particular.

In the world of donors, support which was high post 1994 has now moved away from SRHR. While there is some increase in funding for HIV and maternal health, it is far from adequate. Increasingly, funding is given to mega projects and mega conferences, and to international "consultancy" organizations (mostly based in USA and to some extent in the UK), for providing technical support to governments. As a result, local NGOs have to focus on quantifiable targets and outcomes to survive, which is a challenge for SRHR because the nature of the field is not conducive to dramatic and demonstrable changes. Consequently,

sustained long-term grassroots work on SRHR in many countries has suffered. Within the SRHR movement, there has been a fragmentation of issues into 'RH', 'HIV' etc. with connections not usually being made between these. An inclusive, collective analysis of the future of the field of SRHR is missing, with national SRHR agendas often being set by INGOs, donors and international "consultancy" organizations.

In this scenario, it is important to centre-stage neo-liberal globalisation that is 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. 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 ethic identities and find scapegoats in other groups to make sense of their losses in the world. Further, with the increasing marketization of health services, decreasing public expenditure on health, public private partnerships and WTO policies, universal access to SRHR can seem like a distant dream.

There is a need to take a step back and re-chart our future trajectory. We need to centre human rights principles, hold governments and other stakeholders accountable, and be inclusive and transparent in our own work. Rather than being fragmented, there is a need to forge alliances across SRHR issues. Equally importantly, there is a need to forge alliances with other movements against neoliberal globalization. Some steps in this direction have been taken by groups like ARROW to reach out to those working on poverty alleviation, food insecurity, etc. Ultimately, there is an urgent need to go beyond niches.

Overview of SRHR Issues in India

This presentation by Renu Khanna gave an overview of SRHR issues in the Indian context by first laying out a brief history of the women's health movement in India, then discussing related movements and campaigns, and finally, highlighting the current legal, economic, political and social context impinging on SRHR in India.

Through the 1970s and 80s, women's organisations in different parts of the country focused on the demystification of women's health through self-help strategies, and developing books like 'Shareer ki Jaankari', translating the legendary Our Bodies Our Selves (from the Boston Women's Health Book Collective), into different Indian languages. Shodhini's book on Women, Plants and Healing followed by Na Shareeram Naadhi (My Body is Mine) were other such efforts to take back control and build a feminist perspective on women's health. . A second thread of the Indian women's health movement was action against contraceptives. Campaigns were mounted against harmful, provider controlled contraceptives like Norplant and Net En, and the unethical trials that were being conducted on women without their consent. While women in the West wanted access to contraceptives as a reproductive right,

the women's health movement in India was fighting coercive population control policies. Another theme that health rights and women's health organisations began addressing in the 1980s and 90s, was the need to expand women's health programmes beyond maternal and child health to reproductive health. The International Conference on Population and Development in 1994, and the Beijing Conference in 1995, were landmark events that the Indian women's health movement worked very hard towards. These conferences succeeded in globally legitimising and codifying reproductive and sexual rights respectively. Also, the perspective that health goes beyond the biomedical model and that social determinants are just as important began to gain traction. In the 2000s, women's health organisations struggled to get violence against women recognized as a health issue. In 2005, the 10th International Women's Health Meeting was held in Delhi and the Indian Women's Health Charter, which was a consensus document that received inputs from women all over India and went through many iterations, was adopted.

After HIV/AIDS was recognised and the National AIDS Control Organisation was established, other movements particularly of sex workers, HIV positive people, and LGBT began to gain visibility.

Rather than seeing the women's health movement in India as one unified monolithic strand, it is more accurate to understand it as comprising of many strands that sometimes converge and sometimes not.

Government of India's Reproductive and Child Health Programme 1 (1997) was based on many important principles laid out in the ICPD Programme of Action but very little was implemented on the ground. The analysis that followed RCH 1 and the formulation of RCH 2 was a very inclusive process that produced a strong document incorporating a SRHR perspective. However, the National Rural Health Mission (2005) pegged on to MDG 5 i.e. reducing maternal mortality. As a result, the reproductive and child health agenda was narrowed down to maternal health, with institutional delivery becoming the only real indicator. Indicator 5b on Universal Access to Reproductive Health fell by the wayside. The Government of India justified following an older, narrower framework by citing "strategic and technical reasons". However, even on the question of maternal health, issues like the provisioning for safe abortion services, obstetric morbidities, infertility, and reproductive cancers, and the accessibility and quality of adolescent sexual and reproductive health services including contraceptive services, leave a lot to be desired.

The presentation described the legal context impinging on SRHR in India. In December 2013, the Supreme Court upheld Section 377 of the Indian Penal Code, dealing a blow to human rights and health rights. As a result of the Protection of Children from Sexual Offences Act 2012 and the Criminal Law Amendment Act 2013, the age of consent in law has been raised to 18, criminalizing consensual adolescent sexual activity and making it mandatory to report such activity. Confusion between the Pre-Conception and Pre-Natal Diagnostic Techniques Act and the Medical Termination of Pregnancy Act, hinders access to safe abortion.

Politically, right wing forces are gaining ground and are threatening the right to choose a partner, both in the form of Khap Panchayats that kill in the name of protecting caste and community honour, and in the form of the bogey of 'love jihad' that is used to generate communal polarization for electoral gain. With advances in technology and the proliferation of the private sector, sex selection and cyber and mobile based sexual harassment are becoming easier, and the unregulated expansion of medical markets like reproductive tourism for Assisted Reproductive Technologies (ARTs) and commercial surrogacy, is taking place.

A nationwide UNRISD study in India in 2012 that sought to amplify women's voices threw up some contradictory results. While women are being empowered economically due to increased employment opportunities and credit availability, they are also being burdened with greater responsibility. Husbands and families pressurise them to access credit; this also leads to increasing indebtedness. While employment opportunities for women are increasing, the working conditions are abysmal. Increasing violence against women is widespread, alongside increasing frustration and unemployment among men. Therefore, it is important to recognise the picture of SRHR in India as diverse and complex.

Discussion

In his concluding remarks, the chair Sharad Iyengar highlighted the need to understand the interconnections between national and international developments. He pointed out that the effort to de-medicalise health care and simplify health access must engage with the nuts and bolts of the health system, such as primary health care, midwifery etc. Also, while it is important to see gender based violence as a health issues, SRHR is not just about violence but also about positive rights. There is a need to fix the mindset schism in the country whereby sex and reproduction starts at a young age, but sexual and reproductive health services are practically not available.

A participant commented that HIV is mentioned in MDG6 but not as a cross cutting issue. In high prevalence states, HIV positive women are not educated in reproductive health, thus compromising both HIV prevention and care. Some government guidelines may mention the reproductive health needs of HIV positive women, but very little is implemented in practice.

Another comment emphasized the government focus on meeting targets, with the example of Telangana that wants to meet its MDG targets for infant and maternal mortality by 2015. As a result, there is continuous and extensive monitoring of mothers to ensure institutional delivery. The burden for this falls on ASHAs and ANMs. However, the private sector has been let off the hook and private medical colleges, pharmaceutical companies, clinics, etc. are considered beyond the purview of negotiation. There is a need for movements to interrogate the gaps in their own advocacy and strategies in relation to spaces where we have not been able to make an impact despite ICPD etc. Medical education is one such example.

A participant asked how the economic recession has impacted funding for SRHR globally and in India. Renu responded that sexual and reproductive health is one small sub set of health, which in turn is a sub set of the social sector. Therefore, in a scenario where social sector funding is being reduced in India, the already neglected domain of SRHR is being further neglected. SRHR is seen as a 'soft' issue, and primacy is given instead to increasing health infrastructure, the setting up of institutes like AIIMS, etc.

A comment pointed out that the global scenario is a dynamic one and with shifts in funding, different issues, from HIV to maternal health, occupy focus at different points. The market adapts to these shifts as well. For instance, Polycystic Ovary Syndrome (PCOS) and hysterectomies have become buzzwords today. Therefore, it is important to keep a close eye on the funding for SRHR and where it is going and to what effect.

A participant asked if professional bodies like FOGSI have been tapped by the women's health movement. Renu clarified that neither the women's movement nor the women's health movement have engaged with such professional bodies in a serious collective manner, although individual efforts may have been made.

In conclusion, Sundari highlighted that cross-movement alliances should make rights their centrepiece, and develop points of convergence on issues like neo-liberal globalisation. There is a lot to learn from each other's strategies. Ultimately, various movements are working for the same people and the same women, who are facing all these issues together, be it livelihoods or SRHR. Hence, our movements cannot afford to be disparate.

Session Two

Rights-based Approach to Contraceptive Information and Services

This session began with the chair Poonam Muttreja giving a brief overview of the family planning programme in India, which despite ICPD does not follow a rights based approach. She highlighted the recent case of sterilisation deaths in Chattisgarh as a tragedy where the government was forced by media and civil society efforts to acknowledge the violations that took place. She also briefly introduced FP2020, an international effort to reposition family planning. The Indian government pledged to 'provide FP services and supplies free of cost to 200 million couples and 234 million adolescents,' and 'meet the unmet needs for family planning of an estimated 48 million couples' (quoting the then Health Secretary's speech at the 2012 FP2020 London Summit). She pointed out that thisis problematic – spelling out such targets portents possibility of coercion and not voluntary acceptance of contraceptives.

India's Family Planning Programme: Historical Context

In this presentation, Leela Visaria discussed India's fixationwith population size and the measures taken to lower population growth and fertility in the past and today.Chiefly, the presentation emphasized that the mindset even now on family planning continues to be uninformed and confused. There is awidely held view that problems like poverty and economic sluggishness are due to population growth and size; this is evident from both the admiration for China's success in slowing its population growth, and from the fear that India will overtake China in population size in the near future.

The presentation discussed measures to control population since before Independence, from the efforts of Indian social reformers in the 1920s and 30s to set up family planning clinics to the invitation to Marie Stopes and Margaret Sanger to come to India and do the same. While Gandhi was opposed to artificial methods of birth control, Nehru was not. In 1951 India launched its family planning programme to control population growth and improve maternal health. Although India's desire to bring fertility under control was hailed by international experts, there was concern that family planning should be taken to people rather than confined to clinics, that mere availability of contraceptives would not ensure use, and that India lacked the efficient machinery necessary for effective implementation. On the basis of the desired decline in birth rate, the centre set contraceptive targets and made them time bound and incentives-based. In the 1960s Intra Uterine Device was promoted, sterilization intensified, and condoms distributed at subsidized rates. In the 1970s, vasectomy was promoted through camps as an easy, permanent and inexpensive method. These methods did not prove sustainable due to lack of understanding about people's mindsets and inadequate preparation. Although choice in contraception was offered in theory, in practice programmes were skewed in favour of one method at a time.

In 1975, with the imposition of the emergency, states were a given free hand to introduce compulsion and sterilization was promoted as the most suitable method to quickly lower fertility. The official sterilization targets for 1976-77 were set at 4.3 million, raised to 8.6 million by the states and officially 8.3 million were performed, mostly vasectomies.

In the 1990s, it was increasingly recognized that the zealous pursuit of demographic goals compromised women's rights and quality of care. After the 1994 Cairo conference, the Indian government removed contraceptive targets in 1996.The National Population Policy 2000 set the goal of attaining Total Fertility Rate of 2.1 by 2010, and population stabilization at 1.45 billion by 2016. However, many states have continued to focus on a population control strategy, advocating and imposing the two-child norm. The mindset of obsession with runaway population growth has proved difficult to change.

In view of widespread criticism about emphasis on sterilization, there is now a shift to promote 10-year IUD as a reversible method of contraception. Also, there is discussion on finding ways to raise age at marriage, encourage couples to postpone first birth, and increase inter-birth interval in order to slow the built in population growth momentum.

There is a delayed recognition among officials that India's population will stabilize around 1.7 billion by 2070 only, and implementation continues to be a challenge.

It has taken almost 100 years and a five-fold increase in population to accept the reality of population growth. Although the terminology of population stabilization is now being used, in practice it is still population control. The typical bureaucratic zeal towards numbers, targets, and incentives persists, even after the launch of the National Rural Health Mission in 2005. Media messaging still focuses on the national goal of lowering birth rate or total fertility rate rather than addressing individual goals and concerns. While policy statements take a long-term view of population dynamics, political vision always seems to be short-term. As a result, the mindset about targets persists and population programmes continue to emphasize one method at a time.

The possibility that by 2026, India's population would exceed 1.4 billion and that it will stabilize only around 2071 at 1.7 billion continues to send panic signals among policy makers. It is important for researchers to take responsibility for these perceptions. Academic demographers have undertaken very limited research on determinants of population growth in the past and have had a minimal contribution to policy. Findings of three NFHS surveys are used to a very limited extent. It is only post 1996 that some amount of empirical policy-oriented research has been undertaken.

The presentation concluded by emphasizing the need to focus on quality of care while addressing the high unmet need for family planning, especially in north Indian states. The growth in population is inevitable and we need to plan for a population of 1.5 billion in the next 15 years and of 1.7 or 1.8 billion by 2051. Towards this, changing ingrained attitudes and allaying fears about population explosion is a tough but necessary task.

Discussion

The discussion began with the chair emphasizing that one of the chief reasons that a range of contraceptive methods fail is because a reproductive rights and services approach is missing. Women want fewer children but the reality is that IUDs are not suitable for women with anaemia and Urinary Tract Infections (UTIs). Also, currently expenditure on sterilisation and related incentives is the highest part of the budget; as a result of this pressure of targets, the numbers game has become very important, leading to tragedies like the Chhattisgarh deaths. Perceptions have to be changed at the governmental level, and the current focus on ending child marriage- though coming from a demographic rationale- is an opportunity to do so. Another reality that we have to contend with is that as fertility goes down, sex ratio becomes more adverse.

One participant commented that although there has been a lot of agitation about different contraceptive methods, it must be remembered that the problem lies with the lack of a rights based approach to these methods, which discredits the method itself. Instead of

sterilisation, 10 year copper T was promoted because it can be taken out whenever the woman wants. However, there are still violations when women come for institutional delivery and are inserted with copper T without their consent. To this, another participant responded that the fear of various methods is precisely this fear of violations, although they should not be conflated. However, some introspection is in order because perhaps our strategies should focus on providing information about various methods rather than opposing them. The chair added that every contraceptive method has its side effects and we cannot focus on side effects alone. Indian women are crossing over to Nepal for injectables and given our large young population that is in the reproductive age and sexually active, we must promote temporary methods. At one level, all contraceptives be it Net En or IUDs are provider controlled to an extent. As long as choice and quality of care are the guiding force of our public health system, we can support any contraceptive method. Unfortunately, the government does not have the same perspective about the population momentum and unmet contraceptive needs. In fact, even senior government functionaries harbour many myths and misconceptions about population, and they are not open to hearing differing perspectives.

To this conversation, another participant added that the macro picture of family planning in India is very disconnected from the realities of women's lives. Women want contraceptives that suit them and their stage in life. There is a lack of body literacy amongst adolescents, and without that foundation increasing contraceptive acceptance later in life is difficult. While women want men to take responsibility for family planning, they also feel safest when they are in control of their fertility. Today the prevailing approach is that women should have two children close together, then get sterilised and in due course, get a hysterectomy. But when tribal women (Primitive Vulnerable Tribal Groups - PVTG women) want contraceptives, the state says no. Therefore, the issue of women's autonomy over their own reproduction remains. Counselling is provided but is reduced to instruction by ASHAs about which contraceptive method the user should get. Family planning has happened this way for decades, without any conversation on sexuality. The terminology of family planning itself is also problematic, because people outside of families also use contraceptives. Many of us use this terminology because it has currency but instead we should change our language and use our language as an opportunity to explain our perspectives.

One comment emphasized the need to understand the nuances and complexities behind people's contraceptive decisions. For instance, a study in Kerala found that an overwhelming majority of women prefer to be sterilised themselves rather than have their husbands undergo vasectomies, because if there is a pregnancy despite the husband's vasectomy, then the woman can come under attack for her sexual 'immorality'. To this, Leela responded that providers are supposed to instruct the male vasectomy acceptor to use condoms till three months after the vasectomy in case the procedure fails. Women's groups should be informed about these protocols so they can confront the pressures on women.

A participant from a community based organisation said that at the ground level in Uttar Pradesh the push from the government and affiliated organisations for family planning continues to be very strong. Another participant confirmed that quality issues with IUDs are glaring in the face of issues like inadequate workforce, and lack of training for doctors and ASHAs alike. In places like UP, International NGOs (INGOs) are the main players today but they do not take strong stands vis-à-vis the government. Also, while we are a country with the highest young population, we also need to think about the SRHR needs of this population when it will inevitably age, coming into the older population bracket.

Advocates' Guide for Rights Based Contraceptive Services: Presentation and Feedback

Renu Khanna began her presentation by introducing the Advocates' Guide; SAHAJ was invited by ARROW to develop this guide as part of a two country FP 2020 project. This guide is based on the generic guide developed by Sundari Ravindran and adapted to the Indian context. It has been presented and reviewed at a consultation in Mumbai in September 2014.Renu presented some key points from the revised draft (available in Annexure) and invited comments from the participants.

The Advocates' Guide for Rights Based Contraceptive Services aims to promote the WHO principles and recommendations of non-discrimination, quality, informed decision making, participation, privacy and confidentiality, etc. The guide provides a context to the global and Indian situation, key concepts and definitions, and standards and checklists of monitoring questions against each principle and recommendation. In India, although government guidelines and protocols already exist, awareness about them is very low, even among health care providers. This guide is aimed at activists and practitioners working on women's health in particular, working with adolescents, and also those engaged in rights based work at the grassroots level more generally. Feedback was invited from the perspective of the constituencies that participants were working with, especially about what appeared useful and what could be changed to make the guide more user-friendly.

One participant responded that monitoring may be a challenge since a lot that is promised on paper is not available on the ground. There is a need to prioritise issues in the guide and make it easier to read. Demands and issues can be categorised as long, medium and short term, for instance.

Another participant suggested that the guide should be clear about the group it is aimed at, rights holders or duty bearers. Therefore, the focus of the content should either be what, for instance, young men and women can expect, or what duty bearers should be doing related to adolescents. One comment stressed that safe spaces for young people are very important. Who the provider of information is and their attitude is also very significant. For instance, the language used by providers can create confusion. Sometimes the way information is communicated gives the impression that sexual activity outside of marriage

cannot lead to reproduction, and mostly conversation on family planning excludes conversation on sexuality entirely.

Key questions and points of feedback

- The kit should be clear about what advocates need to monitor and prioritise.
- Duty bearers must be more aware of their roles and responsibilities.
- Demands should be categorised as short and long term for clarity.
- The kit should specify what young people can expect from the health system.
- In case of child sexual abuse, the kit should list out a step-by-step response that parents can expect.
- The kit should be more visual, and can have a separate pictorial tool.
- The audience for the kit can be Self Help Groups, National Rural Mission Livelihoods Groups and Decentralised Planning Forums.
- It is very important for young people to have safe spaces.
- The kit should move away from a language of control to one of pleasure. Contraceptives should be promoted not only to prevent pregnancy but to enjoy positive sexuality. Case studies can be included to discuss rights' violations
- Quality of services and rights violations should not be conflated. Even in a situation of poor quality, rights such as information, consent can be promoted.
- The kit should discuss contraceptives not just before but also after sex i.e. emergency contraceptive pills. Each principle can have a dedicated booklet in the kit.

More graphic representations can be included for a semi-literate audience. Also, the guide could be a useful resource in which to delineate what is to be done in case of child sexual abuse or sexual violence, etc. Identifying key service points in these scenarios will make the directives of the guide more accessible and monitorable. It was also suggested that SHGs could be targeted and mobilized for a more widespread and decentralised use of the guide.

A participant pointed out that as activists we often say that rights are violated when quality of care of contraceptive services is poor. However, the quality of most services in the public health system is poor. It is important therefore to maintain a conceptual and political separation between rights violation (like informed choice, autonomy and so on) and poor quality.

Another participant appreciated the comprehensive nature of the guide, but suggested that the principles that are violated should be prioritised and perhaps there can be separate booklets on each of them.

In her concluding remarks, the chair discussed the efforts of organisations like TARSHI to advocate for comprehensive sexuality education and suggested that perhaps using a different, more culturally appropriate term for the same content may make it easier to promote. Responding to some earlier questions, she also discussed the genesis and process of FP2020, which aims to make access to contraception a global agenda. Given the current context of decreased funding wherein countries like India where there is an overkill of

family planning without following recommended principles, in other countries like parts of Africa, access to contraceptives itself is disappearing, four donors- BMGF,DFID, USAID and UNFPA came together for FP2020. Twenty countries including India have committed to reaching 120 million additional women to support their right to decide freely about whether when and how many children to have. However, Government of India's commitment to reach 48 million additional women seems irrational and a matter of concern. Towards this, a big push from the government has already begun, and a directive from the health ministry to the states indicates that all incentives are going to double. This funding is likely to be diverted from other important areas like AIDS and malaria. And while this is a danger, FP2020 is also an important opportunity since a rights based approach is being promoted by the global community, with commitments of a vast sum of money and more being raised.

Session Three

Rights and Fertility Issues

Continuing Struggle for Access to Safe Abortion

In this presentation, Hemlata Pisal began with tracing the chronology of the Medical Termination of Pregnancy Act 1971 and its subsequent amendments and proposed amendments for 2014. According to an IPAS Study (2003-2004), 8% of maternal deaths are due to unsafe abortion. In the public health system, MTP services are available in only 73% of district hospitals in major states. A qualitative study in six states and a community survey in Maharashtra and Tamil Nadu reveal that among married women who want to limit their families or space their children, the awareness of family planning is high but use of measures is low due to cost, non-availability, or lack of permission from husbands. Also, they are hesitant to visit public hospitals due to long waiting hours, the unsympathetic attitude of staff, and the insistence of doctors on signatures from husbands. The presentation discussed attitudes to abortion found in a study by CEHAT and MASUM (1994-96), where 70% of respondents saw abortion as a women's right over her body and to her fertility, 94% thought single women should be permitted to have abortion by law, and 70% felt that abortion was different and more difficult than delivery. Perceptions about health care and choice of provider were discussed. Figures from the number of MTPs conducted in 13 rural blocks of Pune district between April and October 2014 were presented. In summary, the presentation raised important questions about whether monitoring and regulation of safe abortion is happening and whether the government is serious about making MTP services available in the public health system. It was emphasized that without this, the number of unsafe abortions and deaths caused due to them will not reduce.

Campaign against the two-child norm

The presentation by AR Nanda began with a historical overview of the two child norm, the genesis for which lay in India's target oriented population programme. Post-emergency, the interests of men and of the state converged to shift the focus of family planning on women. In 1992, the National Development Council's Committee on Population recommended that persons with more than two children be prohibited from holding any political post, from parliament to Panchayati Raj Institutions. This was received with a lot of enthusiasm by state governments that followed it up with many legislative and non-legislative measures. The two child norm adversely impacts democratic participation; women's empowerment, health and rights; family security and stability; and the sex ratio at birth. The presentation discussed some research done on the two child norm, including one by the government of India and UNFPA, another by Leela Visaria, and one by CHSJ and University of Washington. Although each of these studies had its limitations, for example the lack of in depth interviews, their findings have corroborated the impact of the two child norm previously discussed.

Advocacy and activism against the two child norm prior to 2012 has included some efforts by the Government of India, NHRC and UNFPA, but to little effect. PFI with its state partners conducted a number of region-wise seminars from 2003-07, targeting legislators, media, civil society, doctors, etc. In three states, the Hunger Project has worked against the two child norm with the primary motive of empowering the women PRI representatives. The presentation discussed other civil society initiatives such as in Himachal Pradesh, Punjab and Haryana, and the different strategies that have and have not worked in advocacy efforts.

The National Coalition against Two Child Norm and Coercive Population Policies was started in 2012, with members like CHSJ, PFI and state-level groups. Chiefly it focuses on advocacy and activism against the two child norm, and some amount of research. It works in the states of Bihar, Rajasthan, Odisha, and UP, among others. The presentation reflected on the learning from this campaign. Given the availability of limited resources and the goal of perspective building, a campaign should have a holistic perspective but within that also have a focused goal. It needs both resources and more research to strengthen and sustain it. Networks have to be more vibrant, and have to be able to function better as a team by sharing more and sacrificing egos. Moving forward, areas for research and evidence building must be identified. For instance, research done on the one child policy in China or on the impact of the two child norm in different regions in India should be showcased. There is a need to be both interdisciplinary and in-depth i.e. a syncretic- intersectionality approach. Our strategies must be well planned, and must target diverse constituencies. For instance, we have to function with different styles at the national and state levels. We must bring together more alliances and networks, and incorporate in our work the myths and facts related to the population control mindset, as well as health, well-being, and gender rights concerns.

Discussion

The discussion began by highlighting the need for people advancing the work on implementation of MTP and PCPNDT Acts in a nuanced manner. There is confusion among community members as well as doctors and other stakeholders alike that abortion is illegal because it is clubbed together with sex selection. Recent government efforts to amend MTP Act have led to the misconception that the pro-choice lobby is looking to expand abortion services at the cost of sex selection, when in fact there is more danger of sex selection in the second trimester than in the first. Matters like these must be clarified and awareness generated.

Leela Visaria discussed the study on two child norm of which she was part, conducted from 2003- 2005. This study selected two districts each from all states at that time where the two child norm was being implemented. It was an essentially rural study, and sought information from Panchayati Raj Institutions about women who had lost their positions because of a third child. PRIs refused to share this information, and the study had to use snowballing technique to find individual women through local NGOs and seek information from them about the others. Finally, ninety women were interviewed. The study tried to reach out to PRIs members but this attempt was not very successful. Some PRI members would try to cheat the system by insisting that the third child they were raising was not theirs, but a sibling's. These instances went unnoticed until someone complained that the two child norm was being violated. As a result, it was the PRI members without powerful connections who suffered disincentives under the two child norm. For instance, with Gujarat's introduction of the norm in 2005, it was tribal members of PRIs who were most affected.

Session Four

<u>Neglected Issues in SRHR</u>

Working with Men and Boys on Gender Equality and SRHR: Experiences and Challenges[1]

In this presentation, Satish Singh discussed the experiences and learning from various projects as well as evaluation studies that engage men and boys in SRHR and gender equality. Although the concept of masculinity is changing, the contextual reality even today remains one of women's low social and health status, and strong caste-based masculine identities that draw on tradition. There are some men in the community who do not agree with violent patriarchal norms. Participatory training allows these men to examine their own beliefs and behaviors, and commit to personal change and social action. Such men become community activists and emerge as alternative role models. The men's groups they form can

[1] Due to unavoidable circumstances, this presentation by Satish Singh was made on Day Two i.e. 9th December 2014. However, since it was supposed to be part of Day One i.e. 8th December 2014, and was included in the agenda as such, this report has placed it in Day One proceedings, as originally intended.

be a platform for community action as well as a vehicle for the transformation of existing social norms.

The approach of CHSJ and its partners is to identify and train a male multi-purpose volunteer on issues of gender, masculinity, social structure, etc. using intersectionality and power as frames of analyses. The focus is on equity, equality and personal change. Training is done in phases, and field level support is provided. The volunteer is encouraged to meet village level functionaries individually and in groups for problem-solving, such as for health service delivery, and to in turn encourage these groups to take up community level campaigns on gender.

Through such efforts, many changes have become visible. Men's group members who have become fathers are playing a major role in prenatal, post natal care of their children and partners.Social and public health charters have been prepared. Women enjoy greater mobility and greater economic opportunities such as bank accounts. There is decline in early marriage, increased use of male contraceptives and sterilization etc. Wives of men who ran shops are now running the shops independently. Collective action is being taken to attend to emergency cases and for better services for women. Men's groups have also started petitioning the government for services for single women. At the home front, men from the groups have started performing many domestic chores like cooking and cleaning. They are also doing women's tasks in the agricultural fields like weeding, they have become less violent according to reports from their spouses, some have been able to delay their sisters' wedding and ensure higher education and many have started caring for their daughters more actively. At the community level, the public health system is being used for all health concerns and not just for reproductive health, and there is iincreased responsiveness from health care providers due to informed and articulate men.

The presentation also highlighted some cautionary points. Change also comes with risks like backlash at home and in the community. There is a need to move beyond paternalism and protectionism, and address structural issues relating to gender and power such as mobility, women's property rights, the declining sex ratio, women's sexual autonomy etc. Keeping a social justice focus means understanding our own prejudices around class, caste, nationalism, parochialism, religious identities, etc. Traditionally, SRHR efforts have focused on improving the health of women, and the work with men has been done instrumentally to reach women. However, male SRHR needs to be seen within a masculinities framework because norms of hegemonic masculinity form a barrier to health care for men. The work with men on SRHR should mobilize them make public services accessible, accountable, and sensitive.

The presentation concluded by stressing the need to move out of 'silos' and understand the inter-sectionality and multidimensionality of change. Towards this, funding and other support must move beyond the short-term project cycle and programs must be willing to continually learn, adapt and innovate.

SRHR and Mental Health Concerns

Ketki Ranade's presentation examined three aspects of SRHR and mental health (MH):

- mental illness as associated with specific reproductive events such as pregnancy and child birth, and other reproductive health (RH) concerns;
- the SRHR needs of persons with mental illness (PWMI);
- and the labeling of certain kinds of sexualities and gender expressions as mental illness/abnormal.

There is a lower fertility rates among women with serious mental illness (SMI) as compared to the general population, for both social and physiological reasons. Women with SMI have higher rates of abortion, and are more likely to have unplanned and unwanted pregnancies. Postpartum depression and postpartum suicide are common diagnosis during the postpartum period for women with SMI. Postpartum depression is known to be linked with intimate partner violence, unhappiness about gender of the child, poverty etc. There is a strong association between depression and suicide with suicides seen as contributing to maternal mortality globally. Further, there are management issues regarding women with SMI in the postpartum period- relapse rates are likely to be higher- and education is key in medication management. Research indicates poor outcomes for infants with maternal depression (pre-term birth, undernourished in first year of life, etc.) and an accumulation of 'intergeneration disadvantage' through their lifespan (poor long term cognitive development, emotional problems, etc.) Population based cohort study among women in the reproductive age from low income countries links common mental disorders (CMDs) with socio-economic deprivation, poor reproductive health (specifically complaints of vaginal discharge), chronic disease, substance misuse (tobacco) and gender disadvantage (domestic violence, low autonomy, early marriage and children).Also, more and more behaviours are being classified as mental illnesses, with pill pushing also on the rise.

People with mental illness (PWMI) are commonly seen as inappropriate, and this stereotype extends to their sexuality. PWMI are seen as predatory, uninhibited and in need of control on the one hand, and asexual on the other. Women with mental illness are more at risk for sexual abuse and violence, with perpetrators often being spouses, relatives, friends and acquaintances, and the abuse taking place at home. Sexual abuse and violence increases risk for depression, post-traumatic stress disorder, anxiety, panic disorder. The wandering mentally ill and PWMI within mental institutions and prisons are especially at risk. In view of these, the presentation discussed policy recommendations. There needs to be integration of maternal mental health into maternal and child health programs, of intimate partner violence among PWMI as part of clinical protocol for sexual violence, and of psychotropic medication into primary health centers.

Reproductive health services in India have focused largely on heterosexual couples within marriage. Homosexuality has been pathologized as a mental illness, with dubious cures and

treatments prescribed for it. This has consequences such as lesbian women's alienation from the health system, and the neglect of their health needs. Lesbian women may avoid seeing the gynaecologist, and may not have children or lactate, thus missing out on cancer screenings. They might want hysterectomies but might find themselves being discouraged by providers. Sexual health services in the context of HIV/AIDS programs usually extend to sexual behaviours that are promiscuous, outside marriage, and non-heterosexual. Such a focus leaves out post-operative care after sex reassignment surgery (SRS) for Trans people who are already vulnerable. Generally also, reproductive and sexual health discourses tend to be framed within the gender binary of man and woman, with the reproductive and sexual health needs of Trans people beyond SRS receiving scant attention. With the NALSA judgment of April 2014 creating a third gender category in India, self-identification of gender is now possible. As states put together programmes on health, education etc. for the third gender, this is an opportunity for us to expand the scope of both SRHR and MH.

Discussion

A participant pointed out that for the first time in 2011, the census introduced a question on sex with the option of male, female or other as a self-declared answer.

Despite a mental health policy draft, the situation for PWMI on the ground continues to be abysmal. Communities brand women with mental illness as witches, and these women themselves prefer to go to local healers because of the stigma they face from health providers. Although feminist health groups discuss and advance mental health concerns, an abiding problem is that diagnosis continues to be limited to the pill, with strong psychosocial support missing.

One participant said that the SRHR movement has primarily been directed at women, and has seen men as instruments to advance women's rights. To successfully put working with men on the agenda, it is important that these ideas be raised at larger levels. This is a challenge given the mindset of department functionaries; for instance, male medical officers themselves have not done sterilisation.

It was pointed out that engaging men and boys is also gender justice work because gender is not only about women. Patriarchy is also against the men who do not follow patriarchal norms of hegemonic masculinity. For instance, patriarchy does not tolerate sexual diversity. Men too stand to gain from dismantling patriarchy and its privileges; they can connect with their families better, and can advance their own and other's human rights given the intersections of gender with caste, class, etc. It is important to create spaces that visibilize non-hegemonic masculinities. It is not easy to do this and efforts are met with resistance, but if even 3-4 men in a village change, the norms begin to shift.

Session Five

Commercialisation of SRHR

This session began with the chair Lakshmi Lingam underscoring the need for clarity while discussing certain decisions that women make that may not be thought of as a positive exercise of their rights. The desire for sons or the decision to rent out her body for surrogacy is complex for a woman. How can we as feminists understand these decisions both as representing agency and autonomy, and in the context of patriarchal and commercial prescriptions? Further, how should we be speaking on behalf of these women?

Sourcing Surrogates

In this presentation, Sarojini N explained the arrangement of surrogacy (definition, types, etc.) and highlighted features about India's assisted reproductive technologies (ARTs) industry that raise important concerns from a medical ethics and women's rights perspective. A surrogate is a woman who agrees to carry a pregnancy to term for a couple or individual who cannot do so themselves. Surrogacy uses ARTs and depending on whether the surrogate's own ova has been used or not, is classified into genetic or gestational surrogacy respectively. Depending on whether a surrogate has entered the arrangement for money or not, surrogacy is also classified into commercial or altruistic. However, even in commercial surrogacy, the language of 'a noble deed' is used by participating parties.

The present draft of the ART Bill that is intended to regulate India's fertility industry permits only genetic surrogacy, although from a women's health perspective, gestational surrogacy where possible, is the less invasive and expensive option. Further, it defines 'couple' as a man and a woman living together in a relationship "in the nature of marriage". This is discriminatory towards single, separated or divorced, and queer people.

At present the commercialization of health and medical tourism has resulted in a flourishing medical market in India. By some estimates, India's rapidly growing commercial surrogacy industry is worth over USD 400 million per year. This is because of a range of reasons that give India a comparative advantage: lower costs in relation to the west, the availability of a large pool of poor women willing to be surrogates, a political economy context that encourages foreign capital and outsourcing, the close monitoring of surrogates by commissioning parents that is possible here, shorter waiting periods, medical infrastructure and expertise of international standards, a lack of binding regulation, and exotic destinations that are marketed in reproductive tourism packages.

However, the existence of such an industry also points to the changing nature of women's work today. With privatization and liberalization, recent decades have seen increasing informalization of women's work and the commercialization of sex and reproduction in newer ways. The state is rolling back from social spending, leaving poor women with work options that are characterized by low wages, long hours, insecurity of tenure, and

inattention to their health and rights. The surrogacy industry today has a range of actors, from agents to tourism providers to lawyers to doctors to hostels. A sign of how commonplace fertility technologies have become is the recent decision by Apple and Facebook to offer egg freezing as an employee benefit. How can we understand such a move in the context of women's reproductive rights and position in workplace, where maternity leave, child care, and crèche facilities continue to be struggles. It must be remembered that the process of harvesting and extracting eggs is invasive, painful, can have serious side effects, and does not guarantee a child. Important questions of ethics, justice and rights are contained at the intersection of science, technology and society.

The presentation discussed findings from Sama's research on surrogacy called 'Birthing a Market', such as selection criteria and women's motivations for becoming surrogates (chiefly financial). Findings pointed out that surrogates were given inadequate information about medical tests, procedures, and risks, and proper informed consent was not taken. Payment amounts varied. The arrangement could involve multiple cycles of IVF and embryo transfer, multiple pregnancies, foetal reduction, C section delivery, and restriction of sexual activity. Also, the stigma surrounding surrogacy and the fear of being seen as someone who was selling her baby or her body meant that surrogates kept these arrangements secret, and would sometimes shift residence etc.

In terms of regulation, the National Guidelines for Accreditation, Supervision & Regulation of ART Clinics in India, 2005 were developed by the Indian Council of Medical Research (ICMR). These are non-binding. The (draft) ART Bill & Rules were developed by the ICMR in 2008, updated in 2010, and currently, a 2013 version has been introduced as a cabinet note. In 2012, the Ministry of Home Affairs issued guidelines for foreign nationals intending to visit India for commissioning surrogacy.

Hysterectomies in India

In this presentation, Chhaya Pachauli discussed the practice of unnecessary hysterectomies and the work of Prayas in advocating against it. Hysterectomy is the complete or partial removal of the uterus and sometimes ovaries, cervix and fallopian tubes. It is recommended in the event of medical conditions like fibroid tumors, endometriosis, abnormal uterine bleeding, cancer, uterine prolapse etc. While no exact statistics exist to show the prevalence rate of hysterectomy in India, it is believed to be the second most commonly performed surgery on women, after caesarean section. However, medical experts believe that with advances in medical science, hysterectomy does not have to be a necessity; women can opt for oral remedies, hormonal injections, intra-uterine devices and endometrial ablation to get rid of problems like heavy bleeding and fibroids. Ideally, doctors should resort to hysterectomy only when all other treatment options fail. Nonetheless, the incidence of hysterectomies is rising due to many factors: for cancer prevention; to be free from menstruation; due to lack of training about other therapies or lack of knowledge about the effects of hysterectomy; and of course, due to increasing commercialization.

In Dausa district in Rajasthan, between April and October 2010, out of a total of 385 operations reported by three private hospitals, 286 were hysterectomy operations. The presentation shared the experiences of some of these women. Interviews conducted by civil society groups with 16 women from Dausa found that their hysterectomies were performed in haste and in the absence of any medical emergency, citing problems like pain in abdomen, back ache, menstrual irregularities, painful and heavy menstrual bleeding, and dubious sonography-based diagnosis of 'pre-cancer'. However, most of these problems are common amongst women from the area and may occur for no particular reason or due to infections that are not uterine. All potential causes were not ruled out through tests before the hysterectomies were done. Similar incidents were reported from Chhattisgarh and Bihar. Hysterectomies are also linked to the roll-out of the Rashtriya Swasthya Bima Yojna (RSBY) insurance scheme, under which private hospitals may remove the uterus of beneficiaries to claim higher insurance amounts.

As part of advocacy against unnecessary hysterectomies, efforts such as a PIL, a national level consultation with stakeholders, and media engagement have been undertaken. As a result, three questions on hysterectomies were added to NFHS IV.

The presentation highlighted that hysterectomies often lead to high out of pocket expenditure, emotional problems, and other complications including: side effects like mood swings, vaginal dryness, osteoporosis, etc.; and lifelong Hormone Replacement Therapy and greater risk of heart disease in case the ovaries have also been removed. The presentation also highlighted related larger concerns, namely: high burden of untreated gynaecological morbidity and lack of primary gynaecological care; irrational treatment practices and no standard protocols; unregulated private health care sector; undue financial burden on the government if hysterectomies are covered under insurance; a patriarchal view of women's bodies that considers the uterus dispensable post-childbirth; and lack of population-level data and trends on hysterectomies. It was emphasized that advocacy is required for affordable, quality gynaecological care at the primary level, in addition tohealth education about hysterectomy. Providers need to be tracked and regulated, grievance redress needs to be operationalised, and more research, population-based and qualitative, needs to be conducted.Health insurance also needs to be looked at critically. Ultimately, although it should be a woman's prerogative if she wants a hysterectomy, the current practice of being misinformed and mislead into one is unethical and criminal.

Discussion

In the discussion, participants had many questions about both surrogacy and hysterectomy. It was clarified that in the event of morbidity or death, the current bill does not stipulate unambiguous and adequate insurance for surrogates. The feminist debate around surrogacy has been a polarizing one, like the debate around sex work. An early feminist position was to seek a ban on surrogacy, although now many feminists seek to regulate the industry and seek maximum possible protection for surrogates.

One participant reflected on her advocacy experience vis-à-vis a Maharashtra state draft of the ART Bill, noting that doctors project ARTs as very easy and basic, and without significant risks to women's health. Politicians and policy makers trust the expertise of doctors in this matter. As a result, it is very difficult to advocate on behalf of women who voluntarily seek ARTs and face problems like little gap between cycles.

One comment emphasized the lack of gynaecological care once women have been sterilized. There is problem with the way we look at women's bodies and its processes like menstruation, which we want to get rid of rather than celebrate as natural. The uterus is seen as a vestigial apparatus, like the appendix, after it has served its function of birthing children, especially sons. Also, often women cannot afford to undergo alternative therapies, even if the doctor has recommended them. Women and their families also do not want to risk potential future conditions like cancer. Therefore, they see hysterectomy as a 100% successful solution that removes the root of the problem.

It was also pointed out that many women medically require hysterectomies and struggle with their decisions to get them. Therefore, there is a need to separate the instances of hysterectomies by age, diagnoses, process followed, etc.

In conclusion, the chair emphasized that maternal health remained the dominant framework for SRHR issues. Once a woman has had children, she is no longer a priority for the public health system and all her other morbidities are left to the private sector. To a large extent, neglect by and of the public health system makes the private sector thrive. Issues of surrogacy and unnecessary hysterectomies are an extension of the private sector's medicalisation of every aspect of women's lives, and must be responded to as such.

Day Two: 9th December 2014

Session Six

Young people's SRHR

This session began with the chair Nilangi Sardeshpande highlighting key themes from the previous day's discussions, and introducing the agenda for Day Two, and the speakers on this panel. That the context of young people's SRHR in India is fraught is clear from the Health Minister Dr. Harsh Vardhan's controversial comments against sex education soon after assuming office. The youth of today is the foundation of India's tomorrow, and needs to be able to make informed choices. The recommendations of the RMMCH+A are good but must be implemented well to be effective. There is a need for comprehensive information and counselling. Currently, even speaking to young people about any one contraceptive method is difficult with the amount of moral policing that goes on in communities. The chair stressed the importance of conversations such as this panel, involving young actors working in the field with young people for their SRHR. These are important to be able to grasp the challenges we face beyond policy, since both policy and grassroots advocacy are equally challenging theatres. To accommodate the many voices on this panel, the panel began with Reena Khatoon's (the Youth Parliament Foundation) presentation, followed by a discussion with Sandhya (SAKAR), Sunita (Mahila Swarozgar Samiti), Neerja Unni (SAKHI) and Dileep Vankar (SAHAJ), moderated by Sanjana Gaind (CREA).

Comprehensive Sexuality Education

In this presentation, Reena Khatoon began by introducing the work of the Youth Parliament Foundation (TYPF), ayouth-run and -led organization that promotes, protects and advances young people's health and human rights. The current landscape for youth SRHR in the country was discussed, including: the launch of the National Adolescent Strategy on Health (Rashtriya Kishor Swasthya Karyakram) that integrates Comprehensive Sexuality Education (CSE) across 7 thematic elements, focuses on engaging peer educators along with frontline health workers, and specifically reaches out-of-school adolescent girls; the Rajiv Gandhi Sabla Scheme, which has been scaled up in 200 Districts; and the Reproductive Maternal Neo-Natal Child Health + Adolescent (RMNNCH+A) strategy that focuses on maternal health and child health**.** Significant gaps were also discussed, such as the conflicting laws on age of consent that act as barriers to accessing services; for instance, the Protection of Children from Sexual Offenses (POCSO) law requires mandatory reporting and this hampers access to safe abortion services by making it difficult to maintain confidentiality. Ideologically, there is a need to integrate CSE advocacy within education and rights-based frameworks, improve implementation, research and innovation, advance non-binary formulations of gender, develop language on CSE, and advance young people's participation in policy and national programs.

The presentation also discussed platforms and processes available for advancing young people's SRHR for post 2015 reviews, as well as recent policy consultations and changes. Despite the new political leadership, we should not throw the baby out with the bathwater. For instance, the NACO merger with the NHM may feel like a step back, especially given that condom advertisements have been rolled back. However, Civil Society Organisations (CSOs) are being asked by NACO to represent their content differently for the purpose of approvals, and not to change their programmes.

In this scenario, the goal of the TYPF programme is to scale up the demand for CSE by increasing community sensitization and young people's engagement with officials, policymakers and healthcare providers using a bottom-up, rights based approach so as to 1) increase young people's access to CSE and understanding of SRHR, 2) advocate for the implementation of CSE in the three states of Maharashtra, UP and Delhi, through 300 local level youth leaders, and 3) build the capacities of youth leaders to strengthen institutions and promote CSE. The presentation discussed some key strategies used by TYPF at the state and national levels, as well as the policy forums that TYPF has participated in and their impact.

Moving forward, there is a need to develop consensus on the definition of CSE and its non-negotiables, and to have a sex-positive and affirmative (and not only disease prevention) approach to teaching young people. CSE should be implemented from an early age (before 9 years), with curricula and methodology that is context-specific, age appropriate and disability friendly. CSE programmes should be aligned with skill-building or community-level employment programmes to reach out to married and/or older women as well as unmarried young women. Where possible, civil society collaboration for the integration of CSE with large scale programmes at the school or community level should be undertaken. In-school remains the primary catchment area for early interventions on CSE, but out of-school pilots should also be encouraged given the unmet need in this area. We need a regular forum for CSOs working on CSE to collaborate, develop material, and consolidate advocacy. Ultimately, we have to work towardsstrengthening safe spaces and convergence platforms for young people to advocate with decision makers.

In the **discussion** of her presentation, Reena reflected on the challenges being faced by TYPF in the various dimensions of its work on CSE. In schools in Delhi, both government and private, there is a lot of apprehension about CSE, even when these schools are approached through organisations already working with them on life skills etc. (rather than through the government).There is fear around the word sexuality and it is routinely suggested that the programme be called health education. While language is important, it is better to be realistic about achieving some results rather than adopting an all-or-nothing approach. At the community level, TYPF has found that frontline health workers like ASHA, Anganwadi, and ANM do not understand CSE because they have not been trained in CSE. Youth leaders working with frontline health workers in UP are getting requests to train them in CSE and

related service provision and accountability. This is an important area of work because more young people access services through these workers than the private sector. In a different format like the peer to peer model, mobilising youth on a subject like sexuality is a challenge. Parents too are willing to discuss the health of their children but not sexuality. The biggest learning for TYPF has been that implementation of CSE is a challenge even where there is agreement on the need for CSE. This is especially true of government officials at the national level. At the village level there is more support. Under the Kasturba Gandhi Balika Vidyalaya, TYPF is doing a pilot on life skills, health education, etc. in eight schools. Here too, organisations that have close ties to the government are apprehensive about sexuality.

Young people's voices from the ground

This panel continued the conversation on young people's SRHR and was moderated by Sanjana Gaind in a Question-and-Answer format. It sought to highlight the experiences and challenges of young activists who are working on the ground on SRHR. Conversation began with panellists introducing their work.

Sanjana: CREA's Its My Body (IMB) programme works with adolescent girls on SRHR by using sports as a medium to collectivise them and enhance their understanding. We work with 15 partner organisations that have been working in their respective fields on issues like VAW, gender etc. for several years. The panellists include two of CREA's IMB partner organisations, SAKAR and Mahila Swarozgar Samiti, represented by Sandhya and Sunita respectively. Neerja from Kerala is a participant from a life skills program organised by SAKHI. Dileep works with SAHAJ on adolescent boys' SRHR.

Sandhya: It is difficult to present your work and its many experiences in a short time frame! We work with Dalit and Muslim girls who face a lot of restrictions and it is very difficult to get them out of the house, or to make friends, or even to reach them on mobiles. Usually, they are under a lot of pressure to embroider saris and other clothes and often their education is stopped for this reason. Even when they do study, Muslim girls' education is focused on subjects like Urdu and Arabic. Dalit girls can have health complications because they are doing everything—eating, cooking, sewing etc., while sitting. There is discrimination in education. If girls are studying till Class five, they come back from school and work at home. They cannot head off to play like their brothers.

Sunita: We work with Dalit girls who face a lot of discrimination, even at home. For instance, they may come home and find that their brother has eaten their share of the food. They usually have no one to speak to about their concerns.

Neerja: I participated in the SAKHI course, after which my life changed dramatically. I began to carry myself with confidence, mingle with others, and even approach the police station with complaints of harassment. There is one incident that particularly comes to mind. I was

returning from dance class with my teacher when a man on our bus began to rub himself against her and harass her physically. My teacher kept quiet but I was outraged. I decided to question the man about it. But he just turned around and asked me, when the woman is quiet, what is your problem? I told my teacher this, and she started crying. Finally she got the courage to call the police.

Dileep: We work amongst the urban poor youth as well as in rural and tribal areas in Gujarat. I can describe our work with an example. One day a boy who had attended our counselling workshop called me to say that his fiancé hasn't had her period in two months. This had become an issue for his family and they wanted to break the engagement because of it. We stepped in to explain to the families that there must be a medical problem, and the issue got resolved. We see everyday in our work that adolescents do not have a forum where they can discuss their issues. In another instance, an 18 year old girl who had not got her period finally got some help from a counsellor at one of our sexuality workshops. In the villages, not only girls but boys too prefer not to talk about sexuality.

Sanjana: It is clear from these experiences that talking about gender and sexuality is very important but also very difficult. We need to create safe spaces where young people can learn about SRHR. This is very difficult because essentially one is challenging the control that exists on girls and their bodies.

*Sandhya :*It is really very difficult to talk to girls about sexuality. Everyone's ears prick! In our work, we have formed groups for young girls (*kishori manch*) where we speak about their likes, dislikes, body, etc. Very slowly changes have become visible. Now girls say quite openly in the group that they want to get facials, get their eyebrows done. They cannot say these things at home, but they go quietly and get it done. Earlier, they would be on play grounds with their dupattas covering their heads. Now they tie them on their waists, and sometimes they even keep them aside. People who watch protest but the girls do it anyway. Girls from our program are approaching health workers for iron tablets themselves. Earlier the girls would never talk about themselves; maybe about their families, their work but never about themselves. This is changing. For instance, one girl we work with was being signalled to by a stranger in the presence of her sister. Her sister taunted her saying her hairstyle was attracting attention. She retorted that she liked doing her hair that way, she had not done anything wrong, and she insisted that she would complain to her father if the stranger did not stop.

Sunita: No one tells young girls about menstruation. Now the girls in our program know what to use when they menstruate and how to care about their bodies even generally. They approach the ANM collectively because they know that haemoglobin check-ups, TT injections, etc. are their right. Earlier they would hide their undergarments and now they hang them out to dry, telling their families that the sunlight is necessary to kill bacteria. Sometimes in the program, they ask for the information they want. They asked if girls can get pregnant by talking to boys, so we had to plan a session to explain this.

Dileep: I agree that the changes are quite visible. We had arranged a picnic with a group of girls who are from a very conservative Marathi community that does not let them leave home much. We discovered that the girls had carried t-shirts and jeans with them, and mid-way to the picnic, we stopped the bus, the boys were asked to get off, and they changed out of their salwar kameezes into these! They were very clear that they wanted to enjoy themselves. We need to break the silence around bodies, sexuality and reproduction. Even at 22-23 years of age, it is not considered appropriate for these girls to say in their homes themselves that they want to get married. Even in schools, reproductive system is a syllabus topic but it is not taught by teachers. Teachers tell students to study it themselves at home. On the one hand there is a lack of information, and on the other there is misinformation. A boy asked me if he could use Japanese oil he had seen advertised to enlarge his penis. Boys do not know about their own bodies, let alone about girls' bodies. In a workshop we took with boys, they did not know about menstruation cycle.

Sanjana: What are the key challenges that you face in your work?

Neerja: It is very difficult to talk about bodies. During a body mapping exercise, none of the participants were willing to lie down and have their outlines drawn. They were also hesitant to label body parts. After the exercise, one of the parents was furious that we had talked about breasts and nipples. I clearly remember that a friend of mine was expelled from school without any inquiry when she got pregnant in class nine. SAKHI followed up the case and found out that she had been raped by her older sister's husband. SAKHI got in touch with the child rights department to get that man arrested.

Sandhya: The key challenge is the restriction on girls. After each session, we do not know if we will be allowed back into the village. The brothers especially can be very disruptive. They send their mothers to sit in on our sessions. The mothers have a problem with us saying that girls should be allowed to do what they want. We try to tell the mothers to think of when they were young, but it doesn't always work. It does not feel like a safe space. The girls are not sent unaccompanied to the sessions because families and communities feel that reproductive health, contraception, etc. are not conversations we should be having with young girls. They would prefer us to use our sessions to teach girls some skill like embroidery. I feel concerned about my own safety. This work is risky. We've had girls tell us that their brothers are saying we will see how these madams come here again. During an argument, one boy had protested that my kurta was half sleeved, even those I was wearing a dupatta! One girl shared in a session that she liked to play games on the mobile, and through her sister-in-law it spread in the village that these people want girls to have mobile phones!

Sunita: We face very similar challenges. The brothers of the girls we work with get upset and try to stop the program. While the girls play football, they stand around mocking them and clap when they miss the goal. Our fear is that if the girls share everything about the program

at home, it will be misunderstood and the community will protest. The project plan has all these strategies but they do not always work and one has to think on one's feet.

Dileep: Last month we had organised a group discussion .We asked the group about condoms and a boy started crying saying I cannot be here, my older sister is in your other group discussion what will she think of me? Even when I look back at my own life, I cannot remember seeing anything about reproductive health in any of my papers throughout school and college. I once asked a science teacher about this, whether reproductive health is ever covered in school and he said that it is in the syllabus but it is not asked in exams. So how do we expect young people to know and remember?

Sanjana: What are some of the strategies that can strengthen our work?

Sandhya: Given that we were facing opposition from brothers for talking about SRHR issues, for our program we decided to take the support of girls' mothers. We held a dialogue between girls and their mothers, to discuss what girls expect from their mothers and what mothers expect from their daughters. This was quite successful and now these mothers are more helpful and side with their daughters to quite an extent. Another important strategy is to keep the influential people in the village such as the *pradhan* (chief), health service providers, etc. on your side. Keep in touch with them regularly and keep them informed.

Sunita: We try to know the girls and their families as much as we can. We have used newspaper reports to generate dialogue with the brothers on rape and gender. Some of the brothers now understand our perspective and support our work. We change and keep up our efforts to engage them.

Neerja: There is opposition to the very term sex education, so SAKHI has called their program the young people and adolescents program and is implementing it in schools. They have gone through the local government and have selected trainers from among the panchayat, ASHAs and anganwadis. An advisory committee was constituted at the level of the panchayat, comprising of various stakeholders including parents, and with their oversight implementation has been done. From among a big group of 100 young people, those interested have been enrolled in the program and are trained in half day sessions on holidays. So the work is happening with school children but through the panchayat and others.

Dileep: We have also put together a youth forum. The boys in this forum are from the village itself so they are accepted more than us as legitimate voices. Many of these boys speak to the parents to keep them informed about the work. We do workshops like pre-marriage counselling, sexuality, and are even asked for follow ups. In schools this kind of work is a problem because principals are not interested. Even then, students want to meet on holidays to have these conversations.

Sanjana: There is so much restriction and fear that we often feel it is not possible to talk to young people about sexuality. Not only is it possible, it is very important to do this given the norms of masculinity and femininity that are at the heart of many issues we confront. When we design programs, we imagine that young people are not very informed or capable but that is not the case. I also want to stress that while talking about sex and sexuality, aspects of fun and pleasure are equally important and it is not always about abuse and violence.

Discussion

A participant pointed out the need to ensure social support for functionaries who are working on the ground. They should ideally be connected to local women's groups and should plug into flagship programs like the National Rural Livelihoods Mission. Without this kind of strategizing, networking and scaling up, it is possible for this work with young people on SRHR to be lost.

Another participant wanted to know if the content of the work with young people on SRHR included conversation on alternative genders and sexualities. It is important to address these issues with young people because often the stigma and trauma experienced by LGBTIQ persons begins at a very young age, and they feel lonely and rejected by society, leading often to suicide. To this, another participant responded that CREA with Tagore International School in Delhi is part of a peer education and sensitisation program specifically on LGBTIQ rights.

It was pointed out that in the urban context there is an abundance of information which can often lead to misinformation for young people who may not know how to understand it. Today we live in a hypersexual media environment that more often than not sends out problematic messages about body image to young people. Further, as more and younger people use social media and the internet, online misogyny and harassment are also becoming challenges.

Schools may welcome workshops only from a protectionist perspective, to focus on abuse and violence, but we can use these opportunities to discuss various aspects of SRHR for young people. Eventually for objectives like reducing violence against women, trafficking, early marriage, etc., the essence has to be empowerment and the fight against social norms.

From the perspective of HIV/AIDS, it was noted that most youth programs contain only fear based messages for children infected and affected by HIV. This cohort is left out by both HIV programs and adolescent programs, and they have unique needs that schools are too scared to meet.

In conclusion, it was also highlighted that the pressure from donors to keep all objectives and outcomes tangible and quantifiable can make it very difficult for activists on the ground. The changes that were highlighted in this panel reflect how girls start thinking more positively about themselves. However, donors are usually only interested in the numbers of

girls delaying age at marriage or prolonging their schooling, etc. Other equally important changes get lost and are never acknowledged. It is important to understand the work with young people on SRHR as long term work that must be done from a perspective that takes their context and the nature of change in this context into account. It was recognised that although the discussion in this panel focused on enhancing SRHR information rather than services, it served to ground the discussions of the other panels of the meeting.

Session Seven

Sexual Rights

No Reproductive Rights without Sexual Rights

In this presentation, Prabha Nagaraja of TARSHI explained TARSHI's perspective on sexual and reproductive rights, and the work that the organisation has done and continues to do to advance sexual rights. Sexual rights isa larger umbrella that covers many reproductive rights, rather than the other way around. Because reproduction can be achieved independent of sex, and all sex is not procreative or heterosexual, sexual rights are distinct from reproductive rights although there are overlaps. Sexual rights bring men and trans people squarely in the picture as opposed to reproductive rights (traditionally seen as pertaining only to women); they are inclusive of all people, irrespective of their reproductive capacities, which includes people with disabilities, people with HIV, SOGIE (Sexual Orientation, and Gender Identity and Expression) issues, sex-workers' rights, etc. In countries where there is no discrimination against same-sex desiring people on the basis of their sexuality, there is also no violation of their reproductive rights. For instance, lesbians can have babies through ARTs in the Netherlands. The presentation listed a wide range of sexual rights as per the WHO (2002).

While there is acceptance of the terms 'sexual health' and 'reproductive health and rights', there is lesser acceptance of 'sexual rights'. This is primarily because of the perception that sexual rights will lead to unrestrained sexual expression and anarchy. Even the final phrasing of the Beijing document reflects this fear in the use of the words 'freely and responsibly'. Today twenty years later, the taboo against homosexuality, bisexuality and alternative family forms persists, resulting in a continued aversion to sexual rights. Many cultures do not perceive women as sexual beings and there is much anxiety about promoting choice and agency for women and young people in sexual matters. Issues in India include partner choice (early marriage, forced marriage, issues of caste, religion, etc.); consent (rape, marital rape, etc.); bodily integrity (forced sterilization, rape, etc.); access to services (safe abortion, contraception, etc.); right to information (lack of CSE); laws (section 377, adultery, obscenity, age of consent etc.)

TARSHI, which began in 1996, approaches issues of SRHR and sexuality from a broader, affirmative, rights-based perspective. For 13 years, from 1996 to 2009, TARSHI ran a helpline that provided information, counseling and referrals on various aspects of sex, sexuality and sexual and reproductive health. The helpline attended to over 60,000 calls from men, women and some Trans people between the ages of 12 and 76 years. 80% of calls were from men. There was a lack of basic information that led to fears and misconceptions. Men had guilt and shame related to masturbation in their younger days. Many young men would have anxiety about their first sexual performance in marriage, so they would want to test their sexual prowess. If this was not done safely, they would begin their marital relationship with guilt and possibly infection. Man also did not know that foreplay was important for new wives. They would force themselves on their wives without realising that her silence is a result not of shyness but of a lack of arousal. Beginning a relationship on such a sour note can colour it for life. Having information can mitigate these negative experiences. Men reported that they wanted to pleasure their partners but did not know how to.

Through publications, workshops, etc. TARSHI aims to build comfort around sexuality using and operationalising a rights language. On CSE in particular, TARSHI has reviewed curricula, trained teachers, produced publications, and built consensus on the definition and need for CSE. Young people lack information and skills, and find it difficult to sift through and apply the abundance of information available today. There is no uniform CSE in the country, and teachers feel ill-equipped and uncomfortable to address sexuality related issues in the classroom. However, CSE is important not only to prevent negative unwanted consequences but also to make choices and enjoy one's sexuality. It has the potential to address several SRHR issues if planned carefully, developed systematically and implemented by trained professionals.

Sexual Violence and Right to Health care

In this presentation, Sangeeta Rege of CEHAT discussed the situation vis-à-vis health sector response to sexual violence, and the issues and challenges emerging from it. The current health sector response is characterised by lack of standard protocols, demand for police requisition, insensitive practices (including observations on past sexual conduct of the survivor, two-finger test, irrelevant comments on the status of the hymen, physical built, etc.), overemphasis on presence of injuries, ill equipped health professionals, and non-recognition of non peno- vaginal assaults such as insertion of objects, anal assaults etc. There are many reasons for this poor health sector response: the dynamics of sexual violence are not taught in medical education, and forensic medical textbooks perpetuate several biases against survivors of sexual violence, such as the following myths: "a person who has been sexually assaulted must have injuries", "a woman who is habituated to sexual intercourse cannot be raped", "well-built women cannot be raped against their will". It is believed and taught that rape is the easiest allegation to make but difficult to prove, there are types of women who can/cannot resist rape, it can be determined whether a woman is

habituated to sex based on examination of hymen and elasticity of anus and vagina, and that there is a propensity to make false allegations including against the examining doctor. This has adverse implications for sexual assault survivors whose therapeutic needs are neglected, with immediate treatment not being provided for infections, injuries, pregnancy prophylaxis, or psychosocial support, and who are forced to report assault when they seek health services such as abortion, STI treatment, etc.

CEHAT collaborated with the Bombay Municipal Corporation to establish a hospital based response model for sexual assault, operationalising WHO guidelines and changes in the Criminal Procedure Code and the Indian Evidence Act. This model ensured informed consent, uniform gender sensitive protocol, chain of custody, standard treatment guidelines for medical care, provision for psychological and social support and interface with police, community, courts etc. A gender sensitive proforma was developed which required no mention of past sexual conduct, no comments on built or nutrition of the survivor, and instead focused on the history of the assault such as its nature, threats, intoxication and if the survivor has urinated, bathed, etc. after the assault.

CEHAT has found that 45% of cases seen at the DILAASA Centre reported completed peno-vaginal penetration, with others including fingering, masturbation, attempted penetration, etc. In majority of cases, the disclosure was due to a health complaint and the assailant was known to the survivor. In terms of medical evidence, only 18 of the 94 (19%) survivors reported bodily/physical injuries and only 36 of the 94 (38%) survivors presented genital injuries. Evidence of semen/spermatozoa was seen only in cases where there was emission of semen. Evidence is lost rapidly with time as well as with activities such as urinating, washing genitals, bathing, and defecation. In terms of overall impact, the CEHAT model confirms that sensitive response by health professionals aids the healing of survivors, enables them to seek redress, reintegrate better into their communities and aids convictions by improving the interpretation of medical evidence in court, such as when the absence of forensic evidence or injuries can be correlated with the nature of assault and activities after assault.

The presentation concluded by briefly summarizing the union government's recent guidelines for medico legal care in sexual violence cases—participants were especially encouraged to engage with the specific guidance on dealing with persons from marginalized groups—and by presenting challenges such as the adverse impact of mandatory reporting on the right to health care.

Disability and Sexuality rights

Renu Addlakha's presentation began with a discussion of the dominant representations of persons with disabilities as victims, heroes, as evil, etc. These are largely perceptions of able-bodied society that are likely to be internalized by the disabled during socialization. Disability encompasses a whole range of conditions, and sexual exclusion is an important

part of social exclusion. There is ambiguity and ambivalence around sexuality and disability, with disabled people thought of as asexual or hypersexual and infantilised in a way that erodes their self-esteem and body image. Women with disabilities have to contend with an additional axis of oppression and are socially invisible because they are considered physically unattractive, sexually unmarketable, and incapable of sex, 'normal' reproduction or motherhood. Women with disabilities are at a higher risk of sexual abuse and violation of their reproductive rights in the form of forced sterilization, abortion, etc.

Disability and sexuality rights include the full spectrum of SRHR such as the right to sexual and reproductive health information, services, contraception, safe abortion, prevention of STDs, pre and post natal care etc. as well as the right to marry, explore one's sexuality without discrimination or coercion, safe sex, etc. However, more focus is required on operationalising these rights. For instance, pap smears are not even recommended by doctors for a disabled woman because they assume she is not having sex. And, what would be a contraception regime for someone who is paraplegic – has this been operationalised into some kind of protocols?

The presentation also discussed a range of myths and misconceptions surrounding disability and sexuality. It is mistakenly believed that disabled persons are asexual because reduced or limited functioning in one area (physical) will have a corresponding impact in another area (sexual). It is not true that physically disabled persons cannot have orgasms; although some kinds of disabilities may decrease sensation in various body parts, it does not mean a total absence of sexual pleasure. Similarly it is assumed that disabled children should not receive sex education because it will encourage uncontrollable sexual behaviour. Disabled children are seen as childlike and in need of protection. Because disability is considered the prime definer of identity, it is believed that there is something wrong with a non-disabled person who relates to a disabled partner, and that disabled persons should intermarry among themselves. It is also assumed that disabled persons will give birth to disabled children, but this only holds true for a small number of disabilities. However, these myths and misconceptions can be a dangerous self-fulfilling prophecy. For instance, if disabled persons are segregated they are likely to marry other disabled persons and hence produce disabled children.

Sex Worker Rights

This presentation began with an overview of the current global status of sex work: criminalization of sex work is the dominant legislative approach. Criminal law conflates trafficking with consensual adult sex work, leading to violence and stigma, as laws against consensual adult sex work undermine HIV prevention, allow for excessive police harassment and violence, and weaken sex workers' ability to negotiate safe sex with clients. When their rights are recognized, sex workers have collectivized to protect their health, bodily integrity and control HIV within their communities and beyond. Thus, decriminalization is the first step toward better working conditions for sex workers (like in New Zealand). However, the

“End-Demand” approach of criminalizing the client, or the Swedish model, is gaining ground. There has been a shift in the global understanding of the rights of sex workers. UN resolutions, international agencies and commissions have stressed on a rights based response to sex work and the need to protect rights, not just by decriminalising sex work, but also by eliminating the unjust application of non-criminal laws and regulations against sex workers.

In India too, people in sex work face various kinds of violence. There is a high level of sexual assault, harassment, extortion, as well as abuse from clients and agents, intimate partners, local residents, public authorities and law enforcement authorities.Law enforcement authorities refuse to take cognizance of complaints made by sex workers. Because sex work itself is seen as sexual exploitation and violence, the violence and exploitation that sex workers face is overlooked or ignored, resulting in discrimination. Sex workers also have to contend with forced rescue to rescue or corrective homes. In terms of legal framework, sex work is not criminal in India. However, laws are used to harass and abuse people in sex work, including the laws against soliciting in public, living off the earnings of prostitution, doing sex work in the vicinity of public spaces, etc. Law enforcement authorities conduct forced raids, rescue, and eviction of adult consenting sex workers. The judiciary too orders closure of brothels, and eviction, forcible detention and rehabilitation of adult consenting sex workers.

This situation has many adverse consequences for sex workers. The criminal prohibitions of sex work deepen the risk of human rights violations for sex workers, by not only facilitating their social stigma and marginalisation, but also by making it impossible for them to enjoy the protection of the law when they face violence or abuse. These prohibitions open the door to harassment and extortion by the police. Criminalizing sex work also undermines efforts to prevent new HIV infections, and hinders the provision of treatment and care to those infected.

The presentation also touched upon the report of the Special Rapporteur on violence against women, which was submitted to the UN in April 2014. SANGRAM, VAMP (Veshya Anyay Mukti Parishad), and the National Network of Sex Workers had participated in this process, submitting detailed case studies, deposing in Delhi and Mumbai, and making recommendations. The final report underscores the need to address violence faced from state and non-state actors in sex work and the lack of avenues for legal redress. It reiterates that conflating sex work with trafficking has led to coercive rehabilitation, noting that the violence against sex workers who are sent to rehabilitation centres is a matter of concern. The report also calls for a review of the trafficking legislation.

The presentation ended with a discussion of the demand for decriminalisation of sex work. Decriminalisation is the repeal or amendment of laws or statutes which make certain acts criminal, so that those acts are no longer crimes or offences. Sex workers call for an end to the criminalized environment created by the law, and want the removal or amendment of

specific punitive laws and policies targeting sex workers, clients and third parties. This demand should not be confused with legalisation, which will mean regulation and control by the state, ushering a zone specific 'licence raj' with mandatory health check-up, criminalizing defaulters and possibly even some aspects of sex work like clients. Sex workers also need appropriate anti-discrimination legislation to enable them to address discrimination, and should be supported to have a meaningful dialogue with policy makers, to collectivise, and to represent other sex workers in consultative processes.

Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Rights

In this presentation, Rituparna Borah laid out questions and real-life case studies in the first person about LGBTQI individuals and their SRHR related concerns. These included:

- A 23 year old woman who attends a posh Delhi college has a girlfriend but must keep it a secret even from her progressive friends. She has severe vaginal pain for ten days and has been referred to a progressive gynaecologist. She is afraid to go because she will be asked if she is married or if she is sexually active with her boyfriend.
- A 20 year old woman from a village in Uttar Pradesh is attracted to other women. Because of the intervention of a local organisation working to combat early marriage, she was not married off till the age of 18. Now that she is 20, there is a lot of pressure on her to marry. She is scared that she will not be able to have sex with her husband.
- A 35 year old hijra is very ill and goes to a hospital for treatment. There is confusion among the hospital staff about which ward to put this person in. There is no consensus and s/he is secluded.
- A 44 year biological woman wants to undergo a sex reassignment surgery to become a man. The doctor s/he is seeing is unsympathetic and tells him/her this is just a passing fancy.
- A female to male transgender who has not had surgery is unsure about what bathroom to use in public places.
- A boy who liked to do make up finds no space where he can even talk about it, let alone do it.
- A biological woman who wants to be a man wears a chest band. The band is painful and gives him/her rashes but s/he is afraid to visit a physician because s/he feels s/he will not be understood.
- A 38 year old Trans woman knows many foreign languages and is regularly called for interviews when she applies for jobs but never gets hired.

These real life experiences are all also instances of SRHR violations. However, these experiences do not usually find the space they need and deserve within SRHR. To begin with, we must view LGBTIQ as separate identities based on sexual and gender difference. However, it cannot be assumed that these are minorities because there is no evidence to

support this claim. There are linkages of LGBTQI issues with issues of caste, class, religion, etc. as well as with the question of visibility. What you look like becomes important. A cis-gender lesbian may have no problem accessing health care but the same experience for a Transwoman could be discriminatory and traumatic. Even with trans identity, male to female has a certain kind of visibility that female to male does not. Traditionally SRHR work has been done with and for women. We need to ask ourselves if our definition of woman is constrained by biology. To include a queer perspective in our work is to ask all of these questions. Crucially, it is also about reaching out to people who feel different from the norms of gender and sexuality.

SRHR of People Living with HIV

In this presentation, Kajal Bharadwaj discussed the SRHR related law and policy framework for people living with HIV (PLHIV). The SRHR of PLHIV includes freedoms such as the freedom of choice regarding consensual and pleasurable sexual expression, freedom of choice regarding reproduction, marriage and family planning, and the fundamental right to access sexual health information and comprehensive sexual health services.

The National AIDS Control Programme includes prevention (targeted interventions with key populations), treatment, testing and counselling, as well as some efforts to integrate HIV within RCH, ARSH and state level health policies. Although this work continues, the NACP has now been discontinued. The legal framework for the SRHR of PLHIV can be found in many places, including the constitution of India, and laws relating to marriage and family, sexual violence, criminal laws relating to sex work, same-sex sexual contact and drug users, laws relating to employment, inheritance and property rights, medical practice and production of medicines, common law relating to consent and confidentiality, and laws relating to obscenity and education.

The HIV/AIDS Bill 2007 was introduced in the Rajya Sabha by the previous government in 2014. Some provisions from the original were modified: prohibition of discrimination was limited to PLHIV and those living with them, provisions outlining conditions for taking informed consent from a representative were removed and the blanket age of consent is now 18, government will commit to providing ART “as far as possible”, provisions related to sex education/IEC generally/counselling for sexual violence have been removed, andthere is to be no protection from criminal charges for providing risk reduction to children. This Bill is now before the standing committee and the approach of the new government remains to be seen. The presentation highlighted important judgments for the SRHR of PLHIV and HIV transmission, including pre-marital mandatory testing, mandatory testing of sex workers, and the right to marry case where the Supreme Court reversed its own ruling (the right to life of a woman trumps the right to confidentiality of HIV positive persons) but specified no protocol for partner notification.

The presentation also discussed the status of parenthood for PLHIV. The proposed regulation for Assisted Reproductive Technologies stipulates that couples interested in IVF be tested for HIV and, that donors not be HIV-positive, even though studies have shown that there is no transmission of HIV through IVF where the donor is HIV-positive. This also does not take into account treatment to prevent mother to child transmission. With regard to adoption, prospective parents require a certificate from a medical practitioner stating that they do not suffer from any chronic, contagious or fatal decease and they are fit to adopt. The status of sero-discordant couples is unclear. Because of the HIV testing of pregnant women, most women find out their HIV status through pregnancy and are blamed for the infection; maintenance of confidentiality and partner notification standards are issues here. NACO guidelines require that the specific offer of abortion be made to pregnant PLHIV; a 2008 study indicated that 16% of women undergo abortions on learning of their HIV status. However, treatment to the pregnant woman can prevent transmission to the child. Despite the long standing WHO recommendation for multi-drug regimen for pregnant PLHIV, the government has fully adopted this only in 2012-13. There is evidence that sero-discordant couples on treatment are now checking viral load suppression and having children. Finally, safe and non-discriminatory delivery options are needed for HIV-positive pregnant women.

The presentation also discussed the role of treatment for the SRHR of PLHIV. At present NACO provides first and second line treatment. PLHIV moved the Supreme Court to ensure access to second line treatment. Close to 7.5 lakh PLHIV are on treatment in India and the government provides treatment based on the production of affordable medicines by Indian generic companies. In fact, today 14 million PLHIV worldwide are on treatment thanks to generic medicines from India. PLHIV are in court to protect generic medicines and challenge patents. Indian groups have been campaigning against multinational companies that are trying to prevent generic production in India. US and EU governments are attempting to stop affordable treatment in India through free trade agreements.

The presentation concluded by listing the challenges for the SRHR of PLHIV. There is crisis both within the global funding on HIV and India's HIV programme. The AIDS Control Department was scrapped within a few months of the new government, with budget cuts and ARV stock-outs being reported. The future of our HIV programme is unclear. Simultaneously, the access to affordable generic medicines is in crisis, with MNC onslaught through litigation, US/EU pressure on India and Free Trade Agreements.

Discussion

The chair began the discussion by emphasizing the need to support interconnected campaigns, although this is a challenge given that work happens in silos and with time and other constraints. For instance, there has been remarkable support from hijras for the access to medicines campaign because of the understanding that this is a battle against not just one disease but in a larger context.

To a question on why the TARSHI help line had shut down, Prabha responded that when TARSHI started the help line, mobile phones were not common. It was easier for men to go out to call, whereas women faced physical and social barriers. When the help line began, only 5% of callers were women and by the time it closed, this had risen to 20% but no further. The help line had to close due to lack of funds. Currently an IVRS model is available but TARSHI has not been able to augment the live counselling element. There is also a recent partnership with CREA and Gram Vaani over dynamic content. TARSHI has been approached by mobile phone operators for a value added service but the terms of the arrangement were unfavourable. Similarly, a call centre model is more focused on volume and is not favourable to long counselling calls.

In response to a question on replicating CEHAT's work with the Bombay Municipal Corporation, Sangeeta pointed out that Mumbai does not need more than 3 or 4 crisis centres. Not every hospital needs to have a crisis centre to be able to respond to sexual violence. However, even in the absence of infrastructure, small hospitals can have trained personnel to screen, provide basic psychological aid and refer cases. The proposed Nirbhaya crisis centres, for instance, are to be located in the hospital premise but will have no interaction with hospital. The CEHAT model was set up in 2000 and external evaluation of its feasibility has been promising. CEHAT is also looking at five subjects in medical education with the aim to teach these with a gender perspective rather than to change curriculum.

In response to a question on the Chandigarh Nari Niketan case, Renu pointed out that although the focus of the case became the right to reproduce, the fact that an intellectually disabled woman was raped in a government home was underplayed. The larger disability movement that is hugely patriarchal did not engage much with this case. It seemed finally like the woman was "allowed" to have the child but the legal age of abortion had also passed. This is a symbolic case that can be archived but its influence has been limited. The fact is that many intellectual disabled women are functioning as mothers in rural areas. It is also questionable whether this case would have taken a similar course if the woman's family had been involved.

One participant pointed out that despite guidelines to prevent mother to child transmission of HIV, integration has not happened. Hospitals, especially private hospitals, are not ready to treat HIV positive mothers.

There was discussion on the dynamics of sexuality in community-level work. One participant mentioned that casting aspersions on the sexual morality of community health workers is often the first backlash experienced when such workers mobilise women at the community level. This has the effect of making community health workers very defensive about their morality and unwilling to talk about sexuality, let alone issues like sex work. Even a married woman who is having an affair will be removed from the organisation not because the other staff members disapprove, but because they believe their work will suffer if she stays. At the same time, it should not be assumed that communities are not ready to talk about sexuality.

Conversation can be and are being had on sexuality in more general terms rather than in identitarian LGBT language. From curriculum review to workshops in urban slums to film screenings and discussions, there are many ways of working on sexuality issues with communities.

It was pointed out that in view of rising global market and religious fundamentalisms, strategies should be devised in terms of the micro, meso and macro. With the recent change in government in India, even the pretence of political correctness seems to have been abandoned. We are not sure if the present regime will understand our language around rights, now that even national security is being framed as economic security. And although it feels like we are under siege, we must strategize and act because another right-wing civil society is fast on the rise. We need to be clever about language around programs like sex education but we cannot afford self-censorship.

There was discussion on both state and activist responses to sex work. One participant asked how a response could be developed to the standard question, "*would you like your daughter to be a sex worker?"* Others responded that with the due protection of the law, sex work can have better conditions, and that anyway other livelihood options for poor unskilled women are equally if not more unattractive, so sex work should be seen as legitimate work for anyone's daughter. Another participant asked about India's perspective on banning sex work, to which the chair responded that even though the Swedish model travelled to Norway and France, India campaigned against it. Even government evidence of the Swedish model suggests that sex work is not disappearing as much as it is going underground, becoming in the process hurried and less safe. A reason why the conversation on sex work becomes very polarizing is because it is needlessly conflated with trafficking. Today, serious questions are being asked about the inflated trafficking numbers that have been historically quoted.

Session Eight

Law and SRHR

Using the Law to Advance SRHR

In this presentation Kerry McBroom discussed efforts of the HRLN to use the law to advance SRHR, citing important judgments that have achieved this. Legal advocacy can be an instrument with which to access justice for the most marginalized members of society and guarantee fundamental rights across India. State accountability is a key component to conceptualizing reproductive and sexual health as rights. This can be accomplished through Public Interest Litigation and Writ Petitions that can ensure the fulfillment of constitutional guarantees; as such, they have potential for immense change, are inexpensive, can set precedents, and are filed and pursued in conjunction with NGO partners. HRLN currently is

involved in roughly fifty cases under its reproductive health initiative, including the Supreme Court case on the implementation of PCPNDT, as well as on the extension of the time limit on MTP.

Increasingly, international and regional bodies are looking at SRHR as human rights, such as CEDAW, HRC and regional courts. In India, key judgments that establish SRHR as human rights are Ramakant Rai, Laxmi Mandal and Sandesh Bansal, which state that every woman has the right to survive pregnancy.

There are different strategies of legal advocacy. Issues can be identified by NGOs, individuals, advocates/activists, or news media. HRLN conducts trainings and consultations, as well as fact-findings, filing of RTI requests, making representations to the government, and filing cases. These strategies are used to ensure implementation. For instance, in the case of Laxmi Mandal and Jaitun, a rights-based approach to TB was applied that intended to show that marginalised people suffer a continuum of violations. This was seen by officials as a "story" that is an exception to a very successful TB intervention, but it was really a demand for action and accountability.

In the case of Pul Mithai, an activist informed HRLN about a slum community of 350 families at old Delhi railway station that lacked essential services. A fact-finding was conducted, and after constant follow up, orders were secured that ensured accountability. Now services are being provided to this slum by a court order that directed the respondents to: immediately have the building for an after –school- programme cleaned, repaired, and maintained; ensure the presence of Anganwadi workers including the doctor at the center during all requisite hours; provide immunization, ante-natal care, counselling, family planning and other services; make arrangements for the supply of potable drinking water to the residents of the slum; and devise a method to ensure regular payments under the JSY to the entitled women. The order also listed the telephone numbers of the CDPOs.

The presentation also gave the example of other such legal advocacy efforts. It concluded by emphasizing that while the law may appear hostile and complicated from the outside, it should be seen as one important tool in a wider toolbox to advance SRHR.

Laws that Impede SRHR in India

In this presentation, Anubha Rastogi elaborated on provisions and laws that impede conversation and action on SRHR. SRHR cases can be brought within the right to life, expanding its ambit. But just as laws can advance SRHR, they can impede SRHR too. In fact, even the non-mention of SRHR in the law is a violation.

In POCSO, the definition of child is anyone below the age of 18. This is a special law that overrides any general law, including the Criminal Law Amendment Act2013, and requires mandatory reporting. While the categorisation of sexual assault into sexual assault and aggravated sexual assault, and the expansion of its definition beyond just penile-vaginal

assault is welcome, to stipulate age of consent as 18 years is very problematic. For instance, who is the offender when two children are booked under POCSO? Mandatory reporting has other consequences as well; it impedes access under MTP. Any sexual activity below 18 is to be viewed as sexual assault, and a pregnant under-18 cannot access abortion services without the doctor having to report her as a victim. However, doctors are expected to protect privacy under MTP. Even if we assume the sexual activity in question was indeed non-consensual, is it fair to push someone to use the criminal justice system given its complications? Even if a help line counsellor or social worker knows of such a case of under-18 'sexual assault' and does not report it, he/she is liable to be prosecuted.

There is an international push to make child marriages void. If a child marriage takes place, it is up to the minor in question, upon crossing the age of 18 or 21, to seek an annulment of that marriage within 2 years. It is their right and theirs alone, and maintenance etc. is done like with a spouse. Now there is international pressure on the government that if it is serious about child marriage then all such marriages must be declared void. This is problematic. In the absence of the government having fulfilled its responsibility, such as to create awareness or even appoint CM prevention officers, child marriages are happening and will continue to happen. With a move like this, women who have adjusted to these marriages and wish to continue in them will have no agency. Also, many young adults legitimise their consensual relationships through marriage, especially if there is social disapproval because they are inter-caste or inter-religion. If all child marriages are automatically void, their parents will clamp down on them.

As voices on SRHR, we need to look at these contradictions and dangers. Even the MTP has not given us abortion as a right and in practice, consent of the partner is sought and other problematic practices are followed. As for sexual rights, in the Indian context while even consensual sexual intercourse under 18 is statutory rape, marital rape is not illegal even if you are under 18. Much more engagement with law is required and there is a huge gap in the understanding of legislators and lawyers that needs to be filled. Through legal advocacy, some of this is achieved. If cases of this nature continue to be argued and petitions continue to be filed, then judges have to read, be prepared and engage. As the lawyer too one has to be prepared to strategize and improvise, depending on the judge. One judge may be persuaded to see the poor condition of reproductive health services as a violation of the right to life and health—even gender discrimination given these are services that only women require, but another bench may be more interested in picking up the corruption angle.

Discussion

The chair Jashodhara Dasgupta began the discussion by highlighting two distinct dimensions of the law. While on the one hand the law can be used for accountability, such as to ensure the provision of health services, on the other hand the law also functions as codified social norm. Today some very problematic social norms are being legitimised through acts like

POCSO under the guise of protecting children. As activists, we are also aware of the limits of the law. We have celebrated the Supreme Court orders in a case like Ramakant but the recent sterilisation deaths at Bilaspur are a reminder that much has not changed on the ground. These are matters of great introspection for us. Also as activists, we have to be especially cautious about this protectionism, such as when we use terms like early and child marriage indiscriminately. For instance in Uttar Pradesh, the police reserves an uncanny enthusiasm for arresting couples that have married even two months short of 18 when the boy is Dalit or Muslim.

One participant noted that in Jharkhand too, the elopement of young people is seen as an epidemic. Instead of having a so-called crime scenario with no victim and two accused, it makes much more sense to just lower the age of consent for marriage.

Also, often people do not want to take cases of violence to the criminal justice system and prefer instead to approach local leaders who pronounce judgment. These parallel systems do not dispense justice. It is important to work at many levels, especially on the ground, if we want a robust system that dispenses justice.

It was noted that while many judges are problematic, there are also some who uphold rights. It is important to keep up dialogue with judges. Often it is dialogue and strategizing that gets results, like if we can get a solution oriented judge in one case (eg. PCPNDT) to pass an order that favours us in a related arena (eg. Two child norm).

Session Nine

Working together to advance our respective agendas: Summary, strategy and discussion

This session began with facilitator Sundari Ravindran succinctly summarizing the key takeaways from the two days of the consultation:

- SRHR issues lie at the intersection of many other issues
- Patriarchal power today is drawing on market and religious fundamentalisms
- There is an altered donor environment within which SRHR funding has reduced and is measured against often unrealistic outcomes.
- There is a changed political reality in India today that threatens SRHR, including coercive population control, denial of abortion, unnecessary hysterectomies, negative laws, etc.
- We need to work together, recognise the linkages in our work, and support each other's issues.

The facilitator invited comments on the modalities of engagement for an SRHR alliance in India, specifically on the kind of alliance we desire, its scope and boundaries.

Alliance-building

Alliance building is often tokenistic rather than meaningful. We include alliance-building in our proposals and publications but these are usually tokenistic representations. To make alliances about meaningful engagement is a challenge that we should start thinking and speaking about very seriously. For instance, issues of PLHIV can be but are not addressed in so much of SRHR work.

One participant felt that the alliance to advance SRHR in India should be a knowledge alliance. It should discuss issues like a queer perspective. Normative notions of marriage and sexuality are too narrow for most people, so we should scrutinize and question the privilege and violence of these normative notions. This includes contemporary issues like love jihad, as well as the ways in which we exclude people in our imaginations. For instance, instead of saying husband and wife we should use the term partner. Even talking about disability and sexuality is a kind of queering.

Another participant felt that while perspective building and knowledge sharing is important; we will have to move beyond that if we do not want to be overtaken by the events and the climate of this time. Within the queer movement there is so much diversity that it can safely be said there probably isn't one queer movement at all. Perspectives on issues like marriage certainly are not monolithic, for instance. However, the experience from the fight against Section 377 is that this was not an LGBT issue alone and we worked hard to build linkages and garner allies. Today with HIV funding reducing, many HIV groups that also work on LGBT issues will have to recalibrate. The experience with the judiciary remains a roll of the dice, and we have to keep up the work of sensitising members of the judiciary workshops about HIV and sexuality. We should be able to articulate minimum commonalities in a language that is accessible to all.

It was also pointed out the need for conceptual clarity for an alliance to be on the same page. While we all want to make a difference in the lives of women and their families, engagement with the public and private health systems and with donor agencies requires a lot of strategizing. One of the reasons civil society has not been very effective with the government is because NGOs speak in different voices and that makes it easy for the government not to take any one very seriously. We need to think about how we position ourselves and we need to produce good documents that clearly articulate our vision, so we can influence those in power who control our lives.

Women's health beyond reproductive health

One participant pointed that the public health system, such as in Jharkhand, is focused on making babies or not. We need to think about how we can inject such a system with the discourse of sexuality. There are many government schemes dedicated to pregnant women

and women in their reproductive age. Even for a scheme like *Sabla*, the nutrition component works well but the non-nutrition component tends to remain underspent.

Reaching out to newer constituencies

It was also pointed out that we need to be able to talk about SRHR issues and our perspective in the mainstream. Towards this, we need to think about the role of the media, especially the social media.

Another participant agreed that the discourse used in mainstream feminism is very academic and elitist, and we need instead to operationalize a language that is understood by more people.

It was also pointed out that SRHR groups must reach out to population studies because the most demographers continue to follow Malthusian rather than rights based approaches.

Sex work and feminism

On the question of sex workers, some participants noted that there is nothing intrinsically wrong with the profession of sex work. The violence in sex work can be contained with a rights-based approach to sex work. It is important to keep morality out of these conversations and to instead focus on the working conditions in the lives of poor women, whether they do sex work, domestic work, garment work or any other.

It was also mentioned that we should be careful about the vocabulary we use to refer to the commercialisations in sexual and reproductive life. For instance, some feminists have called surrogacy in India reproductive trafficking although there is no evidence of the use of coercion or fraud in surrogacy. Today, industries like surrogacy and the participation of poor healthy people in certain clinical trials present us with new and complex issues, but we cannot insist on seeing these issues through irrelevant or moralistic frames.

Young people's issues

It was stressed that urban youth is often left out of SRHR conversation but we should not assume they know everything just because they have more access to modern technologies. It was suggested that we could use a common blog space to share resources.

There has been a lack of inter-generational dialogue within the feminist movement. Many of the younger feminists are considered inexperienced and their views are not given much importance.

Young women who are not mothers are neglected by SRHR programmes. They are excluded from adolescent programs that target delaying age at marriage as well as from maternal health programs, even though they may be facing many issues.

Queering SRHR

Another participant added that the SRHR discourse is predominantly heterosexual in nature, even though the issues themselves are not. When condoms were first used for HIV prevention, it took time before condoms were seen as necessary by men who have sex with men, since condoms were steeped in the population control discourse. In the work with female partners of MSMs, it is the men who find condom usage difficult to negotiate. Often wives have had tubectomies, and get suspicious if their husbands use condoms for sex.

It was also pointed out that with the transgender judgment of April 2014, there is more reason and scope to work together on SRHR issues.

There needs to be clarity about the kind of support and solidarity we need from other movements. For instance, NAPM issued a statement against the 377 judgment. But the feminist health movement was not as vocal. Several lesbian and bisexual women who seek hysterectomies have to confront resistance from their doctors that they will 'lose their womanhood'. And while the feminist health movement has taught us to celebrate our bodies in non-invasive ways, many women who want and need surgery should be able to get surgery, and we should support them.

Issues are seen in silos despite the interconnections between them. Lesbians can talk about many issues like livelihoods but are invited to talk on LGBT identities. The queer perspective should be a part of all our work and not just part of the work that queers do.

Conclusion and Thanks

In conclusion, the facilitator pointed out that some major directions have come up in the discussion, with many pointing out the need for continued engagement for sharing information, developing inclusive language and learning from each other's work and perspectives. For instance, what does a queer perspective mean across the spectrum of SRHR? While organisations like CREA and TARSHI already run blogs, we could think about pooling our resources to meet once every year or two to update and challenge ourselves. The agenda for such a meeting could be structured to factor in more focused, conceptual sessions. That being said, given today's political climate we may have to go beyond perspective building. Of course, everyone is focused on their own discrete area and cannot take up everything but it is important to stay connected. The minimum we could do is call upon each other when we have issues that need concerted attention. The many participants of this two day meetings can continue to share resources, calls for action, etc. Each of us is plugged into our own networks and what is shared will be multiplied accordingly. The purpose of this interaction was not to launch an alliance but really to see if we would like to listen and learn from each other. We are convinced that we are working on interconnected issues.

The session closed with a vote of thanks to the participants, organisers and funders.

Annexure One: List of Participants

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Annexure Two: Consultation Agenda

TIME	TOPIC	SPEAKERS
	DAY 1	
9:30-10:45	I**ntroductory Session** Introduction to the meeting Introduction to participants Overview of the International Context of SRHR Overview of the Indian Context of SRHR	**Chair:** Sharad Iyengar, ARTH Renu Khanna, SAHAJ All participants TK Sundari Ravindran Renu Khanna, SAHAJ
10:45-13:15 11.15-11.45	**Rights-based Approach to Contraceptive Information and Services** Overview of the historical context of Family Planning programs in India TEA Presentation of the Advocate's guide Feedback from the floor	**Chair:** Poonam Muttreja, PFI Leela Visaria Renu Khanna, SAHAJ All participants
13.15-14.15	LUNCH	
14.15-15.15	**Rights and fertility related issues** Continuing struggle for access to safe abortion Campaign against the two-child norm	**Chair:** Alka Barua, Commonhealth Hema Pisal, MASUM AR Nanda
15.15-15.30	TEA	
15.30-16.30	**Neglected issues in SRHR** Men and SRHR SRH and mental health	**Chair:** Alka Barua, Commonhealth Satish Singh, CHSJ Ketki Ranade
16:30-17:30	**Commercialization of SRH** Unnecessary hysterectomies Commercial surrogacy	**Chair:** Lakshmi Lingam TISS Chhaya Pachauli,PRAYAS Sarojini N, Sama

TIME	TOPIC	SPEAKERS
	DAY 2	
9:00 -10:30	**Young People's SRHR** Comprehensive Sexuality Education Young People's Voices from the Ground	**Chair:** Nilangi Sardeshpande, Commonhealth Reena Khatoon, YP Foundation **Moderator:** Sanjana Gaind, CREA **Speakers:** Dileep, SAHAJ Neerja, SAKHI Sandhya, Sakar Sunita, Mahila Swarozgar Samiti
10.30 -11.00	TEA	
11:00 -13:30	**Sexual Rights** No reproductive rights without sexual rights Sexual Violence Sexuality and Disability Sex workers rights LGBT rights SRHR of people living with HIV	**Chair:** Vivek Divan Prabha Nagaraja, TARSHI Sangeeta Rege, CEHAT Renu Addlakha, CWDS Vrinda on behalf of SANGRAM Rituparna Borah Kajal Bharadwaj
13:30 -14:30	LUNCH	
14:30 -15:30	**Law and SRHR** Using the law to advance SRHR Laws that impede SRHR in India	**Chair:** Jashodhara Dasgupta, NAMHHR Kerry McBroom, HRLN Anubha Rastogi
15:30 -16:30	**Summary of issues presented over the two days** Working together to advance our respective agenda: Discussion of strategies	**Chair:** Sundari Ravindran Facilitated plenary discussion
16:30 -17:00	CLOSING AND TEA	