

## Module 3: **Rights**



## Structure of the Rights Module



# MODULE 3

## Module brief

### What participants should get out of the Rights Module

#### Participants will:

- be familiar with the basic concepts of rights, including reproductive and sexual rights
- understand how rights are defined in international human rights documents, and how they are used by various actors (such as non-governmental organizations, governments, the United Nations system) at the international and national levels
- learn about institutions which are promoting, monitoring, implementing and enforcing human rights norms relevant to reproductive and sexual health
- be able to apply human rights concepts and a human rights methodology to analyse reproductive health programmes, policies and research
- acquire the skills to conceptualize and apply a reproductive and sexual rights framework to sexual and reproductive health issues.

### The thinking behind the module

#### The need for a reproductive and sexual rights approach

This module is intended to provide participants with the knowledge and skills they need to apply a human rights framework to analysing and implementing policies and programmes related to reproductive and sexual health. This includes an understanding of the content and nature of reproductive and sexual rights, and the work of relevant institutions. The module also provides concrete examples of the application of a reproductive and sexual rights approach.

Drawing on the Gender and Social Determinants Modules, we look at how human rights and a human rights framework can be used to address the factors which impact on health status and the delivery of health services. Implementing this approach should help to strengthen local, national, regional and international partnerships concerned with reproductive and sexual health.

**The first session introduces the concept of rights.** Through a group exercise we examine the impact that participants believe the promotion or violation of rights has had on their lives to demonstrate that the realization of rights is necessary for reproductive and sexual health. This exercise draws on participants' personal experiences and then relates these to internationally recognized human rights. Drawing out the

gendered aspects of the experiences that participants share allows discussion of the compounding effects of neglect or violation of rights, such as the rights to non-discrimination, privacy and education. It also highlights the fact that the violation or neglect of rights rarely occurs in isolation and that the harmful effects often compound one another. We look at the health consequences of the violation or neglect of rights, as well as at the impact of the way reproductive health policies and programmes are designed and implemented on the realization of rights. This session aims to help participants understand that the discourse of rights may be used very differently: for example when rights are used in advocacy as opposed to when they are used to make policy. However, it is possible to arrive at a shared understanding of the basic concepts.

**Once this conceptual groundwork has been laid, the second session introduces the principles and practice of promoting and protecting human rights.** The discussion is intended to highlight the basics of human rights law, including core documents and key institutions. We look at the obligations of governments under the human rights documents as they are relevant to reproductive and sexual health. This framework then sets the stage for a structured discussion of reproductive rights. These are to be understood as those rights from the international human rights documents which relate to an individual woman's ability to make and effect decisions about her life, and which impact on her reproductive and sexual health. Both the International Conference on Population and Development (ICPD) in Cairo and the Fourth World Conference on Women (FWCW) in Beijing recognized reproductive rights as being integral to, and the foundation for, the realization of sexual and reproductive health. This session is therefore crucial in enabling participants to work with reproductive rights as they are understood by governments and institutions of power. It will also help to provide them with a critical tool in their efforts to make the changes necessary for improving reproductive health.

**The third session provides an opportunity to use human rights concepts and methodology in relation to analysing and improving a public health policy or programme.** The exercise is intended to familiarize participants with applying human rights to their daily work. The session provides participants with the tools to work towards integrating health and human rights concepts into policies and programmes. The underlying premise is that those which respect human rights are better and more effective. The example we use concerns the mandatory HIV testing of sex workers, but the methodology provided is intended to be useful in an analysis of any reproductive health policy or programme.

**The fourth session focuses on the national and international ideological, political and methodological shifts that have taken place in population policies since the Cairo and Beijing conference processes.** The session outlines the history of these processes at the international level and provides national examples of related changes. It

also discusses the changes that are still needed to operationalize the commitments made by governments in Cairo and Beijing.

**The fifth session introduces the concept of sexual rights.** Participants consider international and national efforts to define and implement sexual rights, and compare and contrast sexual rights with reproductive rights. A final exercise gives participants the opportunity to discuss how sexual rights may be useful to their daily work. The fourth and fifth sessions give participants the necessary analytical and methodological background for implementing reproductive and sexual rights.

**In the sixth and seventh sessions participants apply the concepts and methods using concrete examples.** Participants are challenged to apply the analytical and methodological tools from earlier sessions to begin to develop strategies for integrating human rights concerns into their daily work. There are three options in the sixth session. Each is intended to highlight how the promotion or violation of human rights can interact with reproductive and sexual health, and how awareness of this can help to shape interventions and actions. The seventh session looks at efforts – at the international and national levels – to implement reproductive and sexual rights in the years since the Cairo and Beijing conference processes. It focuses on the range of actors, including NGOs (non-governmental organizations), governments and the UN (United Nations) system. It ends with approaches for determining useful actions for the future. This session is geared to providing participants with an approach to linking their work with other actions taking place in their communities and around the world.

## Module outline

		<b>Objectives Participants will:</b>	<b>Format of activities</b>	<b>Time: about 14 hours</b>
	Introduction to the Rights Module	<ul style="list-style-type: none"> <li>● be acquainted with module objectives and contents</li> </ul>	Input	15 mins
<b>SESSION 1</b>	Human rights from a personal perspective	<ul style="list-style-type: none"> <li>● become aware that the promotion or violation of rights is easily identifiable and relevant to everyone's life</li> <li>● understand that the realization of rights is necessary for reproductive and sexual health</li> </ul>	Small group work Big group discussion	25 mins. 50 mins
<b>SESSION 2</b>	Introduction to international human rights in relation to reproductive health	<ul style="list-style-type: none"> <li>● understand the relationship of reproductive rights to human rights</li> <li>● become familiar with concepts and institutions relevant to the promotion, monitoring, implementation and enforcement of human rights norms and standards related to reproductive and sexual health</li> </ul>	Participants' reading and discussion in the big group, supplemented by input from facilitator	2 hrs
<b>SESSION 3</b>	Balancing the burdens and benefits of human rights in relation to reproductive and sexual health policies and programmes	<ul style="list-style-type: none"> <li>● understand the impact that the promotion of rights or violation of rights can have on reproductive and sexual health</li> <li>● be able to use a public health and rights based approach for identifying and solving problems</li> </ul>	Input Individual work and discussion in pairs interspersed with plenary discussion	1 hr 1 hr 45 mins
<b>SESSION 4</b>	Population policies and reproductive rights	<ul style="list-style-type: none"> <li>● be familiar with the Cairo and Beijing conferences, and how they are a product of women's struggle and have reoriented the population and development discourse</li> <li>● recognize that policies are a site of struggle and that the concepts of reproductive rights and health which this course looks at are based on a human rights approach concerned with empowering women, gender equality, and equity in resource distribution</li> <li>● be able to apply a reproductive and sexual rights framework to analyse population control policies</li> <li>● understand how population control policies impact on sexual and reproductive rights and services</li> </ul>	Individual reading Input Discussion in big group	Outside class hours 1 hr 1 hr
<b>SESSION 5</b>	Working with sexual rights	<ul style="list-style-type: none"> <li>● learn about the evolving content of sexual rights and the issues raised by the recognition of them</li> <li>● recognize that sexual rights are a requirement for the achievement of both sexual health and gender equality</li> <li>● understand the difference between reproductive rights and sexual rights</li> <li>● be able to conceptualize practical interventions to realize sexual rights at different levels (legislative, health system, community)</li> </ul>	Big group input and discussion Small group work	1 hr 45 minutes
<b>SESSION 6</b>	Applying a rights framework to reproductive and sexual health issues	<ul style="list-style-type: none"> <li>● apply the concepts introduced in earlier sessions to examples which highlight various ways in which the violation or promotion of rights interact with sexual and reproductive health</li> <li>● become aware of how the understanding of these interactions can help to shape policies and interventions</li> </ul>	Small group work Big group discussion	1 hr 15 mins 1 hr

**Module outline** *(continued)*

		<b>Objectives Participants will:</b>	<b>Format of activities</b>	<b>Time:</b>
<b>SESSION</b> <b>7</b>	Using international human rights to translate government commitments into action	<ul style="list-style-type: none"> <li>● be familiar with a range of approaches to applying reproductive and sexual rights to the work they are engaged in</li> <li>● contextualize their work in relation to the range of actors engaged in similar endeavours</li> </ul>	Small group work	20 mins
			Big group discussion	40 mins
			Individual work	10 mins
			Sharing in big group	50 mins
<b>Concluding session</b>	Using international human rights to translate government commitments into action	● have a consolidated overview of tools and concepts introduced in the module, and their links	Input	15 mins

## Introduction to the Rights Module

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### What participants should get out of the session

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You will introduce participants to the module's structure, contents and objectives.

**15 minutes**

### How to run the session

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This is an input session.



Introduce the module using **overheads** from the Module brief:

- "What participants should get out of the Rights Module"
- "Structure of the Rights Module"
- "Module outline".

## SESSION

## 1

## Human rights from a personal perspective

### What participants should get out of the session

#### Participants will:

- become aware that the promotion or violation of rights is easily identifiable and relevant to everyone's life
- understand that the realization of rights is necessary for reproductive and sexual health.



1 hr  
15 mins

**1 hour and 15 minutes**

#### Materials

- Handout: "Personal accounts of rights being violated"
- Handout of the *Universal Declaration of Human Rights*. This can be downloaded from [www.unhcr.ch/html/intlinst.htm](http://www.unhcr.ch/html/intlinst.htm)
- flip chart or board for writing on

#### How to run the session

This session consists of two activities. The first is in small groups. The second is a report-back and discussion in the whole group, where participants should reach conclusions.



1 hr  
15 mins

#### Activity: Personal accounts of rights being violated



25 mins

#### Step 1: Working in small groups

This first activity is to take place with no reference or access to any human rights document. Participants work in groups to identify situations in which they feel a right was violated.

Divide participants into groups of five. Give each person the handout "Personal accounts of rights being violated", which describes what they should do. Tell the groups that they have 20 minutes for their discussion, and to make notes on the rights which they feel were relevant to the stories they shared to report back to the whole group.



**Step 2:**  
**Whole group**  
**report-back**

Ask the first group to report on the rights that they considered relevant to their group. Why did they see these as important? Note the rights that are mentioned on the board or flip chart. When listing the rights, put these in two separate columns: one for civil/political rights and another for economic/social and cultural rights. Each group then adds to the list rights that have not been mentioned yet. Put rights which are not internationally recognised under the column category to which it is most closely related. At this point, do not go into the stories behind the rights.

Some of the rights that previous participants have raised include:

- right to health
- right to security
- right to be treated equally
- right to respect
- right to emotional fulfilment
- right to information
- right to choice
- right to dignity
- right to earn an income and support a family
- right to make decisions concerning one's life
- right to education.



**Step 3:**  
**Discussion: How**  
**the violation of**  
**rights has**  
**impacted on**  
**reproductive and**  
**sexual health**

Ask participants to volunteer to share stories about what they consider to be violations of rights which impacted on sexual and reproductive health, or about the violation of reproductive and sexual rights.

Some examples that have come up include:

- female genital mutilation
- the right to be informed when one's partner tests positive for HIV
- the right of health workers to be protected from HIV infection
- the right to choose one's marriage partner, and not be forced into an arranged marriage
- the right to use a contraceptive method of one's own choice without overt or covert coercion from the health system
- the right not to be discriminated against in the labour market because of having children



**Step 4:**  
**The Universal**  
**Declaration of**  
**Human Rights**

Hand out copies of the *Universal Declaration of Human Rights* (UDHR). Participants take five to seven minutes to read it individually. Tell them to skip the preamble and to begin reading at Article 1.

Go over each of the rights listed on the board or flip chart and ask participants to identify which article in the UDHR most closely addresses it. If time is limited, choose only those rights which participants thought impacted on reproductive and sexual health.

One point which is often raised, is whether something can be considered a violation of rights even when it is legal within a country's framework. Make it clear that the answer can be yes.

Clarify that human rights standards are relevant to laws, policies and practices. Governments have the primary obligation to promote and protect rights, and they also draft the international standards. Governments have an obligation to amend their national laws to be in line with international human rights standards and to ensure that their laws are not in violation of their international human rights obligations. Those advocating for a change in legislation or procedures can use international human rights norms to call attention to the gap between the national law and the international standard, and thus hold governments responsible for appropriately amending their laws.

In the South African course, some of the violations impacting on reproductive and sexual health that participants identified included female genital mutilation, being forced into an arranged marriage, a woman being denied a job because she had small children, and the difficulty poor women experienced in accessing health services. They then reported female genital mutilation to be covered under Article 3 of the UDHR, which is about the right to security of person. The right to make decisions about one's marriage partner was found to be covered in Article 16, which affirms that marriage shall be entered into only with the free and full consent of intending spouses. Discrimination in the labour market because of having a child was interpreted as violation of the right to equality, and related to articles 1 and 2 as well as Article 23. Article 21, which affirms right of equal access to public services in one's country, was seen as affirming poor women's equal access to public health services.

## Main points for closing the session

There are identifiable violations of rights and obstacles to enjoying rights. Most of the rights protections for the issues we are concerned with are covered in international human rights documents, but existing standards need to evolve and be applied to new situations.

There are different interpretations of rights. But the provisions in the UDHR are written in such a way that all of the concerns can be covered. It is necessary to be clear about how rights language is being used: for advocacy, to make policy, to hold governments accountable, and so on.



Handout

# 1 Personal accounts of rights being violated



*You have 20 minutes to finish these tasks. Appoint one member of the group to report back to the whole group.*

## 1. Thinking back on your own life

Spend two minutes alone recalling one incident when you felt a right was violated.

## 2. Sharing

Share your story with the rest of the group if you feel comfortable to.

## 3. Name the rights

At the end of each story, the person sharing should try to name which rights she or he thinks were relevant to the story and in what ways. Write these down. Group members are then free to suggest other rights which they feel were relevant.

## 4. Develop a list

Start a list of rights from these contributions. Each person shares a story until everyone who wants to speak has had a turn. As the list of rights grows, each time a right is relevant to more than one person's story put an X next to it. If the group is large, try to restrict the stories to avoid repetition.

## 5. Look for systematic differences

Are there systematic differences in the violation of rights that different members of your group have reported on? For example, by race, class and sex? In other words, are women more at risk of experiencing a rights violation and more likely to report violation of the right to non-discrimination, compared to the others?

## 6. Generalizing to uncover further relevant rights

As a final step before returning to the big group, revisit the stories that related to reproductive and sexual health. Go beyond the specific story to consider additional rights you could add to the list if the group considered the issue in general terms. For example, an incident relating to disrespectful treatment in a health facility when a person came for treatment for a sexually transmitted infection (STI) may have been identified as a violation of the right to respect. However, if one considers the wider issue of prevention and treatment of reproductive health problems, a number of rights may immediately appear relevant. In human rights terms, these are some of the issues likely to be relevant:

- the right not to be discriminated against
- the right of access to health services
- the right to information.

## SESSION

## 2

## Introduction to international human rights in relation to reproductive health

### What participants should get out of the session

#### Participants will:

- understand the relationship between reproductive rights and human rights
- be familiar with concepts and institutions relevant to promoting, monitoring, implementing and enforcing the human rights norms and standards related to reproductive and sexual health.

#### About 2 hours

### Materials

#### Handout provided in the manual

- Handout 1: “International human rights in relation to reproductive health.” This is meant to serve as an outline of key points and not as a definitive summary. You may either reproduce it as it is, stressing this point and elaborating on each of the points during the whole group discussion. Or you could rework it, elaborating a bit more on each section, or focus specifically on points you consider important for the particular group.

#### Handouts to be prepared by the facilitator

- Handout 2: The list of ratifications and reservations for all of the human rights treaties by the countries represented in the participant list. You can download this from: [www.unhchr.ch/](http://www.unhchr.ch/). Click on “treaties”, choose the human rights treaty you are interested in presenting and click on “status of ratifications”.
- Handout 3: The box “United Nations conferences and women’s human rights”, on p.144
- Handout 4: The box “Selected examples of reproductive rights”, on p.145
- copies of the various human rights documents mentioned in Handout 1, which can be downloaded from: [www.unhchr.ch/html/intlinst.htm](http://www.unhchr.ch/html/intlinst.htm). These include the *Covenant on Civil and Political Rights*, the *Covenant on Economic, Social and Cultural Rights*, the *Convention on the Rights of the Child*, and *Convention on the Elimination of All form of Discrimination against Women (CEDAW)*.





### Overheads

- overhead of box: “Government obligations to protect, respect and fulfil human rights”, on p.142
- overhead of box: “United Nations conferences and women’s human rights”, on p.144
- overhead of box: “Selected examples of reproductive rights”, on p.145

### Other materials

flip chart or board for writing on

## Readings for the facilitator

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1. Bilder R. An overview of international human rights law. In: Hannum H, ed. *Guide to international human rights practice*, 2nd ed. Philadelphia, University of Pennsylvania Press, 1992:3–18.
2. Bunch C. Women’s rights as human rights: toward a revision of human rights. *Human Rights Quarterly*, 1990, **12**:486.
3. Eide A. Economic, social and cultural rights as human rights. In: Eide A, Krause C, Rosas A, eds. *Economic, social and cultural rights: a textbook*. Dordrecht, Martinus Nijhoff, 1995:1–40.
4. Hannum H. Implementing human rights: an overview of strategies and procedures. In Hannum H, ed. *Guide to international human rights practice*, 2nd ed. Philadelphia, University of Pennsylvania Press, 1992:19–38.
5. Sullivan D. The public/private distinction in international human rights law. In: Peters J, Wolper A, eds. *Women’s rights—human rights: international feminist perspectives*. New York, Routledge, 1995:126–134.
6. United Nations Population Fund. *Programme of action of the International Conference on Population Development*, Cairo, 5–13 September 1994. New York, United Nations, 1996.

## Readings for participants

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Reading 2.

## How to run the session

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This session consists of reading and discussing Handout 1 together in the whole group.



## Activity 1: International human rights and reproductive health



### Step 1: Reading Part 1: The basics

Start with a brief introduction to this session.

In order for participants to be able to use reproductive rights in their daily work and to advance the protections they offer, they must understand both the intrinsic opportunities and limits of the definitions that have been internationally agreed upon. This session is intended to provide the basic framework and structure of international human rights law as the basis for applying reproductive rights to the rest of the work in this course.

Tell participants to read Handout 1 individually, and to stop for a whole group discussion after they have read Part 1. Give them five to seven minutes to read.



### Step 2: Summary and discussion

Ask one or more participants to summarize the main points in Part 1. Once participants have worked with the basic concepts of human rights, engage them in a discussion concerning the human rights of women specifically.

### What to cover in the discussion

#### The public and private spheres

Ask participants whether they think women's human rights are different. Why do they think a separate human rights convention focused on discrimination against women was needed? Point out that the fact that the modern human rights movement was created in the aftermath of World War II partly explains its public orientation and its limited ability to monitor what goes on in the private sphere. Clarify the meaning of the public and the private sphere and the implications for women's human rights. Also note that women can and should claim rights under all the treaties, and that the Convention on the Elimination of All form of Discrimination against Women (CEDAW) is not their only or primary source of rights. It spells out the meaning of discrimination which can then also be used in other parts of the rights system to understand how men and women face different obstacles to enjoying their rights.

#### Men and women and human rights

Take one right from the UDHR and ask participants if they think the violation of that right would be the same for women and for men. You may take, for example, the right to information (Article 19), the right to security of person (Article 3), the right to take part in the government of one's country (Article 21) or the right to work (Article 23). Make the links to the Gender Module, and specifically to evidence in Session 3 on women's access to and control over resources and their political participation.

Take care not to make women's rights appear as a separate claim, so make sure that this section builds from a gender analysis to bring appropriate attention to women's realities. Highlight the fact that while legally all human rights apply to women, in reality they often do not because of gender based discrimination.

#### A systemic problem

Mention domestic violence and how the violation of human rights includes the state's action or inaction in an abusive situation. The systemic

problem is the human rights issue, more than the individual act. Systemic issues could include everything from whether there are education and public awareness campaigns, investigations when domestic violence occurs, a system that supports women who report a violation, shelters, effective remedies, public knowledge of effective remedies, and so on.

### Institutions also violate reproductive and sexual rights

Link this to the discussion on institutions and levels in the Social Determinants Module, and highlight how reproductive rights and sexual rights are violated by a variety of institutions: the household, organized religion, the state, markets and international organizations. The government is obliged not only to respect and fulfil the rights through its policies, laws, and programmes, but also to prevent violations of rights by non-state actors.



20 mins

### Step 3: Part 2: Governments' obligations

Participants read Part 2 of Handout 1 for the next five to seven minutes. Ask a few participants to summarize the main points related to international human rights law and to government obligations.

Put up the **overhead** on government obligations in relation to the right to health, and discuss it.



### Government obligations to respect, protect and fulfil human rights

#### Example: the right to health

- **Respecting the right** means the state cannot violate the right directly. A government violates its responsibility to respect the right to health when it is immediately responsible for providing medical care to certain populations, such as prisoners or the military, and it arbitrarily decides to withhold that care.
- **Protecting the right** means the state has to prevent violations of rights by non-state actors, and offer some sort of redress, that people know about and can access, if a violation does occur. This means the state would be responsible for making it illegal for anyone (private or public practitioner, insurance company) to automatically deny insurance or health care to people on the basis of a health condition. It would be responsible for making sure some system of redress exists and that people know about it and can access it.
- **Fulfilling the right** means the state has to take all appropriate measures – including but not limited to legislative, administrative, budgetary and judicial measures – towards the fulfilment of the right, including promoting the right in question. A state could be found to be in violation of the right to health if it failed to incrementally allocate sufficient resources to meet the public health needs of all of the communities within its borders.

### How have governments successfully respected, protected and fulfilled rights?

Get participants to give you examples of a government successfully meeting its obligation to respect, protect or fulfil the right to reproductive or sexual health, and examples of failures to do so. Some positive examples include the provision of sex education to adolescents, the implementation of a safe motherhood programme, or a family planning programme that provides free and ready access to contraceptive methods. State legislation against sexual harassment in the workplace and against domestic violence against women are positive examples of state action to prevent violation of sexual and reproductive rights by non-state actors. Negative examples include policies and laws that restrict the availability of abortions, the absence of a policy on cervical cancer screening, and family planning programmes that are only integrated with maternal and child health services (thereby possibly excluding men).



#### Step 4: Drawing a circle of rights

Here is a quick, whole group exercise that demonstrates how rights are interrelated:

- both negative and positive steps are needed for all rights
- the enjoyment of one right rests on the enjoyment of others.

The example below is of a woman's right to choose the number and spacing of her children and how she wants to do this (Article 16 of CEDAW). You may choose any right related to reproductive or sexual health.

- Draw a circle in the centre of a flip chart or board and write "A woman's right to choose the number and spacing of her children and how she wants to do this" in the circle.
- Draw other circles around it and ask participants to suggest what rights are useful or necessary to make this right real.
- Then draw lines between these rights as they relate to each other. You end up with a molecule-like figure.
- Place factors that are not rights but necessary conditions on the outer rim of the diagram.
- Note the different actors that are required to make each of these rights actionable.

Suggestions for related rights usually include: freedom of information, laws protecting bodily integrity and freedom from forced sexual activity, access to the benefits of scientific progress, and changes in cultural attitudes that allow women to have fewer children.



#### Step 5: Part 3: Monitoring rights and building political commitment

Participants read Part 3 of Handout 1 for the next five to seven minutes. Ask a few participants to summarize the main points related to standard setting and monitoring mechanisms.

Find out from participants what they know about reproductive rights, and about the paradigm shift following the Cairo conference. Tell them that this will be dealt with in greater detail in Session 4.

Then put up the following **overhead**, which you can also give out as Handout 3. Go over the main points.



### United Nations conferences and women's human rights

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



#### **Step 6:** **Part 4:** **Reproductive rights**

Participants take about five to seven minutes to read through the fourth and final part of Handout 1.

#### **Participants summarize the main points**

Once again, ask participants to summarize the main points. Ask them to give some examples of what they consider to be reproductive and sexual rights: the right to choose one's sexual partner, the right to freedom from non-consensual sex, the right to choose whether one has children, when and how many, the right to a safe maternity and safe abortion, and so on.

#### **Governments and a gender perspective**

How would a gender perspective impact on governmental obligations under the human rights treaties it has ratified? For example, governments reporting under the Convention on the Rights of the Child may be required to provide sex-specific data on children's health, and to put in place policies and programmes that would enable girl children to enjoy the same rights to health, education and social services under the convention as boys do.

### Governments and a reproductive and sexual rights perspective

What would a reproductive and sexual rights perspective bring to government obligations under the human rights treaties it has ratified? The box below gives many examples, which you can put up as overheads and give out as Handout 4.

Go over the **overhead**.



#### Selected examples of reproductive rights

These rights can be used to protect and promote gender equality in reproductive and sexual health.

**The right to life:** Traditionally understood to relate to freedom from arbitrary deprivation of life. Now also includes the positive obligation of the state in relation to, for example, maternal mortality. Think of more than 515 000 women who die each year in pregnancy and childbirth from avoidable complications.

**Rights to bodily integrity and security of the person:** Traditionally understood to relate to actions concerning individuals in the custody of the state. Now also includes understanding this right as including security from sexual violence and assault at the hands of a partner or others. As well as, for example, in relation to population programmes that compel sterilization or abortion, or those that physically prohibit women from receiving family planning services.

**The right to privacy:** Traditionally understood to refer to privacy in relation to a person's home and correspondence. Now also includes some protections in relation to sexuality. In this regard, the Human Rights Committee, the treaty body which monitors governmental compliance with the *International Covenant on Civil and Political Rights*, has stated, directly related to sexuality, that "it is undisputed that sexuality is covered by the concept of privacy" and that "moral issues are not exclusively a matter of national concern in that they are subject to review for consistency with international human rights instruments".

**The right to the benefits of scientific progress:** Traditionally understood to relate to technology transfers between countries of the North and the South. Now, could also include, for example, recognition that a woman's right to control her own reproduction would obviously be enhanced by: access to microbicides, female controlled methods of contraception, research into a greater range of male contraceptives and access to safe abortion.

**The right to seek, receive and impart information:** Traditionally understood only in relation to the media and a free press. Now also in relation to how realization of this right is critical to reproductive

health, for example with respect to reproductive decision making, a woman's ability to make fully informed choices, as well as her ability to protect herself against sexual exploitation, abuse or infection.

**The right to education:** Traditionally understood only in relation to literacy. Literacy is obviously critical to reproductive health, but also, since sexuality is recognized as an element of the human personality, education is essential to developing this aspect of oneself.

**The right to health:** Traditionally understood to refer to the right of individuals to the highest attainable standard of physical and mental health. Increasingly understood to mean that governments must create conditions which assure for all the enjoyment of the highest attainable standard of health, including facilities for the treatment of illness and the rehabilitation of health. Occupational and environmental health issues are also seen as being covered under this right. This right also brings increased attention to women's health issues. For example, this interpretation would draw attention to the almost complete lack of attention and resources devoted to the early detection of cervical cancer by a number of governments, or state controlled reproductive health programmes that exist for some population groups but exclude certain marginalized communities from their consideration and outreach.

**The right to equality in marriage and divorce:** Traditionally understood to refer to the equal ability of women and men to voluntarily enter into marriage and divorce. This right has been often neglected and violated. This neglect or violation may be because it is tolerated, acknowledged or even condoned by governments, or because it remains insidiously hidden or deliberately ignored. As this right is relevant to women's ability to control and make decisions about their lives, its importance is beginning to be recognized by people engaged in reproductive health work.

**Non-discrimination:** Traditionally understood to mean that all people should be treated equally and given equal opportunity, including assurance of equal protection under the law. The last 20 years have seen the development of the idea of substantive equality, which notes that some distinctions are necessary to promote rights for people who are differently situated – but that all differences in treatment must be based on objective and reasonable criteria and a goal which promotes rights. Therefore, applying different approaches to girls and boys in reproductive and sexual health policy and programme development must be based on a valid recognition of gender related differentials. The influence of prescribed gender roles and cultural norms when determining the differentials should be minimized.

## Main points for closing this session

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### It is clear what governments have to do

Government obligations for promoting and protecting human rights have been clearly spelled out. They must take certain steps and effect particular results, even though the processes to do this may vary greatly.

### Institutions and procedures are in place

Institutions and procedures which help to ensure monitoring and accountability do exist.

### Expanded accountability in the traditional framework

Reproductive rights are not new rights but have helped to push for additional accountability under the traditional human rights framework for issues that are relevant to reproductive and sexual health.

### Be clear about how you are applying a right

Key provisions have been written in such a way that many sexual and reproductive concerns can be covered. It is necessary to make it clear whether you are applying a principle to a new set of facts and advocating for that principle, or stating what is already formally accepted in the system. Variations exist depending whether the rights language is being used for: advocacy, to make policy, to hold governments accountable, and so on.

*Session developed by Sofia Gruskin*



Handout

# 1 International human rights in relation to reproductive health

*This is an outline of key points and not a definitive summary.*

## Part 1: The basics of international human rights law, including core documents, key institutions and how the human rights of women fit in

International human rights law defines what governments can do to us, cannot do to us, and should do for us. The implementation of international human rights law relies in the first instance on the actions of governments themselves, although monitoring systems exist.

The legal obligation for implementing human rights is focused on governments, but all kinds of other actors have responsibilities for promoting rights, such as corporations, individual health care providers, and so on.

Human rights law is meant to be equally applicable to everyone, everywhere in the world, across all borders and across all cultures and religions.

Human rights are primarily about the relationship between the individual and the state. International human rights law consists of the obligations that governments have agreed on in order to be effective in promoting and protecting the rights of individuals.

When governments fail in their obligations to, or when they deliberately restrict rights without valid justification, they can be seen under international law as being responsible for violating rights.

The modern human rights movement was created in the aftermath of World War II and focused on key abuses identified at the root of that conflict. This partly explains its public orientation and the limits of its ability to protect what takes place in the private sphere.

The key human rights document is the *Universal Declaration of Human Rights* (UDHR). It is not a legally binding document; it represents the shared aspirations of governments about what rights are, and why they should exist for all people everywhere.

The two covenants, the *International Covenant on Economic, Social and the Cultural Rights* and the *International Covenant on Civil and Political Rights*, further clarify the rights set out in the UDHR. Unlike the UDHR, they are legally binding documents on those countries which ratify them.

These three documents together are often called the *International Bill of Human Rights*. Other human rights documents that have been developed elaborate and in some cases move beyond these three. This means that the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) or the *Convention on the Rights of the Child*, which might seem particularly useful for work in reproductive and sexual health, should not be read in isolation. The understanding of

governmental obligations under the human rights treaties continues to develop, so the interpretation of the rights contained in the *International Covenant on Civil and Political Rights* is now much more sensitive to gender equality than it was even a few years ago. Governments are legally responsible for simultaneously complying with all their obligations under all of the treaties they have ratified.

Rights considered to be more civil and political include rights such as the right to life, to be free from torture, to vote, to information or to association. Rights considered to be more economic, social and cultural include such rights as the right to education, to work and to the highest attainable standard of physical and mental health.

Human rights are used in a number of different ways by different actors: as grounds for making policy and programme decisions; to analyse what a government is or isn't doing and to point out that the gaps may be legally recognizable violations; and perhaps both informally and formally as an advocacy tool. Some may primarily use the formal system of rights (international treaties and their reflection in national law) and some may primarily use the principles behind them (informal). Given these differences it is always important to be clear how the rights language is being used and for what purpose.

## Part 2: Governmental obligations under international human rights law, including permissible limitations on rights

For every right, governments have three levels of obligation: they have to respect the right, protect the right, and fulfil the right. To respect a right means not to directly violate it. To protect the right means enacting laws setting up mechanisms to prevent violation of the right by non-state actors. To fulfil the right means to take active steps to put in place institutions and procedures, including resource allocation, that will enable people to enjoy the right.

Human rights machinery recognizes that resources and other constraints can make it impossible for a government to fulfil all rights immediately and completely. In practical terms, a commitment to the right to health is going to require more than just passing a law. It will require financial resources, trained personnel, facilities and, more than anything else, a sustainable infrastructure. Therefore the realization of rights is generally understood to be a matter of progressive realization, of making steady progress towards a goal.

Enforcing the rights of individuals is supposed to take place in the first instance at the national level, by governments.

If governments fail to or are unwilling to enforce the rights of individuals, then the international system can be used to dialogue and sometimes to critique the situation. It is important to recognize that much rights work in health is about incorporating rights standards to strengthen state practice, and is not only based on denouncing states for failures.

To determine whether a government is doing all it can to ensure that rights are being realized, look first at the scope of the government's

obligations (respect, protect, fulfil), then at permissible limitations on those rights. From there it is possible to begin to determine whether a violation has occurred.

Governments can legitimately restrict most rights. This means most rights are not absolute. Rights that can never be restricted, even if justified as necessary for the public good, include the right to be free from torture, slavery or servitude, the right to a fair trial, and the right to freedom of thought.

Public health is a valid justification for restricting most rights, for example state interference with freedom of movement when necessary to impose quarantine or isolation at a particular time for a serious communicable disease, such as Ebola fever. This is a restriction that may be necessary for the public good and therefore could be considered legitimate under international human rights law. The basic principles to consider before rights can be legitimately restricted, like in the case above, are spelt out in the Siracusa Principles. These principles are discussed in detail in Session 3.

## Part 3: Monitoring rights at the international level through human rights treaty bodies. Building political commitments through the international conference processes, such as Cairo and Beijing

### Treaty bodies

Every UN human rights treaty has a treaty monitoring body called a committee, which monitors the compliance of the states that have bound themselves to the treaty legally (ratification). Ratification by a state of a UN human rights treaty implies that they are willing to take part in the monitoring process.

Whether and to what extent a government is in compliance with its obligations under a particular treaty is monitored through a system of regular reporting by the government to the Committee concerned.

These periodic reports by a government to these committees include information on the steps it has taken to implement its obligations, any difficulties it has had in doing so, and exactly how it has incorporated its obligations into domestic law.

It is supposed to report on both law and practice.

The reports are potentially self-serving, but they are becoming more and more effective. This is because treaty monitoring bodies are less and less likely to accept them at face value. Treaty bodies also get information from NGOs (non-governmental organizations), often in the form of “shadow reports”, which they can use in questioning the official government report. The work of NGOs is critical to this process.

Treaty bodies also issue “General Comments” and “General Recommendations”, which can help to further elaborate their interpretation of rights contained in the treaty. For example the treaty body that monitors the Women’s Convention has elaborated recommendations on health, violence against women and HIV/AIDS.

### International conferences – political commitments

The declarations and programmes of action of international conferences such as those in Cairo and Beijing are key to moving the human rights agenda forward because they help clarify and give content to certain rights and clusters of rights, for example by getting international consensus at government level on the notion of reproductive rights across a series of international conferences beginning in Cairo.

While international conferences do not make new law, they are important as they reflect the political commitments of governments at a very high level. They are also important for bringing visibility to new issues.

These conference commitments are about government action and about what should or should not be done at the national and international level. They are about setting out not just a declaration of principles, but also a programme of action, designed to be relevant to all policy and programme work in reproductive health.

In addition, the treaty bodies have begun to use the commitments in Cairo and Beijing around reproductive rights in their dialogues with governments. This has helped to make governments more accountable for the provisions in the documents.

## Part 4: How to think about reproductive health in the context of human rights, and therefore about reproductive rights

Reproductive rights are not new rights. They relate to an individual woman's or man's ability to control and make decisions about her or his life which will impact on her or his reproductive and sexual health. According to international consensus no new rights have been created. Rather, the constellations of rights that together make up what we call reproductive rights have been identified from within the existing human rights documents.

Reproductive rights are understood to be entitled to protection for their own sake, but also because they are essential as a precondition for the ability to exercise other rights without discrimination.

Reproductive rights means considering governmental obligations under the human rights documents in a whole new light. For example, consider the rights to education, health and social services in relation all of the well-known causes of maternal mortality. A government which fails to provide education, health and social services to young women of reproductive age, could well be found to be in violation of these rights now recognized as part of reproductive rights. This is likely not to have been the case before the Cairo conference.

Consider the additional elements of information that a gender perspective and recognition of the existence of reproductive and sexual rights would bring to governmental accountability under the human rights treaties it has ratified. Think through the added dimensions that considering a right from this perspective brings. For example, the right to bodily integrity and security of the person was traditionally understood to relate to actions concerning individuals in the custody of the state. But now it can also be interpreted as security from sexual violence and assault at the hands of one's intimate partner or others.

# SESSION 3 Balancing the burdens and benefits of human rights in relation to reproductive and sexual health policies and programmes

## What participants should get out of the session

### Participants will:

- understand the impact that the promotion of rights or the violation of rights can have on reproductive and sexual health
- be able to use a public health and rights based approach for identifying and solving problems.



**2 hours 45 minutes**

### Materials

- Handout: "A case study for analysing a reproductive health intervention"
- overhead: "The Siracusa principles", on p.153
- overhead: "Population policy of country X", on p.154
- overhead: "Four quadrants: The quality of human rights and public health in a programme", on p.155
- flip chart

### Readings for the facilitator

1. Alexander P. Sex workers fight against AIDS: an international perspective. In: McClintock A, ed. *Sex workers and sex work*. Durham, Duke University Press, 1994.
2. ECOSOC. *Siracusa principles on the limitation and derogation provisions in the International Covenant on Civil and Political Rights*. New York, United Nations, 1984:1–6 (UN Doc. E/CN.4/1984/4).
3. Gostin L, Mann J. Toward the development of a human rights impact assessment for the formulation and evaluation of public health policies. In: Mann JM, Gruskin S, Grodin MA, Annas GJ, eds. *Health and human rights: a reader*. New York, Routledge, 1999:54–71.
4. International Federation of Red Cross and Red Crescent Societies and the François-Xavier Bagnoud Centre for Health and Human Rights. The public health–human rights dialogue. In: Mann JL, Gruskin S, Grodin MA, Annas GJ, eds. *Health and human rights: a reader*. New York, Routledge, 1999:46–53. 1994. New York, United Nations, 1996.

## Readings for participants

Reading 4.

## How to run the session

This session consists of two activities. It starts with a presentation by the facilitator to the full group. In the second activity, participants work individually and then in pairs, with intermittent discussions in the whole group and input from you.



### Activity 1: Rights in the context of health policies or programmes



#### Step 1: Introducing the theme

Begin with an introduction of the purpose of this session – to enable participants to recognize the implications of the violation of rights or the promotion of rights in the context of health policies or programmes, so that they will be able to design and implement more effective policies and programmes.

#### What your input should cover

**Overhead** Start the input with an explanation of the Siracusa principles, which were briefly referred to in Session 2.



#### The Siracusa principles

In order for governments to validly restrict the rights they see a need to restrict, for example to movement or information, certain criteria have to be met. The restriction must be:

- in accordance with a law or policy
- in the interest of a legitimate objective
- strictly necessary to achieve that objective
- carried out by the least restrictive alternative
- not drafted or imposed in an unreasonable or discriminating way.

The idea is that the restriction is the last resort after the government has done all it can do.

Illustrate with an example.

### Population policy of country X

Faced with a severe economic crisis, which included growing unemployment, rising prices and pervasive poverty, the government of country X has decided that stringent population reduction measures need to be introduced. The government believes that population growth in their country has cancelled out development efforts and that the most effective policy option would be to intensify state sponsored population reduction measures. In an effort to drastically reduce birth rates, contraceptive technologies whose safety or efficacy has not been adequately tested are being introduced. A programme of severe incentives and disincentives is also being considered. Under this policy, the number of children a woman already has determines the family planning method she may use. Those with no children can have the oral pill, those with one child may have an IUD inserted, and those with two or more children are sterilized. Before the introduction of this policy, poor access to resources compounded by repeated pregnancies and inadequate health care resulted in very high reproductive morbidity rates in women. The new policy does not address these issues and is introducing family planning services in a context of high reproductive morbidity without the back up of comprehensive reproductive health care.

Evaluate this example against the Siracusa principles. Here are some useful points for discussion.

**Principle: In accordance with the law.** In the example, a policy has been put in place, which means that this principle has been adhered to. The policy framework ensures the possibility for accountability, redress and challenge. This is different from situations where actions are taken by representatives of the government without a policy.

**Principle: In the interest of a legitimate objective.** The objective in the example is unclear. Coping with the economic crisis is a legitimate objective, but it is unclear from the facts presented if the objective is to cope with the economic crisis or to reduce population growth for its own sake. Either objective could be legitimate, but the question must be considered.

**Principle: Strictly necessary to achieve that objective.** Whatever the objective, it would be difficult to justify this policy as strictly necessary to achieve it.

**Principle: The least restrictive alternative** Again, an evaluation would include asking whether, at least, the range of methods could be made available to all women and men seeking family planning services.



### Step 2: A methodology for maximizing the public health and human rights elements of policies and programmes

This methodology is adapted from: International Federation of Red Cross and Red Crescent Societies and the François-Xavier Bagnoud Centre for Health and Human Rights. The public health–human rights dialogue. In Mann JM, Gruskin S, Grodin MA, Annas GJ, eds. *Health and human rights: a reader*. New York, Routledge, 1999:46-53.

Introduce participants to the following methodology. It attempts to maximize both the public health and human rights quality of policies and programmes.

There are four steps:

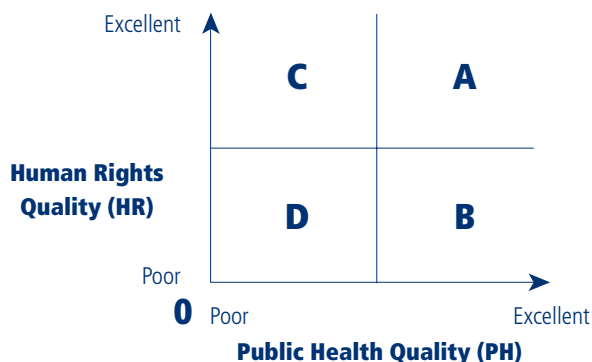
1. Considering the extent to which a policy or programme represents good public health.
2. Considering the extent to which it is respectful of and promotes rights.
3. Considering how to get the best balance between health and rights.
4. Considering whether this is the best approach for dealing with the public health goal the policy or programme seeks to address.



### Step 3: Working through the steps

This chart helps you go through the steps.

#### Four quadrants: The quality of human rights and public health in a programme



SECTOR EXPLANATIONS:

**A:** best case

**C:** need to improve PH quality

**B:** need to improve HR quality

**D:** worst case; need to improve both PH and HR quality

About the chart:

- vertical axis: human rights quality
- horizontal axis: public health quality
- quadrant A: optimal human rights and optimal public health
- quadrant B: excellent public health but human rights aspect needs to be improved
- quadrant C: human rights aspect is fine but public health suffers
- quadrant D: bad public health and bad human rights

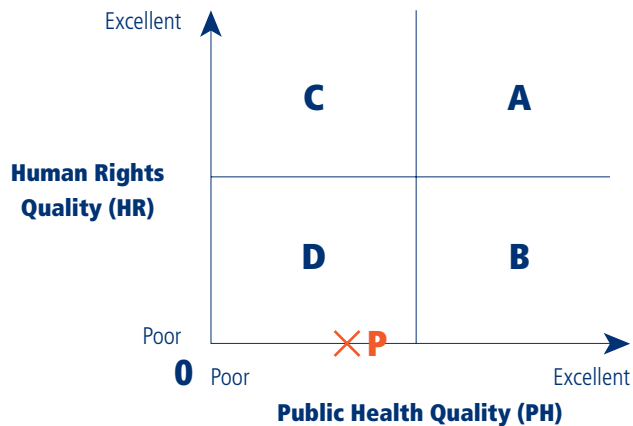
The assumption is, generally, that in designing and implementing a health policy or programme quadrant A is where one would prefer to be. A programme or policy which is respectful of rights, while still achieving its public health goal, is going to be better than one that limits or restricts rights.

How do we use the chart to work through a policy or programme in order to maximize both the public health and human rights aspects?



**The first step: What makes a good public health intervention**

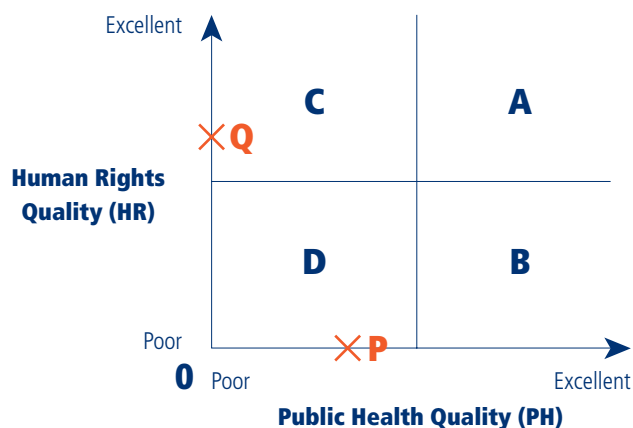
Mark the extent to which the policy promotes and is good for public health as a point P along the horizontal axis. (See Figure 1 below) If the point lies within quadrant B, this indicates good public health quality, and the farther right the point, the better it is. If the point lies within quadrant D, this indicates poor public health quality, and the farther left the point, the poorer the quality.

**Figure 1**

At this point, brainstorm about elements participants would consider in deciding if something is a good public health intervention. Note these down on a flip chart. The list should include: effectiveness, coverage, feasibility, cost, community involvement, and so on.

**The second step: Consider the rights aspect of the policy**

Consider the rights aspect of the policy and mark this as a point Q along the vertical axis. (See Figure 2 below) If the point lies within quadrant C, this indicates good human rights quality, and the farther north the point, the better the human rights quality is. If the point lies within quadrant D, this indicates poor human rights quality, and the farther south the point, the poorer it is.

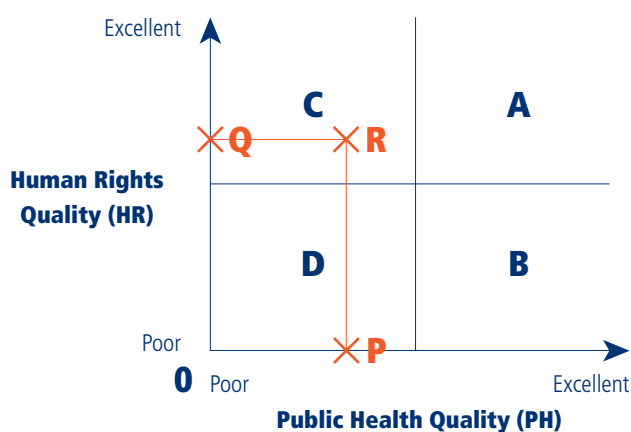
**Figure 2**

Suggest that determining the human rights value of a policy or programme can be done by considering each of the rights in the UDHR and determining for each right if it is positively or negatively impacted upon, or irrelevant. Ask participants to remember government obligations as well as the Siracusa principles. Make it clear that sex based discrimination in the UDHR should be integrated across the various relevant rights in the UDHR.

### The third step: Where public health and human rights intersect

Draw a vertical line from P on the horizontal axis, and a horizontal line from Q on the vertical axis. The point of intersection of these two lines, R, gives the quadrant in which the policy lies for its public health and human rights quality. (See Figure 3 below)

**Figure 3**



The goal is to be in quadrant A or move toward it by working through the various aspects of the policy.



## Activity 2: A case study for analysing a reproductive health intervention



### Step 1: Assessing the quality of public health

Give each participant a copy of a case study of a health intervention with instructions for analysing its public health and human rights quality. The handout given here is an example. While the steps for analysis stay the same, you may wish to substitute this case study with another.

Participants complete the public health analysis of the intervention. They may discuss this with their neighbours before reaching a decision.



### Step 2: Whole group discussion on the public health quality

After participants have analysed the public health quality of the intervention, they move into a whole group discussion.

## What to cover in the discussion

### Questions to guide the discussion

Ask participants these questions which are linked to the public health quality of the intervention:

- What are the reasons for focusing on this population?
  - presumption that they are at a higher risk of being infected
  - large number of sex partners from whom and to whom they could presumably receive or transmit infection
  - real or perceived lack of power to negotiate condom use with clients
  - increased likelihood of having other STIs: assumption is that they are more likely than other people to contract HIV and spread it to others (their clients)
  - politically expedient: looks like something is being done.
- Why not focus on testing clients?
- Is there likely to be pre- and post-test counselling?
- What test is likely to be used? How accurate is the test given at six month intervals likely to be?
- Will all sex workers be tested? Which sex workers are likely to be identified?
- What happens to sex workers once they are found to be infected?
  - If the card is removed are these women likely to immediately find other sources of financial support? Why do women generally engage in sex work? Will this need go away if they are found to be infected? Will revoking their cards impact on sex workers' ability to use health and other services?
- Does this approach in any way control the clients' rate of transmission to these women?
- Given the health commissioner's concerns, is this approach likely to be effective in preventing heterosexual transmission?

Put up your **overhead** transparency of "Four quadrants: The quality of human rights and public health in a programme". What is the level of consensus among participants for the public health quality of the intervention? Call out at each point beginning with 0 along the horizontal axis of the chart, running your pen along the axis. Ask participants to raise their hands when they think you have reached the quality of the intervention. Mark this point on the horizontal axis. Let this point be P.



### Step 3: A rights analysis using the UDHR

Ask participants to now carry out a rights analysis of the intervention using the UDHR. Are any of the rights being restricted? If yes, are these restrictions valid under the Siracusa principles? Participants work individually, consulting with their neighbours if they want to. Make it clear that sex based discrimination, which a gender analysis would reveal, is included in this analysis.



### Step 4: Whole group discussion on the human rights quality

Facilitate a discussion in the big group on the human rights quality of the intervention.

### What to cover in the discussion

Rights to be considered and discussed include Article 1, Article 2, Article 3, Article 5, Article 6, Article 7, Article 8, Article 9, Article 12, Article 13, Article 20, Article 21, Article 22, Article 23, Article 25, Article 27 and Article 29. While many of these rights may not be immediately relevant to the example provided, a discussion will allow the consideration of the proposed intervention from a rights framework.

You have the option of using the International Covenant on Civil and Political Rights or the International Covenant on Economic, Social and Cultural Rights, or the Convention on the Elimination of All forms of Discrimination Against Women, if you are familiar with their interpretation.



#### Step 5: Where do the quality of public health and human rights intersect for this intervention?



Put up your **overhead** transparency of “Four quadrants: The quality of human rights and public health in a programme” again, with point P now marked on it. Find consensus for the human rights quality of the intervention. Call out at each point beginning with O along the vertical axis of the chart, running your pen along the axis. Ask participants to raise their hands when they think you have reached the quality of the intervention. Mark this point on the vertical axis Q.

Draw a vertical line through point P and a horizontal line through point Q. Mark the point of intersection R. In the case provided in the handout, this point R is likely to lie in quadrant D. In other words, the intervention is of poor public health as well as poor human rights quality.



#### Step 6: Discussion: How to move towards quadrant A

### What to cover in the discussion

#### Questions to raise

- How can we make the public health objective respond to the problem in as targeted, precise and gender sensitive a manner as possible?
- How can we make the response to the problem more effective?
- Is the policy/programme overly restrictive or intrusive (for example, does it reach too many or too few people?)
- What changes do participants propose to reduce the severity, scope and duration of the burdens arising from the policy?
- What does improving human rights do to the public health quality of the intervention?

Participants may propose a number of different options. You can discuss each of these in relation to whether they are of a better public health and human rights quality than the example. Anonymous voluntary testing and counselling sites available to the general population, including sex workers, and the promotion of condom use are usually seen as having better human rights and public health quality. However, there may be debates about feasibility and coverage.

## Main points for closing this session

### Respect for rights makes for more effective interventions

Policies and programmes which respect rights are actually better and more effective. Human rights and public health concerns are not incompatible.

### Considering human rights is a useful way of assessing current programmes

Considering human rights in the design, implementation or evaluation of health policies and programmes is a useful way to determine if existing health policies and programmes promote or violate rights, especially gender equality, and to judge their effectiveness.

### Public health decisions are often politically expedient

Public health decisions are often made for political expediency, without consideration of their effects on human rights, and even to some degree their effect on public health.

### People working in public health have an important human rights responsibility

- People working in public health have a responsibility to look at whether human rights are promoted, neglected or violated by actions taken in the name of public health.
- The links to the government that exist for anyone working in public health, whether as an agent of the state or because they receive government funding, impose a dual obligation to promote and protect health, as well as to promote and protect human rights.
- People working in public health have the power to decide to restrict rights, so this responsibility has to be taken seriously.

### Health policies that violate rights have negative consequences

Health policies or programmes that violate rights have long term negative consequences in that they make it harder for people and communities to trust any policies or programmes.

*Session developed by Sofia Gruskin*



## Handout

# 1 A case study for analysing a reproductive health intervention

*Read the following case study and then evaluate its public health quality using the questions to guide your thinking.*

## Case study

In this particular country, the health commissioner is concerned with preventing heterosexual transmission of HIV/AIDS. She decides to add an HIV test to the routine testing for sexually transmitted infections (STIs) given to sex workers every three months. Sex workers are given a card to carry which says they are disease free. If they are found to be infected with an STI, their card is temporarily revoked for a three month period. The HIV test will be added to the STI tests at the six month interval. If a woman is found to be HIV infected, the card will be permanently revoked.

### Analysing the public health components

Take 10 minutes to complete the public health analysis of this intervention. You may discuss it with your neighbours if you wish to. Ignore the rights aspects for the moment. Go through the following steps:

- state the public health problem being addressed
- state the goal of the proposed action
- determine the public health quality of this intervention. Is this good public health? Will it achieve the stated goals?

Bear in mind the various elements of a good public health intervention listed earlier in the session: effectiveness, coverage, feasibility, cost, community involvement. You should consider all these when determining the quality of any public health policy or programme. Once you have considered them for this analysis, identify the place on the horizontal axis of the chart “Four quadrants: The quality of human rights and public health in a programme” below which you think represents the public health value of the programme. Mark this point P.

### Analysing the human rights components

After the whole group discussion and voting on the public health quality of the intervention, take 20 minutes to complete the human rights analysis of this same intervention. You may discuss this with your neighbours if you wish to. Ignore the public health aspects of this intervention for the moment. Go through the following steps:

- look at the UDHR (starting with Article 1) and consider every right that is being violated or promoted by this intervention
- think through how exactly the right is being impacted upon in the short term as well as in the long term
- remember to consider for each right, government obligations to respect, protect and fulfil it
- recall the rights which can never be restricted (as discussed in Session 2)
- pay attention to the severity, scope, frequency and duration of whatever violation you see.

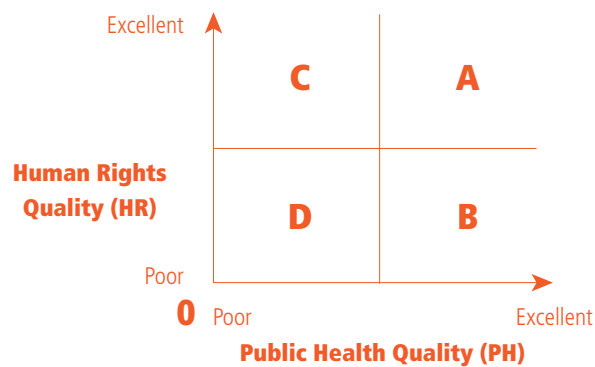
Once you have completed the analysis, identify the place on the vertical axis of the chart which you think represents the human rights value of the programme. Mark this point Q.

### Assessing the overall quality of public health and human rights

Draw a vertical line through P and a horizontal line through Q. R, the point of intersection of these lines, represents the overall public health and human rights quality of the intervention.

#### Four quadrants:

#### The quality of human rights and public health in a programme



#### SECTOR EXPLANATIONS:

**A:** best case

**C:** need to improve PH quality

**B:** need to improve HR quality

**D:** worst case; need to improve both PH and HR quality

#### Discussion in the whole group

After this, there will be a whole group discussion and you will vote to arrive at the point on the vertical axis which represents the group's consensus on the human rights quality of the intervention. In this way you will identify the quadrant the intervention fits into, which will indicate the combined quality of its health and human rights components.

## SESSION

## 4

## Population policies and reproductive rights

This session has been adapted from Klugman B, Fonn S, Tint KS. *Reproductive health for all: taking account of the power dynamics between men and women*. Johannesburg, AIDOS and Women's Health Project, University of the Witwatersrand, 2000: Module 2, Activity 3: "Comparing politics: population control versus human rights and health".

### What participants should get out of the session

#### Participants will:

- be able to apply a reproductive and sexual rights framework to analyse population control policies
- understand how population control policies impact on sexual and reproductive rights and services
- be familiar with the content of the International Conference on Population Development (ICPD, Cairo) and Fourth World Conference Women (FWCW, Beijing)
- understand how these conferences are a product of women's struggle and how they have reoriented discourse on population and development
- recognize that policies are a site of struggle and that the concepts of reproductive rights and health which this course looks at are based on a human rights approach concerned with the empowerment of women, gender equality, and equity in resource distribution.

**2 hours (excluding time spent on reading outside class hours)**

#### Prior preparation

- Handout 2 is to be distributed to participants on the afternoon before this session is run. See instructions under Activity 1 on p.165.

#### Materials

- Lecture notes for the facilitator: "The international women's movement and the reproductive and sexual health and rights agenda"
- Handout 1: "Differences in health services: population control versus a human rights approach"
- Handout 2: "Population policy of the Ayn province of Jull, 1997"
- overhead: table from Handout 1



2 hrs

## Readings for the facilitator

### Analyses of country population policies

1. Dasgupta J et al . From contraceptive targets to reproductive health: India's family planning programme after Cairo. In: *Confounding the critics: Cairo five years on. Conference report. Cocoyoc, Mexico 15-18 November 1998*. New York, HERA, 1999:68–74.
2. Klugman B. Population policy in South Africa: a critical perspective. *Development Southern Africa*, 1991, **8(1)**:19–33.
3. Population and family planning policies: women-centred perspectives, *Reproductive Health Matters*, 1993, **1(1)**. This edition of *Reproductive Health Matters* carries analyses of the population related policies of Japan, India, Malaysia, Mexico and South Africa. In particular, see TK Sundari Ravindran's "The politics of women, population and development in India" (pp.26–38).

### Analyses of population control and women's and human rights discourse

4. Hartmann B. Population control has not gone away. In: Boston Women's Health Book Collective. *The new our bodies ourselves*. New York, Simon and Schuster, 1999:723–724.
5. Petchesky R. From population control to reproductive rights: feminist fault lines. *Reproductive Health Matters*, 1995, **6**:152–161.
6. Sen G, Germain A, Chen L, eds. *Population policies reconsidered: health, empowerment and rights*. Boston, Harvard School of Public Health and International Women's Health Coalition, 1994. Of particular relevance to this session is the article by C Garcia-Moreno and A Claro "Challenges from the women's health movement: women's rights versus population control" (pp.47–61).

### Analyses of the role of women's movements in relation to the international agenda

7. Chen MA. Engendering world conferences: the international women's movement and the United Nations. *Third World Quarterly*, 1995, **16(3)**:477–493.
8. Freedman LP. Censorship and manipulation of reproductive health information: an issue of human rights and women's health. In: Coliver S, eds. *The right to know: human rights and access to reproductive health information*. Philadelphia, University of Pennsylvania Press, 1995.
9. Sen G, Corrêa, S. Gender justice and economic justice: reflections on the five year reviews of the UN conferences of the 1990s. *Dawn Informs*, 2000, **1**:5–7.

## Readings for participants

At least one reading from each of the categories above.

## How to run the session

This session consists of three activities. The first is an individual reading assignment for the evening before this session. The second activity is an input by the facilitator. The third activity is a discussion of the readings in the whole group.

### Activity 1: Reading

This is to be done the day before the session. Divide participants into groups. Give them Handout 2. Tell them to read the handout and write down their responses to the questions.



1 hr

### Activity 2: The role of the women's movement in promoting a reproductive and sexual health and rights agenda



40 mins

#### Step 1: Your input

Begin with the rationale for this session. In order to analyse and improve current reproductive health services, it is important to understand how and why they began, what their intentions were, and how these influence the possibilities for developing and maintaining gender sensitive sexual and reproductive health programmes which have a human rights orientation.

In many countries, the organization of reproductive health services is shaped by national population policies concerned with lowering or increasing population growth. While in some countries population policies have been revisited and changed following the ICPD (Cairo), the process of reorienting health systems and services is slower. In some cases women's health advocates have identified and worked with sympathetic policy makers to bring about such shifts.

This input session provides information on the role of the women's movement in bringing a gender and human rights perspective to reproductive health issues, shifting the focus away from reducing birth rates.

Prepare a talk on the role of the women's movement in promoting a reproductive and sexual health and rights agenda, and the nature of the paradigm shift after Cairo. Your talk should be accompanied by visuals in the form of overheads or a power point presentation to engage participants' attention.

#### Start with participants' experiences

Ask participants about their own experience before giving them more information. For example, ask them what they know of the involvement of the women's movement or women's groups in their country in promoting a reproductive health/rights agenda. Why did governments come to an agreement in Cairo that reproductive services should be



20 mins

### Step 2: Comparing the population control



### approach with a human rights and reproductive rights approach

integrated into primary health care? What are the implications of this for women? Men? Adolescents? And so on.

The talk should cover the points in the lecture notes for the facilitator. Ground your input by drawing on the literature, and the experiences of specific countries.

After your talk, present a comparison between the population control approach and a human rights and reproductive rights approach to reproductive health.

Put up as **overheads** the tables from Handout 1. Also give the handout to participants.

### What to cover in the discussion

#### Why does the table distinguish between a needs based and a rights based approach?

Meeting needs is one dimension of human rights. However, programmes often stop short of addressing human rights when they go beyond meeting immediate needs. Many health policies are needs oriented – that is they aim to help address health problems. Few policies actually manage to challenge women’s position in society – to promote women’s equality to men and their access to and control over resources. Yet it is these steps which are necessary to improve women’s overall well-being. A human rights approach not only meets immediate health needs but empowers women. It also publicly promotes equality between women and men, for example in relation to sexual and reproductive decision-making. (The reference to meeting women’s needs as opposed to changing women’s position in society is often described in the literature as meeting women’s practical needs on the one hand, and promoting their strategic needs or interests on the other. Given the targets of this course, spending time on complex concepts like practical and strategic gender interests does not seem appropriate.)

In the next module you will explore this issue further, by looking at the difference between gender specific policies and gender redistributive policies. Both promote human rights.



1 hr

### Activity 3: Implementation of the reproductive rights agenda - challenges posed by the legacy of population control



10 mins

### Step 1: Introduce the activity

This activity aims to help us understand the legacy of population control programmes in health services. It illustrates that population control has not gone away despite the acceptance of the ICPD agenda by governments, and emphasizes the need for continued efforts.



## Step 2: Discussing the reading

### What to cover in the discussion

Start a discussion on the case study of a population policy in Handout 2.

#### The post-ICPD population policy of the Ayn province of Jull

##### No reproductive or sexual health goals

Ayn's post-ICPD policy contains a peculiar combination of reproductive health language and demographic goals. While many of the goals relate to the reduction of birth rates and fertility, there are also goals related to infant and maternal mortality. Interestingly, no reproductive or sexual health goals are included.

##### The policy violates rights and does not consider non-state actors

Ayn's population policy also violates rights in many of the ways that the pre-ICPD policy of Jull did. The wide range of incentives and the suggestion of disincentives to government servants is cause for grave concern. The consistent references to couples in Ayn's population policy indicate that it is married women and men who are the focus of services, and unmarried women may not have access to them. Similarly, the discussion throughout is about the number of children couples may have before accepting contraception, thereby indicating that those beyond the reproductive age group are not included.

Further, the policy does not really focus on preventing violations of reproductive rights by non-state actors, for example within the household, the community and religious institutions.

##### The same assumption as before 1994

Even though it was formulated after the Cairo conference, the assumption of this policy is still that population size causes poverty. The policy does not recognize the role of the development models adopted by a country in causing or accentuating poverty.

##### Beyond maternal health

The policy defines women's health needs beyond maternal health, to include a few additional reproductive health services. The range of services offered has been slightly expanded to include reproductive tract infections (RTIs) and sexually transmitted diseases (STDs), and there is a move to promote male methods of contraception. Issues such as access to safe infertility treatment are not the focus in the new policy.

##### The new policy does not adopt a rights based perspective

It is interesting to note that while quality of care is mentioned, it is discussed purely in terms of improving infrastructure and training. There is no mention of better information and counselling, of client-provider interaction, of expanding choice, and so on. Community participation is mentioned as important, but for implementing the policy and not in shaping it or directing it in any way. Thus, the new policy falls way short of upholding a rights based perspective.

## Main points for closing the session

### Demographic trends are indicators not goals

Demographic trends (fertility, mortality and migration) are useful indicators of development efforts, rather than goals in their own right. Population control policies of the past, although originally motivated by a concern that high rates of population growth could negatively impact on population well-being, often degenerated into policies pursuing fertility reduction as an end in itself. They were driven by demographic targets in many parts of the developing world. In countries with large populations, a system of incentives and disincentives was often adopted to recruit more and more “acceptors” of family planning.

### From population control to human rights

The ICPD in Cairo in 1994 brought about a paradigm shift in reproductive health services – from population control to human rights: meeting women and men’s needs and promoting women’s equality with men in sexual and reproductive decision-making in policy and programme formulation. The women’s movement, and gender sensitive politicians and bureaucrats, had a key role to play in bringing about this shift.

### Women’s bodies are often the objects of policy

Despite this change, women’s bodies are frequently the objects of policy, whether these are national government population policy or the “policy” of men’s control within the household. Interventions, whether in legislation, government policy, health services or advocacy, should put women’s right to control their bodies and to decision-making in relation to sexuality and reproduction at the centre of their goals.

### What about pro-natal policies?

The ICPD is yet to lead to changes in the pro-natal policies of some of the countries facing below maintenance birth rates. In some such countries, the government provides incentives for particular ethnic groups and particular income groups to produce more children, and not others.

### Words can have different meanings

Although many countries with population control policies have started to rethink or have even changed their population policies since the ICPD, it is important to remember that the same words can have different meanings. Different interest groups are interpreting the Cairo and Beijing documents differently. Many international and national agencies and individuals have started to use this language to refer to family planning services, rather than to the integrated services and holistic approach intended in the definitions in the ICPD *Programme of Action*.

### Continue the struggle for human rights, health and health care

It is essential therefore that all of us interested in upholding a rights based perspective – whether as managers of health services or as NGOs or within donor organizations – continue our struggle for human rights, health and health care.

*Session developed by Barbara Klugman and TK Sundari Ravindran*



Lecture  
notes for  
the  
facilitator:

## The international women's movement and the reproductive and sexual health and rights agenda

*The following is meant to serve as an outline of key points, and not as a definitive summary of the issues. You may want to adapt it to focus on points you consider particularly pertinent to the group you are working with*

### The input is in two parts

The first part is about the involvement of women's movements in reproductive health. The second part discusses the impact of women's participation on the population control agenda, culminating in the International Conference on Population and Development in Cairo in 1994 and reaffirmed at the Fourth World Conference on Women at Beijing in 1995 and in the subsequent five year reviews of each.

### 1. The involvement of women's movements in reproductive health

Women in all parts of the world, throughout history, have been responsible for women's health – childbirth, contraception, and abortion. Over the past few centuries, the professionalization of health care has displaced women's control over these processes. Doctors and scientists are seen as the embodiment of knowledge on the human body and on health. Natural processes such as childbirth became medicalized, and women's control over these has been eroded. Midwives, who for centuries have cared for women through pregnancy and childbirth, have been marginalized.

Abortion, practised by women in most parts of the world since time immemorial, has been criminalized in the past century. Though it is legal in most countries, this is usually on limited grounds such as in the case of danger to the woman's life or where pregnancy is the result of rape. There are still some countries where abortion is illegal. It is not women who can choose whether or not they want to continue a pregnancy, but law enforcers and medical practitioners.

While many lives, including those of women, have been saved by modern medicine, the beneficiaries of medical knowledge and technology have very little control over decisions about how and when these are used, and to what effect. For example, decision-making about how women should give birth, whether abortions should be legal, or on the kinds of contraceptives that should be developed are made at the top, by scientists and medical professionals.

During the three decades from the mid-1960s, when the international community was promoting a population control agenda, women's organizations in many parts of the world were involved in efforts to change the medicalization of reproduction and the denial of the right to control and regulate one's own fertility and sexuality.

Women have taken up struggles against these issues as individuals and as organizations, in their own countries and internationally. These struggles have taken many forms:

- Welfare services – for example providing shelters for women who have been abused
- Local self-reliance – for example alternative services provided by women for women, or initiatives to help women understand how their bodies work and enable them to make informed decisions about contraception
- Oppositional politics – women mobilize around specific campaigns such as violence against women or against the testing of technologies on women without their full involvement and agreement
- Engagement politics – women establish mechanisms to participate with government and other players in policy and programme debates and implementation.

The particular form of engagement has depended both on the specific interests of the women concerned, and on the national or community context.

Where the prevailing context is completely antagonistic towards women's rights, women's groups have found the provision of alternative services to be the most feasible response. Where government creates some space for engagement and may be persuaded by good evidence and the knowledge that their constituencies' needs are not being met, there may be opportunities to engage with government to help make change happen.

Strategies for change are discussed in greater detail in the Policy Module. The key issue here is that women's groups have mobilized around health rights and services for years, and with the onset of population policies, women's groups became the major force articulating how and why such policies abused people's human rights and did not meet their health needs. In some contexts they have managed to identify and work with allies within the government to prevent or change policies.

## 2. The impact of women's participation on the international reproductive health agenda

During the late 1970s, and more so during the 1980s and 1990s, women organizing nationally started to make links across the globe. The International Women's Health meetings, held once in four years since 1981, provided one such forum, which brought together activists working on women's health and rights. Opposition to population control policies began to be articulated in terms of women's rights.

In the 1990s, women's groups engaged with multilateral institutions, especially the United Nations, to promote an understanding of reproductive health as a broad and inclusive area which needs to be addressed from the perspective of the individual, and through a human rights lens.

In doing so, a new discourse has emerged, which instead of seeing control of population numbers as the solution to world poverty, recognizes that poverty results from diverse factors, of which unequal economic power

relations are the most significant. This is coupled with consumption patterns in countries of the North and corruption amongst national elites, so that what resources there are, are not equitably shared within countries.

In this discourse, control over reproduction is the right not only of couples but also of individual women and men. Gender equity and women's empowerment is seen as critical for women to be able to exercise their reproductive rights. Contraceptive technology is meant to help women and men realize their reproductive choices, rather than help governments keep down the birth rate.

This approach, known as the reproductive health approach:

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

These values were consolidated through the consensus reached at the ICPD in Cairo in 1994, and re-affirmed at the FWCW in Beijing the following year, and in the five year reviews of both in 1999 and 2000. These conferences applied existing human rights frameworks to the area of reproduction.

The specific approach to sexual and reproductive rights and health can be grasped in brief through the definitions of these given out in the handout "Definitions" of the Opening Module, and in the detail of the Cairo and Beijing texts. (Ask participants to refer back to this handout in their course files at this point.)

The diversity of the chapters of the ICPD Programme of Action illustrates the extent to which population matters are now being considered in broad terms – how population trends interact with the environment and the economy and should be used in the planning and monitoring of development interventions; and how consumption patterns need to be addressed in the quest for equality and quality of life for all.

The international women's health movement has targeted UN conferences as key moments for building an international consensus on applying human rights frameworks to the fields of reproduction and sexuality, since they set a clear international and national agenda for governments, the private sector, NGOs and international agencies. They also influence the direction of donor funding, which is of critical importance to the poorest countries of the world and their people, who are dependent on such funds for the provision of basic services.



## Handout

## 1

## Differences in health services: population control versus a needs based and a human rights approach

Source: Klugman B, Fonn, S, Tint KS. *Reproductive health for all: taking account of the power dynamics between men and women*. Johannesburg, AIDOS and Women's Health Project, 2001:82. Reprinted with kind permission of AIDOS (The Italian Association for Women in Development) and Women's Health Project.

	<b>Population control/ family planning</b>	<b>Meeting women's needs</b>	<b>Promoting women's rights</b>
<b>Defining women's health</b>	A narrow bio-medical meaning as maternal health, or the health of women of reproductive age, focusing on birth and child bearing without death or disease, and on contraception.	Provision of services of a high standard which are women-centred – based on women's experiences and needs. Recognition that women's health needs go beyond reproduction.	A broad understanding centred on the right of women to make autonomous choices about reproduction and sexuality.
<b>Goals</b>	Demographic reduction or increase of fertility and population (main goal). Improve women's and children's health and family welfare (secondary goal).	Improve women's health. Provide women with a range of services ensuring choice, for example in methods of contraception.	Women's control over their bodies; sexual and reproductive decisions. Right to information, privacy, bodily integrity. Gender equality generally as it impacts on health, for example food security, education, control over income, and so on.
<b>Assumptions</b>	Population size/growth is the main determinant of poverty, under-development and environmental sustainability. Population control will reduce fertility.	Poverty is due to the economic growth model of development. Focus is on meeting basic needs and not on population control. Improving women's status and providing quality reproductive health programmes will help to reduce fertility.	The interaction of inequalities – based on class, on other social divides such as caste or ethnic group, and on gender – lead some to be poor and others to be wealthy, some to be empowered and others to be disempowered. These inequalities can and should be challenged in order to achieve social justice. A more equitable distribution of resources, such as education and health services, are part of this challenge.
<b>Service range</b>	Contraception; infertility (if in support of increasing population growth rates); maternal health; abortion (if culturally acceptable and seen as part of a population-control agenda).	Within sexual and reproductive health: contraception; maternal health; abortion; STDs, RTIs; HIV/AIDS; sexuality; violence against women; cancer screening. Part of broader primary health care so that reproductive health needs can be met alongside other service needs (e.g. chronic diseases, mental health, occupational health).	Information and counselling services to build women's confidence to challenge their subordinate position to their sexual partners and in society. Community based activities to organize women to challenge social inequalities. Organization of men to understand and take on their role in promoting women's equality in sexual and reproductive decision-making and in society generally. Focuses beyond services to laws and policies, for example maternity leave, against rape.

*chart continues*

	<b>Population control/ family planning</b>	<b>Meeting women's needs</b>	<b>Promoting women's rights</b>
<b>Age and marital status</b>	Married women; reproductive age (15–44 years).	Women of all ages throughout their life cycle, married and unmarried.	
<b>Service delivery standards</b>	Quality of care is usually not emphasized as focus is on quantity of women seen.	High quality of care is promoted as a part of professional health standards at the core of service delivery.	High quality of care is promoted both as a health related right and also as a woman's rights issue – with a focus on respect, dignity, confidentiality and choice.
<b>Information and education</b>	Communication is top-down, focusing on directions for contraceptive use. Persuasion and motivation are the information processes. Provider gives advice on what is best.	Full information provided on risks and benefits of contraceptive technologies so women can exercise choice.	Focus on understanding the body and sexuality in order to make decisions and be in control of one's life. Promotion of women's sexual and reproductive rights. Attention to men's responsibility in relation to sexual and reproductive rights and health.
<b>Participation</b>	Policies usually top-down with providers driven by targets or other policy considerations.	Health workers understood to have more knowledge than users, but an effort to ensure women's needs are met.	Mobilization of women for better health policy. Use of peer education to build and empower women for action. Efforts to draw on community input regarding priorities for health service provision and evaluation of services.



## Handout

# 2 Population policy of the Ayn province of Jull, 1997

*Read the following policy, and note down your responses to the questions given below. You will discuss these with the whole group tomorrow.*

## 1. Introduction

... The 1994 International Conference on Population and Development articulated a call for a broader and more holistic population policy approach, linking demographic concerns, including fertility reduction, to a range of reproductive health concerns, particularly those affecting women. It also called for increased male responsibility for sexual and reproductive behaviour. Jull is signatory to this call. The reproductive health approach must necessarily be integrated into the province's population policy initiative.

... Rapid growth of population has serious implications for socio-economic development and the preservation of the environment. This has resulted in the following:

- Production of food may not keep pace with population growth. Already, 51% of female children and 47% of male children in this province are malnourished.
- Pressure on land and other facilities will result in social tension and violence.
- Housing in rural and urban areas will become a serious problem. There is already a backlog over the last 20 years of 4.7 million new urban housing units.
- 44.3 million people in rural areas and 7.3 million people in urban areas will not have access to sanitation facilities, and 13 million in the province, will not have safe drinking water by the year 2001.
- There will be 25 million people below poverty line in this province by the year 2001, and there will be an increase in the number of illiterates and number of unemployed.
- The environmental degradation resulting from increasing population growth will be untenable. ...

## 2. Population stabilization goals

... The demographic goals of the province are set as under [sic]

	Current rate	5 yrs hence	10 yrs hence	20 yrs hence
Natural growth rate	1.44	1.15	0.80	0.70
Crude birth rate	22.7	19.0	15.0	13.0
Crude death rate	8.3	7.5	7.0	6.0
Infant mortality rate	66.0	45.0	30.0	15.0
Maternal mortality ratio	380	200	120	50
Couple protection rate (%)	48.8	60.0	70.0	75.0
Total fertility rate	2.7	2.1	1.5	1.5

## 3. Structures and processes for implementation

... Population stabilization committees will be set up at the district and sub-district level. The sub-district population stabilization committees will encourage each village government and town corporation to prepare a Population Stabilization Action Plan, which will specify the demographic goals and expected levels of achievement annually and a charter of social actions for population stabilization, arrived after consensus within the community. The Action Plan will also specify actions to be taken to achieve the goals within a specified time frame. ...The Sub-district Action Plan will be formed based on all these local Action Plans. It will include specific interventions for improving the quality of services. The financial and technical support required for the implementation of these Action Plans will be made available through the District Population Stabilization Committees.

... Improving quality of services will be an important process for implementation. The essential ingredients for quality in service delivery are:

- availability of medical and paramedical personnel in the required places at the required times
- adequate technical and managerial skills and a degree of commitment and motivation amongst personnel delivering family planning services
- an enabling environment for quality services in terms of adequate infrastructure, essential equipment and sufficient supplies of drugs, dressings and other materials
- community participation in the programmes. (in helping implement the programme).

## 4. Specific operational strategies

- a) ... Promotion of terminal methods of contraception, through:
- increased focus on couples with parity 2
  - ensure reduction of births occurring in women of parity 3 and above
  - promote vasectomies to account for at least 30% of all sterilizations ...
  - target those couples who are likely to have more children in an attempt to have sons with the introduction of the girl child scheme: the only daughter or one of two daughters of a couple adopting sterilization will get a series of monetary benefits until she is 20 years old, and a lump sum when she is 20 years old, provided she remains unmarried until she is 18 years. ...
- b) Promotion of spacing methods of contraception, through:
- information campaign on spacing methods
  - ensure proper screening procedures before IUD insertion and monitor retention levels
  - increase access to condoms and oral pills through community based distribution programmes and social marketing. ...
- c) Shift target setting for both terminal and spacing methods from the provincial level, which is top-down, to the village government level.
- d) Ensure safe delivery through equipping first referral units, providing a fund at the village government level for transporting emergency delivery cases.
- e) Ensuring safe abortion through training of personnel, and equipping more health centres to provide the services. ...
- f) RTI/STD prevention and management mainly through making the services of a gynaecologist available at specified timings (on a contract or consultancy basis where recruitment is not possible) in 450 Primary Health centres designated as Primary cum Women's Health Centres. ...
- g) Incentives:
- i) Incentives will be provided at the community level, to those villages, which exceed a couple protection rate of 60%. Such incentives will include additional works, school buildings and development schemes including Low-Cost Sanitation Scheme and Weaker-Section Housing Scheme. ...
  - ii) Incentives will also be provided to individuals. This will be in the form of a cash award of (the equivalent of) US\$2500 to three couples per district selected by lucky dip in each of the following categories:
    - those with two girl children adopting a permanent method of contraception
    - those with one child adopting a permanent method of contraception
    - those with two or less children accepting vasectomy.

In the sanction of development schemes (housing loans, credit for investment in small scale enterprises, micro-credit programmes for women) to individuals, other things being equal, preference will be given in the following order of priority:

- acceptor of a permanent method with two girl children
  - acceptor of vasectomy with one child
  - acceptor of permanent method with one child
  - acceptor of vasectomy with two children
  - acceptor of any permanent method with two girl children.
- iii) Incentives will be provided to service providers in the form of a gold medal and/or cash awards, including to teams of service providers who have achieved performance levels above the prescribed minimum standards under the sub-district Action Plans. ...
- iv) Government expects that its employees should serve as role models and that they must take the lead in adopting the two-child norm. Government will accordingly examine the desirability of limiting perquisites routinely provided to government employees such as leave travel grants (usually provided for the employee, his/her spouse and children) and educational grants for the first two children only. ...Government will also explore the possibility of modifying service rules and promotion policies such that the adoption of the two-child norm is encouraged.

Note: Ayn and Jull are fictitious names for a real case.

## Questions

1. What are the implications of this population policy for the right of couples and individuals to choose if they want to have children, when and how many? Why?
2. List aspects of this policy which you believe violate any of the rights guaranteed by international human rights documents?
3. What are the implications of this population policy for health services? Why?
4. How different would reproductive health services in Ayn be if they were oriented towards individual choice?

SESSION  
**5****Working with sexual rights****What participants should get out of the session****Participants will:**

- learn about the evolving content of sexual rights and the issues raised by their increasing recognition
- recognize that sexual rights are a requirement for the achievement of both sexual health and gender equality
- understand the difference between reproductive rights and sexual rights
- be able to conceptualize practical interventions to realize sexual rights at different levels (legislative, health system, community).

**1 hr and 45 minutes****Materials**

- Handout: "Determinants of HIV transmission in Botswana"
- overhead: "ICPD definition of sexual health", on p.180
- overhead: extract from the South African Constitution, on p.180
- flip chart

**Readings for the facilitator**

1. *Health and Human Rights*, 2000, **4(2)** (special focus on reproductive and sexual rights).
2. Health, Empowerment, Rights and Accountability. "Gender equality and equity", "Reproductive rights and reproductive health", "Sexual rights". *Women's sexual and reproductive rights action sheets*. New York, HERA, 1998.
3. Gupta GR. Strengthening alliances for sexual health and rights. *Health and Human Rights*, 1997, **2(3)**:55–63.
4. Miller AM. Sexual but not reproductive: exploring the junction and disjunction of sexual and reproductive rights. *Health and Human Rights*, 2000, **4(2)**:68–109.

**Essential readings for the participants**

Readings 2 and 4.

1 hr  
45 mins

## How to run the session

This session consists of two main activities. The first is an interactive input session, with contributions from participants along the way. The second is a small group activity.



### Activity 1: The right to non-discrimination and sexual health



#### Step 1: Sexual health

Put up on an **overhead** the following definition of sexual health:

#### ICPD definition of sexual health

Sexual health has been defined in the ICPD Programme of Action as “the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases” (ICPD 7.2). [United Nations Population Fund. Programme of Action of the International Conference on Population Development, Cairo, 5–13 September 1994. New York, United Nations, 1996:7.2]

Write up the following statement on a flip chart:

#### Constitution of the Republic of South Africa, Act No. 108 of 1996

“(2) No person shall be unfairly discriminated against, directly or indirectly, and, without derogating from the generality of this provision, on one or more of the following grounds in particular: race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture or language.”

Read the constitutional clause to the participants and then ask them the following question:

- How does the right to non-discrimination in this clause relate to sexual health for all people?

Refer participants to the definition of sexual health on the overhead. Take responses. If the room is very quiet, give participants an opportunity to “buzz” with their neighbour for about two minutes. Then ask the question again and take responses.

### What to cover in the discussion

This activity aims to help participants recognize that various types of discrimination can and do impact on people's sexual health.

#### Discrimination can impact on people's sexual health

Discrimination and inequality impact on many and diverse aspects of people's lives, including that most intimate of issues, sexuality and sexual experience. Coerced sex, in the form of rape, having no choice in whom one marries, or peer pressure to engage in sexual relations at a young age, can all have negative psychological effects on a person. In addition, in the context of sexually transmitted diseases and particularly HIV/AIDS, it can be life threatening. Traditionally those in the health field have focused on the reproductive health dimension of sex, leaving aside the emotional and mental health dimensions, as well as the physical health dimensions beyond reproduction.

In some instances, discussion of discrimination in relation to sexual health is conflated with discussion on gay rights. The discussion in this course should illustrate that many people suffer abuses which undermine their sexual health, irrespective of their sexual orientation.

All people, whether women or men, disabled, homosexual or heterosexual must:

- have access to information, education and counselling on human sexuality and sexual health in a language and form that they can understand
- be able to protect themselves from sexually transmitted disease
- be able to choose if, when and with whom they have sexual relations
- be free from fear of, or actual perpetration of, sexual violence or any form of pressure to have unwanted sexual relations
- be free from violence which might result from their voluntary sexual relationships
- expect and demand equality, full consent, mutual respect and shared responsibility in sexual relationships.



#### Step 2: Sexual rights

Before participants begin this exercise, present the following information to the group:

- Although paragraph 96 from the *Platform for Action* of the FWCW (Beijing) does not use the word sexual rights, it is commonly referred to as the sexual rights paragraph and is commonly understood to form the framework for sexual rights. (Note that this paragraph is limited to the sexual rights of women. You might want to challenge participants to rework it for an adolescent heterosexual boy, for example.)
- In a process similar to formulating reproductive rights, no new rights were created at Cairo and Beijing. But there were attempts to ensure that matters beyond the traditional boundaries of human rights would get adequate attention and protection.
- If the group is interested in knowing why the actual language of sexual rights is not used in the *Platform for Action*, refer them to the facilitator's readings, which will provide the necessary background.

Ask participants to refer to the handout from the Opening Module, Session 4: “Definitions”, which contains the ICPD definition of reproductive rights and the FWCW definition of sexual rights, and given them about 10 minutes to individually read these two definitions. They should then consider the following questions and write down key points.

- What is each paragraph on reproductive rights and on sexual rights trying to address?
- Why was there a perceived need for a specific sexual rights paragraph?
- Why does the paragraph 96 of the FWCW focus on women’s sexual rights?



### Step 3: Whole group discussion

Once participants have written out their points, go over each of the questions in the whole group and use this as an opportunity for participants to share their thoughts and clarify their ideas. If participants do not raise key issues like those listed below, bring them up yourself. At the end of the discussion, put up the overhead on the ICPD definition of Sexual Rights to reinforce the points made.

### What to cover in the discussion

#### The differences between sexual rights and reproductive rights

Many people consider sexual rights to be a subset of reproductive rights. These two sets of rights are, however, conceptually different in significant ways, and hence require different remedies.

#### Reproductive rights are limited to certain groups

Sometimes one hears practitioners saying “We just put it all under reproductive rights”. The problem with this is that it can mean that the needs of people who fall outside the arena of reproduction are ignored – older women; women and men who do not have children.

#### Disconnecting sexual activity and reproduction

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

People have sexual relations from adolescence into old age. As long as they are having sexual relations, they have sexual health needs – related to information, education, services, and protection from sexually transmitted diseases, and to problems of sexual function. The term “sexual rights” includes the right to sexual health irrespective of one’s reproductive status. Sexual rights include the full range of protections across rights, over and above health concerns alone.

#### Why focus on women’s sexual rights?

Unfortunately coercion in sexual relations is commonplace in many cultures. At its most extreme is the problem of rape, whether as part of war, or in peace time. There are also forms of violation of sexual rights that are specific to certain cultures and religions, like female genital mutilation and forced temple prostitution. It is therefore essential that governments recognize the right of each individual to

decide if, when and with whom they want to have a sexual interaction, and to ensure that these rights are protected and promoted by state and non-state actors.

The paragraph focuses on women because it is predominantly women whose sexual rights are abused. However, sexual rights should apply to everyone. If a culture of sexual rights were promoted amongst adolescent boys, for example, it would help build their ideas of masculinity in ways which promote their own self-esteem, while building a culture of respect for women.

### Sexual rights within a traditional human rights framework

Within a traditional human rights framework, sexual rights can be understood to include such rights as freedom from torture, arbitrary killing and execution, and arbitrary detention, protection of bodily integrity, rights to information, expression, and development of the personality, freedom to participate in political and cultural life, and a move towards state accountability for non-state actor violence. The language of autonomy, dignity and civic participation for women has also been noted in some writings (see Miller 2000, Reading for the facilitator 4).



## Activity 2: Exploring sexual rights using an example

Divide participants into four groups.

Introduce the group exercise to participants. Propose that rather than discuss sexual rights in abstract, you will look at ways of realizing sexual rights at various levels using a specific example.

Give each of the four groups a different identity:

- Group 1: health service management
- Group 2: policy makers
- Group 3: a peer education NGO
- Group 4: a rights based advocacy group

Give all groups a copy of the handout: “Determinants of HIV transmission in Botswana”. Ask them to look at the figure illustrating the determinants, which is supported by some of the text from the Botswanan policy.

Using the information in the handout, ask participants to identify at least three interventions that their group could make in order to promote sexual rights. They must write these up on a flip chart under the heading of their group identity. Give them 40 minutes.

For the last 5 minutes of the session, ask each group to put its chart of activities on the wall and let the participants walk around the room reading the charts. Put a blank piece of paper next to each chart with “Additions” written on it. Encourage participants to spend some time between and after future sessions adding any ideas they have for actions that each group could take. You may do the same.

### The sorts of ideas that might come out of each group

Health service management	Policy makers	Peer education NGO	Rights based advocacy group
<ul style="list-style-type: none"> <li>● Train health workers to be able to cope emotionally with seeing women who have suffered violence; provide them with the skills to offer the necessary counselling and information and to seek redress for violations.</li> <li>● Train health workers to identify and treat sexually transmitted diseases correctly and sympathetically.</li> <li>● Develop a health promotion strategy targeting traditional leaders to gain their support for an end to obligatory sex that denies women the ability to protect themselves from disease or to choose if, when and with whom to have sexual relations.</li> </ul>	<ul style="list-style-type: none"> <li>● Understand the wide range of laws (e.g. criminal, family, health, labour) that affect sexual rights.</li> <li>● Modify laws, policies and programmes in order to ensure full support for sexual rights.</li> <li>● Give urgent attention to promoting women’s access to employment in order to limit their recourse to sex as an exchange commodity.</li> <li>● Develop and implement a youth development strategy that creates opportunities for young people in career development, accessing sports facilities and recreation activities</li> <li>● Run a campaign against unprotected sex.</li> <li>● Provide more resources for implementation.</li> </ul>	<ul style="list-style-type: none"> <li>● Identify peer education materials which provide accurate information on sexuality.</li> <li>● Raise awareness that both women and men have the right to control and make decisions about their sexuality and sexual relationships.</li> <li>● Raise awareness about the health risks that women and girls face, including violence.</li> <li>● Train facilitators to use such materials.</li> </ul>	<ul style="list-style-type: none"> <li>● Mobilize all health oriented and rights based NGOs to develop a campaign for an end to discrimination on the basis of sexual orientation.</li> <li>● Lobby the departments of health in each province to provide sexual health services to adolescents, not only to women of reproductive age.</li> <li>● Inform women of their legal rights and encourage them to recognize and report violations.</li> <li>● Monitor legislation on violence against women, sexual harassment, etc. and use findings to advocate for changes.</li> </ul>

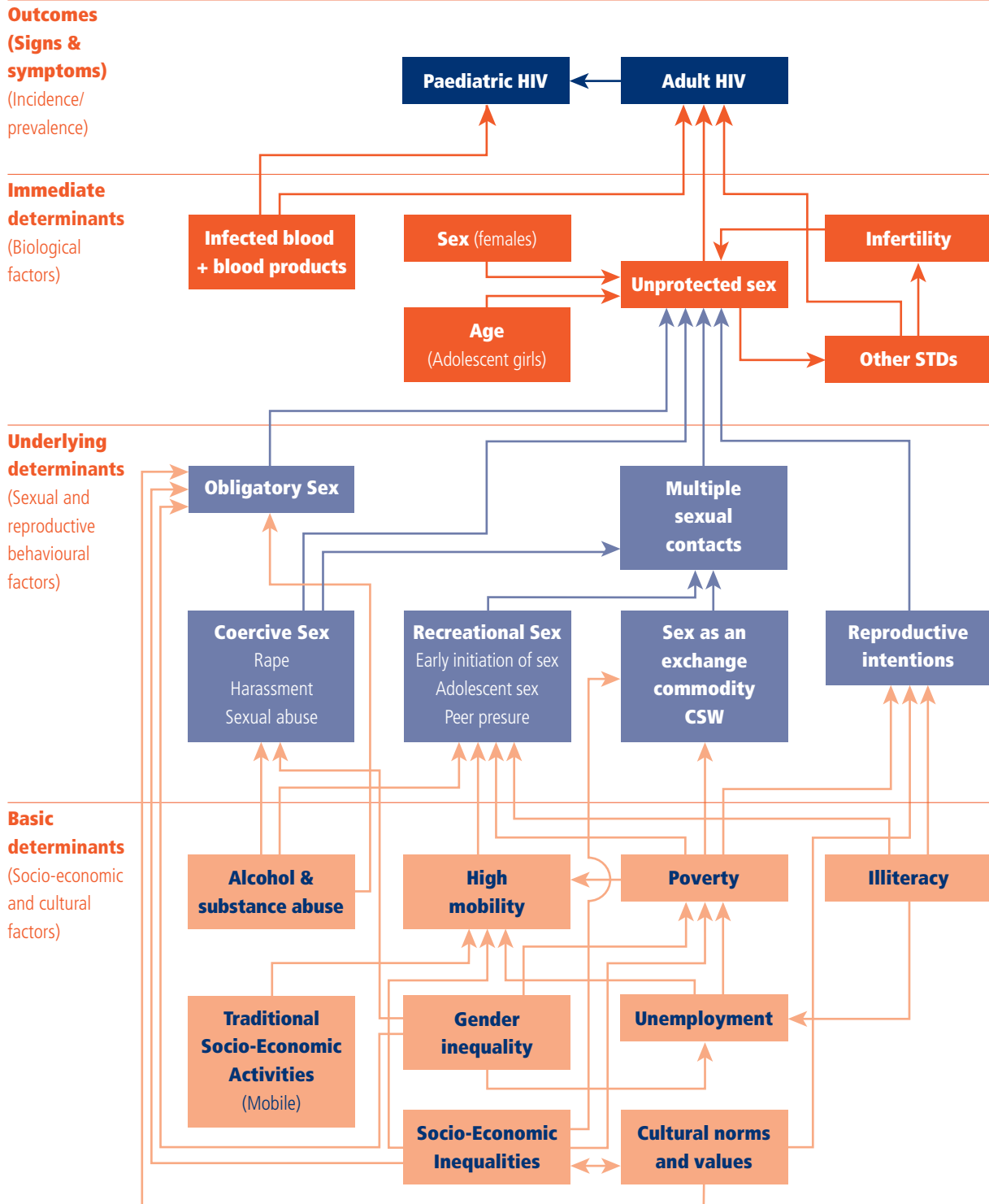
*Session developed by Barbara Klugman and Sofia Gruskin*



Handout

# 1 Determinants of HIV transmission in Botswana

**Figure 1: Determinants of HIV Transmission in Botswana**



Source: Government of the Republic of Botswana. *Botswana HIV and AIDS: second medium term plan: MTPII 1997 – 2002*. Gaborone, AIDS/STD Unit, National AIDS Control Programme, Ministry of Health, Republic of Botswana:15–18.

### Gender

As is the case elsewhere in sub-Saharan Africa, the patterns of the HIV epidemic in Botswana, particularly in the sexually active age group, has a clear gender bias ... The gender gap widens in the youth group 15–29 years, where 68% of infections were women. Certainly biological difference in part explains this gender bias. However, these variables do not sufficiently account for this gender disparity in the distribution of HIV infection.

... Lack of women's empowerment against prejudicial cultural and traditional practices in sexual and reproductive matters and relationships have been identified as factors that make women vulnerable to HIV infection. On the other hand, an exclusive focus on women is necessary but not sufficient in promoting gender equality in sexual and reproductive matters. Promoting the role and responsibilities of men in sexual and reproductive issues is in its own right critical in protecting both men and women against HIV infection. Such an approach may reduce various forms of sexual abuse and exploitation and promote positive sexual and reproductive behaviours.

### Sexual and reproductive health factors

... As yet there have been no systematic studies done on the prevalence and incidence of sexual health problems such as rape, sexual harassment, violation and exploitation especially among young people in Botswana. However, judging from media reports and public concern, the prevalence of rape and sexual violation is high in Botswana. Such social ills present serious risk for HIV infection, especially for women. There is anecdotal evidence that teenage girls have sexual relations with older men. This sexual relationship formation pattern may in part explain the disproportionate rate of HIV infection between teenage boys and girls. However, since most girls who have sexual relationships with older men are likely to have peer boyfriends, most boys may be infected through this route. There is also concern about the possibility of sodomy among incarcerated prison populations. A study conducted in the Botswana prisons report that the practice of "thigh sex" is common among male inmates. This practice may be a risk factor in cases of cuts and open sores among those practising this behaviour.

## SESSION

## 6

## Applying a rights framework to reproductive and sexual health issues

### What participants should get out of the session

#### Participants will:

- apply the concepts introduced in earlier sessions to case study examples which highlight how the violation or promotion of rights interacts with sexual and reproductive health
- recognize how the understanding of these interactions can help to shape policies and interventions.

**2 hours 15 minutes**

#### Materials

- Handout 1: “Minna’s story”
- Handout 2: “I wanted choice”
- Handout 3: “A golden flower withering prematurely”
- *Universal Declaration of Human Rights* (You have the option of using human rights treaties, such as the Convention on the Elimination of All Forms of Discrimination Against Women for this exercise if you are used to working with their interpretation.)

#### Readings for the facilitator

1. Cook R. Abortion laws and policies: challenges and opportunities. *International Journal of Gynaecology and Obstetrics*, 1989, supplement to **3**:61–87.
2. García-Moreno C. *Violence against women, gender and health equity*. Harvard Center for Population and Development Studies Working Paper series No. 99.15. Boston, Harvard School of Public Health, 1999:1–8.
3. Hord CE, Gerhardt AJ eds. *When contraception fails. Initiatives for reproductive health policy*. Chapel Hill, IPAS, 1996.
4. Tarantola D, Gruskin S. Children confronting HIV/AIDS: charting the confluence of rights and health, *Health and Human Rights*, **3(1)**:61–86.
5. United Nations. *Declaration on the elimination of violence against women*. New York, United Nations (United Nations General Assembly Resolution 48/104, 20 December 1993).
6. United Nations Population Fund. *The state of world population 1997. The right to choose: reproductive rights and reproductive health*. New York, UNFPA, 1997: 53–62 and 66.



## How to run the session

This session consists of two activities. The first is an exercise in small groups using a case study. The second is a group report-back followed by a discussion and inputs from the facilitator.

This exercise focuses primarily on using a rights based approach for developing strategies and action steps. This session is complementary to the application exercise in Session 5 of the Policy Module, which is intended to build on this one.



### Activity 1: Reading and preparing responses

Divide participants into groups of seven to ten. Give each group a case study and ask them to prepare to present their responses to the big group. Handouts 1 to 3 provide three stories on HIV/AIDS, abortion and maternal mortality. Each highlights different aspects of how the promotion or violation of human rights can interact with reproductive and sexual health and how awareness of this can help to shape both policies and interventions. Each case study poses the same set of questions. You can use all three cases or only the one that seems most relevant to the group you are working with.

It is useful for more than one group to work on a particular case study so that in the discussion in the big group it becomes clear that there is a need for various strategies to be used simultaneously to address particular issues.



### Activity 2: Whole group discussion

The groups come back to the whole group. Each group has to present a summary of their responses to the questions in the handouts. This should take about 10 minutes per group. After each group presentation give a maximum of 10 minutes for questions for discussion.

#### What to cover in the discussion

The example given here uses the story in Handout 1: “Minna’s story” to highlight the possible points of discussion and the range of possible responses that groups may present.

1. **Identify how this situation (HIV/AIDS in the family) may impact on Minna’s health.**
  - How does it affect her sources of support, including financial, family, education, economic opportunity?
  - How does it increase her vulnerability to HIV/AIDS, violence, rape, STIs, psychological trauma, and so on.
2. **Identify the various causes of poverty, causes of lack of income, causes of gender based discrimination and the root causes of HIV.**

**3. List each of the relevant actors and consider each of their responses to the situation.**

- Relatives, school system, NGOs, mother, government (including the Ministry of Health and the Ministry of Education), self.

**4. Identify the gaps or inadequacies of the responses that a rights approach highlights.**

- Minna – not heard
- Family – discrimination: favours males, won't pay her fees
- Mother – requests she stay home
- School – did not waive fees, discrimination, not in support of Minna
- NGO – didn't prioritize situation, won't/can't help
- AIDS service organization – didn't provide for affected people. Was there adequate service for the mother?
- Government – not providing education, not providing adequate care, allowing economic exploitation of family, of Minna.

**5. Use the Universal Declaration of Human Rights to identify each of the rights implicated in the situation. For each right discuss how and in what ways it is relevant. Be sure to consider the three levels of government obligation (to respect, protect and fulfil) as discussed in Session 3.**

- Articles 1, 2, 3, 6, 7, 8, 9, 16, 22, 23, 24, 25, 26 of UDHR

**6. Using this analysis, determine essential actions that should be taken to ensure this situation does not happen again. Consider both short and long term approaches and pay particular attention to the concepts respect, protect and fulfil.**

- Short term approaches
  - Method for determining what Minna wants
  - AIDS service organization to stop withholding services
  - Equal education for girls and boys
  - Get school authority to waive fees now; get them to waive fees in extreme circumstances
  - Rally donations
  - Listen to Minna (allow her to participate in the decisions that affect her) both about how her mother should be cared for and about going to school
  - Work to make her choices equal to those of her brothers
  - Mother should receive drugs and not have to sell sewing machine
  - Support for other children in similar circumstances.
- Long term approaches
  - Increase funding for education and health care
  - Gender equality through legislative change, and so on (pay attention to Women's Convention [CEDAW])
  - Provision of free education
  - Provisions against child labour
  - General economic equity
  - International funding assistance, and not exploiting labour force

- Incorporation of human rights provisions into domestic legislation
- Improved health care, welfare, social services, and so on.

**7. Discuss the three types of actions identified: those that will impact on the underlying causes (conditions), those that are specific to the occurrence of the violation and the harm done, and those that are focused on the rights related consequences of the violation (the kinds of legal remedies that can be accessed, and so on).**

**Start a discussion after each presentation**

At the beginning of the first of these discussions, mention that the Policy Module will be addressing how to make these actions happen through a policy analysis and developing a strategy for policy change.

**There is a need for different and complementary strategies**

Even when faced with the same issue, groups may choose different approaches to address them. No single solution is sufficient.

Draw out the economic, social, cultural, civil and political dimensions of the issue under discussion in greater detail. Encourage other participants to add new factors. Similarly, encourage other participants to identify relevant rights that the reporting group has not mentioned.

Then discuss how using rights can facilitate choices in problem solving. It can introduce some order when we approach problems that may seem insurmountable. This can lead into a discussion about short and long term strategies. Emphasize the need to locate whatever strategy one chooses in the wider context.

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## **Main points for closing the session**

**Human rights documents are useful**

Using the rights as they are spelled out in the human rights documents can provide a convenient methodology for categorizing issues and allow for a shared framework, even amongst diverse actors, in determining strategies for action.

**Range of short term, long term and concurrent strategies**

No single action or short term approach will be sufficient to solve these issues. Attention must be given to employing a range of strategies at the same time, both short and long term strategies, if health issues are to be adequately addressed.

**Forming partnerships outside the sector**

Strategies to address reproductive and sexual health issues require partnerships with allies outside the health sector.

*Session developed by Sofia Gruskin*



## Handout

## 1

## Minna's story

Adapted from Gruskin S, Tarantola D. *Children confronting AIDS: a health and rights perspective*. Abidjan, UNICEF, UNAIDS, 1997.

Today Minna has told her teacher she has to stop going to school. Minna is 12 years old. She lives in a small town. Her father was a bus driver and her mother a seamstress. Her father died of AIDS six months ago after an illness that exhausted the family's resources. Her mother is very sick and has had to stop working. Two months ago, she had to sell her sewing machine to buy the drugs she needed. Her mother has told Minna that she must stop going to school and help to take care of her. There is no more money for school fees. Minna has been a very good student and is eager to continue. Minna has two brothers, aged 14 and 16. They will be able to continue going to school because relatives will pay their school fees.

Minna's relatives have approached the local education authority asking them to waive her school fees but were told this was not possible. They turned to a local AIDS service organization for help but were told that while Minna's situation was unfortunate, their mandate was still limited to providing care and support for people living with HIV. They turned to a local NGO Education For All. This NGO had a long waiting list for children seeking their support.

Minna's family met and decided they had done all they could do and that Minna should be sent to the capital city where young girls can easily find employment as domestic helpers.

### Questions for discussion

1. Identify how this situation (HIV/AIDS in the family) may impact on Minna's health.
2. Identify the root causes of the situation.
3. List each of the relevant actors and consider each of their responses to the situation.
4. Identify the gaps or inadequacies of the responses that a rights approach highlights.
5. Use the *Universal Declaration of Human Rights* to identify each of the rights implicated in the situation. For each right discuss how and in what ways it is relevant. Be sure to consider the three levels of government obligation (to respect, protect and fulfil) as discussed in Session 3.

6. Using this analysis, determine the essential actions that should be taken to ensure this situation does not happen again. Consider both short and long term approaches and pay particular attention to the respect, protect, fulfil concepts). Consider three types of action:
  - those that will impact on the underlying causes (conditions)
  - those that are specific to the occurrence of the violation and the harm done
  - those that are focused on the rights related consequences of the violation (the kinds of legal remedies that can be accessed, and so on).



## Handout

# 2 I wanted choice

From: Budlender D, ed. *Health in our hands: proceedings and policies of the 1994 Women's Health Conference*. Johannesburg, Women's Health Project, University of the Witwatersrand, 1995. Reprinted with kind permission of AIDOS (The Italian Association for Women in Development) and Women's Health Project.

I am the eldest daughter of seven children. I had a Catholic upbringing. We went to church virtually every day. Secretively since my first year at university I had become sexually active with one partner. I always had to hide my contraceptive pills so that no one should know, especially my mother and father. There was no notion of privacy in the family with six other siblings. Some kid brother is always running through your drawer and there were no lockers at university, so it always was: what if I miss?

Then finally, I fell pregnant. I was 21 and had just graduated. I was a product of 1976. I was a young black kid and the world was at my feet. But I was pregnant. Who could I go to? I confided in an older friend, as telling my boy friend was not an option. She said "Why are you so stupid?"

We started knocking on the doors of doctors. The doctors said they couldn't help. No amount of tears or shouting helped. Then my best friend said her other best friend knew someone who had helped many others. She said I should tell my parents that I will stay out for a few days for civic action. Luckily in those days we could always use the excuse that you were picked up by the police!

My friend said they must get me to bleed and then it would be okay. They were pumping water and vinegar in me. My friend was also very Catholic. She said that if her husband came home I must get out. We started at ten in the morning. But they could not induce bleeding.

By the third day I was quite ill. My pelvis and uterus were badly battered. All my friends were trying to help me. Then we found a doctor who was struck off the roll because he had done this to people in the neighbourhood. He said he must first induce bleeding. I was very delirious at this stage. I don't know what the doctor did to me, but he got me to bleed. We went to the clinic, I had a short D&C, I went home. My parents could not understand why I was so sick. I told them that three years of varsity and political action had taken its toll.

Without my best friends I would have died. I wanted choice. I wanted to be different. When my friends fell pregnant their life was predetermined. I wanted choice, and the choice was for life and it was my choice and I made that choice.

## Questions for discussion

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1. Identify how this situation may impact on this woman's health.
2. Identify the root causes of this situation.
3. List each of the relevant actors and consider each of their responses to the situation.
4. Identify the gaps or inadequacies of the responses that a rights approach highlights.
5. Use the *Universal Declaration of Human Rights* to identify each of the rights implicated in the situation. For each right discuss how and in what ways it is relevant. Be sure to consider the three levels of government obligation (to respect, protect and fulfil) as discussed in Session 3.
6. Using this analysis, determine the essential actions that should be taken to ensure this situation does not happen again. Consider both short and long term approaches and pay particular attention to the respect, protect, fulfil concepts). Consider three types of action:
  - those that will impact on the underlying causes (conditions)
  - those that are specific to the occurrence of the violation and the harm done
  - those that are focused on the rights related consequences of the violation (the kinds of legal remedies that can be accessed, and so on).



## Handout

## 3

## A golden flower withering prematurely

This case study was used in the course run in Kunming, China by the Yunnan Reproductive Health Research Association (YRHRA), Kuming Medical College, in 1999.

Jinwan village is a rural village inhabited by the Lahu minority community. It is located more than 60km away from the nearest town. The nearest bus terminus is at the seat of the township government, 30km from Jinwan. On sunny days, tractors can make the travel from the township government to Jinwan, but in the rainy season this mountainous stretch can be traversed only on foot. There is only one rural doctor in Jinwan. In case of serious illness, the villagers have to travel more than 30km to the township hospital or to a further away county hospital or prefecture hospital for treatment.

Generation after generation of women in Jinwan have given birth at home. Local tradition considers that women's menstrual blood is unclean and will bring bad luck to men if they touch it. It is also believed that tractors or ox-carts cannot be used to carry pregnant women because their blood and even their breath will bring ill luck to the drivers. For this reason, pregnant women experiencing difficult labour have to be carried by their relatives the entire distance of 30km to the township hospital. There is a private clinic in Nanxi village, which is 15km from Jinwan. Hearing from word of mouth that the midwifery services provided in this clinic are both excellent and cheap, some women in difficult labour are now being taken there for delivery.

Jinhua (in Chinese, "Golden Flower"), is one of the most beautiful young women in Jinwan. She was married during the last spring festival. During this spring festival, on the anniversary of her marriage, she was already 9 months pregnant. People congratulated her and wished her a safe delivery and healthy baby. Jinhua has had no prenatal examination, nor any information or counselling since she became pregnant. The township hospital had sent her some materials publicizing new methods of delivery. But Jinhua has not received much education and could not understand what was in these materials.

One night, Jinhua felt that she was about to give birth. But the baby did not come out even eight hours after the membranes had ruptured. Her relatives were greatly alarmed and quickly brought her to the private clinic. Doctors in the clinic worked hard for 3 hours and eventually she delivered a baby boy who had already suffocated to death. Then Jinhua began to haemorrhage. Her relatives again carried her to the township hospital, and then to the county hospital. Unfortunately, Jinhua did not survive the ordeal. She passed away on arrival at the county hospital.

## Questions for discussion

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1. Identify the various causes of this situation.
2. List each of the relevant actors and consider each of their responses to the situation.
3. Identify the gaps or inadequacies of the responses that a rights approach highlights.
4. Use the *Universal Declaration of Human Rights* to identify each of the rights implicated in the situation. For each right discuss how and in what ways it is relevant. Be sure to consider the three levels of government obligation (to respect, protect and fulfil) as discussed in Session 3.
5. Using this analysis, determine the essential actions that should be taken to ensure this situation does not happen again. Consider both short and long term approaches and pay particular attention to the respect, protect, fulfil concepts). Consider three types of action:
  - those that will impact on the underlying causes (conditions)
  - those that are specific to the occurrence of the violation and the harm done
  - those that are focused on the rights related consequences of the violation (the kinds of legal remedies that can be accessed, and so on).

## SESSION

## 7

## Using international human rights to translate government commitments into action

### What participants should get out of the session

#### Participants will:

- learn approaches to applying reproductive and sexual rights to the work they are engaged in
- contextualize their work in relation to the range of actors involved in similar efforts.



**2 hours**

#### Materials

- Handout 1: “Cairo and Beijing in your country”
- Handout 2: “Actions that some multilateral agencies have taken to implement the Cairo and Beijing agreements”
- overhead: Handout 2
- overhead: “How does your work fit into the larger framework”, on p.199
- flip chart on board for writing on

#### Readings for the facilitator

1. Earth Summit Watch. *One year after Cairo: overview of country reports*. An overview of the country-by-country survey of ICPD implementation. Available online at: [www.earthsummit.watch.org/cairo1/](http://www.earthsummit.watch.org/cairo1/) (Date accessed: 2000).
2. United Nations Division for the Advancement of Women, United Nations Population Fund, United Nations High Commissioner for Human Rights. *Roundtable of human rights treaty bodies and specialized agencies on human rights approaches to women’s health, with a focus on sexual and reproductive health and rights*. New York, UNFPA, 1998.
3. United Nations Population Fund. *The state of world population 1997. The right to choose: reproductive rights and reproductive health*. New York, UNFPA, 1997:53–62 and 66.

## Essential readings for participants

Reading 2.

## How to run the session

There are two activities in this session. The first is work in small groups followed by a whole group report-back and discussion. The second is an individual activity to determine participants' personal priorities in implementing reproductive and sexual rights, followed by sharing in the whole group.



### Activity 1: Looking at Cairo and Beijing



#### Step 1: Cairo and Beijing in participants' own countries

Begin by telling participants that efforts to implement reproductive and sexual rights, and Cairo and Beijing more generally, are happening all at once at a variety of different levels around the world. Ensuring that reproductive and sexual rights can become a reality for women everywhere requires action from NGOs, governments, and the international system. In order to keep this work moving forward, it can be useful to see how our work fits into the larger picture of what various institutions, international and national, are doing.

Divide participants into four or five groups. Give them the following questions for discussion (Handout 1). Ask them to come back to the big group after 15 minutes.

- Has information about Cairo and Beijing and, more generally, about reproductive and sexual rights, been disseminated in your country? Who are the actors involved in this process? What kinds of information are being disseminated by each of them, to whom and how?
- Has the government or any other actor put into place an institution, mechanism or process to review if and how the provisions of Cairo and Beijing are being implemented?
- Have there been any changes in laws, policies, or resource allocation concerning reproductive and sexual health since Cairo and Beijing? Who has been involved in making this happen?



#### Step 2: Sharing information with the whole group

Participants come back to the whole group and each group takes three to five minutes to report back. Using a flip chart, group the answers they give according to the following categories. Bear in mind that there should be information on each of the categories of actors at each level.

Actors	Levels
● The United Nations	● International
● Other intergovernmental organizations	● Regional
● Governments	● National
● Non-governmental organizations	● Local
	● Community

Summarize the major points.

Participants are likely to have enough information about what these actors are doing within their countries, but they may be less aware of the details of the global activities which these actors are involved in. Distribute Handout 2.



Present Handout 2 as **overheads**.



## Activity 2: Participants' personal priorities



### Step 1: Participants reflect on their own work

Ask participants to take five to ten minutes to consider how the work they are doing fits into this larger framework by thinking through the following questions and noting down their answers.

Put up the questions below as an **overhead**.



#### How does your work fit into the larger framework?

- Which reproductive and sexual rights issue do you consider to be a priority in your own work?
- What is the current status of this issue in your country?
- What steps or actions do you think are needed to improve the status of this issue? This includes considering actors that need to be engaged, the materials and resources that will be needed, and the strategies that would need to be adopted.
- What problems do you anticipate will arise when you try to do this work?



## Step 2: Committing to action

Start a discussion in the whole group. Make the point that exactly what you do is not as important as the fact that you take concrete action. Reproductive and sexual rights, and Cairo and Beijing, are only as strong as people's willingness to use them. It is our own responsibility, no matter if we sit in a government or an NGO, to make these commitments real.

Go around the room and ask each person to commit aloud to one action they will take in the next year, no matter how small, to make reproductive and sexual rights a reality in the populations they work with. Make sure that each participant gets the chance to speak.

Write down each participants' commitments on a flip chart. Push participants to be specific, and to make the connection between the action they propose and the promotion of reproductive and/or sexual rights. For example, if a participant says that she or he will work more on Safe Motherhood, ask for details about the specific action or actions. Would it be new interventions? Advocacy? Research? Also ask participants what aspects of reproductive and sexual rights their action would promote.

Tell participants that, if they would like to, they can work with this same intervention in the application exercise at the end of the Policy Module.

Aim at no more than two to three minutes per participant, or a maximum of 50 minutes for all participants.

Pass on the flip charts containing participants' commitments to the facilitator of the Policy Module for follow-up work.

### Main points for closing this session

There are many actors/institutions around the world which are trying to promote reproductive and sexual health and rights.

Systematically considering how one's work fits into a bigger picture can be a useful tool for determining priorities and setting action steps for the future.

*Session developed by Sofia Gruskin*



Handout

## 1

## Cairo and Beijing in your country

*You have 20 minutes to discuss, as a group, the following questions. Appoint one person to note down key points emerging from the discussion and report back.*

- Has information about Cairo and Beijing and, more generally, about reproductive and sexual rights, been disseminated in your country? Who are the actors involved in this process? What kinds of information are being disseminated by each of them, to whom and in what ways?
- Has the government or any other actor put into place an institution, mechanism or process to review if and how the provisions of Cairo and Beijing are being implemented?
- Have there been any changes in laws, policies, or resource allocation concerning reproductive and sexual health since Cairo and Beijing? Who has been involved in making this happen?



Handout

## 2

## Actions that some multilateral agencies have taken to implement the Cairo and Beijing agreements

*To update and add to this information, refer to the websites of the various United Nations agencies including the World Health Organization, and the United Nations Population Fund.*

### The United Nations

The majority of current efforts within the United Nations to implement and to monitor what has happened since the Cairo and Beijing conferences involve supporting national implementation efforts and ensuring accountability for what is being done at the national governmental level.

The Commission on the Status of Women has been responsible for reviewing the implementation of Beijing.

The Commission on Population and Sustainable Development has been responsible for reviewing the implementation of Cairo.

The treaty monitoring bodies responsible for overseeing the government obligations under the human rights treaties have begun to think about issues related to reproductive and sexual health, such as maternal mortality or HIV/AIDS, in the way they interpret government obligations under their treaties.

### World Health Organization (WHO)

WHO is committed to implementing the agreements from Cairo and Beijing and those from their five-year reviews.

It addresses these key actions in many of its activities, including:

- collaborating with United Nations human rights treaty bodies to ensure attention to sexual and reproductive health issues in their monitoring of countries
- collaborating and assisting countries to respect, protect and fulfil reproductive rights, and to adopt a human rights framework in implementing their reproductive health programmes
- developing a practical tool for assessing gender considerations in reproductive health research
- developing a strategic approach to contraceptive introduction, involving participation of all key stakeholders
- supporting research on women-centred barrier contraceptive methods and on microbicides
- developing guidelines and norms for reproductive health interventions, including maternal and newborn health, preventing and managing sexually transmitted infections, eligibility criteria for contraceptive use, and the provision of safe abortion
- developing indicators for monitoring reproductive health programmes at country and district levels
- developing guidance for adolescent health programming and interventions.

### United Nations Population Fund (UNFPA)

Post-Cairo, UNFPA policy guidelines for gender, population and development were revised in 1998. The new policy, “Support for Mainstreaming Gender Issues in Population and Development Programmes”, has led to the following strategic and programmatic changes:

- redefining strategies and priorities to adopt two different but complementary approaches: mainstreaming the perspective of gender equity in the main programme areas on the one hand, and on the other supporting strategic projects for women
- work with human rights treaty bodies to incorporate reproductive rights issues in the reporting mechanisms of CEDAW (the Convention of the Elimination of All Forms of Discrimination against Women)
- attempts to implement gender equality and equity and the promotion of human rights in all its programme support to countries. Examples include support for formulating new family and marriage codes guaranteeing reproductive rights and gender equality in countries of Francophone Africa; and support for efforts in Latin America to incorporate sexual and reproductive rights as well as gender equity into the new Constitution in Ecuador and Venezuela.

## SESSION

## 8

## Module summary

## What participants should get out of the session

## Participants will:

By the end of this session, participants will have an overview of the tools and concepts introduced in the Rights Module. They will understand the links with the tools introduced in the Gender Module and in the Social Determinants Module.



15 mins

15 minutes

## How to run the session

This is an input session that pulls together all the tools and concepts introduced in the Rights Module. It also makes the links with tools and concepts introduced in the Gender and Social Determinant Modules.



## What to cover in your input

**Overhead** Include the main points from the Module brief and also the graphic representation of the module “Structure of the Rights Module”.

## Weaving in a gender perspective

Highlight how this module weaves a gender perspective into the application of human rights concepts. It builds on the social determinants analysis of health status and health service delivery, and focuses on how human rights and a human rights framework can be used to address these factors. This is most evident, for example, in Sessions 5 and 6.

## The last of the Foundation Modules

This marks the end of the Foundation Modules of this course, which are intended to develop a gender and rights perspective and provide the tools for analysing issues and problems using gender, social determinants and rights concepts. This means, for example, that for any intervention or policy we examine or plan, we would ask:

- Does this consider underlying causes/social determinants at all levels of the problem being addressed? Does it identify the rights implicated in each of these factors?
- Does it address gender issues? Does it attempt to transform gender power relations?
- Does it address the rights implicated? In what ways?