

IFHHRO Annual Conference

Engendering Health and Human Rights
30th September - 1st October 2005
Mumbai, India

Programme and Abstracts

Conference Venue

YMCA International House and Programme Center
18, YMCA Road, Mumbai Central, Mumbai – 400008
Tel: 022-3070601 / 3091262



The International
Federation of Health
and Human Rights
Organisation
Centre for Enquiry into Health and Allied Themes



Cehat
Centre for Enquiry into Health and Allied Themes



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into Health &
Allied Themes

**Engendering Health and Human Rights
IFHHRO Annual Conference 2005
YMCA, Mumbai Central, India.**

30th September, 2005, Friday -9.00 am

Welcome and Introduction - Adriaan van Es and Ravi Duggal (Co-Chairs)

Prof Paul Hunt - Keynote Address Dept. of Law, University of Essex, UK UN Special Rapporteur on Right to Health	Engendering Health and Human Rights: Maternal Mortality as a Violation of the Right to Health
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Plenary Session I - 09:45 am - 11:00am

Vibhuti Patel Head P.G. Dept. of Economics, Mumbai	Gender Based Violations and Discrimination in South Asia
Aleid Bos IFHHRO, Netherlands	Combating Violence against Women with International and Human Rights Law

Questions / Comments from the floor and Summing up

11.00 am - 11.15 am Tea / Coffee Break

11:20 am - 1:20 pm Parallel Sessions (Each speaker will get 20 minutes)

Sub Theme 1

**Women's Health and Human Rights Concerns in Situations of War and Conflict,
Including Ethnic, Communal, Race and Caste Dimensions**

Co-Chairs: Amar Jesani / Len Rubenstein

Presenter	Title
Len Rubenstein - USA	War- Related Sexual Violence in Sierra Leone: A Population Based Assessment
Sathyasree Goswami - India	The Forgotten Person Understanding Women's Human Rights Violation in Armed Conflict Situation
Zamrooda Khanday - India	Honour and Health: Women's Life in The Valley
Michael Wilks - United Kingdom	Involvement of Health Professional in Abuse of Prisoners
Surinder Jaiswal - India	Women's Health Concerns in Conflict Situation

Sub Theme 2

Domestic Violence as an issue of violation of Health and Human Rights

Co-Chairs: Dr. Seema Malik/ Marianne Begemann

Liliya Sazonova - Bulgaria	Domestic Violence as a Health and Human Rights Issue
Sohini Basu - India	Health Disorders of abused Women: A Study in Kolkata
Tapas Kumar Basu - India	Role of Health Professionals in IPV
Khairul Hafiz - Bangladesh	The Most Horrific Domestic Violence, Acid Violence - In Context of Bangladesh

Sub Theme 3

Dealing with Sexual Assault and Harassment for protection of rights of victims and survivors Co-Chairs: Ruben Naidoo/ Dr Rukhmini Krishnamurthy

Shanti Ranjan Behara - India	Sexual Assault, Harassment, Rights and Social Justice
Sanchoy Kumar Chanda - Bangladesh	Violence against Commercial Sex Workers (CSW) in Bangladesh
Vina Vaswani - India	Atrocities against Workers of the Unorganised Sector - Day Light is a Long Way Off

Djordje Alempijevic - Europe	Severity of Injuries among Sexual Assault Victims
1:20 pm - 2:50 pm Lunch Break	
Poster Presentations during Lunch Break	
Arvind Tiwari & Satyani Guin	Medical Care in Indian Prison: Perspective and Issues
Abijit Das	Violence Against Women, Health and Rights - Policy and Programme Implications in India
Anjali Kulkarni	Health Care Where It Is? Rural and Urban Poor Women
M.Gunasekaran	Barriers to Health Rights
Manmohan Sharma	Issues Emerging Working with HIV+ Person in the State Of Punjab
Mary Venus Joseph	Health Rights of Women in Kerala - an Enquiry
2:50pm – 6:00pm Parallel Sessions (Each speaker will get 20 minutes)	
Sub Theme 4	
Misuse of Reproductive Technology, Gender Discrimination and Rights Violation	
Co Chairs: Lakshmi Lingam/ Anna Dani	
Hagit Peres - Israel	Owners of Female Bodies and Owners of Future Children: Arab-Bedouin Women in Inter-Cultural Encounters with Prenatal Services
Meghana Joshi - India	Addressing Infertility- A Reproductive Health Right
Nirmala .V - India	Impact of Gender Discrimination and Violation of Human Rights on Sex Ratio in India
Sub Theme 5	
Violation of Rights of people living with HIV/AIDS	
Co-Chairs: Shalini Bharat / Jaime Miranda	
Mariette Correa, and David Gisselquist - USA	Defeating HIV Stigma with Accurate Information About HIV Risks In Health Care Settings
Ahmad Rana Gulzar and Ahmad Rafi-ush-shan - Pakistan K.I. Jacob - India	Gender, Sexuality and Health Addressing Stigma and Discrimination at the Community level through Home/ Community Owned Care and Support Program
Shuguang Wang - China	Success in Developing an Innovative Cultural Strategy to Promote HIV Prevention and Human Right in Minority Ethnic Yi Community Of China
Sub Theme 6	
Discrimination in access to healthcare, especially reproductive health	
Co-Chairs: Dr. Julian Sheather / Dr. Sanjay Nagral	
Joe Thomas- Australia Mridula Bandyopadhyay - India	Public Health Implications of HIV/AIDS related Stigma, Discrimination, and Human Rights Violations: Issues, Challenges and Emerging Responses
Tarujyoti Buragohain - India	Level of awareness of RTI, STI and HIV/AIDS ad Gender Discrimination in Treatment in India



Len Rubenstein - USA	Maternal Mortality in Heart Province, Afghanistan: A Case Study in understanding Discrimination in Access to Health Care
Samal Viswo Varenaya - India	"Triple Jeopardy" of Women – Discrimination in Access to Healthcare based on gender, caste-status and disability
6:30 pm onwards Cultural Evening - Conference Hall 1 and 2	
1st October 2005, Saturday 9:00	
Introduction - Robert Simon and Dhruv Mankad (Co-Chairs)	
Plenary Session II - 9:15 am - 10:00 am	
Sofia Gruskin Health and Human rights Harvard School of Public Health	Addressing the Missing Link of Gender Equity in Health Human Rights-What Hasn't Been Considered: what needs to be
Lakshmi Murthy Women Activist and Freelance Journalist	Missing Links Civil Society Perspective
Questions and Comments from the Floor and Summing up	
Valedictory Session by Aruna Sharma Jt. Secretary, National Human Rights Commission, New Delhi "Role of NHRC in Promotion and Protection of Health and Human Rights"	
11.00 am - 11.15am Tea/Coffee Break	
Parallel Sessions (Each speaker will get 20 minutes)	
Sub Theme 7	
Good Practices and Strategies for Engendering Health and Human Rights	
Co-Chair: Dr Anant Phadke / Prof Tarantola	
Anant Bhan and Sunita Sheel - India	Engendering Health and Human Rights in Developing Countries: What does Bioethics Have to Offer?
Geeta Sodhi - India	A Community based Clinic's Approach to Addressing Sexual Violence
Paredes, A. Giannina - Peru	Therapeutic Groups: Listening to Women who have Experience Domestic and Sexual Violence
Márquez Lilly - Ecuador	Perception and Reality of the Access of Reproductive Health in Ecuador
Dr. R D Lele - India	Health Management Organisation Linked to Insurance
Sub Theme 8	
Monitoring Gender Concerns in Rights Violations	
Co chair: Marianne Haslegrave/ T.F.Thekekara	
Saskia Bakker - Netherlands	Engendering Health and Human Rights
Julian Sheather - United Kingdom	National Medical Associations and Gender Equality
Raju Prasad Chapagai - Nepal	Judicial Response to Reproductive Rights through Public Interest Litigation: A Nepalese Experience
Abhijit Das - India	Family Planning in India: Rights, Laws and Standards
Sub Theme 9	
Data and Evidence on Gender Inequities in the Human Rights context	
Md. Rezaul Karim and Rakib Hossain - Bangladesh	Women's Health and Security Concerns in Shrimp Cultivation and Shrimp

	Processing Plants in The Coastal Areas of Bangladesh
Ocen Sam Fortunate - Uganda	Young People Rights Violation, an Engine to HIV/Aids Prevalence rates among young people
Ramesh Chellan - India	Socio-Economic and Medical Provider Correlates of Post Abortion Complications among Married Women in India: Findings from Reproductive and Child Health Survey
Bijoya Roy - India	Gender Dimensions of Health Sector Reform: Challenges and Limitations to Women's Health and Rights
1:20 pm – 3:00 pm Lunch Break	
Poster Presentations during Lunch Break	
Purna Chandra Upadhyaya	Engendering Health and Human Rights: The Case of Nomadic Women Healers and their Cultural Practices in Uttar Pradesh' (Especially In Mirzapur District)
Nilika Mehetro	Women and Disability Management in Rural Haryana
Soubhagya Ranjan Padhi	Endangering Health and Human Rights of Tribal Women in the Koraput District of Orissa
Pratibha Joshi & Devyani Bhardwaj	Women's Midlife Transition..... Is The End Of Life?
Shampa Sengupta	Access to Information on Health: Rights Denied to Women with Disabilities
Shilpa Johny	Gender & HIV/Aids: Double Jeopardy of Women
3:00 pm – 6:00 pm - Parallel Special Training Sessions (Please note: This requires separate prior registration)	
4:00 pm – 4:15 pm Tea/Coffee Break	
CEDAW and Human Rights Trainer: Manisha Gupte	
Orientation on Gender Equity Concerns in Health and Human Rights Trainer: Sophia Gruskin and Vibhuti Patel	
Orientation in use of 'Sexual Assault Evidence Kits' for better care and Evidence Documentation Trainer: Dr.Amita Pitre and Dr. Ruben Naidoo	
3:00pm onwards Parallel Film Festival	
Please visit the Market Place where stalls have been put up by various organisations displaying and selling their products at the Basketball Court of Venue	

Note- Kindly consult the Registration Desk for information on the rooms for the respective sessions



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Engendering Health and Human Rights IFHHRO Annual Conference 2005

The Conference

IFHHRO conducts annual conferences on themes linked to health and human rights each year. The conference theme for year 2005 is Engendering Health and Human Rights. The Conference is being held in Mumbai, India on 30th September and 1st October 2005.

There is one plenary session on each day of the conference and a number of parallel sessions on sub themes. The plenary sessions have invited speakers and sub-theme session presenters are selected on the basis of abstracts submitted. Each sub theme parallel session has up to four presenters who will make 15-20 minutes for presentation and 40 minutes are provided for open discussion.

Objectives

The overall aim of the conference is to debate and bring to the table issues of gender inequities within the human rights context and discuss good practices and strategies for engendering health and human rights, including the role of health professionals.

Outline of the Theme

While human rights in itself is about equity, the character of society, which presently is dominated by a patriarchal and class differentiated framework, determines the extent of equity that will be found in reality. Human rights are no exception. The fact that a separate mandate called CEDAW was necessitated in the international arena clearly reflects that gender equity is a concern that needs to be addressed separately. Given this reality the theme Engendering Health and Human Rights has been taken up as the focus of the 2005 IFHHRO Conference.

The *Universal Declaration of Human Rights* adopted by the United Nations General Assembly in 1948 outlined a consensus on the human rights of all people. However, tradition, prejudice, social, economic and political interests have combined to exclude women from prevailing definitions of “general” human rights and to relegate women to secondary and/or “special interest” status within human rights considerations even in the 21st century. This marginalisation of women in the human rights domain has been a reflection of gender inequity in the world at large and has also had a formidable impact on women’s lives. It has contributed to the perpetuation of women’s subordinate status and thus has made the process of seeking redress for human rights violations disproportionately difficult for women and in many cases outright impossible.

But the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted in 1979 by the UN General Assembly changed this. The issue of gender, since CEDAW, has moved to center stage in the debate on human rights. CEDAW has laid the foundation for women’s international human rights laws, transcending national, religious and customary laws. To address the legal, social and economic structures at the root of women’s weak position in law and society, CEDAW requires States to undertake constitutional, legislative, and socio-economic reform aiming at the elimination of all forms of discrimination against women in the private as well as in the public sphere. Yet, in most societies there still exist extensive gaps between principles of gender-equality and self-determination, and the local traditions and customs that govern women’s everyday lives.



Gender concerns in the rights and equity framework revolve around four key issues that violate gender equity. The first is gender based violence like sexual assault, domestic violence and violence against women (*especially rape*) in conflict situations. The second is gender discrimination based on misuse of technology like genetics, prenatal diagnostics, ultrasound (*such as prenatal sex-selection*). The third is access to healthcare, especially reproductive health services, including issues around contraception and reproductive technologies. And the fourth is the absence of gender concerns in the health and human rights movements as well within associations of health professionals.

The global human rights framework and the human rights movement have not adequately dealt with nondiscrimination and equity concerns when it comes to gender issues. This conference aims at filling this gap with regard to the above issues and including a special focus on the role of health professionals: how to commit doctors and nurses in the rights-based approach of the right to health of women and girls, how to help them prevent violence, and adverse medical and other (cultural) practices against them; how to empower health professionals in protecting the rights of women etc.

This conference will focus on engendering health and human rights by pushing the boundaries of the health and human rights discourse to cover all aspects related to women's discrimination and gender based violations and in creating an effective and responsive system for enforcing human rights that are also gender just. The response of health professionals and their perceptions, attitudes, practices etc. will be an integral part of this discourse.

Organisers

The International Federation of Health and Human Rights Organisations (IFHHRO)

The International Federation of Health and Human Rights Organisations (IFHHRO) was established as a network of organisations with similar human rights agenda, upon an initiative of the Johannes Wier Foundation (the Netherlands) and Physicians for Human Rights (USA) in 1989. The objectives of IFHHRO are the protection and promotion of the right to health and other health related human rights, the mobilisation of medical expertise in the investigation of human rights violations, and the protection of health workers seeking the promotion of human rights. These goals are pursued by means of advocacy, fact-finding missions, research and publications, education and special projects.

IFHHRO campaigned for the appointment of a UN Special Rapporteur on the Right to Health, participated in drafting the Istanbul Protocol for the investigation and documentation of torture. The IFHHRO was a consultant for the U.N. Committee on Economic, Social and Cultural Rights (CESCR) on the Right to Health. Affiliated organisations have developed expertise on a variety of subjects such as hunger strikes, patient's rights and psychiatry, health and human rights under political violence.

The IFHHRO has the following Affiliates: Physicians for Human Rights (PHR) - USA, PHR - UK, PHR - Denmark, PHR - South Africa, PHR - Israel, Palestinian PHR, the Johannes Wier Foundation (the Netherlands), the Centre for Enquiry into Health and Allied Themes (CEHAT, India), the Health and Human Rights Foundation (HHRF, Bangladesh) and the Zimbabwean Association of Doctors for Human Rights. And Observer Organisations are: Amnesty International, the British Medical Association, the International Committee of the Red Cross (ICRC), the Turkish Medical Association, the World Medical Association and the International Council of Nurses.

Affiliated organizations

Physicians for Human Rights (USA)
Doctors for Human Rights (UK)
Physicians for Human Rights (Denmark)
Johannes Wier Foundation for Health and Human Rights (Netherlands)
Physicians for Human Rights (Israel)
Palestinian Physicians for Human Rights
Centre for Enquiry into Health and Allied Themes (CEHAT, India)
Health Research and Rights Foundation (HRRF, Bangladesh)
Zimbabwean Association of Doctors for Human Rights

Observers:

Amnesty International
British Medical Association
International Committee of the Red Cross
International Council of Nurses
Turkish Medical Association
World Medical Association

The Centre for Enquiry into Health and Allied Themes (CEHAT)

The Centre for Enquiry into Health and Allied Themes (CEHAT), is a centre founded by the Anusandhan Trust in 1994, has been working with a rights based perspective on health and



health care for over a decade. CEHAT considers health and health care as a human right. Socially relevant and rigorous academic health research, advocacy and action undertaken by CEHAT is for the well being of disadvantaged masses, for strengthening peoples' health movements and for realizing right to health and healthcare. CEHAT acts as an interface between progressive peoples' movements, social policy and academia.

CEHAT's projects are based on its ideological commitment and priorities and are focused on four broad themes, (1) Health Services and Financing, (2) Health Legislation, Ethics and Patient's Rights, (3) Women's Health and (4) Investigation and Treatment of Psychosocial Trauma. An increasing part of CEHAT's work is being done collaboratively and in partnership with other organisations and institutions, including public health agencies. Among its current activities CEHAT is involved in a major national initiative on health as a human right with the idea of promoting and advocating universal access to basic healthcare, is running a primary healthcare program focusing on training health workers in peoples' organisations and building capacities of the latter in advocacy for strengthening local public health systems, is collaborating with a public hospital to run a crises centre for survivors of domestic violence, is undertaking research on healthcare systems and financing strategies, is coordinating a national initiative of research and advocacy on abortion and related issues, is advocating and campaigning against gender discriminatory practices like pre-conception and pre-natal sex-selection and domestic violence, is promoting and advocating use of ethical review of social science and health research and is involved in health and human rights education.

OUR TRUSTEES

Amar Jesani: He was the founder coordinator of CEHAT from 1994-1999. During 2000-2002 was Programme Coordinator at the Achutha Menon Centre for Health Science Studies . Presently a freelance consultant on ethics and health and human rights issues , he is the Coordinator of Centre for Studies in Ethics and Rights (CSER).

Dhruv Mankad: Graduate in medicine. He is a leading spokesperson on Primary Health Care in Maharashtra. He was director of VACHAN, a *Nashik* based NGO, for nine years. Presently Managing Trustee of Anusandhan Trust.

Manisha Gupte: Masters in microbiology. She is a leading spokesperson at the National level on Women's rights and health issues. A founder trustee of MASUM, a grassroots-level woman centered development organisation based in *Pune*.

Mohan Deshpande: Graduate in medicine. Involved for more than a decade in school health education and training of Village Health Workers.

Padma Prakash: Doctorate in sociology. Women's rights, health activist, journalist and editor

Vibhuti Patel: Doctorate in economics. Women's rights, and social activist. Has made important contribution to women's studies and gender economics. Presently, Professor and Head Dept. of Economics, SNTD University, *Mumbai*

Ravi Duggal: Masters in sociology and business management. Has been involved in social sciences and health research for over two decades. He has done pioneering work on health financing/economics, private health sector, and health systems and policies. He has authored over 80 papers and articles and 15 Books and Research Reports.

Themes and Sub Themes

Focus Theme 1: Gender Based Violations And Discrimination

In all societies women are subjected to inequities, discrimination, and violence. While causes, circumstances, and consequences vary from one country to another and from one culture to another, laws, stereotypes, and traditions greatly affect women as a group in all spheres of life, public and private. There has been growing recognition that various types of discrimination do not always affect women and men in the same way. Moreover, gender discrimination may be intensified and facilitated by all other forms of discrimination. It has been increasingly recognized that without gender analysis of all forms of discrimination, including multiple forms of discrimination, in particular, racial, ethnic, religious and caste-based discrimination, xenophobia and related intolerance, violations of the human rights of women might escape detection and remedies to address them may also fail to meet the needs of women and girls. It is also important that efforts to address gender discrimination incorporate approaches to the elimination of all forms of discrimination.

The construction of gender roles implies that women have far lesser access to productive resources and decision making compared to men, resulting in unequal balance of power. Unequal treatment and discrimination in child rearing and caring practices in the family, male preference especially in south and south-east Asia and denial of rights to health care and education to girls are some factors which make women vulnerable to different forms of violence.

Yet, the process of identifying and articulating the gender-specific aspects of human rights in general, and violence against women in particular, remains incomplete. Recent discussions about gender-based violence, whether in the home, the community, at the hands of the state or private actors in situations of armed conflict or in peacetime, illustrate the urgent need to further develop concepts and the strategies. In particular, these debates have shown that the evolving concept of bodily integrity is central to questions of gender-based violence and discrimination. Work on violence against women as a human rights violation has highlighted the way in which women's bodies are often the target of human rights abuse. Women's right to health, and their reproductive and sexual rights are thus continually put at risk. In this context, it is increasingly evident that notions such as freedom from violence, the right to privacy, and bodily integrity has been defined from the experience of men as the norm of the human person, and has failed to take gender differences into account.

Gender based violence leads to devastating and long term mental and physical consequences, sometimes leading to death and disability among women and girls. It is violation of basic human rights to safety, security and life without discrimination. The WHO believes that at least one in five women have been physically or sexually abused by a man sometime in her life and research suggests that women are more at risk from their husbands , fathers, neighbors or colleagues than they are from strangers. The negative impact of gender based violence leads to unwanted pregnancy, complications during pregnancy, miscarriage, low birth weight babies and maternal mortality.

From acid burning, dowry-related violence and "honor" killings to rape, battery, and psychological abuse, women are subjected to the basest forms of abuse and humiliation. Such torture of women is rooted in a global culture which denies women equal rights with men, and which legitimizes the violent appropriation of women's bodies for individual gratification or political ends. Violence against women is compounded by discrimination on the grounds of race, caste, religion, ethnicity, sexual orientation, social status, class, and age and by social and cultural norms that deny women equality and also renders women more vulnerable to abuse. The common thread is discrimination against women, the denial of basic human rights to individuals simply because they are women.



Sub Theme 1

Women's health and human rights concerns in situations of war and conflict, including ethnic, communal, race and caste dimensions

In situations of conflict, rape is used as a tool for "ethnic cleansing" or genocide. Rape as a, forced pregnancy sexual torture of women in minority communities, women prisoners and refugee women in situations of armed conflict. The consequences for victims of sexual violence in war are grave and may affect women for the rest of their lives. These include serious and chronic medical problems, psychological damage, life-threatening diseases such as HIV/AIDS, forced pregnancy, infertility, stigmatization and/or rejection by family members and communities. In India Dalit women are the most discriminated and exploited persons in a Indian society dominated by caste hierarchy and patriarchy. For them, the intersection of caste and gender means that they are subject to the most extreme forms of violence, discrimination and exploitation. In case of Violence against Refugee and Displaced women The role of the health professional extends beyond the provision of temporary medical relief. The health professional is in a privileged position to provide support and protection to survivors of violence. Medical evidence and medical intervention have great legitimacy in law and society because of the skills and knowledge that health professionals represent. They therefore enjoy an acceptability that transcends class or communal boundaries. Consequently, if the medical profession takes a position against violence, its members can become catalysts for deep- rooted social change.

Sub Theme2

Domestic violence as an issue of violation of health and human rights

Domestic violence is a violation of a woman's rights to physical integrity, to liberty, and all too often, to her right to life, itself. And when a government fails to provide effective protection from such abuse, domestic violence is torture. Role of Health professionals in responding to Domestic Violence is of crucial importance.

Sub Theme 3

Dealing with sexual assault and harassment for protection of rights of victims and survivors

Physical and sexual abuse lie behind some of the most intractable reproductive health issues of our times unwanted pregnancies, HIV and other sexually transmitted infections, and complications of pregnancy. A growing number of studies document the ways in which violence by intimate partners and sexual coercion undermine women's sexual and reproductive autonomy and jeopardize their health. The negative consequences of abuse extend beyond women's sexual and reproductive health to their overall health, the welfare of their children, and even the economic and social fabric of nations. By sapping women's energy, undermining their confidence, and compromising their health, gender violence deprives society of women's full participation. From health professional's point of view it is even more important that documentation of essential evidence is done appropriately.

Sub Theme 4

Misuse of Reproductive technology, gender discrimination and rights violations

Sex selective discriminatory practices: pre conception and pre diagnostic techniques are abuse by the medical professionals, which is against the medical ethical practice. Unsafe abortions, criminal or illegal, are a cause of excessive maternal morbidity, mortality and misery. Human experimentation with new methods of abortion in contravention of stipulations and guidelines fall in the same category Technology is overused, sometimes used inappropriately, and misused by unqualified doctors. There is a huge magnitude of reproductive violations. There is the creation of a new form of the international medical research networks; the technology transfers; the global markets for surrogacy which follow established international adoption routes; the expanding international demand for and supply of fetal tissue, eggs, embryos for medical research; the international stockpiling of frozen embryos. The global scenario has undergone major changes after the controversy on ICs in the 1980s. The paradigm has shifted from 'population control' to 'family welfare', and from 'women as targets' to 'reproductive rights'. Medical ethics is central, and informed consent today means much more than a thumb impression on the dotted line

Sub Theme 5

HIV discrimination and human rights violations

HIV continues to spread throughout the world, shadowed by increasing challenges to human rights, at both national and global levels. The virus continues to be marked by discrimination against population groups: those who live on the fringes of society or who are assumed to be at risk of infection because of behaviors, race, ethnicity, sexual orientation, gender, or social characteristics that are stigmatized in a particular society. In most of the world, discrimination also jeopardizes equitable distribution of access to HIV-related goods for prevention and care, including drugs necessary for HIV/AIDS care and the development of vaccines to respond to the specific needs of all populations, in both the North and South. As the number of people living with HIV and with AIDS continues to grow in nations with different economies, social structures, and legal systems, HIV/AIDS-related human rights issues are not only becoming more apparent, but also becoming increasingly diverse.

Stigma, discrimination and social exclusion leave vulnerable groups such as women and girls, drug users and homosexuals without access to treatment and social services. Denial of information further hampers efforts to prevent or address HIV/AIDS, and without the expectation of health care, at-risk individuals are discouraged from testing. Human rights violations occur even in the health sector itself, as individuals seeking information and treatment are discouraged or turned away. Frequently, the confidentiality of HIV/AIDS patients is breached.

Sub Theme 6

Discrimination in access to healthcare, especially reproductive health

Women are unable to access public health care facilities in many developing countries and that is due to their dependency and inability to make any decision on need to access health care services which is dependent on the male members of the family, who are given priority. Especially as far as reproductive health is concerned Women with disabilities face additional problems and raise particular issues related to health, reproduction and sexuality. Women with disabilities often encounter physical, attitudinal, and policy barriers in seeking to meet their health care needs

Focus Theme 2: Addressing the Missing Links of Gender Equity in Health and Human Rights

The lives of women and men, the work they do, the income they receive, the roles they are given and the relationships that they share are all shaped by social norms and traditions which treat women and men differently. Truly, we live in a world where gender matters. Such norms and traditions, and the ideas that underpin them, are also manifested in laws, institutions and economic and social structures, such as the family and the job market. But the gendered responsibilities and rewards of participation in society are not only different for women and men they are usually inequitable.

In many parts of the world, simply being a woman is a health risk. Gender inequities undermine women and children's health, limit their access to health services, and constrain women's decision-making power. Violence against women — which affects as many as one in three women around the world — can lead to a host of health problems, including traumatic injury, unintended pregnancy, low birth-weight, sexually transmitted infections (including HIV), depression, and suicide

Women's health is intimately linked to the issues of gender equity and violence. All efforts to improve women's sexual and reproductive health must work to reduce discrimination and strengthen the position of women and girls in society. Major gaps exist in our understanding of gender and health, largely because much research in the past has to some extent bypassed women. In many countries, there is a serious lack of rigorous sex-disaggregated research. Health research has tended to overlook the specific consequences of disease and illness on women and men, and neglected to examine fully the different social, cultural, and economic contexts within which women and men work and live .



Health services for women usually emphasize and cater to the reproductive health needs of women, and little effort is made by the health sector to help women realize that they are persons in their own right, with their own personal health needs. Women's health needs are given less attention within the structure of health-service provision than the health needs of children. Their quality is poorer, and more often than not, women's needs are subordinated to population-control programs. Focus on women when discussing contraception and family planning has had more to do with containing population growth than enhancing the health and well being of women. Research in this domain has been motivated largely by widespread concerns about the need to curtail high birth rates and control population growth. Programs for women have invariably been geared toward the reproductive role of women and a narrow family-planning focus. Women's medical services often have a lower priority within the structure of health-service provision than those for children and men, and their quality is poorer. This perpetuates the notion that women's needs are secondary to others. Women are viewed "first as mothers or future mothers," whereas men's health "is never defined from a family or fathering perspective"

Mainstreaming a gender perspective needs to be coupled with mainstreaming mental health issues as well, because women disproportionately suffer from mental health disorders and are more frequently subject to social causes that lead to mental illness and psychosocial distress. With the current shift in gender identity it is often difficult to define or conceive a state of well being. To delineate the stress experienced by women one has to probe into the inner world of one's experience. This would unearth one's sense of identity, role acceptance, compliance, ambivalence, vulnerability and many other personal issues. The long prevailing sexist attitude, which incidentally is pathological, has done much damage to a woman's sense of identity. This has created feelings of powerlessness and helplessness as well as ambivalence about one's role and gender identity.

In the human rights context it is an unfortunate legacy of the patriarchal structures upon which human rights law has been built, that issues pertaining primarily to women, such as domestic violence, rape, marital rape, sex selection, etc. continue to struggle for recognition within global human rights bodies and agendas. However, developments over the last few decades have provided women with the basic mechanisms through which their rights under various international instruments might be enforced. Much, however, remains to be done. Women who are multiply disadvantaged, such as indigenous women, dalit women, migrant women, commercial sex-workers, disabled women and older women have often been overlooked in the quest for 'universal women's' human rights. Where their concerns have been addressed, the approach has often been to simply 'add and stir'. Further, in order for human rights instruments to have any value, they must be utilised by those entitled to enforce them. Violence against women occurs in virtually every corner of the globe and its prevalence does not appear to be decreasing dramatically. As we move ahead in the 21st century it is thus more crucial than ever that dominant human rights discourses are challenged and a discourse acknowledging diversity and gender equity is realized.

Subtheme 7

Good practices and strategies for engendering health and human right

Sharing and learning of , good practices and promising approaches to engender health and human rights. How have countries addressed gender equality across the different levels of policy making and human rights violations. To develop conceptual clarity regarding what constitutes a strategy; and efforts to actualize the gender agenda for health and human rights discourse: which would include-Action research, Policy advocacy and lobbying, Communication, Networking and alliance building. This would also include promising approaches for integrating gender perspectives in national shadow reports and other national monitoring and accountability processes

Sub Theme 8

Monitoring gender concerns in rights violations

Currently, no tracking system exists to monitor progress in reducing gender-based human rights violations. Data sources are fragmented, and there is no formal mechanism available to coordinate

data collection, analysis, or report distribution. There is need to come out with benchmarks and indicators to monitor gender concerns in human rights violations.

Sub Theme 9

Data and evidence on gender inequities in the human rights context

Gender mainstreaming is both a technical and a political process. The link between both is the “recognition of the benefit”. To move from awareness to implementation of gender sensitive policies, policy makers, health managers and health professionals need to clearly see the positive implications of integrating a gender into their work. As long as this does not happen there will only be more isolated experiences based on individual’s commitment. How can we develop the understanding of the benefits of gender mainstreaming? An effort has to be made to convey the existing evidence to the policy makers and health managers and to use evidence and technical debate as awareness raising tools. Gender evidence will have a twofold effect on policies. On the one hand, it will serve to ensure political commitment and resources and, on the other hand, it will serve to promote good evidence-based policies.



Plenary Session Speakers

Day 1

Paul Hunt (Key note address)

Engendering Health and Human Rights: Maternal Mortality as a Violation of the right to Health.

UN Special Rapporteur, Right To Health,

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Vibhuti Patel

Gender Based Violation & Discrimination in South Asia

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Aleid Bos, LLM

Conventions, Committees, Governments and Health Professionals. Combating violence against women with international human rights law.

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Day 2

Sofia Gruskin

Addressing the Missing link of gender equity in health Human Rights-What hasn't been considered

Health and Human rights

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Lakshmi Murthy

Missing links civil society perspective

Women Activist and Freelance Journalist

India

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Oral Presenters

Focus Theme 1: Gender Based Violation and Discrimination

Sub Theme - 1

Women's health and human rights concerns in situations of war and conflict, including ethnic, communal, race and caste dimensions

Abstract No. 101

Title: War-Related Sexual Violence In Sierra Leone: A Population-Based Assessment

Author: Len Rubenstein, E-mail: lrubenstein@phrusa.org

Key words: *Sexual Violence, Quantitative Survey, Human Rights, Gender, Sierra Leone*

Objectives: In 2002, Physicians for Human Rights (PHR) and the United Nations Assistance Mission in Sierra Leone (UNAMSIL) conducted one of the first studies that set out to scientifically document the extent of sexual violence as a result of war. In turn, PHR sought to create a model for standardized methodology for assessment of sexual violence.

Background: Sierra Leone's decade-long conflict has been one of the deadliest in recent history and has been marked by an extraordinary level of brutal human rights abuses. The devaluation of women in society made women particularly vulnerable to egregious human rights abuses during the conflict in Sierra Leone.

Methods: PHR combined a quantitative survey with testimonies, which permitted triangulation of converging and diverging lines of evidence. Through the survey PHR documented the objective prevalence of human rights abuses among internally displaced persons (IDPs), including war-related and non-war-related sexual violence (as well as other human rights abuses). The survey was conducted in 991 households— 9166 household members in 4 sample locations representative of the total IDP population. PHR also explored women's subjective perceptions about gender roles and their human rights.

Results: An alarming 94% of households surveyed reported one or more abuses. One in eight households reported some form of war-related sexual violence among its members. Nine percent of respondents reported sexual violence (*i.e.*, approximately 50,000-64,000 IDP women). The forms of sexual violence reported were very serious: 89% of women reporting sexual violence were raped; 33% reported being gang raped. The rebel force, Revolutionary United Front (RUF), was most often reported as perpetrators (51-71%) for all abuses and, stunningly, the majority of women detained by the RUF had suffered sexual violence and other terror tactics. Among respondents reporting sexual violence, the study probed beliefs about punishment for perpetrators, as well as willingness to provide their names to the Truth and Reconciliation Commission or the Special Court. With respect to thoughts about women's rights and gender roles in society, the questionnaire obtained results which warrant further analysis and discussion. For example, stated beliefs about women's rights (*e.g.* to space the number of their children) coexist with a widespread acceptance of domestic violence and subjugated gender roles within the private sphere.

Conclusions: PHR's study demonstrates the critical role that public health methods can play in population-based assessments of the prevalence and distribution of human rights abuses, including sensitive issues such as sexual violence. Such data may prove critical for establishing accountability in Sierra Leone and elsewhere; it is also useful for policy-making, program planning, guiding humanitarian relief efforts, and planning treatment and prevention programs for survivors. While the objective evaluation of prevalence of abuses is critically urgent in terms



of the Truth and Reconciliation Commission and the Special Court, as well as in devising humanitarian policies and programs to respond to health needs of IDPs, women's subjective perceptions of rights and gender roles provide an important opening for critical debate about the structural constraints on women's rights and well-being in Sierra Leone an society.

Abstract No. 102

Title: The Forgotten Person

Understanding Women's Human Rights Violation In Armed Conflict Situations

Author: Goswami Sathyasree , Email: sathyasree1974@yahoo.com

Keywords: *Violence, Conflict, Womens Rights, North East, India*

A beautiful part of the world being unknown to most North Eastern India is home to more than 200 of India's 300 odd listed tribes and most of these are of the Mongoloid stock belonging to the Tibet-Burmese and Mon-Khmer races. At war for over five decades now it is sandwiched between most international borders of India. A violent turmoil existing in five of its seven states is on account of a perceived threat to identity, pathetic infrastructure, traditional societies unable to cope with the sudden transformation to modern life and a huge gap between the level of aspiration of a highly literate society and an abysmal lack of opportunities presenting a continuing state of a complex political emergency in the region.

This paper aims to highlight the multifold human rights violation that a woman faces in the given context of poverty and armed conflict. It explain how there is little acknowledgment of the situation of armed conflict, and women's rights are sacrificed as there is a resurgence of patriarchal values. Violence caused by development paradigm coupled with the conflict situation has created or intensified poverty and its impact on women. The public health system does not address women's health problems such as mental health, stress disorder and trauma women face in times of war, conflict and natural disasters. The paper highlights the ground realities of women's condition and position in an area of conflict.

There is large-scale displacement of people on account of conflict and natural disaster; women face greater economic pressures with growing food insecurity and face serious health consequences. The breakdown in infrastructure and basic civic amenities such as water, roads, bridges and hospitals has further compounded the problem. On the other hand it is very difficult for young people to find employment and there is a powerful incentive to join rebel groups as they can at least make some money.

State propelled victimization is evident in the area and the onslaught on the woman is three sided; extremist, police, army, para-military forces. There is an urgent need for improved protection for women by the law of armed conflict in the light of the fact that women experience war fundamentally differently from men, irrespective of whether the man is a civilian, combatant or part of militia.

People born in the region are used to understanding fighting by extremist groups, gun fires, police torture, bomb blasts and arbitrary arrests as an accepted part of life; however the entire mire is a part of larger arms, drugs and political nexus. In this situation no woman lives a dignified life and that the woman is a totally forgotten person. Information gathered for this paper is through experiential understanding, secondary sources like books, documentation by various groups within in North East India and India, news clippings, and personal interactions.

It is understood that in the situation of war there is gross violation and marginalization of women's rights, sometimes extreme violence, exclusion of women from decision making and peace processes.

Abstract No. 103**Title: Honour & Health: Women's Life In The Valley.****Author:** Khanday Zamrooda, Email: zamrooda@hotmail.com**Key Words:** *Honour, Conflict, Women health, Need, Reproductive health, Islam*

The paper is trying to look at the way the last 16 years of conflict situation in the valley of Kashmir (India) has made health and especially women's health a need based requirement to be dealt with when there is absolutely no other option left for the family. The paper will also look at the way women's health especially reproductive health in the face of fundamentalism has become a taboo and hence been neglected to such an extent that family honour overshadows the health of young girls in the state.

My area of work is the state of Jammu and Kashmir in India that has been under insurgency for the last sixteen years. I have been working in the state for the past two years conducting a research on the effects of Conflict on Women's Reproductive Health and the negotiating skills used by the women to live life with the more or less non-existing health structure in the state. The state is divided into six districts with 12 million populations but there is only one functional reproductive health hospital in the state in the district of Srinagar averaging a minimum of forty-five kilometers from any of the other five districts. In scenario of conflict the people of the state are left to mercies of the local healers and the non-professional doctors. The study has used the qualitative method of research. In-depth interviews of twenty-five women were conducted over a period of eight months. The interviews were conducted in three districts of the state across the socio-economic strata with age group ranging from 12 to 65 years old. The analysis has thrown a light on the way in which the militants (insurgent forces) in the state under the guise of Islamic religion not only controlled but also dictated the Reproductive Health of the women in the State. It has brought to light the methods by which these terrorizing forces controlled the government health structure with the private medical practitioners to follow their dictates. The study hopes to be able to produce a base line data of health scenario in conflict situation, to be able to bring forth the repercussions on health which at all times get un-noticed in the larger scenario of the war crimes.

The research "Negotiating reproductive health needs in a conflict situation in the Kashmir Valley" published in 2005.

Abstract No. 104**Title: Involvement Of Health Professionals In Abuse Of Prisoners****Author:** Wilks Michael, E-mail: Michael@mwilks.demon.co.uk**Key words:** *Health Professional, Prisoners, Abu Ghraib*

The paper gives a history of recent events at Guantanamo Bay and at Abu Ghraib. Following press reports in June 2004 reports of the involvement of physicians in the abuse of prisoners at these facilities, there has been confirmation in official reports, following investigation, of medical personnel failing to report evidence of torture, failing to intervene to stop it being repeated, and making available to interrogators information from confidential medical files, thereby allowing interrogators to exploit weaknesses. Although these are likely to be isolated events, rather than evidence of institutionalised abuse, there is a pattern here that has been repeated many times and in many countries. Doctors appear to have been able to accept a state ideology, in this case a declaration from the President of the USA that Al Qaeda terrorists were no longer covered by the terms of the Geneva Convention, followed by a Justice Department document that redefined torture, stating that "for an act to constitute torture...it must inflict pain that is difficult to endure". This acceptance leads doctors to justify grossly unethical practice. The paper will examine this events in the context of previous abuse involving health professionals, including Germany, South Africa and Chile, and look at the way in which medical bodies can become complicit. As an example, recent declarations from the US military and intelligence community



that “physicians assigned to military intelligence have no doctor-patient relationship with detainees and, in the absence of life-threatening emergency, have no obligation to offer medical aid,” have received little opposition in the USA. In new guidance issued to the military the Pentagon has subtly changed the wording of a 1982 UN resolution on the ethical duties of health professionals with respect to prisoners. At first glance, this seems to provide more protection to prisoners, but when one realises that the guidance sets out ethical guidance only in the context of a “provider/patient *treatment* relationship” (my italics) and outlaws “interrogations not in accordance with applicable law” there must be considerable concern, given the President’s own view that these “terrorists” are detained outside conventional laws or conventions.

The paper goes on to show that USA professional bodies have themselves blurred the boundaries of their own ethical statements. The American Psychiatric Associations’ Statement on Psychiatric Practices at Guantanamo Bay is weak. Far worse is the recent Report of the American Psychological Association’s Presidential Task Force. This rehearses conventional ethical principles in relation to individual patient care, but then performs a total “about turn” when it comes to sanctioning psychologist input and advice on techniques to be employed in interrogation. In effect, it becomes acceptable for a health professional to dispense with any ethical responsibilities once his/her training and expertise is used outside a strictly therapeutic context. The use of such knowledge in creating techniques intended to damage the minds of people under interrogation, and to advise how these techniques can be refined, is grossly unethical.

The paper suggests that only international and national medical institutions, working together, can successfully oppose this change in ethical emphasis. Through bodies such as the World Medical Association, national medical associations should:

- Review and re-establish their principles regarding the proper ethical relationship between physicians and detainees
- Call on international institutions to support and apply these principles
- Establish a responsibility on NMA’s to develop accountability in how these principles have been applied or modified in their own countries

Abstract No. 105

Title: Women’s Health Concerns in Conflict Situations

Author: Surinder Jaiswal, Email: surijas@tiss.edu

Key Words: Conflict, War, Abuse, India

Violent conflicts have a profound effect on women. Even though women are more likely than men to be effected they have no say in the conflict. They suffer from war and conflict in many ways including dying, experiencing sexual abuse, and torture, losing loved ones, homes and communities. Besides direct impact of violent conflict such as rape, prostitution etc. research shows that there is also a sharp increase in other forms of violence against women such as war time domestic violence. Loss of family members such as spouses, brothers and sons mean not only emotional loss but also the loss of economic support and social legitimacy. Further loss of work, community and social structure affects women in unique ways because of their care taking roles in families and communities. Thus apart from the direct stressors of conflict, the many long term consequences of violent conflict for the economy, essential services, social systems and life patterns produce considerable stress. The impact of these chronic stressors on the health of women can be very great in terms of mortality, morbidity and disability.

This paper seeks to understand women’s health concerns in conflict situations particularly in ongoing violent situations such as the civil strife in Kashmir, with reference to both physical and mental health problems, their access to health care, discrimination and other concerns (where conflict has a direct impact on women’s health) through women’s experiences of conflict and its varied impact on their health and related matters.

Sub Theme - 2

Domestic violence as an issue of violation of health and human rights

Abstract No. 201

Title: Domestic Violence As A Health And A Human Rights Issue

Author: Sazonova, Liliya, Email: cwsp@cwsp.bg

Key words: *domestic violence, health, human rights, Bulgaria*

The paper focuses on domestic violence - the so called “invisible” violence often not even seen as “criminal” but dramatically shaping human lives and leading to demolishing consequences. Therefore, the main argument of the essay is that domestic violence is not only a matter of family privacy but also an issue of public concern that violates fundamental human rights. To prove this argument, the way different kinds of domestic violence – physical, sexual, psychological, economic, etc. violate fundamental human rights is shown. Additionally to the human rights approach, domestic violence is elaborated as a health problem.

In this line of reasoning, the ambition of the paper is to demonstrate how the issue of domestic violence as a health and a human rights problem is tackled in Bulgaria. This objective is accomplished by presenting concrete cases of local or regional projects and good practices of preventing or countering gender-based violence undertaken by various Bulgarian non-governmental and governmental structures.

The above-mentioned aspects of domestic violence as a health and a human rights problem are thematically developed in three separate chapters. In the first chapter definitions of key concepts used in essay like “domestic violence” and “public health approach” are offered.

In the second one the analysis of the newly adopted Law on Protection against Domestic Violence in Bulgaria illustrates some aspects of the role of the state in preventing and countering violence within the family. The importance of such an overview of the Law is based on the presumption that states are obligated under international law to take effective steps to protect women from violence and hold batterers accountable and to guarantee to women equal protection of the law. In this regard, the first implications of the Law requiring from the law enforcement officials to recognize and take action against domestic violence are pointed out. Together with the above-mentioned governmental efforts some examples how the non-governmental sector approaches domestic violence as a violation of women’s human rights are included in this chapter. For instance, the Bulgarian Violence Against Women Monitoring Program who works to further women’s human right to be free from domestic violence is presented. The program is part of the International Stop Violence Against Women Website providing advocacy and information about domestic violence and other types of gender-based violence in 30 countries from the Central and Eastern Europe, the Commonwealth of Independent States (CEE/CIS), Kosovo and Mongolia.

The last part of the paper elaborates the health aspects of violence. Together with the therapeutic health approach, the public health emphasis on preventing violence is stressed. Here a number of good practices and concrete cases of awareness raising campaigns undertaken by Bulgarian NGOs are mentioned. For instance, the Center of Women’s Studies and Policy’s *Break the silence on violence in Rhodopa Region* Project. Additionally, the *Cultivation of Non Violence Awareness* Program aimed at individual and group consultations for boys and men with violent behavior so that to prevent future aggression is presented.

In order to achieve bigger objectivity both legal instruments and health practitioner’s and health researcher’s publications are referred to. Additionally, the paper addresses some examples from the author’s own practice as a consultant on a help-line for victims of violence and as a coordinator of programs sensitizing public opinion about the issue of domestic violence.



Abstract No. 202**Title: Health Disorders Of Abused Women: A Study In Kolkata****Author:** Basu, Sohini, Email: gharebaire@yahoo.co.in**Key words:** *domestic violence, women, qualitative research, health, welfare programmes, Kolkata*

This exploratory study conducted in Kolkata in the year 2004 has been a part of a research on violence and development. In this approach women have been seen primarily as a resource for development. Since half of any national population is female, an efficient development project or plan must tap the potentials of women in order to fully exploit the resources. The World Bank has recognized that violence against women presents a problem and that rape and domestic violence 'account for about 5% of the total disease burden among women aged 15-44 in developing countries.' (World Bank, 1993). In other words, it is not only a hindrance to effectiveness or efficiency of development process but also poses several health problems. Hence the research question to be addressed here is: To what extent do victims of domestic violence show evidence of dysfunctions in both physio-psychological health?

In this study the researcher aimed to understand the violence from a woman victim's perspective. Hence fifty victims who had been out of abusive relationships for at least 6 months post abuse and outside the relationship context referred to the researcher by women's organizations and non-governmental organizations (NGOs) were interviewed. Appropriate semi-structured interviews and objective psychometric measures like General Health Questionnaire-28 (GHQ-28) were used to assess health conditions.

It was found that women exposed to domestic violence suffered from a form of psychological traumatization. This, in turn, had serious repercussions on functioning both within and outside the family. A serious anxiety disorder, sense of fear and helplessness developed within them owing to exposure to or witnessing of events that at times threatened life. This is marked by a pattern of potentially capability eroding responses to such traumatic experiences which included (a) psycho-physiological problems like unnecessary anger, tension, irritation, and sleep disorders; (b) avoidance of trauma relevant stimuli; (c) recurrence of traumatic events in the form of memories or flashbacks; and (d) reduced performance level at workplace and home. Moreover, the findings resulted in the emphasis on multifarious complex needs of abused women.

To conclude, services in many areas are essential to provide rehabilitation of these survivors so that they strive to acquire self-confidence, self-sufficiency and self-empowerment. Once we recognize the burdens these women face, we have to look after the quality of their lives by providing necessary resources and services like sensitization trainings for care-givers, access to health services and welfare programmes for victims and the like that promote healing and well-being of them.

Abstract No. 203**Title: Role Of Health Professionals In Ipv****Author:** Basu, Tapas Kumar, Email: basutk@hotmail.com**Key words:** *Intimate Partner Violence (IPV), women, health professionals, community, development*

The aim of this paper is to emphasize the hitherto inadequately utilized role of the health professionals as an essential part of any synoptic scheme to solve the hateful practice of intimate partner violence (IPV) eroding the social fabrics. For our purpose, 'health professionals' mean providers and facilitators of health care service like doctors, nurses, paramedical workers, State government and local government officials attached to health services including health assistants, NGOs dealing with health issues and other social activists in the field of health. A host of historical evidence shows that women have always suffered from domestic violence, particularly, from

abuses perpetrated by their husbands. Yet, the task of identifying and articulating the issues involved in intimate partner violence (IPV) remains inadequate. Still lesser adequate is a systematic, multi-pronged and practical approach to the solution of this problem. But without such an approach we can hardly make any headway in tackling the social evil.

This paper attempts to design a scheme for activating health professionals to take up a positive part in building up a community-wise bottom-to-up demand upon the relevant authorities to frame and implement proper policies in the legal-cum-socio-economic sphere for eradicating IPV. For this, highly motivated and professionalised non-government organizations (NGOs) should take upon themselves the onerous responsibility of getting other health professionals properly sensitized and involved in the concerned process at the beginning. This is no education on the basis of need assessment, but a participatory interactive process of qualitative nature based on equal partnership. The concerned professionals will imbibe from this process by themselves the ability to adopt an equality-based and woman-supporting attitude in their work, to realize how health is related to gender violence, to make women realize their own rights to personal health needs as full-fledged human beings, and to interchange their experiences among themselves thereby facilitating the formation of associations to ventilate these. Such associations, initially formed at the lower level, may be organized gradually at the district, State and National levels, each higher level consisting of representatives of immediately lower ones. They will, in the fashion of pressure groups, urge the authorities in power to take suitable legal, political, social and economic measures for minimizing IPV. In this way, demands and supports of the civil society will, as proper inputs, produce desirable outputs in the form of government decisions. If we can get such a scheme going, health professionals will go beyond their traditional function of providing temporary medical relief to provide support and protection to survivors of violence. They will be able to relate women's health to gender discrimination in society and will play their role accordingly. IPV seeks to continue male domination in society. Apart from the inherent injustice embedded in it, this entails a heavy social cost. By disempowering women it disallows them to contribute their best to production, decision-making and participation in the development process of the country. Unless violence against women is stopped, sustainable development will suffer to the detriment of the entire society.

Abstract No. 204

Title: The Most Horrific Domestic Violence, Acid Violence-In Context Of Bangladesh

Author: Hafiz Khairul, Email: hafiz@acidsurvivors.org

Key Words: *Acid attack, Prodigy Consequences, Underlying Responses, Role Model, Bangladesh*

Acid attacks represent an exceptionally cruel addition to the long list of violence especially against women and children. In Bangladesh, there is one acid attack per day. Isolated incidents of acid violence take place in other countries like in India, Pakistan, China, Malaysia, Srilanka, Vietnam, Cambodia, Nigeria; But nowhere else except Bangladesh, this violence is addressed in an organised way since the grounding and effective role playing of Acid Survivors Foundation (ASF) by providing assistance in the treatment, rehabilitation and reintegration into society of survivors of acid violence and to counter further acid attacks. So this study on acid violence in Bangladesh context and the ASF would be a role model for the others.

Of course, numbers are momentous only to convince the authorities about the seriousness and pervasiveness of the crime, and the need for special measures to deal with it. The audacity in acid attacks is that they are clearly and cruelly planned to permanently disfigure, debilitate and, eventually, destroy the person at the receiving end, both physically and psychologically.

Acid burn injuries necessitate immediate chemical burn first-aid and prolonged, continued and complicated medical treatments as larger portion of the body or vital organs i.e, head, eyes, ears, nose, mouth or joints are affected simultaneously. In most developing countries, the specialized



acid burn management, reconstructive and plastic surgery are only available at capital cities that are not always reachable for the poor. Also not all the medical practitioners are aware of chemical burn treatments, specially the psychological distress of the victim immensely affect the total healing process, unless they are sensitized, or trained. Sometimes, the nurses and even doctors suspend themselves in providing support to the victim due to the horrific disfigurement which becomes horrendous for them too. Poverty, lack of education, lack of health service, relevant infrastructure unavailability, public health insecurity, social attitude, and knowledge gap makes the rights, to have treatment for such complicated burn victims, very poor. All these revealed the urgent need for more informed and sensitive responses from healthcare professionals, not to mention families, friends, employers, colleagues and society as a whole.

The root causes of acid violence and other forms of violence against women and children are similar e.g. gender based violence, patriarchal structures and poverty. Prevention campaign will only be successful if there are successful prosecution. The Bangladesh National Women's Lawyers Association (BNWLA) and the ASF estimate that only 10% of attackers are ever brought to trial. New law regarding special tribunal for acid cases is an excellent opportunity to improve the prosecution rate.

To bring about long term changes in the values and attitudes to prevent acid violence in the principle of zero tolerance for such violence, it is important that the respective Government (to the constitutional obligation and commitment to the international accords), NGOs, professionals and civil society are actively, effectively and efficiently working toward developing immediate support services and the elimination of acid violence from the total surface.

Sub Theme - 3
Dealing with sexual assault and harassment for protection of rights of victims and survivors

Abstract No. 301

Title: Sexual Assault, Harassment, Rights & Social Justice

Author: Behera, Shanti Ranjan, E-mail : livelydemocracy@yahoo.com

Key Words: *Sexual Assault, Harassment, Rights, Justice,*

Objectives: of the paper is to discuss sexual assault, harassments, are human rights violations not only in India but also in advanced countries like United States of America, Canada, with reference to law and social and political practices.

Background: The paper reflects the clear connection between men and violence, arrests, imprisonment in jails in Australia, United States of America. Of course, social process and personal conduct are always involved in violence. The culture of masculine violence, underlying inequality of men and women in a patriarchal society, control of major institutions from church to corporations, political parties to governance, media to judiciary confirms women's subjugation. The long history of gender relations, roles between men and women give a sense of entitlement to respect, deference and service from women. When the women fail the perform the traditional role, men's position is threatened, dignity & authority is challenged, it leads to violence and often sexual assault. In contemporary western society there is a pattern of masculinity (authoritative, aggressive, heterosexual, able-bodied, physically brave) which is more respected than other patterns.

According to a study of World Bank, in established market economies, gender-based violence is responsible for one out of every five healthy days of life lost to women of reproductive age.

The United Nations Development Fund for Women (UNIFEM) stated that "Women can not lend their labour or creative ideas fully if they are burdened with the physical and psychological scars of abuse".

The paper also showed the occurrence, consequences (Physical, psychological, immediate and long-term impacts, social, health behaviours, vulnerability factors for victimizations etc.

Sexual Assault Report also rise sharply in Armed Forces. In 2004, military criminal investigators, received 1,700 allegations of sexual assault involving members of the armed forces worldwide. The allegations included 1,275 incidents in which a service member was the victim, and 1,305 incidents in which a service member was allegedly the perpetrator. There were 1.5 million active-duty troops that year.

The paper also calls for the development of the sexual Assault Care Centre in Canada, the Canadian Law etc. So far as sexual harassment is concerned the paper presented the abridged version of the judgment of Supreme Court of India in (Vishaka and others Vs State of Rajasthan & others – AIR1997 Supreme Court 3011) and Code of Conduct for work place.

Methods: The information collected and used for the paper are from the Universities, findings from Research Institutions, National and State Commissions for Women, National and State Human Rights Commissions, judgments from Courts etc

Results

We looked into –

- Sexual Violence and Adolescent Sexuality.
- Sexual Rights in International Documents
- Sexual Assault in Comparative Penal Law etc.



Conclusions

The paper calls for a focus that the victim is never at fault. The offender is responsible for the offence and strongly recommends for amendment of Rape Law & higher sentences for the offender.

Abstract No. 302

Title: Violence Against Commercial Sex Workers (Csw) In Bangladesh: The Hidden Picture Of Violation Of Human Rights

Author: Chanda Sanchoy Kumar, Molla Musaraf Husain, Rahman Fazlur, Islam Tuhinul
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Key words: CSW, Violence, Brothel, Human Rights, Bangladesh

Background: Several hundred thousand of Commercial Sex Workers (CSW) carries on their existence in many different ways including providing brothel-based sexual services in different parts of Bangladesh. This group has been unrecognized yet as high-risk group for violence and violation of health and human rights. Even there is no valid or organized information on violence among this group. Only print media reports very often about the violence against the Commercial Sex Workers in Bangladesh.

Objectives: Objective of the study is to estimate the incidence and severity of violence experienced by CSWs in a brothel in Bangladesh, and to gain an understanding about the types and causes of violence experienced by CSWs, health seeking behaviors and to sensitize the policy makers and stakeholders about the safety concerns of the brothel-based CSWs.

Methods: During August and September 2004, about 176 out of 952 CSWs in Tangail Brothel (situated in northern part of Bangladesh) were interviewed with a structured questionnaire. Those who lived for last 12 months or more in the Tangail Brothel were included in the study. Trained female interviewers conducted a face-to-face interview with each CSW. Incidence of violence in preceding one year was collected along with their socio-demographic characteristics.

Results: All CSWs experienced number of episodes of violence during their staying period at brothel. The estimated incidence of physical violence is severe enough to restrict themselves from their normal activities for couple of days or took medical treatment for the ailments were 62/100 person-years. The most common type of physical assaults were beating (81.8%), punch (50%), kick (34.5), cutting (30%), cigarette burn (12%) and others like pulling of hair, crushing of fingers, burn with hot iron or hot water bottle in body or private parts (33.4%). The reasons were failure to negotiation (44.54%), monitory (35.45%), customer was drunken (25.45%), perverted customers (16.36%), forced sex (10.9%), failure to satisfy customer (10.9%), others like wanted to be freed from brothel, refused to have sex during menstrual period etc. (20.9%). Violence is usually done by customers (57.4%), pimps (39%), local musclemen (32.7%), law-enforcing personnel (19%), Co-CSWs (18%), and others like boyfriends (2%). 98% cases required medical treatment, and hospital stay in many cases. Violence prevented them to resume normal duties in 77% cases

Conclusion: Sex workers in Bangladesh are deprived of their rights socially, and politically. Violence is very common in brothel and incidence rate is much higher than our national data making the CSWs as most vulnerable group for violence. To promote the safety of this high vulnerable group, immediate program should be taken by the policy makers.

Abstract No. 303

Title: Atrocities Against Workers Of The Unorganized Sector–Daylight Is A Long Way Off

Author: Dr. Vaswani Vina, Email: nirvigna2001@yahoo.com

Keywords: Atrocities, Gender –Based, Unorganized Sector, India



In assault cases like in most other situations, the public outcry and media sympathy lies with those young in age and of the “weaker sex”. This gender bias however takes backseat when the same crime is committed against “commercial sex workers”. When rape and assault happens to be on a CSW, there is a guarded response & opinions are loaded against the aggrieved.

Sometime ago, a CSW was taken to a police station in a large city of India, illegally detained & sexually assaulted by a constable while on duty. Only on pressure by women’s rights activists, was a case registered and the lady was sent for examination on the 7th day after the crime was committed. By which time no evidence was forthcoming on medical examination. Moreover, the Medical Officer, did not collect the evidence objectively and documentation was woefully inadequate. Irrespective of the publicity pressure put on the administration by NGOs & medicolegal fraternity, no concrete steps were taken to ensure the safety of the citizens.

This case brings to the forefront many issues related to the rights of people working in unorganized sectors, levels of abuse that take place, lack of empathy from health care workers and the delay in collection of physical evidence that results in miscarriage of justice. This paper will discuss these issues, probing for avenues of possible improvement in the medical & legal service provided.

Abstract No. 304

Title: Severity Of Injuries Among Sexual Assault Victims

Author: Alempijevic Djordje*, Slobodan Savic, E-mail: djolea@fon.bg.ac.yu

Key words: *Sexual Assault, Injury, Victim, Medical Examination.*

Objectives: It is generally accepted that, among the other consequences, victims of sexual assault may sustain body injuries. This study aims to provide an overview of type, frequency, patterns, and severity of body injuries in sexual assault victims.

Background: Sexual violence may be regarded as a global problem, not only geographically, but also in terms of age and gender of victims. It is a harsh reality for millions of victims worldwide, predominantly women. The estimation is that one out of five women experience sexual aggression during lifetime. Although sexual violence in many countries remains primarily legal concern, it is becoming more often perceived as a public health problem. There are numerous negative effects of sexual violence on victims’ health including body injuries, pregnancy, transmission of sexually transmissible diseases, exposure to HIV/AIDS, increased risk for adoption of unacceptable sexual behavior (e.g. early beginning of sexual activity, multiple sexual partners, etc.) and negative effects on mental health.

Method: We perform retrospective study of files in District Court of Belgrade to select cases where plead guilty or verdict guilty has been passed for sexual offences as defined by Criminal Code of Republic of Serbia. Analysis of medical record and other available medical evidence has been performed following the selection of the cases. Clinical Injury Extent Score (CIES) was used for estimation of injury severity.

Results: A total of 113 court cases have been analyzed for five years period (1995-1999). All victims (113) were female, at average 24.08 years old (range 5-80 years). Medical examination in majority of the cases (84%) took place within 72 hours post-assault, while approximately in half of the cases (52%) examination was completed on the day of assault. Due to delayed referral, body examination was not conducted in 12 victims (10.6%). Other victims underwent complete body examination that reveals at least one extra genital injury in 64 cases (63.4%), no extra genital injuries in 36 victims (35.6%), whereas for one victim medical records were inconclusive. Injuries were most frequently located on limbs (32%), face (23%), and torso (7%), whereas other regions were rarely affected.



Bruises were the most frequently observed injuries (50%) regardless of body region, excluding neck. Abrasions and contusions were somewhat less frequently present, while only two victims sustained lacerations.

Although insufficient quality of medical records made certain constraints, the severity of injuries was estimated. Majority of victims (44%) sustained light injuries (CEIS-1), 18% has moderate injuries (CEIS-2), whereas severe injuries (CEIS-3) has been documented only in one victim of sexual assault.

Conclusions: Body injuries may result from sexual assault. In our study at least one extra genital injury was present in 64 cases (63.4%). Body injuries were predominantly located on extremities and face, in form of bruises (50%), while other types of blunt trauma were less frequently observed. Light injuries (CEIS-1) were prevailing over moderate (CEIS-2), and severe injuries (CEIS-3) among the victims of sexual assault in our study.

Sub Theme - 4
Misuse of Reproductive technology, gender discrimination and rights violations

Abstract No. 401

Title: Owners Of Female Bodies And Owners Of Future Children: Arab-Bedouin Women In Inter-Cultural Encounters With Prenatal Services

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Key Words: *cultural perception of the body, universal human rights, cultural relativity, culturally competency, medical praxis, Israel.*

This paper reveals an Arab-Bedouin perception of ownership of the body and of future children at the stage of pregnancy, discussing the possible influences on decision-making in the arena of use or refuse to use of prenatal medical care. The paper then concentrates on how medical professionals should take into account these different ways of viewing ownership of the body and of approaching the implementation of decision-making rights. The question emergent is what kind of cultural awareness and competence should Medical professionals develop when treating Arab-Bedouin women who are the larger non-western community in South Israel?

Data was collected from a preliminary short term survey conducted at the Soroka University Medical Center (hospital) in Israel, as part of the activity for reducing infant mortality among Arab-Bedouin population. About 30 Arab-Bedouin women who were in birth-hospitalization were interviewed about their knowledge and understanding of Amniocentesis tests. The women were then asked whether they would agree to utilize such tests if they were medically recommended to them. Many of the women responded that in that case the decision would not be theirs but of their husbands and extended families. These results were triangulated with data collected through participant observation and conversations with Bedouin mothers of children born with congenital malformations at the neonatal unit at the hospital. Conversations with medical personnel in the hospital indicate that the dominant medical discourse presupposes that all women are the ultimate controllers of their bodies, and therefore able to make independent decisions about using or avoiding the use of various medical services with strong implications over the future of both mothers and (future) children. This assumption leads to a praxis in which pregnant women are usually the first to be approached and informed by medical staff about possible problems in pregnancy, while husbands are often considered of secondary importance concerning decision-making on the future of their wives pregnancies.

This brief example illustrates how Western-biased perceptions of the human body as the sole ownership of (female) individuals may lead to inter-cultural miscommunication due to misunderstanding of the source of women's possible resistance, and ultimately may lead to misjudgment of women's responses to medical recommendations.

In terms of moral values this case example raises a dilemma between a relativistic approach supporting the legacy of respecting 'otherness' versus a universal approach to human rights emphasizing gender equality and women's rights.

This paper suggests that obtaining optimal intercultural communication and establishment of mutual trust between medical professionals and Bedouin users of prenatal services requires maintenance of a delicate balance between a respect to Others' perceptions of body and children ownership and between supporting the rights of women in making independent decisions over their bodies.

Abstract No. 402

Title: Addressing Infertility- A Reproductive Health Right

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Key Words: *Infertility, Contextual Vulnerability, Treatment Seeking, Male Involvement, Mental Health Concerns ,Mumbai*

Focus of Paper: This paper is the output of an M.Phil study on “Understanding the Experiences of Childlessness among Low-Income Group Women in Mumbai Slums”. The framework considers *gender* as a central element of stratification and attempts to understand the position of *women* and their vulnerabilities to reproductive health vis-à-vis their social class, cultural, educational and occupational background.

Objectives and Methods: Through the use of narratives, in-depth interviews and Focus Group Discussions, perceptions of women regarding the causes and consequences of infertility, treatment seeking behavior, role of men in sharing this experience and the various coping strategies used to deal with the condition of childlessness were examined. Analysis of data reveals how women’s social contexts, their living and working conditions, the roles they play, their position in and interaction with spouse/family and medical personnel and their accessibility to resources determine their varying experiences of childlessness.

Lessons Learnt: This study points to the severe lack of focus in reproductive health policy on women without children. Reproductive health has largely been defined within the biomedical model; allowing women’s bodies to be brought under medical scrutiny and treatment to be provided accordingly. This conceptualization has filtered into and pervaded the understanding of a wide range of medical and health professionals and policy makers. In policy this gets translated into a focus on family planning, which essentially concerns itself with provision of contraceptives and meeting sterilization targets. The concept of ‘Reproductive Health’ however, is multidimensional, hence concerned with a wide range of conditions related to the freedom from disruption of reproductive functioning and potential. It thus follows that reproductive health; related choices and rights would include not only the ability to choose when to have children or avoid unwanted child-bearing, but also the possibility of bearing wanted children. The prevention, diagnosis and treatment of infertility are thus an integral part of right to attaining reproductive health.

Conclusions: A growing body of research has verified the importance of infection as a cause of female infertility worldwide and traced the link between Sexually Transmitted Infections (including a symptomatic infections), postpartum and post abortion infections, Pelvic Inflammatory Disease, and tubal damage. Government of India recognizes the issue of infertility as a Reproductive Health right and it is imperative that large scale preventive interventions be adopted. Data reveals that in the hospital settings by sheer virtue of entering the medical set up women are at a greater risk to mental distress and discontinuation of or inconsistency in treatment seeking. Creating an enabling environment in hospitals through setting up of infertility counseling clinics within the Out Patient Department, training of medical staff in helping couples deal with the psychological trauma of infertility, helping them with educational information and considering alternatives like adoption, would be key areas of intervention. Directly linked to reducing the psychological burden of childlessness is the involvement of family and community members in providing support systems, which can be made possible through educational community level interventions and promoting the culture of support groups.

Abstract No. 403

Title: Impact Of Gender Discrimination And Violation Of Human Rights On Sex Ratio In India

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Key Words: *Sex ratio, sex discrimination, gender disparity, infant/child mortality, human rights, India.*

Although the Constitution of India confers right to equality to all citizens before law, social, cultural, economic and political factors make them unequal in practice. Gender disparity manifests

itself in various forms, the most obvious being the continuously declining female ratio in India. The National Policy for the Empowerment of Women 2001, includes equal human rights and fundamental freedom for both males and females in all spheres of life, besides elimination of discrimination and all kinds of violence against the girl child and women. The rights of girl child also ensures protection against pre-natal sex selection, feticide, health, education, food and nutrition, and child labour. The issue of declining sex ratio has caught the attention of policy makers, administrators, social thinkers, NGOs and researchers in different disciplines for long, due to the discrimination and violation of female children's and women's rights to a dignified life in the Indian society. Factors like poverty, scientific development contributing to female feticide, dowry system, and the religious role of males in society have all worsened the conditions of females in general. Sex selective abortions lead to enhanced morbidity and mortality among women, besides leading female fetus from the 'womb to the tomb' and the infants from the 'cradle to the graveyard'. The problem of inequality and discrimination is thus multifarious, which is further structured and perpetuated by the social system, which calls for a holistic treatment. Against this background, the present paper proposes: i) to examine the impact of sex discriminatory practices on sex ratio in India in general and among children in particular; ii) to survey infant and child mortality by sex; iii) to observe the kind and extent of abortions taking place in India; and iv) to make a primary survey of the nature of discrimination and attitude towards it in the society. The study would be based on data drawn for National Family Health Survey - 1 & 2, Family Welfare Programme in India Year Books, Census of India, and Sample Registration System Bulletins, besides primary data collected locally. The methodology would include simple averages, ratios, percentages, correlations and statistical tests for analyses. The results confirm the existence of gender discrimination as a major cause of adverse sex ratio in India. This situation is aggravated by the socio-cultural and economic conditions prevailing in the country. The consequence is severe violation of female human rights in the country. It calls for corrective measures through education, mass media, women's empowerment, strict legal action against the violators of the various protective laws and acts, besides political commitment and involvement of NGOs.



Sub Theme - 5
Violation of Rights of people living with HIV/AIDS

Abstract No. 501

Title: Defeating Hiv Stigma With Accurate Information About Hiv Risks In Health Care Settings

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Key words: *HIV, human rights, misinformation, iatrogenic, stigma.*

Objective: To describe incomplete and misleading information communicated to the public and to health care professionals on risks for HIV transmission through blood exposures, and to consider the impact of this information on people's risk of HIV infection and stigma.

Background: Within the overall human rights framework, the right to health as part of the right to life has been well established in various international declarations, conventions and national constitutions. The right to accurate information about threats to health is a logical component of the right to health.

Method: We identified incomplete and misleading information through literature review and discussions with doctors, counselors and people living with HIV/AIDS.

Results: People, including the medical community, have been misinformed regarding the contribution of blood exposures to the epidemic, the survival of the virus outside the human body and the transmission efficiency of the virus through various invasive procedures. Due in large part to a low suspicion of efficient HIV transmission through the iatrogenic route, evidence for HIV transmission in health facilities in various parts of the country have been downplayed or ignored. Similarly, evidence from research studies pointing to associations between medical procedures—especially injections, as well as other blood exposures—and HIV has been discounted or ignored.

Voluntary Confidential Counseling and Testing Centres (VCCTC) have for years been the prime interface between the HIV-positive individual and the State. With these centers functioning primarily to address and change individual personal risk behaviors, particularly sexual behaviors, sexual blame gets further reinforced. Similarly, prevention messages stress sexual exposures, while mention of unsafe injections focuses on injection drug use, not medical injections. Other common blood exposures, e.g., in dental care and tattoos, are ignored.

Implications: Misinformation about risks of acquiring HIV from unsafe health care has several linked human rights implications. First, people are not aware of the need to protect themselves from acquiring HIV in health care settings. Second, this has led to HIV/AIDS being almost exclusively equated with sexual 'promiscuity', and to subsequent blame, guilt, and shame. This second issue is a particular concern for women, who are increasingly on the front lines for HIV testing through the Prevention of Parent to Child Transmission (PPTCT) programme. With expanding PPTCT programmes, counseling and testing is not only extended to ALL pregnant women (irrespective of any risks of acquiring the virus), but women have very little choice to refuse. Women are usually tested first and, if they test positive, their husbands are called in for testing. Significantly, an important proportion of husbands of HIV-positive women test HIV-negative. Given the way HIV-positive women are treated in India, the discrimination to which they have been subjected, this programme would inadvertently further victimize them.

Conclusion: Removing the unnecessarily strong and unwarranted emphasis on the sexualization of the epidemic would go a long way in ensuring that women are not further victimized. Accurate

information about unsafe health care and about other possible exposures that could have led to the infection is a necessary first step in this regard.

Abstract No. 502

Title: Gender, Sexuality And Health

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Keywords: *HIV, Sexual Relationship, Gender, Pakistan*

Introduction: As a young Muslim nation with a complex anthropology, Pakistan continues to struggle with a common sense of identity. This struggle also touches our personal lives particularly amongst young people with severe identity and gender stereotyping issues, poverty and low levels of literacy. This confusion is propounded and manifests clearly in sexual behaviors and practices. Community based sexual health /HIV/AIDS prevention programs in Pakistan must incorporate self-reflection, self-concepts and identity issues to ensure ownership and sustainability of their programs. Working on self-encourages/ facilitates strong self-concepts, which translates to assertive behavior, negotiation skills and a sense of rights.

Gender identity refers to how one thinks of one's own, gender: whether one thinks of oneself as a man (masculine) or as a woman (feminine). Society prescribes arbitrary rules or gender roles based on one's sex. These gender roles are called feminine and masculine.

Methods/procedures: Promote Peer education, Life Skills Training's and educate public on gender sexuality- for behavior change. Exercise responsibility in sexual relationships, by abstinence addressing power imbalances, negotiation skills resisting pressure during sexual intercourse, encouraging contraception use. Gender Sexuality education must be a central component of development/reproductive health programs designed to prevent STIs/pregnancies and HIV infection.

Results: In Pakistani socio cultural framework is supremely gender and often-sexual relationships are framed by gender roles, power relationships, poverty, class, caste, tradition and custom, hierarchies of one sort of another. Here for many the term "man" is a male gender identity not a sexual identity. The phrase males who have sex with males, or men who have sex with men is not about identities and desires it is about recognizing that there are many frameworks within which men/males have sex with males, many different self-identities, many different context of behavior. The public arena is male dominated and male-to-male friendship is expressed in the public domain.

Conclusions: To bring ownership among individual/communities to work on HIV/AIDS prevention could only be achieved by incorporating self-concepts and identity issues. Must need to explore and understand male-to-male desires, as to involve men, if we are truly to develop effective and sustainable HIV/AIDS prevention strategies amongst males who have sex with male.

Abstract No. 503

Title: Addressing Stigma And Discrimination At The Community Level Through Home/Community Owned Care And Support Program

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Key words: *AIDS, Stigma, Community Programme, Discrimination, Andhra Pradesh*

A word about us ... AIDS control Foundation of India – (ACFI) HIV/AIDS control and care and support initiative of St. Paul's Trust, spear heading the war against HIV/AIDS from 1991 has so



far produced more than 1120 varieties of I.E.C. and B.C.C Materials on HIV/AIDS, **which is a world record**. Through our Care and support model i.e. home/community owned care and support, we are taking care of more than 5000 PLHA including 226 HIV infected children in 7 Mandals (Blocks) out of 57 Mandals in East Godavari District – one of the Hyper-endemic districts in Andhra Pradesh.

Since our home and community based care and support is community based, we have changed the word community based by **community owned i.e. Home/Community owned care and support program**. And we were the first to introduce the ultimate answer to HIV/AIDS i.e. the unique initiative - **prevention linked care and support**. Also we were one among the few to develop a care and support model which goes a long way in addressing stigma and discrimination and to make any project area PLHA friendly. **That is why our home and community owned care and support program is being accepted and recognized as one of the best models in the whole world.**

The First HIV case reported to St. Paul's Trust happened to be Mr. M. Raju in the year 1992 and we are happy to announce that he survived with out A.R.V. for 12 years and now he is on A.R.V.

Already a 1000 plus Government and Non-Governmental institutions both from with in the country and out side the country has visited St. Paul's Trust to study our Home/Community owned care and support program. Majority of the visitors have already implemented our model in their project area.

St.Paul's Trust through its humble work has shown a way for others as to how we can address stigma and discrimination and make any project area PLHA friendly. Through the following activities in 7 Mandals (Blocks) we could address stigma and discrimination and PLHAs are able to live a life in dignity with out any stigma and discrimination. **PLHA are able to run mini hotels, sell all kinds of eatables(Fruits and Vegetables), sell Milk and Milk products** and could work as servers in hotels, sweet stalls and female PLHA working as servant maids etc. with out any stigma and discrimination.

Out of 226 HIV infected children, more than 100 are studying from L.K.G. to 10+ level in private and government schools and colleges with out any stigma and discrimination(NDTV has made a documentary nearly 3 years back showing how HIV/AIDS infected children are studying in private and government schools with out any stigma and discrimination). Important activities to address stigma and discrimination. Counseling, Medical Support- Treatment of opportunistic infections (OIS).

Training :Staff Training, Self Care/Care Givers Training, Peer Educators/Volunteers Training Goodwill Meetings, Linkages – Referral Services: District Tuberculosis Center(DTC) for DOTs, Temporary Hospitalization Wards for serious patients. , VCTC (Voluntary Counseling Testing Centre), PPTCT (Prevention of Parent to Child Transmission) Emergency Services, Burial expenses etc., National Family Benefit Scheme/Widow Pensions and other schemes , Gram Sabha (Janmabhoomi) for awareness , Medical Care of Infected Children, Nutritional Support, Special Nutrition to HIV infected Children, Children's Care(Affected children), Linkages and Referral Services to Children, Picnics, Tours for Children, House to House campaign—Intense I.E.C. and B.C.C activities., Community based rehabilitation (C.B.R), Income Generation Activities, Community Mobilization, Self Help Groups(Credit and Thrift groups), GIPA/ MIPA, CNP+ (Networks of Positives), Positive Speaker's forum, Advocacy, Involving the District Administration Mainly the District Collector—DRDA,SC Society etc.(Multi-Sectoral approach)

Abstract No. 504

Title: Success In Developing An Innovative Cultural Strategy To Promote HIV Prevention And Human Right In Minority Ethnic Yi Community Of China

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Key words: *HIV human right policy environment minority China*

Objective: This study carried out in Sichuan of China by West China Ethnic Minority Health Promotion Volunteer Organization (WCMhealth) and Centre for International Program Development in HIV Social Study (CIPD), Sichuan Academy of Social Sciences P R China is the first to explore how to use cultural resources to build evidence-based culturally appropriate strategy to promote community commitment and mobilization at multi-sector levels, to advocate health and human right through change policy environment, and to support decision-making on the best use of healthcare and cultural resources to reduce collective vulnerability to HIV/AIDS in local Yi ethnic community, where resources are scarce and public health infrastructures least developed in China.

Background: The HIV/AIDS epidemic in China has had a significant impact among ethnic minorities who reside in the poorest and most socially disadvantaged rural areas. The provinces of Sichuan, Yunnan, Xinjiang, and Guangxi, with over 25 minority groups, have the highest reported HIV-rate, which has been as a highly challenge of health, human rights and development in these ethnic areas of China. However, the empirical evidence in previous studies showed the official traditional approach, which has used “official-led” social anti-epidemic campaigns with a simply threatening moralistic strategy from major Han cultural power and value based perspective, were having little effect in promoting development of health behavior and human right environment in the various ethnic minority cultural groups.

Methods/Strategies: Project is designed with a coherent and expanded comprehensive approach to link three focuses: 1) capacity building and empowerment through developing the ethnic peer-led communication strategy to make action in communities; 2) community mobilization and advocacy through cultural leaders involvement by a participatory approach to adopt their own initiatives (faith and descent-based cultural response to impact of various difficult issues at community level); and 3) policy formulation and sustainability through integrating project into local governmental programs of cultural, socioeconomic development and healthcare policy by development approach.

Results: Evidence from empirical and qualitative data in both process and effective evaluation in three years study clearly indicated that WCMealth & CIPD have proved to be successful model of practical cost effective in ethnic minority community to significantly promote: 1) community based health behaviour change; 2) key stakeholders (ethnic Yi cultural leaders, community leaders and local government officers) involvement in community advocacy and mobilization; 3) maximize use of cultural and community resources at multi sectoral levels to advocate human rights and reduce poverty; and 4) cultivation of policy environment in commitment to the development and delivery of sustainable and replicable HIV programs for all Yi ethnic groups and a broader range of ethnic minority communities.

Conclusions/lessons learned: Effective change in community full evolvment and promoting health behaviour and human rights was achieved through using cultural resources to develop an expanded comprehensive strategy which was integrated into the pivotal ethnic cultural system and existing structures of community organizations.



Sub Theme - 6

Discrimination in access to healthcare, especially reproductive health

Abstract No. 601

Title: Public Health Implications Of Hiv/Aids Related Stigma, Discrimination, And Human Rights Violations: Issues, Challenges And Emerging Responses

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Key words: *Public health, HIV, Human Rights, Stigma, Developed countries*

Increasingly, the inter-linkages between health and human rights in the context of HIV/AIDS are being acknowledged. Although, health is understood as a human right, less attention is given to the trajectories of health impact of HIV/AIDS related social exclusion. This paper develops a discourse on public health consequences of HIV/AIDS related stigma and discrimination and discusses causes, forms, and patterns of discrimination. Discussion on agents of discrimination, emerging responses to AIDS Related Discrimination (ARD) are also presented. Some of the major conceptual concerns in explaining and tracing the interrelationship between HIV/AIDS, public health, and Human Rights are also introduced. The intellectual rigor and clarity of such conceptualizations has its consequences on our ability to combat discrimination experienced by people living with and affected by HIV/AIDS. Stigma is a process of justifying the group action of excluding someone based on perceived or real, undesirable characteristic - behaviors related to HIV infection - This process could take place through a variety of channels of communications; from interpersonal communications to mass media. In a private realm of communication, stigmatization could remain as a personal opinion. However, in the public realm stigmatization is always a precursor for discrimination. In the context of HIV/AIDS, objectives of stigma reduction, combating discrimination, and promoting human rights of individuals and communities are expected to contribute towards creating an enabling and supportive environment, which is essential for HIV prevention and care.

In popular as well as intellectual discourse on HIV/AIDS, the terms stigma, discrimination, and human rights violations, are often used synonymously or interchangeably without describing the differences between these concepts. Such conceptual ambiguity comes from bias in approaches, lack of data and evidence based discourse, as well as the political context. In exploring the deeper meaning and implications of the concept of stigma, discrimination, and human rights, we pose the following questions.

- a) The social phenomena described as stigma, discrimination and human rights violations, are they similar, or are there shades of differences in their meaning in the context of HIV/AIDS?
- b) What are the policy and program implications of these differences?
- c) Strategically, is it necessary to prioritize these concepts in developing policies and programs?
- d) What is the most beneficial approach? Stigma reduction efforts, discrimination reduction efforts, or promotion of human rights?
- e) Should the contextual variation have any implications in selecting priorities?

HIV/AIDS related stigma, discrimination and human rights discrimination is alive in developed as well as developing countries. Developing countries often present active discrimination whereas developed countries present proactive discrimination, often camouflaged as policy and procedures. This paper identifies the public health consequences of HIV/AIDS related Discrimination as it impacts on social cohesion, impacts on quality of life, burden of disease, on the course of disease progression, on prevention efforts, on service delivery, surveillance, quality of care and in the implementation of best practices. Some of the emerging responses to HIV/AIDS related stigma and discrimination are advocacy and community mobilization, community education, policy responses, administrative and professional guidelines and legal responses

Abstract No. 602**Title: Level Of Awareness Of Rti, Sti And Hiv/Aids And Gender Discrimination In Treatment In India****Author:** Buragohain Tarujyoti, E-mail- tburagoahin@ncaer.org**Key words:** *RTI/STI,HIV/AIDs, Gender, India.*

Gender discrimination in health-seeking behaviors is an important area and must be addressed on a priority basis. Gender discrimination starts at birth in India. Girls are discriminated against with regard to food and nutrition, immunization, education, and treatment against dangerous diseases. This paper attempts to understand the extent of discrimination among men and women who have at least one symptom of Reproductive Tract Infections (RTI)/Sexually Transmitted Infections (STI) are seeking treatment.

The Reproductive and Child Health (RCH) approach emphasizes a healthy sexual life for couples. However, diseases like Reproductive Tract Infections (RTI)/Sexually Transmitted Infections (STI) and Human Immune-deficiency Virus (HIV)/Acquired Immune Deficiency Syndrome(AIDS) affect not just a couple's sexual life, but also the health of their newborn children.

Reproductive Tract Infections (RTI) defined as an infection of the reproductive system of a man or a woman, refer to three different types of infection: (i) sexually transmitted infections (STIs) – also known as sexually transmitted diseases (STDs), caused by viruses, bacteria, or parasitic organisms that are passed through sexual activity with an infected partner. (ii) Endogenous infections, which appear an overgrowth in the vagina. (iii) Iatrogenic infections, which are introduced into the reproductive tract by a medical procedure, such as menstrual regulation, induced abortion, IUD insertion, or childbirth. All these three types of RTIs overlap and are considered together. The RTIs and STIs, are also known as Urinary Tract Infection (UTI), and are both the gateway to HIV& AIDs.

In India, the awareness about Reproductive Tract Infection (RTI) among women is higher than among men by eight percentage points, but the level of awareness about Sexually Transmitted Infections (STI) among men is higher than among women by seven percentage points. The awareness about HIV/AIDs among men is higher than among women by 18 percentage points. In general, in most states and union territories men are more aware about STI than about RTI, whereas women are more aware of RTI than STI. Among both males and females, awareness about HIV/AIDs is substantially higher than of RTI and STI. In India, about 30 per cent of women in the 15-44 year age-group had at least one symptom of RTI/STI, as against only 12.3 per cent of men in the 20-54 year age-group. However, only about 38 per cent women sought treatment, as against 55 per cent men. The inter-state variation, represented by co-efficient of variance in case of treatment sought among women and men, is 51.3 and 39.7 per cent respectively.

Abstract No. 603**Title: Maternal Mortality In Heart Province, Afghanistan: A Case Study In Understanding Discrimination In Access To Health Care****Author:** Len Rubenstein, E-mail: lrubenstein@phrusa.org**Key words:** Maternal Mortality; Essential Obstetric Care; Survey, Human Rights; Gender-Based Discrimination, Afghanistan.**Objectives:**

In 2002, Physicians for Human Rights (PHR) conducted a rapid assessment of maternal mortality in the Herat province of Afghanistan in order to (1) provide an accurate estimate of maternal mortality in Herat; (2) assess violations of women's rights that might contribute to maternal deaths; and (3) evaluate maternal health services in the region.



Background:

Maternal mortality is widely recognized as an indicator of the level of marginalization of women in a society, as well as of the functioning of the health system. Ninety-nine percent of maternal mortality occurs in the developing world; discrimination against women in both the private and public spheres exacerbates contexts of poverty and inadequate health care. Afghanistan is one of the poorest countries in the world, ranking 170 of 174 on UNDP's Development Index in the year the study was undertaken. In 1997, the maternal mortality ratio in Afghanistan was reported to be one of the worst in the world: 820 per 100,000 live births.

Methods: PHR's study included a randomized, population-based survey of 4486 women from 34 urban and rural villages/towns in seven of the thirteen districts of Herat province. The women provided maternal mortality information on 14,085 sisters in structured interviews with Afghan researchers. In order to gain insight into individual experiences of health care providers and family members, PHR also conducted detailed qualitative interviews. Finally, PHR conducted a comprehensive survey of all health facilities in the districts of Herat province that were sampled.

Results: The household survey found the maternal mortality ratio for Herat province to be 593 per 100,000 live births; 92% of maternal deaths were reported from rural areas. The health facility survey found serious deficiencies in the availability and accessibility of Essential Obstetric Care (EOC). Individual interviews with health practitioners and family members reported on the many barriers to care, including inadequate supply of medications and equipment; traditional beliefs and male decision-making; ignorance of the warning signals for serious obstetric complications; unaffordability of care; and lack of transportation.

Conclusions After twenty years of war and almost a decade of brutal and systematic discrimination under the Taliban, meaningful reconstruction of the country must include attention to reducing the alarming levels of maternal mortality as an urgent human rights as well as public health priority.

These findings can be understood in light of the findings of two earlier studies conducted by PHR on women's health and human rights in Afghanistan. The first study, conducted in 1998, documented how the Taliban's systemic gender discrimination seriously undermined the health and well-being of Afghan women. The second study, conducted in 2000, assessed the degree to which Afghan women perceived that violations of their human rights by the Taliban regime were responsible for affecting their health and well-being. Together these three studies demonstrate the critical importance of protecting women's human rights, including their health rights, to creating a fully democratic Afghanistan.

Abstract No. 604

Title: "Triple Jeopardy" Of Women – Discrimination In Access To Healthcare Based On Gender, Caste-Status And Disability.

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Key Words: *Gender Inequity, Access , Healthcare, Disability*

Objective – To address the key issue that violate gender equity – discrimination in access to healthcare, especially reproductive health services based on gender, caste-status, and disability. The focus is also on contraception and safe motherhood including abortion related issues.

Background – Access means that services are available within reach of women who need them. Denying access to health services to women both physically and psychologically is a form of social injustice. Men make the major health decisions while women are often reluctant as they feel threatened and humiliated by health workers, or pressured to accept treatments that conflict with their own values and customs. Therefore policy-makers – government and non-government

– need to address and educate within communities and at the national level to support and improve access to health, family planning and abortion-related services.

Methods – A Three-pronged strategy is adopted:

First, to identify factors that prevent women from accessing the life-saving healthcare needs – distance from health services; high cost requirements; women’s lack of decision-making power within the family and their dependency on male members; poor services by health providers and unwillingness to travel to rural interiors; policy barriers and lack of proper knowledge about certain disabilities.

Second, to raise awareness about consequences of poor health of women that equips them with knowledge regarding reproductive life span; sexuality, reproduction, contraception, unsafe abortion, decision-making skills and gender relations including knowledge about various disabilities like mobility, vision, hearing, speech, and cognitive disabilities. Stress will also be on old-age related disabilities such as osteoporosis, diabetes, arthritis, obesity, urinary incontinence, and depression.

Third, to make accessible, healthcare environments and services, especially to women with disabilities. These include:

- Involve people with disabilities as part of a team to help determine and meet accessibility requirements.
- Observe some basic rules of etiquette while interacting with women patients.
- Provide medication, training and literature.
- Provide employment opportunities to people with disabilities.
- Monitor to ensure that the affected members are actually benefited.

Results/Conclusions –

- Social taboos and unequal power relations between men and women often prevent women from accessing healthcare.
- Women face high risk for unwanted pregnancy, unsafe abortions and other sexual and reproductive health problems.
- Health services are often not available in the rural interiors. Lack of training, equipment and protocols, drugs and basic supplies, including blood for transfusion; misdiagnosis; negative attitudes of health workers; and/or overcrowded emergency wards lead to costly delays for women seeking treatment.
- Women and community members often do not know how to recognize, prevent or treat health complications, or when and where to seek medical help.
- Interference by traditional healers, local quacks and political opportunists sometimes paralyses the situation and aggravates health complications.



Focus Theme 2: Addressing the Missing Links of Gender Equity in Health and Human Rights

Subtheme - 7

Good practices and strategies for engendering health and human right

Abstract No. 701

Title: Engendering Health And Human Rights In Developing Countries: What Does Have Bioethics Have To Offer?

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Key words: *Bioethics, human rights, developing countries, women's health, gender discrimination.*

The bioethics movement arguably started gaining ground at the same time as the human rights movement and the women's health movement (late 1950s and 1960s). While the human rights movement and the women's health movement have been supporting each other, bioethics has tried to remain aloof. This has been a flaw as bioethics shares the fundamental value of 'protecting the vulnerable' with the other two movements. The feminist philosophers have contributed to the field of bioethics by adding a discourse on the power relationships in the social systems, which impact the professions such as medicine, as well as biomedical and social science research. Feminist approaches to bioethics acknowledge the patterns of dominance and subordination existing in the social system, and power hierarchies within professions, and offer critiques to the same. Its emphasis on the principle of social justice distinguishes itself, and the emerging discipline of global health ethics from the mainstream/modern bioethics. Feminist analysis can offer strategies to better address issues and concerns in bioethics.

There have been many controversies in biomedical research and clinical medicine, including the exclusion of women from trials for a long time (leading to drugs being released in the market without being tested for safety among women), lack of informed consent and deception in research on women's health etc.

This is perhaps a reason that feminist bioethics developed as a strong (& independent) stream of thought within bioethics to address the larger inequity issues and specifically gender discrimination in the practice of medicine. Some shared goals of feminist bioethics are: (1) to provide moral critiques of actions, practices, systems, structures, and ideologies that perpetuate women's subordination; (2) to devise morally justifiable ways to resist the economic, social and cultural causes of women's subordination; and (3) to envision morally desirable alternatives to the world as we know it: sexist, racist, ableist, heterosexist, ethnocentric, and colonialist (social justice is of over riding concern). Feminist bioethicists recognize that women are oppressed in our society; oppression takes many different forms. It is often compounded by other forms of oppression based on features such as race, ethnicity, sexual orientation, and economic class. Feminist bioethicists believe that oppression is objectionable on both moral and political grounds, and most are committed to transforming society in ways that will ensure the elimination of all forms of oppression.

Bioethics is a growing field in developing countries, and there is an increasing interest in it. Our paper will examine this trend and also strategize how feminist bioethics, which best captures the essence of and supports the concept of engendering health and human rights, can be made the focus of this growth. We will look at emerging models of south-to-south co-operation in bioethics. We will also make strategic suggestions for partnerships with those working in the field of bioethics to further the aim of engendering health and human rights globally, and especially in developing countries.

Abstract No. 702**Title: A Community Based Clinic's Approach To Addressing Sexual Violence****Author:** Sodhi Geeta, E-mail: swaasthya@satyam.net.in, gsodhi@vsnl.com**Key words:** *Community based clinic, community based programme, sexual violence, strategies for, addressing sexual violence***Issue:** Violence against women is the denial of fundamental human rights to women. International human rights instruments such as CEDAW affirm the principles of fundamental rights and freedoms of every human being. CEDAW is guided by a broad concept of human rights that stretches beyond civil and political rights to the core issues of economic survival, health, and education that affect the quality of daily life for most women.

Sexual violence, as a form of domestic violence, is quite commonplace although it is often not talked about. It leads to far-reaching physical and psychological consequences, some with fatal outcomes.

Programme: Swaasthya is an NGO in Delhi working on reproductive & sexual health issues. Amongst other things, Swaasthya is also involved in community based work. As part of its comprehensive reproductive and sexual health work, Swaasthya operates a community based clinic that is primarily run by field staff who belong to the community itself. Other elements of its programme comprise of a *Mahila Panchayat* and micro credit groups. These groups are run by women from the community, with Swaasthya only providing technical back-stopping.

As part of its services, counseling is provided to women who visit the community based clinic. The counselor is a trained field staff from within the community. This makes her more acceptable to the community as they view her as one of them who understands their context. This is important if women are to bring up their issues of sexual violence. Women who generally come to the clinic are married women who belong to the community and from neighboring slum colonies. In our experience, women who have talked to the counselor regarding sexual violence had actually visited the clinic for STI treatment or with a complaint of PID. On finding vaginal lesions during internal check up, the doctor suggested that they speak to the counselor. It is during these sessions that some women have poured their hearts out about the sexual violence that they have been subjected to by their husbands. Besides counseling the women, the counselor has also linked them to the *Mahila Panchayat* where they could take some social and legal recourse.

Results: Some women who have sought the intervention of the *Mahila Panchayat*, have managed to resolve their issues by leaving their husbands or coming to a point of self belief where they are thinking of ending the violent relationship.

The paper will discuss design and strategies of Swaasthya programme for addressing sexual violence.

Conclusion: Domestic violence is a complex problem and there is no one strategy that will work in all situations. If strategies and interventions are designed within a comprehensive and integrated framework keeping in mind the interconnections between gender dynamics of power, they are likely to be more effective. A multi-layered strategy that addresses the structural causes of violence against women while providing immediate services to survivors ensures sustainability and is perhaps the only strategy that has the potential to eliminate domestic violence.**Abstract No. 703****Title: Therapeutic Groups: Listening to Women who have Experience Domestic and Sexual Violence****Author:** Paredes, A. Giannina, E-mail: demus@demus.org.pe

Key Words: *Violence, mental health, gender, identity, therapeutic groups, Peru*

Domestic violence is a complex situation that makes us aware of the discrimination and subordination of women in our society. This violence is still been tolerated and overlooked in some societies. The magnitude of this situation is revealed in statistics that shows us that at least one of three women in the world has been physically assaulted. Moreover, the Institute of Legal Medicine from Peru, reveals that each hour 9 women are suffering domestic violence. DEMUS, is a peruvian NGO that has been working for the last eighteen years protecting women's rights.

DEMUS, incorporates in the struggle for women's rights various forms of intervention like psychology, laws, communication, social assistance, sociology and arts. All together this disciplines allow us to have a better understanding of the dynamic of violence and discrimination that affect women's life and mainly their mental health.

The main objective of this presentation is to share DEMUS' five years experience working with therapeutic groups. This groups are formed by women who have suffer from domestic violence and sexual abuse. Our aim by this supports groups is to offer women the opportunity to share their suffering, to express their feelings of anger, pain, loneliness, without being judged, and recovering their capacity to make decisions and overcome this situation.

Therapeutic groups show us the impact of violence on women's mental health and lives, that in extreme cases can also end up in death. The therapeutic groups shows to women that they are not alone and makes them feel relief to share their feelings with other women that are living similar situation, in despite socio-economic, education, cultural or ethnic differences. Maybe the most important for women is the opportunity to listen themselves. These therapeutic groups help women change their views on the way society expects them to behave. Women will think now more about their own needs rather than making others their priority, as the way our gender socialization expect from us.

Our proposal is to evidence the impact that violence against women have for their mental health, their identity and subjectivity. Recovering their history and their voice. Therapeutic groups is offer as a model of psychological attention, responding to a demand that is not being attend by our society. But the most important is the opportunity to offer women a possibility to think of themselves, to question their situation and to evidence the position of subordination that women still have on our society, that limits our development and empowerment.

Abstract No. 704

Title: *Perception And Reality Of The Access Of Reproductive Health In Ecuador*

Author: Márquez Lilly, E-mail: lilly_marquez@yahoo.es

Key words: *HIV, Councelling, Reproductive, Health, Ecuador*

CEMOPLAF: *Its role in sexual and reproductive field in Ecuador, The developed Experience, Life conditions of the Users, Strategies and used methods, Learned Lessons, Conclusions*

Good Practices and Strategies for Generating Health and Human Rights

Objective: Visualize CEMOPLAF experience in the access to sexual and reproductive services through the integral care CEMOPLAF: Its role in sexual and reproductive field in Ecuador **This** experience has its origins in the work performed in the Medical Center of Orientation and Family Planning (CEMOPLAF, for its initials in Spanish), which is a non-profit organization (NGO).

CEMOPLAF, mainly attends poor women living in urban-marginal areas. Sexual and Reproductive health services are offered, including women who live with the HIV and AIDS. The services are

gender-focused. As a preventive measure, it has been incorporated a previous and basic level of counseling to the medical appointment, and the case is linked to a system of reference and counter-reference of organizations that mainly work in the legal area and in the defense of human rights.

Life conditions of the Users: The 60% of the homes have a feminine management, the social and economical pressure that many of our users receive, becomes a heavy psychological burden. The lack of access and of power of decision is one of the major problems that these women face regarding their sexual and reproductive health care. Access to family planning methods, for example, is fairly good. A large group of women live family relationships in which their partners maintain and defend sexual practices with multiple partners, based on a patriarchal structure perpetuated by the macho educational system. Under it, the use of a preservative, in or out the home is a practice that question their masculinity. A recent phenomenon, caused by this very same situation of poverty, is that a lot of women have increased their sexual and reproductive risk in order to face their economical needs, as well as their children's.

Strategies and used methods: We work in the following manners:

- Giving counseling and orientation, directed to women and their partners, in sexual and reproductive areas, with family planning and ITS, including HIV and AIDS.
- Providing information and education regarding the gender issue.
- Making women know about their rights to access to quality health services.
- Inter institutional work, coordinated for reference and counter reference regarding human rights' violation and legal assistance.

Learned Lessons: To provide a confidential space of quality and warmth, where no one is to be judged, criticized or questioned; in which thoughts and feelings are respected and, the professional and the user, together, could look for the best alternatives.

To make an approach to the daily experiences of the patient and, if possible, work with the couple in their sexual and reproductive health and lives. To elaborate a critical route regarding the health risks that the user face in her familiar and personal relationships. A reference and counter reference net for psychological and social attention of the users. A broader participation in capacitating networks and gender work with the users.

Conclusions: Increasing, through the personal, social and communitarian work, the women's capacity to empower themselves in their sexual and reproductive health and care, surpassing the barriers built by centuries of superstition, rejection and abuse. CEMOPLAF keep building networks for the promotion and defense of sexual and reproductive rights



Sub Theme - 8
Monitoring gender concerns in rights violations

Abstract No. 801

Title: Righting Health Sexually: Examining The ‘Health & Human Rights’ Approach To Sexuality

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Key words: *Sexuality, Health, Human Rights, HIV/AIDS, Non-discrimination*

Although public health and human rights are widely regarded as powerful, modern approaches to defining and advancing human well-being and generating change, they have also been powerful tools for maintaining *status quo* of hierarchies of power. Thus, the labeling of a concern, policy or programme with “health” or “human rights” does not give it unqualified value. Highlighting some elements of a ‘health and human rights’ approach to sexuality – that might prove useful to health policy and practice in the context of diverse sexualities – this paper will suggest that neither ‘health’ nor ‘human rights’ should be employed without an interrogation of the ways in which each concept functions.

The growing diversity of rights-based advocacy in public health and health policy has inevitably engaged questions of sexuality. United Nations human rights bodies are increasingly taking on new norms and laws relating to sexual diversity, health and harm; struggles for law reform engage with sexuality and rights claims in the context of sexual violence, HIV/AIDS and emerging demands for sexual non-discrimination. The World Health Organization has formulated a working definition of sexual rights, and for health policy-makers, programmers and planners, recognition that effective health interventions require an understanding of complex sexualities has become evident.

With these links between health and human rights growing globally and locally, the full potential of a progressive human rights approach to health has not yet been explored. So how will sexuality be included in work on health and human rights? In search of the exact nature and/or terms of its inclusion this paper will highlight several problems that arise at the intersection of sexuality, rights and health.

Of the ‘health and human rights’ approaches developed through global work, this paper would focus on the one claiming that promoting and protecting health requires explicit and concrete efforts to promote and protect human rights. The paper will establish how this approach could take on the many complicated ways that discrimination on the basis of gender, race/caste, sexual orientation, HIV status, age or disability affects health status. It would also include how intersecting discriminations, like sexual forms of racial/caste discrimination affect health, or the right to health. Recognizing sexuality as a critical element of humanity and establishing a fundamental right to health can play a broader role in social justice claims. However, the paper will caution, call for scrutiny and challenge the dangerous tendency to ‘normalize’ and ‘discipline’ human behavior when public health and human rights advocacy are coupled together.

Drawing on the seminal works of Alice Miller, Carole Vance and Lynn Freedman, the paper will argue that a critical use of the ‘health and human rights’ approach to sexuality can be part of a politically perceptive and accountable coalition strategy. Because of its focus on persons of non-hetero normative sexualities this approach can contribute both to revitalizing calls for social justice in health for the most diverse range of people and to transforming the nature and practice of state accountability in ensuring conditions for the ‘healthy’ life of all persons.

Abstract No. 802**Title: National Medical Associations And Gender Equality****Author:** Dr Sheather, Julian, E-mail: jsheather@bma.org.uk**Keywords:** *Health, BMA, Gender, Ethics, UK*

This paper explores two basic issues. Firstly it looks at the broad question of the ways in which national medical associations (NMAs), such as the British Medical Association (BMA), can promote gender equality in the provision and uptake of health services. Here it will look at the development of the BMA's understanding of gender rights, and of the right to health, and the policy work it has undertaken to promote gender equality. It will look in particular at the work of the BMA's Science and Ethics Committees and explore the ways the BMA has promoted this agenda, through its teaching, publishing and lobbying activity. It will also explore the BMA's work in promoting human rights and related issues in medical teaching and training.

Secondly this paper takes a critical look at issues of gender equality in the United Kingdom medical workforce. It details both the historical development of women working in medicine in the UK, and looks at current and future trends in employment. It then goes on to look at the role played by the BMA in relation to gender equality in the medical work place. It explores the actions and policy decisions that the British Medical Association has taken – or at times failed to take – in promoting gender equality. Using a rights-based framework, it seeks to explore the extent to which the medical profession has promoted or stifled gender equality in the workplace.

A crucial aspect of the paper is the recognition of the need to disaggregate the variety of complex and interdependent factors that lead to gender discrimination. It will therefore consider the ways that interlinked issues such as race, class, education and religion impact upon the role of women in medicine, and looks at their effect on employment.

This paper seeks to identify good practice in promoting gender equality. It looks at gender-sensitive policies that the BMA has worked to promote, including flexible working and the provision of child care services to facilitate equality of employment opportunity.

Abstract No. 803**Title: Judicial Response To Reproductive Rights Through Public Interest Litigation: A Nepalese Experience****Author:** Chapagai, Raju Prasad, Email:gender@propublic.wlink.com.np, rpchapai@enet.com.np**Keywords:** *Public Interest Litigation, Court, Reproductive Health, Nepal*

Throughout much of the history of Nepal, defective cultural beliefs allowed women only limited roles in society. Many people believed that women's natural roles were as mothers and wives. Women were considered to be better suited for childbearing and household work rather than for involvement in the public life. Till 1990, Nepalese society denied women some significant rights and freedoms accorded to men. Since the promulgation of democratic constitution in 1990, women's efforts to control their own reproductive systems have been an important part of the women's rights movement. In 1991, Nepal also ratified "Convention on the Elimination of all Forms of Discrimination against Women 1979" that has further vitalized the reproductive issues.

Though the constitution doesn't explicitly incorporate reproductive rights but it provides wide scope for the materialization of these rights in living reality. The Article 11 not only guarantees formal equality but also aims at securing substantive equality that requires state to devise various measures to promote reproductive health of the women. Directive principles provided under Article 25 and 26 further impose positive obligation upon state to give priority to women's health.



Moreover, Article 9 of the Treaty Act 1990 gives the status of domestic laws to the ratified human rights conventions; therefore, reproductive rights guaranteed under the conventions are also equally enforceable. Scope of remedy in the case of violation is also effectively provided especially through the Article 88 as it empowers the Supreme Court with jurisdiction for “Judicial Review” and “Public Interest Litigation”.

In this backdrop, the paper is mostly aimed at assessing applicability of Public Interest Litigation (PIL) in enhancing enforceability reproductive rights. It highlights major achievements of judicial intervention in this regard through critical analysis of selected Supreme Court decisions in light of state obligation under the constitution and ratified conventions. For examples, the Supreme Court for the first time in *Mira Dhungana V. His Majesty’s Government et al* (1995) asked government to eliminate discriminatory laws against women that ultimately resulted in reform of abortion laws also through which women are now provided freedom of choice where or not to have abortion within first twelve weeks of pregnancy. In *Annapurna Rana V. Kathmandu District Court* (1998) the Supreme Court recognized women’ right to control over their own body through nullifying “Virginity Test Order” of Kathmandu District Court. Most significantly in *Mira Dhungana V. His Majesty’s Government et al* (2001) the Supreme Court labeled marital rape as heinous sexual crime and endorsed the sexual autonomy of women even within marital bond. Judgments concerning maternity leave, breastfeeding promotion, forced abortion, sexual harassment, state protection of polygamy are also counted important in this regard.

The paper finally observes that Public Interest Litigation has become instrumental in promoting government accountability towards reproductive rights, eliminating discriminatory legal provisions and accelerating law reformation process. However, It’s effective exercise is still more expected for furtherance of meaningful realization of reproductive rights in future.

Abstract No. 804

Title: Family Planning In India : Rights, Laws And Standards

Author: Das Abhijit, Email – abhijit@sahayogindia.org

Key Words: *Reproductive Rights, Family Planning, Human rights, Advocacy, India.*

The concept of Reproductive Rights has gained currency since the International Conference on Population and Development (ICPD). In the ICPD Program of Action (PoA) Reproductive Rights have been mentioned as embracing “certain human rights that are already recognized in national laws, international human right documents and other relevant United Nations consensus documents”. This paper uses the benchmarks of international human rights standards and national law to review of the concept and practice of the national Family Planning programme in India. It starts with a comparison of the terms Family Planning, Contraception and Birth Control and the importance of the distinctions in a rights approach. The paper traces the history of the Malthusian idea in Europe and its relationship to eugenics and the implementation of sterilization programmes based on eugenic laws. The paper relates modern reproductive rights and human rights to the design and delivery of family planning programmes. On the basis of this understanding of rights and law the paper reviews the current practice of Family Planning in India especially in the eleven years since ICPD. The paper describes recent experiences of using human rights standards and national laws to improve Family Planning programme service delivery as well as accountability, and the different results that have been obtained using both legal as well as social advocacy strategies. The paper concludes with a series of recommendations on how rights based approaches may be used for setting standards for services, improving their delivery as well for monitoring them and ensuring accountability.

Abstract No. 805

Title: Proposal participation HOM - IFHHRO Conference: *Engendering Health and Human Rights*

Author : Saskia Bakker, Email: s.bakker@hom.nl.



Key Words: *Womens, Human Rights, NGO, Netherland*

The Instrument

Health Rights of Women Assessment Instrument (HeRWAI), provides women's organizations and NGOs with a hands-on tool to use human rights in a practical manner. It helps women's organizations and NGOs to analyse the impact of government policy on women's health. It also assists them to investigate the interrelation between national and international policies and their combined impact on women's health.

Human rights based approach to women's health: When using the instrument, women's organizations or NGO's will be stimulated to use human rights standards. Human rights are universal, legally binding and not limited to a certain group or area. By referring to human rights obligations NGOs strengthen their arguments to improve women's health. Most countries have ratified the *Convention on the Elimination of All forms of Discrimination Against Women* and the *International Covenant on Economic, Social and Cultural Rights*. This means that, the governments of these countries are obliged to protect women's health rights. HeRWAI is based on these treaties and also uses other widely accepted texts describing women's health rights, such as the MDGs.

Outcome: With the outcome of the analysis, users can lobby for measures that better protect women's health rights. HeRWAI provides them with strong arguments to support their lobby.

Contribution HOM:

Taking HeRWAI as the basis, HOM could contribute to the Conference either by giving a presentation of the instrument or by giving a workshop on the basis of the instrument.

Presentation: Health Rights of Women Assessment Instrument (HeRWAI)

HOM will give a presentation of the instrument to the participants of the Conference. The following issues will be discussed in the presentation:

- What is HeRWAI? (background and content)
- Who can use HeRWAI?
- Why use HeRWAI / What can you achieve by doing an analysis with HeRWAI?
- What is the Added value of an analysis with HERWAI?
- The use of HeRWAI in Pakistan, Bangladesh, Kenya and the Netherlands.

Duration : 20 minutes

Materials : HeRWAI Brochure and the Discussion guide (short version of HeRWAI)

Workshop:

Using HeRWAI- a practical tool to analyse impact of government policy on women's health rights

In an interactive workshop, HOM will familiarise participants with the use of a human rights approach to women's health. The basis for the workshop will be the Health Rights of Women Assessment Instrument (HeRWAI), a practical tool to analyse to analyse the impact of government policy on women's health. If possible, HOM will present the workshop together with Naripokkho. Naripokkho has tested the instrument some months ago, and analysed the government policy towards Eclampsia. Otherwise, HOM will base the workshop on a case that it has worked with before: for example the withdrawal of the pill from the social insurance package in The Netherlands.

- Presentation instrument
- Use Discussion guide on case

Duration : 3 hours

Group Max : 20 persons

Materials : HeRWAI Brochure and the Discussion guide



Sub Theme - 9

Data and evidence on gender inequities in the human rights context

Abstract No. 901

Title: Women's Health And Security Concerns In Shrimp Cultivation And Shrimp Processing Plants In The Coastal Areas Of Bangladesh

Author: Karim Dr. Md. Rezaul and Hossain Rakib, E-mail: rk@bttb.net.bd, E-mail: mrakib_hossain@yahoo.com

Key Words: *Women, Shrimp Farming, Insecurity, Health Risk, Gender Discrimination, Bangladesh*

The aim of the study is to highlight the activities performed by women who are involved with shrimp cultivation in the southwest coastal belt of Bangladesh. The main focuses of the study was to find out the consequences of shrimp farming activities on the socio-economic state of affairs of women and its impact on their health and securities. Shrimp farming has become an integral part of the economy of Bangladesh. The shrimp sector is the second largest export industry of the country. Presently, it contributes more than 10 percent of the country's total export earnings with an annual income of more than US\$ 300 million and employing more than 600,000 people. The area under shrimp cultivation has registered a three-fold increase over the last decade.

The paper has been prepared on the basis of information received from primary and secondary sources. Women's working in the shrimp industry and shrimp fry collection from the coastal shores are considered target group of the study. A number of case studies and focus group discussion including interview of experts regarding the health risks for women involved in the shrimp cultivation were also included in the study.

The issues of social and human rights violation in the shrimp industry is really a matter of great disquiet that concerns the women involved in shrimp cultivation. The health and insecurity of women has increased through the occurrences of kidnapping, rape, wage discrimination and other forms of female harassments. Various types of health risks including cold and fever, skin diseases, diarrhea, respiratory and reproductive tract infection and even HIV/AIDS are getting prevalent for women. Among others, reproductive health conditions of women are worsening more. Women are forced to be involved in the shrimp cultivation process as they do not have any other viable employment alternatives. The women associated with the shrimp culture process are generally poor and illiterate. They are socially, economically and physically disadvantaged group.

The lives of people in the coastal areas have been adversely affected both economically and socially by the shrimp culture. It may also be said that the shrimp culture has been succeeded to some extent to provide some rays of hopes to some women at least for some days. But their hopes and expectations, discontent and sufferings are now increasing that needs to be critically addressed. Though lately, the time has come to think by the all concerns - what are the best ways and means, how the benefits of the shrimp culture can be reached to the women those are involved with the process of shrimp cultivation at the grass root level, in the coastal areas of Bangladesh. It is urgently necessary to develop a holistic and integrated approach addressing the socio-economic affairs, health and security issues of women for sustainable management of shrimp farming in the country.

Abstract No. 902

Title: Young People Rights Violation, An Engine To Hiv/Aids Prevalence Rates Among Young People.

Author: Ocen Sam Fortunate, E-mail: ocensam@yahoo.com

Keywords: *Child Health, HIV, Rights, Reproductive Health Rights, Uganda.*

Issue: The rights of young people in Uganda have continually been violated yet young people account for the biggest population of the country. According to UBOS (Uganda Bureau of statistics) 2002 report, young people account for 78% of the country's population yet they are the most vulnerable to HIV infections. Young people are denied their rights to sexual reproductive health, rights to non discrimination and rights to marriage when they are HIV positive, right to privacy, right to information and knowledge.

Description: To examine and evaluate the impact of human rights violation among young people in Uganda, a study was conducted by Makerere Child Health Development Center in Busia, Eastern Uganda and according to the research findings, the highest adolescent pregnancy rate was 37% while the National rate is 31%. In Busia, children 12 to 18 years are considered to be mature enough to engage in sexual activities. Almost 68% of the adolescents were reported to have been pregnant at one time or another, while 40% experienced problems during pregnancy. Busia is one of the districts in Uganda with the highest prevalence rates of HIV/AIDS.

Lessons learnt: Violation of sexual and reproductive health rights, rights to education and lack of enough parental care engines pregnancy rates, numbers of school drop outs and increases the HIV/AIDS prevalence rates among young people.

Recommendation: Actions of prevention of HIV/AIDS among young people should strongly focus on the strengthening their rights to good child mentorship, parental care, love and good upbringing, sexual reproductive health and rights, education and other basic rights of young people.

Abstract No. 903

Title: Gender Dimensions Of Health Sector Reform: Challenges And Limitations To Women's Health And Rights

Author: Roy Bijoya, Email: bijoyaroy@hotmail.com

Key Words: *Health Sector Reform Policies, Gender Inequality, Women's health needs, Accessibility, Availability of health services to women*

Acquiring highest possible level of health is a fundamental human right and can be attained with co-operation from various sectors along with health sector. The paper aims to explore how changing provisioning system of state health care system impacts upon gender equity and women's basic right to general and reproductive health.

The practice and provisioning of medical care situate women and men differentially in terms of needs, access, utilization of services and overall as users. Interestingly over the years despite realizing increasing gender gap and discrimination through misutilisation of technology, high maternal morbidity and mortality and violence there seems to be widening gap between those advocating women's health and health reforms. In the early nineties health sector reform gradually gained centre stage in India across public health practitioners acknowledging the need to reform public health system coupled with fiscal crisis of the state. Reforms meant pruning of state intervention, responsibility and promotion of privatization. Interventions are premised on cost efficiency and recovery, quality control. Health care reform programmes were and are being implemented across primary, secondary and tertiary level health care promoting model of care that perpetuates health as freedom from disease and health care as treatment of disease with increased usage of technology. Reforms of this nature will prevent the public health care institutions at different levels to act as interconnected referral units and behave more as individual separate units that can fall easy prey to commercial interests of private investors.

In public and private sphere right of women to health is at precarious situation. Whatever rights to health care women have gained is by virtue of being child bearers and as adolescent girls who



will be future mothers. Her health care needs as human being are recognized less. Different South Asian countries show how reform policies lack gender analysis and in spite of acknowledging discrimination and inequitable access to health care services limited role has been played. In Indian context changes through reforms over a decade within the public sector health care institutions will influence the availability and accessibility of services to women as very few have the right to make decision. Even when they make decisions they are not only guided by the decisions made by the male family members but also by priority accorded to her health in comparison to the others, cost of care (medical and non-medical) and availability. Juxtaposed market driven approaches to health care are likely to marginalize and violate right of women to general and reproductive health.

Using this framework the paper will build linkages between health sector reform programmes, gender and women's health needs. It will analyze country (India) specific reform strategies that bear its impact on access, availability (indoor and outdoor services, clinical and non-clinical services), utilization of general and reproductive health services and its implication on women's health across differential age group and class. Examples from state level experiences will be referred to and concern areas posing challenges to women's right to health through reforms can be identified.

Abstract No. 904

Title: Socio-Economic And Medical Provider Correlates Of Post Abortion Complications Among Married Women In India: Findings From Reproductive And Child Health Survey

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Keywords: *Induced abortion, Spontaneous Abortion, Post abortion morbidity, Treatment seeking behavior, India.*

Objectives: This study seeks to understand levels of post abortion complication and treatment seeking behavior in India and across the states, and to determine the socio-economic and medical provider factors which influence post abortion complication and abortion related care in the country.

Background: India, with the passing of Medical Termination of Pregnancy (MTP) Act 1972, permits legal abortion for various socio-medical reasons. However, only a small fraction of induced abortions take place in medical establishments registered and recognized for that purpose whereas many abortions are conducted by untrained persons and in unsafe conditions. Hence, post abortion complications pose a risk to women and are an important issue in reproductive health.

Materials and Methods: The study uses data from the Reproductive and Child Health (RHS) and Rapid Household Survey (RHS)-1&2, conducted in 1998-99. The sample covered 4,74,980 currently married women in the reproductive age group of 15-44 years. The present study considered those who have had induced and spontaneous abortions. To examine the net effect of various socio-economic and medical provider factors on post abortion complications and treatment seeking behavior in different health sectors, logistic regression and multinomial logistic regression models have been employed out respectively.

Results: It was found that 39.5 percent of women reported any one or more post abortion morbidity within six weeks preceding survey. The commonly reported problems were excessive bleeding (21.0 percent), followed by weakness (21.6 percent), pain in lower abdomen (18.9 percent), backache and body pain (15.0 percent), high fever (11.3 percent), and foul smelling discharge (4.8 percent). Among those who reported problems, nearly eighty percent of women have taken care from some source. Rural women, women with low level of education, and women with poor economic condition are more likely to report post abortion complication. Complications are more

likely for abortions by untrained persons, followed by public, and private sector institutions in that order.

Conclusion: The results indicate high level of post abortion complications in the country. There is urgent need to provide quality health care services for post abortion care. Health care service providers, public as well as private sectors, must be better informed about the details of the MTP Act so that they can implement the Act more effectively. It is also likely to be of significant interest to policy makers and programme managers.



Poster Presentation

Poster No. P01

Title: Violence Against Women, Health And Rights – Policy And Programme Implications In India

Author: Das Abhijit, Email – abhijit@sahayogindia.org

Key words: *Health, Violence, Policy, Women, India.*

Violence Against Women (VAW) is acknowledged as one of the most pernicious forms of human rights violations. There is also an increasing awareness that VAW is a very important public health issue. However there is little provision of addressing VAW within the health system in India and the relationship is restricted to the provision of medical certificates or to emergency trauma care. Even though some collaborations between hospitals and Non Government Organisations (NGOs) have been started in the country to provide support to victims of VAW, there has been no systematic review and planning done to understand and outline the role of the health sector. This paper relates VAW to the health sector, not only through its medical role but also provides an analysis of how some of the major health programmes can contribute VAW and human rights violations. The two programmes that are reviewed are the Revised National Tuberculosis Control Programme and the Family Planning Programme. The paper explores the possibility to address VAW within the health sector by analysing the National Population Policy 2000, National Policy on the Empowerment of Women 2001 and the National Health Policy 2002 and the National Rural Health Mission. The paper concludes with a set of recommendations for improving the response of the health sector to VAW at the policy and programmatic level.

Poster No. P02

Title: Barriers To Health Rights

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Key words: *Health Rights, HIV, Reproductive Health*

The majority of problems that all people living with HIV/AIDS are confronting today originate from a lack of respect for human and health rights. Although AIDS is now treatable, less than 5% of the 40 million people living with AIDS have access to antiretroviral. The 34 countries targeted by the initiative are home to 94% of people needing treatment in the developing world (1). However, all 65 million people living with the diabetes or hypertension are getting treatment with out economical problems and are not stigmatized (2). Health should be one of the goods of life to which man has a right (3). However, it looks like an honest assessment of the global situation today shows that it is the market where peoples' attitude and stigma decides who lives and who dies. To address the greatest health crisis in the past 500 years, a human-rights based – rather than market based- approach and effort towards strategies of changing stigma and peoples attitudes is the only realistic strategy for an epidemic that is concentrated in poor and marginalised communities who have neither access to health care nor the ability to pay for treatment.

In the context of the above, this paper concentrates on health right of people living with HIV/AIDS, who need more than an average 'reproductive health package'.

Poster No. P03

Title: Issues Emerging Working With Hiv + Persons In The State Of Punjab

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Key words: *Human Rights, HIV, Women, Punjab*



The Status of any society can also be best adjudged by observing towards status of Human Rights in a given society meaning by how far the Human Rights of Individual are guaranteed, respected & being implemented. The Human Rights is reflected more differentially in an unequal society. The Human Rights of women & Children get reflected in the prism more unequally where the concept of gender equity is not being implemented. The paper will try to attempt to understand the Human Rights of Women & Children and its gross violation in the area of HIV Positive people. Our presentation will try to draw lesson, issue, solution and also the prevailing status of Women and Children who have got the HIV Positive status being silent recipient. Our people will also try to understand their status and position with in the frame work of their social and economic rights. It has been generally observed that in the absence of generally defined HIV Positive people rights, all the above-mentioned category (Male, Female and Children enuch) sufferer badly. But in the case of women & children they are the worst sufferer by being of having HIV Positive status. Women are the worst sufferer because generally gender equity is violated not by individual but even by the State and also by the Societal Gesture.

They suffer because of the prevailing gender based violence like sexual assault, domestic violence against women. All these three categories operates in converting normal women into HIV Positive. Women & Children also suffer because of their low economic status and more of their domestication. They also suffer for not having associability to available health services and also the increasing trend of costly remedies available in their case.

We will like to present this paper on the basis of our experience working in the three district of Punjab with HIV Positive male, female and Children. We will like to present five cases one of male, three women and one child.

Poster No. P04

Title: Gender & Hiv/Aids: Double Geopardy Of Women

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Key words- *Gender, HIV/AIDS, Women, Vulnerability, Rights, Kerala*

Background: Present statistics indicates that 5.1 million people in India are infected with Human Immune Virus (HIV), making India second only to South Africa in the number of HIV infected individuals in a single country. HIV is an extra ordinary kind of crisis it requires an exceptional response that remains flexible, creative and vigilant on the one hand and on the other hand those who are affected needs a multi dimensional approach to their lives. Now HIV infection in India has a woman face because of its fastest growth in the subpopulation in the ratio of 3:1. How Gender & HIV/AIDS (Acquired Immuno Deficiency Syndrome) make women jeopardized?

Gender is a crucial element in health inequalities in developing countries. Gender can be conceptualized as a powerful social determinant of health, which interacts, with other determinants such as age, family structure, income, education and social support and a variety of behavioural determinants. In a patriarchal system, men dominate women and exercise control over their lives including their sexuality and reproductive choices. Indian women's vulnerability for HIV is further fragmented by a combination of factors such as biological, social- class, caste, urban/rural location, sexual orientation, culture-, economic and legal etc. These factors have an impact on women's access to services, resources and information.

Objectives: A study was conducted with women who are HIV positive in Kerala To examine the complexity of HIV/AIDS and to learn more about the specific problems faced by women living with HIV How the concept of gender & HIV/AIDS make their life vulnerable

Methods: Case Studies and Informal Interviews with HIV infected women **Results & Conclusions:** Case studies and interviews with women from the study illustrates that low status in family, sexual violence, economic and social problems such as poverty, lack of education are some of



the primary reasons to get infection. Cultural orientation inhibits them to talk about sex to their partners, which results in infectious status.

In the middle-aged women, after sterilization they do not practice serious use of condoms, because they think it is primarily for family planning.

Among the newly married women they know their status only at time of pregnancy, which results in psychological trauma and other related aspects. Most of them are widows and they know their sero status at a later stage of partner's HIV infected life. After the death of their partner, some of them are being expelled from their home and undergoes various violations of human rights.

Poster No. P05

Title: Women's Midlife Transition Is The End Of Life?

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Key Words: *Women Midlife Transition Awareness Policy*

Introduction

Today, women's health and longevity have improved significantly. Even as recently as a century ago, a large percentage of women did not live up to menopause. The women who did not live long after menopause. Improved nutrition and medical care have contributed to the longer life of women. Nowadays, women are encouraged to live in good health and happiness after their fertile years are over. Menopause might mean the end of fertility but not an end of active life itself. There is no valid reason why a woman should not be well and comfortable in the years – or decades – ahead. Unfortunately in our cultural and traditional milieu the women as well as the society itself is not aware of this transition period. Our Government health policies have never targeted and made a life cycle approach for women. The woman's maternal health and population control become the focal point of the government programmes. Menopause related physical and mental problems have no place in any of their policies/ programmes.

Methodology

A study was conducted by the Department of Social Work, University of Lucknow to assess the knowledge, attitude and practice of women during menopause.

Sample Size

100 Women (age group 45-55)

50 Urban (50 % working and 50 % Non-working)

50 Rural (50 % literate and 50 % Non-Literate)

Control Group – their immediate family (spouse) peer group and Gynaecologist.

Tools

Questionnaire (inclusive of depression rating etc.)

Focus Group Discussion (to capture their knowledge, attitude and practice.)

Observation.

Result

The problems related to women normally cut across all barriers, similarly in our study, the results cut across all above mentioned parameters, focusing that the basic knowledge of the target group seemed quite low and its outcome was that they considered it to be an end of active and productive life and this manifested in the form of acute depression, psychological turbulences etc. in the rural background however the situation seemed more alarming with women being subjected to witch hunting and other forms of violent practices.

Discussion/ Conclusion

Menopause is not a disease but a natural phenomenon.

Massive awareness to be created amongst the women and their family/ peer group.

The medical fraternity should remove the myth that the symptoms are not due to mental disorder but hormonal. Support from midlife peers.

Government policy should incorporate needs of women's menopausal phase.

Counseling centers should strongly emphasize that midlife period is a time for continued growth and creative expression.

Poster No. P06

Title: Endangering Health And Human Rights Of Tribal Women In The Koraput District Of Orissa

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Key Words: *Health disparities, Gender inequality, Illiteracy, Orissa*

The western concept of development has contributed to an increase in economic and gender inequalities, notwithstanding its promise of providing improved living conditions. An improved health facility and apt human rights for women especially tribal women is a device in ensuring sustainable development. Their empowerment and access to decision making will certainly lead to sustainable future for the country.

Despite the rosy picture of greater human rights in recent days, women are facing gender inequalities in every sphere of life. Tribal women are identified to be the most exploited class for obvious reasons of their socio-economic inequalities. Eradication of atrocities against them still remains a distant reality. The negative effects of gender inequalities and environmental degradation yet again has seriously challenged the very existence of them. It has lead to nutritional deficiencies, more pollution of rivers and ponds with fertilizers and pesticides, affecting health of expectant mothers and babies.

As per scheduled Area Order, 1977, Orissa is one of the scheduled areas. About 45% of state's geographical area has specified as scheduled area. The order again specifies that Koraput district is one of the major scheduled area of the state. The tribal communities are living throughout the length and breadth of the district. According to 2001 census they constitute almost 50 % of the total population of the district. Among tribal population women constitutes 50.44%.

Though tribal women constitute half of the total tribal population they live in a male dominated society. The women folk work more than the men do. Invariably polygamy is the practice which leads to large number of single women in the society. Frequently they are tortured by their intoxicated and dipsomaniac husbands. Some tribal girls like gonda girls are also sexually harassed by their male folk. All these practices are definitely a mockery at the innocence of tribal women.

Time is ripe now to evaluate seriously the gender issues in tribal communities of Orissa. In this context the present paper focuses on the emerging gender issues of tribal society in the Koraput district of Orissa.

Data are collected from both primary and secondary sources. Information's are collected through various informal discussions with both female and male from different parts of the district, health professionals and other related persons for enriching the study. In addition to these primary sources, a good deal of information is collected from secondary sources, viz. the census reports, District census hand book, Statistical abstracts etc.

It is observed that apart from various gender inequalities tribal women of Koraput district are deprived of health facilities. Their accessibility to professional standards of health is severely



limited. Till now most deliveries take place at home by using primitive tools in unhygienic conditions. Vasectomy is not accepted in the present time. Women's choice in dealing with unwanted pregnancies is limited. Nutritional levels are low among tribal women. Anemia rate is high among them.

To sum up, tribal women face many consequences of gender inequality, contrary to the myth that they enjoy a high status in their society. All-out efforts by both government and non-government agencies should be made to check any kind of exploitation of the tribal women, particularly in regard to their health and education. Various awareness programmes can bring about better results to combat gender inequalities in tribal society.

Poster No. P07

Title: Access To Information On Health : Rights Denied To Women With Disabilities

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Key words: *Human Rights, Disability, Women, Health*

Background / Introduction

Women with disabilities are denied of access to most of the things we take for granted in our lives. When it comes to health care, there is no exception. People with disabilities are in general denied of rights to information. However women, being women, are targeted by both families and outer societies.

Methods: Women with disabilities are not a homogenous group. Workshops for different groups were organized. Individual interviews were also used.

Results: A 28 year old Graduate woman with hearing /speech disabilities goes to Government Hospital in Kolkata. Staffs refuse to talk to her. She tries to write down her complaint. She was told not to waste hospital's time. She was told to bring with her "someone who can talk". A 23 year old student with visual disabilities wants to know about her chances of being a mother. No material in Braille/larger prints available. Private Doctor says her mother must accompany her. Her teachers in schools scold her for asking such questions. A 30 old woman with mental disabilities suffer from severe pains in lower abdomen area. She goes to doctor with her mother He asks the mother about her illness. She tries to explain but doctor does not listen. She asks what her ailment is, doctor ignores her.

Discussion: Neither hospitals nor private doctors treat women with disabilities as individuals. They cannot access information on health without having an escort with them. They are treated as minors and always ask to bring family members with them. Their right as Human Beings totally ignored.

Conclusion(s): To sensitise medical professionals is an important area to be worked on. Not much work from Government side towards this is found. Disability is not a medical issue now but Human Rights issue. All out effort to ascertain it is required.

Poster No. P08

Title: Medical Care In Indian Prisons: Perspectives And Issues

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Key Words: *Prisons, Medical Care, Prison Managers, Jail Manual, Madhya Pradesh*

Objectives of the Study: The study aims to:- understand the extent and quality of medical care in the prisons; analyse role of prison managers to realise right to health in the prison setting; and suggest ways and means to strengthen health care in prisons.

Background: The right to health is one of most sacred rights and is covered by *Article 21 of the Indian Constitution*. The Supreme Court has expanded the scope of the *Article* by laying down that the right to life includes the right to healthy living with dignity for every individual. The *Committees and Commissions* set up to review prison conditions from time to time have severely criticised medical care provided to the prisoners. The present study is based on the data collected from 16 prisons of the Madhya Pradesh State. The primary assumption of this study is that prison doctors and prison managers could act as *the change agents* in providing qualitative health care in prison setting. They may also help in preventing torture and ill treatment in the prisons if they are properly sensitised regarding their obligations under national and international law for protection and promotion of human rights of prisoners.

Methods: The present study is exploratory in nature. Primary data have been collected using interviews (individual and group) and focused group discussions with cross-sections of people including prison doctors and the prisoners. Total 300 samples have been drawn from 16 prisons from the State of Madhya Pradesh, India.

Results: Appalling conditions of overcrowding, lack of sanitation, inadequate diet, unhygienic living conditions and lack of health awareness among prisoners are the most responsible factors for various diseases (viz. tuberculosis, diarrhoea, anaemia, malarial fevers, skin diseases, sexually transmitted diseases and respiratory related problems) and health related problems in prison setting.

In none of the prison having woman prisoners is lady doctor appointed. Mentally ill persons (prisoners) detained in the Central Prisons are not attended by psychiatric social workers. The Prison Visiting system is redundant and ineffective.

Proactive approach of Human Rights Commissions regarding responsive prison medical system has proved quite successful in curbing custodial violence and deaths in judicial custody. Prison medical services are not effectively linked with State Health Services.

Conclusion: Broadly, it is found that thorough medical examination of newly admitted prisoners is not being carried out in the prisons. The vision, mission and perspective plan for medical care in prison setting is missing. Doctors and para-medical staff posted in the prisons lack training in *Torture Medicine and Human Rights Jurisprudence with special reference to health care in prisons*. Overcrowding, corruption and clandestine approach of the prison managers (i.e. Superintendents and Jailors) and doctors are main factors for sub standard quality of medical care in the prisons. The study came out with various recommendations relating to provision of proper medical care for prisoners, restructuring the prison medical services, and effective monitoring mechanism in order to provide effective medical care to the prisoners.

Poster No. P09

Title: Health Rights Of Women In Kerala – An Enquiry

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Key Words: *Kerala Women, Health Status, Health Rights, Self Help Groups, Community Participation*

Introduction: Health Status Of Women In Kerala

In Kerala the rapidly declining growth rate, highest mean age at marriage, a very high level of acceptance and awareness of family planning methods and fertility control, a moderate decline in the mortality rate, low birth rate and death rate along with higher female life expectancy, low infant mortality with negligible gap between rural and urban and lower levels of disability are commendable health indicators.

Whether Women In Kerala Have Health Rights? – An Enquiry



The attractive health parameters of Kerala State has left the presenter with a curiosity to enquire into health rights of women in Kerala, with the following objectives.

Objectives:

To find out the level of awareness and utilization of health rights among women in community.
To study the role of Integrated Child Development Scheme in enhancing the capacity of mothers at grass root level to look into the health and nutritional needs of the family.

To study the opinion of the following on Health Rights of women in Kerala

Professional Social Workers

Health Care Professionals like doctors, nurses and community health workers.

Human Law Network

Methodology:

- Focus group discussion
Women in community among two Self Help Groups

- Personal interview

The Medical social workers in Government and private hospitals

Human Rights law Network

Health care providers (doctors, nurses and community health workers in Government Hospital)

Results: – Responses From The Cross Section Of The Society

The women in community who are members of kudumbashree project are well aware of their health issues and utilizing their health rights rather unknowingly. They have adopted the small family norm with the consent of their spouses.

The Integrated Child Development Scheme is successfully implemented in Kerala with high degree of community participation.

Medical Social workers are of the view that, many educated women are not aware of their rights and they have lot of misconceptions on health rights.

Human rights law network - Legal awareness camps organised at community level is the preventive step for the occurrence of sexual harassment, child sexual abuse and abortion through sex determinations. They are of opinion that the women need to be sensitized on reproductive rights.

Health care providers – Women in general are availing the health services at Government Hospital and they are aware on their rights. But they are not utilizing their rights adequately because of lack of cooperation from the male counterparts.

Good Practices Leading To Better Awareness Of Health Rights Of Women In Kerala

High literacy among Women.

Wide network of health infrastructure and manpower, policies of successive state governments.

Increase in awareness level among women through mass media and Kudumbashree efforts.

Economic empowerment of women at grass root levels through kudumbashree units to maintain healthy life styles.

Existence of Adolescent Clubs for girls.

High level of participation of women in legal Awareness camps and counseling.

No discrimination in basic and higher education, health and nutrition, employment in girls.

Conclusion - Challenges In Human Rights Of Women In Kerala

Following are the challenges facing the Kerala Society presently.

Domestic violence

Child Sexual Abuse

Reproductive Rights

Suicidal Attempts

Alcoholic Spouses

Poster No. P10**Title: 'Engendering Health And Human Rights: The Case Of Nomadic Women Healers And Their Cultural Practices In Uttar Pradesh' (Especially In Mirzapur District)****Author:** Upadhyaya, P.C*, E-mail: pcupadhyaya@rediffmail.com**Key Words:** *vagrant, nomadic, ex-criminal-tribe, tattooer, ethno-medical occupation, Uttar Pradesh***Objectives:** The main objectives of the study depends upon keeping in view of these issues involved in the study:

1. To assess the various occupations based upon the socio-cultural practices of Nat women in the area taken for the study.
2. To analyse the present traditional healing roles performed by the Nat women in Mirzapur District.
3. To find out the impact of traditional beliefs and practices upon the health care of Nat women.
4. To analyse the present health care system and the role of state health facilities among them.

Background: Nats are *vagrant* tribes. Since long times they are *nomadic* people moving from one place to another. They have been placed in the category of *ex-criminal tribes* by the British Colonial administrators during 1871. They originally belong to Rajasthan. Their main profession on which they are dependent are acrobating feats, snake charming, rope dancing, domestication of reptiles and animals, performing of magical shows, selling beads and amulets, tattooing practices, collection of herbs and medicinal plants etc. In this article special emphasis has been given on Nat women healers who are expert in diagnosing various diseases to apply their traditional practices generally known as the community doctors among the poor and marginalised section of the society. At present they are mainly found in the South-eastern part of Uttar Pradesh in Mirzapur and Sonbhadra District. Still they are illiterate and ignorant and largely depend upon the traditional modes of occupations.**Methods:** This study is based on fieldwork conducted among the various Nat settlements situated in various villages of Mirzapur District using participant observation method and interview and case study method. A total of ninety two households were taken for the study. Among a total population of 617 persons, the sample was consisted of 356 males and 315 females which gave the sex ratio of 88.48%.**Results:** This paper gives the result about the healing practices of Nomadic Nat women who contribute to their cultural roles depending upon certain practices as beliefs, customs, rituals generally found in rural areas of Mirzapur District. This reflects how Nat women healers have acquired certain properties of diagnosis of certain diseases as arthritis, batash, lakwa, backache and pain in various parts of body as abdomen generally occurred in pregnant women. It displays how specialized roles of Nat women healers who perform the midwifery roles, *tattooers*, dentists and surgeons etc. are significant enough to judge the health condition among the people. Keeping in view the engendering health and human rights of Nat women healers of this area, it shows how certain factors relate to Nat women who are living as semi-nomadic, illiterate and underprivileged in the society as compared to others, make their life more vulnerable and denies access to human rights unsatisfactorily.**Discussion:** In U.P. certain ethnic communities are involved in such hazardous *ethno-medical occupations* and they apply cures in an unscientific and random way. The point is that these should be analysed and discussed in a proper way as to be placed in the mainstream National Health Policy of the country.**Poster No. P11****Title: Women And Disability Management In Rural Haryana****Author:** Mehrotra, Nilika , E-mail: nilika@mail.jnu.ac.in,

Key Words : *Disability, Cultural Perceptions, Social Management, State Policy, Haryana*

The term disability holds a multitude of meanings ranging across age, caste, gender and class, exhibiting divergence in types of impairment, severity and prognosis. One's perception of disability is profoundly shaped by social values and beliefs, which distinguishes between the 'able' and 'disabled body. This study elucidates cultural perceptions and social management of physical disabilities in the life of women in the rural context of Haryana, India. It also explores the role and strategies of community, family and state in supporting disabled women. It is argued that women with disabilities face double discrimination due to prevalence of traditional gender roles and expectations and the stereotypes of disability.

This research is based on qualitative field research project on disabled women in rural Haryana funded by ministry of Social justice and Empowerment.

The study reveals that a strictly patriarchal agricultural set up of society puts emphasis on ability to do hard manual work. Only those with severe locomotor disabilities are seen as *ashrit* (dependent) or *viklang* and thus in need of support. For instance limb deformities are considered to be more disabling than being deaf and dumb. Mental illness is not recognized as illness or disability. Such a person may be referred to as *bholi* (simple) or *bawli* (innocuous). As a group, however, disabled are seen to be afflicted from several social stereotypes that marginalize them. Disabled are stereotyped as hot tempered, sexually impotent and unreliable. Thus, disability is culturally constructed and socially negotiated. Men take care of the treatment. Women are primary care givers. Family and kinship networks create and allocate resources Disabled women experience disability and gender discrimination simultaneously. Though stereotyped to be incomplete, they are expected to fulfil all the gendered duties and primarily taken to be working members of the society. Almost all women are married off either to other disabled or to other socially appropriate persons. A social practice of marrying two or more sisters (cousins) in the same household aids in finding the groom for the disabled girl. Traditional gender roles are strictly enforced, with concessions granted situationally. In the marital home woman has a harder life. Older women receive help from the daughters and daughter in laws. Rural society does not perceive disabled as people with any special requirements. Disabled are culturally conceived to be incomplete but not necessarily redundant.

The Disability Act 1995 ignores gendered realities of everyday lives of disabled, situated in families, wider kinship networks and communities. State definitions have been instrumental in creating a new awareness, which might lead to exclusion. There was no evidence of special schools or community based rehabilitation programmes in this area. NGOs' initiatives are also almost negligent. Poor access to health care, lack of education and indifference of state towards the harsh realities of disabled rural women further marginalizes them. The study clearly shows the inaction and insensitivity of the state policy for Disabled towards rural disabled women as much of its content is heavily biased for urban middle class population.

Special Training Sessions

CEDAW and human rights

Trainer :Manisha Gupte

The training will elaborate on the implementation of CEDAW by various countries who have ratified and used this international treaty within their domestic jurisdiction for fighting against discrimination and human rights violations.

Orientation on gender equity concerns in health and human rights

Trainer: Sofia Gruskin and Vibhuti Patel

The links between human rights and public health clearly indicate that violations of women's human rights often carry with them serious consequences for women's health. Addressing the gender equity concerns with a rights-based approach will help health care providers, managers, and policy makers understand how societal factors, including gender inequality, influence reproductive health. It also encourages a broader response to women's health problems that reaches beyond the health sector, which requires political will and leadership.

Orientation in sexual-assault evidence recording for better protection of rights of victims/survivors

Trainer: Amita Pitre, Ruben Naidoo

Role of a health professional is extremely critical in cases of sexual assault. The doctor is the first safe contact in most cases. In cases of criminal offences, in examining the victim and the offender, the doctor acts on behalf of the state. There is a need to emphasise here that the doctor is primarily a carer. The doctor-patient relationship, medical ethics experts point out, overrules all else and must be maintained in the best interests of the patient.



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