

Body as Space, Body as Site: Bodily Integrity and Women's Empowerment in India

KANCHAN MATHUR

The identification of women with their physical bodies is the root cause of their oppression in a patriarchal culture and society like India. Most often women are denied the rights to emotional, mental, psychological and physical spaces. The fact that the female body is constantly under pressure to conform and mould into prescribed social and cultural roles brings into question the spaces that need to be protected as well rights that need to be claimed so that women's bodily integrity is respected. This paper highlights the struggles and spaces that Indian women have negotiated in their quest for empowerment.

The female body is a contested terrain the world over. Constructed differently in different contexts, it remains a site where power is played out. Though the body is intensely "personal" in that it rests in individuals, its manifestation is shaped by the same variables that influence social relations, gender, age, class and ethnicity. This paper argues that the dichotomy between the woman's body and the mind is a synthetic one and socially constructed. Most often women's identification with their bodies and its physical manifestation results in suppression and denial of rights to emotional, mental, psychological and physical spaces. This demarcation into mutually exclusive categories of mind and body results in loss of "personhood", loss of control and autonomy over their bodies and violation of bodily integrity. Women live in constant threat of violence; are discriminated against and exploited, are denied the right to spatial mobility, right to make informed choices over their bodies and sexuality. Societal control over and regulation of these spaces violates bodily integrity rendering them powerless. Respect for bodily integrity is therefore a prerequisite for women's empowerment in any context.

This paper explores the connections between body and rights and the complex and complimentary relationship between bodily integrity and women's empowerment, specifically in the Indian context. The different sections of the paper focus on the outcomes of the movements for naming and claiming bodily integrity, especially vis-à-vis violence against women, reproductive rights and issues of sexuality. This paper analyses the key factors influencing and changing policy and its implementation and identifies areas that need to be further explored to enable women to empower themselves and sustain changes in gendered power relations.

1 Defining Bodily Integrity

Bodily integrity includes women's intrinsic right to have control and autonomy over their bodies. This includes the right to:

- A life free from fear of violence and living in safe environments. This includes women's right not to be subjected to physical, sexual, or emotional violence inside the home by intimate partners or outside by people including those acting on the part of the state.
- Spatial mobility and ability to make decisions regarding where they can go, who they go with, how they travel, and the time of the day or night they can travel.
- Make informed choices regarding sexual and reproductive health including choice in marriage – whether to marry, whom to

This paper was first presented at the regional scoping workshop on Pathways of Women's Empowerment, BRAC University, Bangladesh, August 19-22, 2006. I gratefully acknowledge the inputs of Sharada Jain in formulating the conceptual framework of this paper. I also wish to thank Varsha Kalla and Etee Purohit for their research support in preparing this paper.

Kanchan Mathur (kanchan@mail.tgs-solutions.com) is at the Institute of Development Studies, Jaipur.

marry and when (age) to marry, and to demand the provision of sexual and reproductive health services that are sensitive to their rights and needs.

- Sexual well-being and the right to a healthy and self-affirming sexuality free of violence, coercion, and disease. Pursuing a satisfying, safe and pleasurable sexual life.
- Education on bodily integrity and awareness about bodily integrity, which would not only address the dangers of violations of bodily integrity, but would allow them to care and take pride in their bodies “as women”.
- Expression of self-identity and behaviour as defined by women themselves. This would include an expression of their emotional, mental, spiritual, psychological and physical spaces and desires.

2 Social Construction of the Body

In the Indian context, the woman's body is a space where culturally coded and socially sanctioned norms of the desirable woman are inscribed. The socialisation of the girl child is a complex process, the main purpose of which is to inculcate in girls the appropriate codes of conduct including self-effacement and self-denial and to train them to see their life primarily in terms of service to others. The rules for the presentation of bodily self in everyday life are clearly defined and they are socialised into conformity from a very early age. The identification of women with their bodies thus becomes the root cause of their oppression in a patriarchal culture. A woman is identified primarily with her bodily functions, seen essentially as a vehicle for male sexual satisfaction and reproduction and its natural corollary, childbearing, rearing and nurturing. Her entire life, her roles, her position and status in society, are defined by this primary bodily function.

In a deeply ingrained system of patriarchy, a woman's identity and role continues to be defined through her (subordinated) relationship to men. In most Indian families, a daughter is viewed as a liability, and she is conditioned to believe that she is inferior and subordinate to men. Sons are idolised and celebrated. “May you be the mother of a hundred sons” is a common Hindu wedding blessing. The origin of the Indian idea of appropriate female behaviour can be traced to the rules laid down by Manu in 200 BC:

Pita rakshati kaumare, bharta rakshati youvane,
rakshanti sthavire putra, na stree swatantry amarhati

(In childhood a female must be subject to her father, in youth to her husband, when her lord is dead to her sons; a woman must never be independent) (Manusmriti IX: 3) [Shastri 2000].¹

Virginity and chastity are virtues, which are entrenched as part of the socialisation pattern of girls. The expectation of bravery or “macho” behaviour in men gets interpreted and accepted as the right to inflict violence on their part as opposed to acceptance of violence on the part of women who are expected to be not only chaste, but also obedient and “good”. The typical image of a “good woman” is still one who upholds the honour of the family, maintains the “culture of silence” prevailing in the private domain and is obedient and sacrificing.

The girl child, right from childhood, is made to follow certain norms of behaviour, for instance, how to speak, how to dress, for whom to dress up, how to sit and behave in the presence of males, her mobility is restricted to the extent that very often movement outside the home has to be with prior permission. As Visweswaran (1990) puts it a woman's modesty signifies the masculinity of her community. She becomes “the symbol of violence as the shame and subjection of her community is represented in her”. Ironically, the common denominator that cut across all communities and often classes remains female modesty.

The construct of the mini-woman begins early with household responsibilities. Early age at marriage is a norm² and in some rural areas, nearly half the girls between the age of 10 and 14 are married. Because there is pressure on women to prove their fertility by conceiving as soon as possible after marriage. Adolescent marriage is synonymous with adolescent childbearing: roughly 10-15 per cent of all births take place to women in their teens [Coonrod 1998].

Social norms and practices also define women's spaces vis-a-vis men, i.e., her identity is linked to her role as a mother, wife or daughter; they carry the burden of “honour” and “shame”.³ The expectation from her is a negation of herself as a woman and submerging her existence with the male. Women do not have the right to express their desires and discussions, especially pertaining to their bodies and sexuality are a taboo. As a corollary she has no right to exist after the death of the husband even if she is capable of supporting herself financially. Social values, hence, prescribe that women do not have the right to question or make independent choices, be it over their labour, body or sexuality. They are conditioned into believing that all that takes place within the four walls of the home is “personal” and hence not to be made “public”. They are also conditioned to believe that matters pertaining to the family if made public would bring “shame” and “dishonour” to the family.

Women also consciously, and unconsciously, discipline themselves to be the bearers of tradition, harmony and familial and social honour. The female body therefore, becomes the edifice on which gender inequality is built and legitimised. Hence, negating the self in the cause of the family/community becomes her prime concern/responsibility. Throughout her life cycle she is socialised into accepting her “lower” status. Even if she is subjected to extreme discrimination or physical violence she accepts it as her fate [Mathur 2004].

Hence, the woman's body is continuously made to fit and mould to societal expectations with a severe denial of rights, her bodily integrity constantly violated.

3 Naming and Claiming Rights

Over the last three decades or so the concerted efforts of the women's movement and several organisations at lobbying, political demonstration, and collective mobilisation have focused on bringing about change in women's lives. Women have acquired greater spaces with increased political participation, educational and economic access and gender just laws. Besides, with the recent opening up of spaces for talking of sexual and reproductive health, female desire or of alternative sexualities, today

visible shifts are also discernable with women naming and claiming rights to bodily integrity.

3.1 Action against Violence against Women

Violence against women has been and remains a key issue in the Indian women's movement. Throughout the 1980s, Indian society witnessed numerous struggles by women's organisations on issues of dowry deaths, rape, custodial rape, abduction of women, sati (the burning of a widow on the husband's funeral pyre), female infanticide and foeticide, sexual harassment of young girls and women in public places (eve teasing), branding of single women as witches, representation of women and their bodies in the media and trafficking in women and prostitution. It is important to note that there has been a legal reform by the government in response to each of these issues of violence against women during the past decade [Agnes 1996].

Nationwide Anti-Rape Movement: The women's movement in India during the mid-1970s and after came into being around the issue of rape [Datar 1988]. The focus was on the state as it was seen as the agent of this violence. In a number of rape cases, the protectors of "law and order", the police and other state repressive forces proved themselves to be notorious perpetrators of violence against women. Protests against rape have constituted the most public acknowledgement of violence against women. National awareness was heightened during the lengthy legal process in the course of which several of the popular myths and preconceptions about rape were made evident [Gandhi and Shah 1992: 36; Agnes 1992].

In the course of 1979-80, a widespread national level campaign on the Mathura case brought women's issues on to the public agenda. The acquittal of two policemen involved in the rape of a minor tribal girl by the Supreme Court highlighted several crucial aspects of women's operation, viz, the roles of class and caste in oppression of women and issues of accountability of public servants and the judiciary in achieving the constitutional guarantees. The agitation's sparked off by the Mathura case led to significant changes in the Evidence Act, the Criminal Procedure Code and the Indian Penal Code (IPC) including the introduction of a category of custodial rape [Agnihotri and Mazumdar 1995].⁴

Protest against Dowry Murders: In the wake of anti-rape mobilisation and demonstrations there emerged the question of familial atrocity of burning women for bringing in insufficient dowry. The Progressive Organisation of Women in Hyderabad made the first protests against dowry harassment, i.e., killing/burning of women because of inadequate dowry in 1975. Ever since, women's organisations have been demanding more stringent, deterrent measures to check crimes against women. In early 1982, 30 women's organisations in Delhi, under the name of Dahej Virodhi Chetna Manch (Anti-Dowry Awareness Raising Forum) jointly organised a protest march against dowry, and they were joined by several hundred ordinary women and men, including the "parents of dowry victims". They questioned police inaction and tardiness in investigation, highlighting government's lethargy towards this problem. They demanded ostracism or

bride-burners/killers and pleaded with legal pundits and legislators to suggest some system of summary trials for such crimes against women [Kelkar 1992: 86-87].

One year after the agitation began, the government started to initiate legislations against dowry murders. The Dowry Prohibition Act of 1961 – which had stipulated, "giving and taking dowry is an offence" – was amended twice during the anti-dowry campaign, in 1984 and again in 1986, to make it more stringent. Through the amendments of 1984 and 1986, the scope of "dowry" was widened to include anything given in connection with marriage either before, at the time of or after the event (customary and traditional gifts were excluded). The offence was made cognisable and non-bailable and the prescribed minimum punishment was five years of imprisonment and a fine not less than Rs 15,000 or the equivalent of the value of such dowry, whichever was more. An amendment brought in 1986 makes the husband and in-laws punishable, if a woman commits suicide within seven years after marriage and it has been proved that she has been subjected to cruelty (Section 498A). A new criminal offence of "dowry death" (Section 304B) has been incorporated in the IPC. However, despite these legal reforms, the problem persists.

Female Infanticide and Foeticide: India has a tradition of killing female babies (custom of 'Dudhapiti') by putting opium on the mother's nipple and feeding the baby, by suffocating her in a rug by placing the afterbirth over the infant's face, by feeding them with poisonous olender berries (kellar community in Tamil Nadu) or simply by ill-treating daughters.

However, declining sex ratio as evident in the census of India has taken a new turn with widespread use of new reproductive technologies (NRTs) in India. NRTs are based on the principle of selection of the desirable and rejection of the unwanted. Female infanticide was practised among selected communities, while the abuse of NRTs has become a generalised phenomenon encompassing all communities irrespective of caste, class, religious educational and ethical backgrounds. Consumerist culture-oriented economic development, commercialisation of medical profession and sexist bias in our society, combined together have created a sad scenario of "missing girls".

The campaign against sex-selective abortions has been valiantly carried on in India for the past two decades, mainly due to the efforts of women's groups and sensitive health professionals.

The Anti-Sati Movement: In September 1987, when a young, educated widow was forced to immolate herself on her husband's funeral pyre, the incident shocked the public at large as also the women's groups in Rajasthan where the incident occurred and throughout the country. It brought to the fore that the deep-seated belief system had been left untouched by the so-called education system. The women's groups organised rallies, approached the court, sent telegrams and petitions, and succeeded in exposing state inaction on the issue. They tried their best to bring a stay-order on the "widow-burning" ritual but in vain. Police and political parties, the regional press as well as powerful local vested interests succeeded in virtually paralysing the state machinery. For the first time in the history of India, feminists

declared they would not stand by while their sisters were murdered in the name of tradition. Ultimately, a central legislation – the Commission of Sati (Prevention) Act, 1987 (Act 4 of 1988) – providing for stringent punishment including death sentence for abetment of sati, was passed by the Parliament. However, the political will to enforce the existing law has been conspicuously absent. Most of all, the manner in which law is viewed and enacted demonstrates that the state's perspective is not even gender neutral. It is clearly biased and tilted in favour of patriarchy.

Vishakha Judgment, 1997: In September 1992, when a grass-root worker of the Women's Development Programme⁵ (WDP) was gang raped, the Supreme Court of India recognised sexual harassment at the workplace as not only personal injury to the affected woman, but also a violation of fundamental rights. It lay down guidelines of the landmark Vishakha judgment of August 1997. The judgment vindicated the struggles of women's organisations all over the country. For long labelled "eve-teasing" and "light flirtation", this intrusive and humiliating behaviour, which can leave a deep impact on the psyche, began to be taken seriously as a form of violence against women. The Supreme Court guidelines⁶ make employers and institutions responsible for implementing both preventive and remedial measures to make the workplace safe for women. Yet, it is this very provision that has proved to be a stumbling block in implementing the guidelines.

Studies undertaken by women's groups in different parts of the country have come up with the same findings: not many institutions have set up mechanisms like complaint committees to tackle sexual harassment. And where the committees do exist, they are ineffective with no real powers. Most women therefore, continue to suffer in silence – either enduring the harassment, or quitting their jobs when the going gets too rough. In extreme cases, some even end their lives. In June 2000, it took the suicide of Sangeeta Sharma, an advocate in the Andhra Pradesh High Court to highlight the fact that women lawyers, ironically enough, have no recourse to the law prohibiting sexual harassment at the workplace. Unwilling to publicly reveal the names of her harassers because she feared harm for herself and her child, Sharma's suicide note contained allegations of sexual harassment by fellow lawyers and senior advocates. It is also worth-mentioning that the Supreme Court of India, the guardian of the law of the land, does not have a policy on sexual harassment, or a committee to deal with complaints.

Though some of the government departments across sectors have set up sexual harassment committees their effectiveness needs to be evaluated. On the other hand, where the private sector is concerned a study in August 2001 by Sanhita, a Kolkata-based women's group, found that, an overwhelming 95 per cent of the respondents felt the probability of women facing sexual harassment in the workplace is very real. In the private sector, 68 per cent of the incidents of sexual harassment were committed by the boss, who wields unbridled power and controls privileges and rewards, unlike in the public sector [Murthy 2002].

Domestic Violence Bill: In August 24, 2005, the Lok Sabha passed the Protection of Women from Domestic Violence Bill 2005 to protect women from domestic, physical, sexual, verbal, emotional

or economic violence. The bill is the result of a decade-long campaign by women's groups, social and legal bodies and non-governmental organisations (NGOs) for a civil law against domestic violence [Sarkar 2005]. The bill was subsequently passed into law.

The Protection of Women against Domestic Violence (PWDV), Act was initiated by the Lawyers' Collective Women's Rights Initiative (LCWRI), and drew heavily on the UN Framework for Model Legislation on Domestic Violence. It was a large participatory process, involving wide consultations across the country, and active roles by the ministry of human resource development and department of women and child development (DWCDD), the National Commission for Women, and the parliamentary selection committee that opened the draft bill to public participation. Protests by women's groups to the NDA Bill 2002 and the national advocacy campaign initiated by Action India in 2003-04-05 across eight states collected 2.5 lakh signatures and helped ensure the act's passage.

In a historical context, the passing of the PWDV Act 2005 was a revolutionary legislation giving women a civil law to protect against domestic violence and ensure the right to residence in her home. It covered four areas: definition of domestic violence, the definition of domestic relationships, the right to residence and the right to obtain protection orders. It includes a provision for "protection officers" and for "counsellors", and suggests creating guidelines for service providers and magistrates to deal with domestic violence cases.

At the National Women's Conference in February 2006, representatives from 23 states demanded effective implementation and enforcement of the PWDV Act, 2005. This resulted in the formation of a secretariat in Delhi to work in cooperation with state networks and consolidate the pressure building up from the ground to ensure that all states fulfil their commitments to bringing the domestic violence law to the ground (Gender Solutions Exchange Discussions 2007).

Another area of concern for both the women's movement and civil society has been that of women's reproductive health rights and issues.

3.2 Care of the Body

Women's health in India is inextricably linked to their lower status. They are expected to eat last, leave the best food for the men of the family and to ignore their own illnesses, while managing the entire household. This often results in malnutrition, and is one of the main reasons behind the high rate of morbidity and mortality of women (HDR South Asia 2000). The intra household distribution of food continues to reflect the gender biases of society. Due to the household gender hierarchy and social norms underlying intra household resource allocation, women's well-being, including health and nutrition not only becomes secondary to the survival of the household, but also to the well-being of male members. Empirical studies from India suggest that under resource constraints households are likely to exhibit discriminatory practices in the allocation of resources favouring male members at the expense of female members [Behrman 1988; Browning and Subramaniam 1994].

Discrimination against girls/women begins before birth and continues till death. According to the 2001 Census the all India sex ratio increased from 927 in 1991 to 933 in 2001. However, there is a sharp decline in the juvenile sex ratio⁷ from 945 in 1991 and to 927 in 2001, with Haryana, Punjab, Maharashtra and Gujarat showing the lowest juvenile sex ratio in India [Census of India 2001]. The practices of female infanticide, female foeticide and strong son preference in most communities are factors contributing to this imbalance, which is also indicative of the low value and secondary status of the girl child. Recent modern technologies like amniocentesis are used for sex selective abortions and have exacerbated discrimination against the girl child. However, adult sex ratios are showing an improvement because of higher and increasing life expectancy at birth for women.⁸

Oppression of girls tends to increase during adolescence – an important phase in her life cycle. The onset of puberty and the changes that start in a child during puberty involve sex organs and sexual feelings; the child is not prepared by society to face them. The anxiety around pubertal changes and issues around it are often left unaddressed and can result in poor reproductive health. It affects the personality and relationships of the individual long into adulthood.

Girls are given very little choice regarding when to marry or whom to marry. With little or no initiation into sexual intercourse many of them end up with serious reproductive tract problems. Due to the expectation of male progeny not long after marriage, girls who are hardly out of childhood themselves are forced into early pregnancy. The socialisation pattern is such that gender disparities in breast feeding patterns of baby boys by the mothers themselves are also evident in numerous studies and reflect the deep-rooted gender bias [Das Gupta 1987; Khan et al 1983]. Moreover, unequal sharing of household labour during pregnancy, soon after childbirth, during child caring and rearing, overburdens women.

The inter-generational transmission of ill-health hence starts with the nutrition of the mother because the child of an inadequately nourished mother is likely to grow slower than as that of a well-nourished mother. Babies with a low birth-weight are more likely to die or be stunted and underweight in early life than those with a greater birth-weight. This reduces their ability to fight disease and increases their chances of ill-health or death, both during childhood and in later life [ACC/SCN, cited in Harper et al 2003]. Kabeer (1992) similarly argues that inter-generational transmission of poverty occurs through the under-nourishment and overwork of pregnant women. In India, 56.2 per cent of the women are anaemic [NFHS III 2005-06]. The cycle of high fertility and a high proportion of children who are chronically energy-deficient, poor immunisation coverage leaves mothers prone to health risks. Weak mothers giving birth to weak children without adequate nutrition increases the possibility of weak adolescent girls who again get married early and pushes them further into inter-generational cycles of poverty and ill-health.

Reproductive health issues of girls/women in the pre-puberty stage or related to menstruation or other health problems are seldom discussed. Issues related to older women including menopause are largely ignored. Physical health and mental health are often interconnected and stress and depression affect women's

reproductive cycle [Chatterjee and Walia 1998]. However, it is not uncommon for serious conditions to be described as "psychosomatic", particularly when the affected person is a woman. While such concerns are absent in policy discourse and reproductive health programmes, often women themselves ignore these as unimportant as they do not have time to attend to them. Women also tend to ignore chronic conditions like mental stress, reproductive problems, weakness, aches and pains. In such a scenario the notion "caring" for their body is alien to most women.

The stigma around the body and reproductive health issues within the family and community prevents women from accessing information related to their own bodies. While women display disturbingly low levels of awareness about health (including antenatal care, contraception, immunisation and nutrition during pregnancy), the health delivery system continues to be insensitive in its response to poor women's needs and to provide outreach, especially in remote and distant areas. Hence, though there are caste/class differentials in access, a large majority of women continue to have poor access to healthcare facilities. Women's low self-esteem also impacts on their reproductive choices and decision-making ability.

National Health Policy

The National Health Policy (1983) did not give separate identity to health issues relating to women and formulate strategies and approach to address them. The reference to women's health became an incidental issue. The population policy with the initiation of the family planning programme from 1952 focused upon fertility control of women and ignored other health needs of women [VHAI/WHO 2000]. Following the Cairo and Beijing conferences, India initiated changes in its own approach to the family welfare programme in a phased manner by adopting a target free approach in April 1996, the reproductive and child health programme (October 1997) and the national population policy (March 2000). However, the responsibility of contraception continues to fall on women with consequential side effects on their health and the role of men in family planning being overlooked. Of the 30,167 sterilisation cases reported, 95 per cent were female sterilisations [NFHS II 2000]. Most long-acting contraceptives have been experimented on women's bodies with negative side effects.

A loose network of groups (including women, health and civil rights groups) has come together in different campaigns against population control policies and new contraceptive technologies and for reproductive rights [Vishwanath 2001].

Injectibles: Women's groups have carried out campaigns protesting long-acting contraceptives on the grounds that they have been inadequately tested, have negative side effects and that the country lacks the infrastructure to provide sufficient follow-up.

A campaign against long-acting hormonal contraceptives was launched by women's groups and a small sympathetic forum of concerned doctors in the country. In December 1984, there was a protest demonstration against a meeting of the family planning association of India with representatives of the government and pharmaceutical companies. The group demanded ban on all long-acting contraceptives and withdrawal of approval for

NET-EN; to make public all studies in India on Depo Provera and NET-EN immediately; to stop experimenting with hazardous drugs and contraceptives on third world women and to institute a public enquiry on the controversial injectable and implanted contraceptives (genderwaar.gen.in/IN/campaigns).

In 1985, a court case in Mumbai filed by the government, in which Women's Centre and Medico Friends Circle (MFC) were interveners, stalled the move by a private practitioner to import Depo Provera. In 1986, public attention was focused on the unethical trials of Net En on poor rural women in Andhra Pradesh [Bal et al 1999]. Stree Shakti Sanghatana of Hyderabad, along with Saheli (a woman's group in New Delhi), filed for a stay order on the trials which were being carried out without the informed consent of the subjects. In December 1998, a meeting on 'Improving Contraceptive Choices in the National Family Welfare Programme' was hosted by the Institute for Research in Reproduction, Mumbai. The agenda was to seek approval to introduce injectable hormonal contraceptives like Net En and Depo Provera in the national family welfare programme. Despite protests from representatives from women's groups and health activists, the outcome of the meeting was to recommend the introduction of injectables, albeit in a phased manner (genderwaar.gen.in/IN/campaigns).

Quinacrine Sterilisation: Health and women's rights networks have used various opportunities to raise awareness about the campaign against quinacrine sterilisation (QS)⁹ in India. In 1997, women's health advocates around the world were alarmed to discover that large-scale clinical trials had been conducted with QS on over 1,00,000 women in 25 countries. At least one-fifth of the QS cases in the world were done in 26 centres in India before the ban. In most countries like India, the trials were covert.

This led to intense campaigns by women's groups in several parts of the country. Protest demonstrations were held in front of clinics of doctors practising QS in the cities of Delhi and Kolkata. Saheli, a prominent women's rights group, published an in-depth study that countered the arguments put forward by QS advocates and media reports and questioned the government's failures in regulating and monitoring illegal drug trials. It finally led to the Supreme Court to ban QS in 1998. A study conducted in 2003, however, found that five years after the ban, medical practitioners in India were still using quinacrine to sterilise women [Dasgupta 2005].

Sex-Selective Abortions: The campaign against sex-selective abortions consolidated itself in Mumbai around 1981-82 in the form of two fora – the Forum against Sex-Determination and Sex-Preselection Techniques (FASDSP) and later on, the Doctors against Sex-Determination and Sex-Preselection Techniques (DASDSP). Public awareness drives, identifying doctors who performed these tests and talking to them or exposing them as well as alerting women's groups all over the country about the issue was worked upon [Gupte 2003].

Due to the growing pressure of the campaign in Mumbai, the state of Maharashtra decided to ban the tests on January 1, 1987. The centre banned all sex-determination tests in 1994, under the Pre-Natal sex-Determination Technologies (PNDT) Act (*ibid*).

In fact, the law was observed more in the breach. The act did not criminalise the doctor under the IPC, but let the Medical Council of India deal with violations of the act. Until 1999, not a single doctor had been booked or tried under the PNDT Act of 1994. Sex ratio in many parts of the country continued to decline. Then in 2000, the Indian Medical Association got involved in the campaign and sent out letters to all its branches asking that they prevent their members from breaking the law (Infochangeindia.org). It was only after a Supreme Court order in May 2001 that the act was actually implemented [GOI 1994].

As seen above some of the issues related to women's bodies and sexuality have been addressed by networks working on reproductive health and rights, yet many issues remain unaddressed and need further exploration. The section below attempts to elaborate on these.

3.3 Sexuality

Apart from the repeatedly acknowledged and cited fact that research on sexuality is so minimal here because sex is a taboo subject in Indian society, and hence, difficult to study. It is also true that sexuality is often considered a frivolous diversion from the more critical problems of poverty, war or drought. Conceptualisation of sexuality as an essential aspect of one's identity and selfhood, shaped by social and cultural contexts, has begun to emerge in research studies only recently [Bharat 2003]. It has also been argued that, "It was only with the growing feminist concern with the rights of women to their lives and bodies, that sexuality has gained a more enduring prominence" [John and Nair 1999].

However, ideologies about sexuality continue to be deeply entrenched within structures of patriarchy and the state also acknowledges a limited and narrow aspect of sexuality. Although pleasure, comfort and intimacy find expression through sexuality, social norms within the Indian context allow for sexual expression only between men and women and that too within the boundaries of marriage. Sex is seen primarily as an instrument for reproduction negating all aspects of pleasure and desire intrinsic to it. If sexual needs are at all acknowledged beyond procreation, it is only for men.

Women are denied rights over their own body and sexuality. They do not have control and autonomy over their sexuality and cannot decide freely on matters related to their sexuality including sexual and reproductive health, free of coercion, discrimination and violence [Sheth 1992]. Many a times women are actively prevented from acquiring sexual agency, while their bodies continue to be considered the property of their men and their communities [Ray 2005].

The problem is even more severe when it comes to the question of alternate sexuality/lesbian gay transgender bisexual (LGBT) identities, which are denied legitimacy, considered undesirable, unnatural and deviant. As recent works point out, the fact still remains that those persons, whose sexual behaviour does not conform to a society's norms, face penalties ranging from discrimination to violence. The decisions of legal systems, the police, employers and healthcare services are frequently influenced by an individual's gender, sexual practice and identity, especially in the context of heterosexual marriage being the formal and approved frame of all sexual behaviour. Those who do

not conform are not to be allowed to freely associate with others, to work, to live healthy lives, or to experience sexual pleasure [Misra and Chandiramani 2005:13].

It is not surprising therefore that non-normative gender/sexual expressions (e.g., same sex sexual partners) are largely invisible, and the issues related to these expressions are declared unimportant even in the face of severe and wide-ranging human rights violations [Sharma and Nath 2005]. Those who recognise themselves as outside the heterosexual "norm" experience constant pressure of hiding the truth about themselves. There has been reporting of lesbian couples committing suicide since their relationships are not accepted in their societies and by their families. Lesbian suicides are a result of society's attempt to restrict women's choices and control their lives and sexuality (ibid).

Besides the law also defines "normalcy" of sexual behaviour with heterosexuality as the defining factor. Section 377, IPC, 1871 states that:

Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with (imprisonment of life), or with imprisonment of either description for a term which may extend to 10 years and shall be liable to fine.

While the actual law on homosexuality is ambiguous, it is used to penalise male homosexuality. No distinction is made between homosexual rape and consensual homosexual sexual activity under this act [Gongoli 1998].

Organisations working in the development sector and movements struggling for human rights in India have largely failed to address sexuality issues. Support groups tend to be specific to particular identities (e.g., lesbians) or amongst people who engage in same sexual behaviour without ascribing to an identity (men who have sex with men), limited to a few metropolitan areas and serve mostly middle and upper middle class individuals. The other category of work related to same sex sexualities is that of the explicitly political activists groups. This includes groups such as Lesbians and Bisexuals in Action (LABIA) in Mumbai, PRISM in New Delhi and other groups whose political activism combines with their role as resource organisations such as Sangama in Bangalore and Humjinsi and Alternative Law Forum [Sharma and Nath 2005]. On the other hand, Sex Workers Forum Kerala is struggling to give space and voice to the hitherto sexually marginalised communities in Kerala. In Lucknow, an NGO named Bharosa Trust is working on issues of sexual health.

Bodily integrity includes the process of expanding the real freedoms that women enjoy, and the freedom to express one's sexuality and sexual orientation or gender identity is a development issue as important as any other.

4 Influencing and Changing Policy

A striking feature in the Indian context has been the symbiotic yet conflicting relationship that has developed over the years between the government, people's movements, NGOs and women's movement. The state policies and programmes have been shaped and influenced by this relationship. The key turning point in the 1970s was the Committee on the Status of Women in India (CSWI) report 'Towards Equality' which was the initial step in the engagement of the women's movement around issues of women's empowerment with the state.

The 1980s and early 1990s saw substantial progress in the women's movement. The changed political scenario and the agency of key people within and outside government ensured that women's groups and activists played an important role in the formulation of the new education policy, the national perspective plan for women (1988-2000) and the setting up of various national commissions including the National Commission for Women (NCW) (1992).¹⁰ The pioneering work of Self-Employed Women's Association (SEWA) in organising women in the unorganised sector contributed to the setting up of a national commission for self-employed women that made wide-ranging recommendations to ensure the security and rights of women in the informal sector, a sector that is growing by the day [Jandhyala 2001]. The commission highlighted the problems faced by self-employed women in its report *Shramshakti*, in 1998. However, the government was not very enthusiastic about implementing the recommendations contained in the report and SEWA lobbied for it the respective states by holding several conferences. SEWA's efforts bore fruit when it struggled hard to implement minimum wages for garment stitchers and influenced the government to supply goods by the women's groups to various government institutions, such as jails, hospitals and schools. SEWA lobbied the government of Gujarat for a maternity scheme for landless agricultural labourers. As a result the government through the labour ministry started implementing the maternity protection scheme in 1987 [Sooryamoorthy and Gangrade 2006].

The women's development programme (WDP) and Mahila Samakhya (MS) are examples of innovative programmes designed as fallout of the above policies. The involvement of women's groups in the design of these programmes was a positive step.

The WDP (1984) was one of the first initiatives for women's development and empowerment in India. The project attempted to reach rural women through eliciting partnership between the state government, NGOs and academics. It registered a clear recognition that a fresh approach to women's development was needed. The focus was on enabling rural women to address issues related to education, health, environment, wage-employment, violence against women, empowerment of women and girls. A new understanding on issues of violence and health emerged through the project. Health issues emerged during the various meetings at the village and block level when women began demanding information on issues that affected their daily lives. These included problems like infertility, family planning operations, government health-delivery services, methods of abortion and contraception. Hence, issues of violence related to women's health and body became a major area of concern [IDSJ 1988]. The Mahila Samakhya programme, of the government of India in 1989 was initiated to translate the goals of national policy on education into a concrete programme for the education and empowerment of women in rural areas, particularly belonging to socially and economically marginalised groups. The programme recognises the centrality of education in empowering women to achieve equality and endeavours to create an environment for women to learn at their own pace, set their own priorities and seek knowledge and information to make informed choices [Mahila Samakhya Uttar Pradesh, Annual Report, 1992-93; GOI 2002].

Both WDP and MS programme are government programmes. Both these initiatives have given ample leaning on possibilities

and frustration of working directly with the government. While WDP has become "spiritless" due to lack of political will on the part of the state government, the implications of the recent linkage of MS with the Sarva Shiksha Abhiyan needs to be further assessed.

The women's movement also gave rise to the anti-alcohol agitation in various parts of the country in the 1970s and 1980s. Various women's groups in Himachal Pradesh, Uttaranchal, Tehri Garhwal and Pithoragarh had waged a war against the liquor trade and alcohol abuse. The women's experience of collective action has led to a reshaping of power relations in the family and in the community with women acquiring new decision-making powers to protest against social evils and, in some cases, even putting an end to oppression.

One major strategy of women's organisations also has been to demand changes in police structures and practices. These demands have resulted in innovations such as: special cells to address crimes against women within municipal police stations in various cities; training on violence against women for the police and more recently, a shift towards composite policing (e.g., in Maharashtra), where training and equal opportunities policies are being integrated [Chakravorty 1998: 431-38].

The GOI has also made several efforts to mainstream gender in public policy. In 1993, the Gender Planning Training Project (GPTP) was initiated as a joint collaboration between the government of India and the British Overseas Development Agency with the aim of developing a training resource capacity by drawing on trainers and potential trainers from diverse agencies: government training institutions and departments, academic institutions and NGOs. In terms of its approach, strategy and content this project constituted a landmark of sorts in the entire experience of gender training in India. This project spanned a period of three years from 1993-96. It attempted to ensure that gender training was not used just to sensitise people, but to develop an integrated gender focus on both the personal as well as professional fronts for individuals from different agencies [Mathur and Rajagopal 2006].

Other enabling structures include Women's Development Corporations in about 18 states to channel financial assistance to women's economic enterprise. The Rashtriya Mahila Kosh was established under the social safety net to reach microcredit to poor women through self-help groups (SHGs) in 1993. The nationalised banks have given a special recognition to women SHGs for special finance.

Advocacy efforts by several women's groups led to reservation for women in panchayats bodies through the 73rd amendment and the Policy for the Empowerment of Women was finally released in March 2001. The Ninth Five-Year Plan (1997-2002), while reaffirming the earlier commitment adopted a women component plan as one of the main strategies and directed both the central and the state governments to ensure "not less than 30 per cent of the funds/benefits are earmarked in all the women's related sectors". The Tenth Plan emphasised the complementary roles of the women's component plan and gender budgeting to ensure that women receive their rightful share in development. For the first time, gender analysis of the union budget was carried out in 2001-02. A need was realised to analyse state budgets with a gender perspective since the states and union territories account

for the bulk of the expenditure in the social sectors which impacts on the welfare, development and empowerment of women.

Legal Rights Reforms and Their Implementation: As elaborated earlier, during the last 30 years and more of the women's movement the government has amended several laws that affect women, including laws related to dowry, and rape. The laws related to cruelty, maintenance, prostitution and obscenity have also been amended. India has also ratified international conventions such as the Convention on the Elimination of Discrimination against Women (CEDAW). It has set up family courts in some states and the judiciary has issued a series of progressive judgments in favour of women including the implementation of the PWDV Act 2005.

However, though the Hindu law now gives women equal rights in ancestral property, the government has been singularly reluctant to address the issues of minority women's rights. The constitutional stipulation to chart a uniform civil code has been unsuccessful so far because, by and large, the effort has been to impose Hindu law in the name of a uniform code and to ignore even the positive aspects of personal laws of other communities.

Besides, significant loopholes remain both with regard to the law and its implementation. Various aspects of policing have come under severe criticism from the Indian women's movement in recent years. One of the biggest problems has been that women's complaints of rape, molestation or sexual harassment are routinely disbelieved. Refusal to file complaints has been documented as a serious problem faced by victim-survivors. It is thus necessary to look at the police as interpreters, who architect meaning whilst reading what women define as crimes into legal definitions of crime. The decline in reported crime as the 1991-95 statistics show in the case of sexual harassment is not necessarily an indication of good policing or reduction in its occurrence. Equally, an increase does not tell us whether there is a rise in crime or a rise in reporting as the molestation statistics indicate [Baxi 2001].

5 Drivers of Change

In reviewing the major historical trends with regard to bodily integrity and women's empowerment in the Indian context over the past three decades it is evident that many issues have opened up. However, the above trends have not happened automatically. Several anticipated and some unanticipated forces have driven these changes, including in many cases the action of women themselves. Indian women have acquired greater space in political, economic and educational spheres. Certain anticipated and unanticipated drivers of change and enabling factors have emerged including public policy, NGO development interventions, women's education and paid work, legal reforms, and movements and struggles

Women's Movement and Women Themselves: The single most important contributing factor in this process of change has been the vibrant Indian women's movement, which has spread to various parts of the country. Although it is at times alleged that activists within the movement are urban, western and middle class and the movement has little to do with the lives of thousands of poor, rural, underprivileged women all over India, it is not they who make up the backbone of the movement, or of the many,

different campaigns that are generally seen as comprising the movement. The collective action of women in the anti-alcohol agitation in Andhra Pradesh and several similar campaigns in other parts of the country were started and sustained by poor, low caste, often working class women. Similarly, it is rural women who have taken a lead to protect the environment. From their origins as a spontaneous protest against logging abuses in Uttar Pradesh in the Himalayas, thousands of supporters of the Chipko movement, mainly village level women, have won bans on clear felling in a number of regions and influenced the natural resource policy in India. There are numerous such examples.

NGO Interventions: While the key to the success of several programmes in the Indian context is the NGO-GO collaboration. However, NGOs have also come together and put up a strong resistance to government policies or demanded implementation of policies to which the state is paying lip service. For instance, they have come together in different campaigns against population control policies and new contraceptive technologies and for reproductive rights. In a recent example, Sahara Samay tv a news channel in a series of sting operations showed doctors from Rajasthan, Gujarat, Madhya Pradesh and Uttar Pradesh readily agreeing to do foetal sex detection and perform sex selective termination of pregnancy. In most of the incidents, the doctors had also violated the MTP Act by agreeing to abort fetuses beyond the stipulated time period. The government of Rajasthan suspended some of the erring government doctors and sealed a few private clinics and nursing homes. However, no prosecution activities have so far been initiated by filing cases against them in the court of law under PC and PNPT Act and unless this is done no actual punishment would be possible. The women, health and human rights groups are campaigning against the state inaction and have organised many agitations.

Public Policy and Innovative Programmes: The agency of key people within and outside government has ensured that women's groups and activists played an important role in the formulation of several public policies. The new education policy, the national perspective plan for women (1988-2000), the setting up of various national commissions including the national commission for women (1992) and the national empowerment policy 2001 are a few examples. These policies have resulted in women/girls increased enrolment in schools, greater access to economic resources and microcredit, improved healthcare, gender just laws and entry into public spheres.

Perhaps, the most significant development for women in the last few decades has been the introduction of 33 per cent reservation for women in local panchayats (village level structures). In the early days, when this move was introduced, there was considerable scepticism. Women's ability to cope with leadership roles was questioned. Many negative statements were made regarding elected women in panchayati raj institutions (PRIs) and urban local bodies but have proved to be simplistic, even false, in a majority of cases. Though some of the problems still remain, to a greater or lesser degree, what is also true is that more and more women have shown that once they have power, they are able to use it, to the benefit of society in general and women in particular.

Challenges: Many issues concerning women's rights to bodily integrity remain despite the above policy changes, programmatic interventions and legal reforms. Though change is visible in many quarters, there is still a long way to go for women's equality and empowerment to become a reality. Mindsets of the large majority of people including the educated middle class as well as the bureaucracy let alone the leaders of different faiths and religions in the country still need to undergo a change for attitudinal and behavioural change to become evident. Bridging the gap between policy and implementation would be an essential first step towards addressing these issues.

For a country of India's magnitude change in gender power relations will not come easy. It is evident that for every step the movement takes forward, there will be a possible backlash, a possible regression. The Indian woman today is in a state of flux. There have been achievements, but also a lot of disillusionment with the state. While the 73rd and 74th constitutional amendment has facilitated the entry of a large number of women into positions of local governance and urban bodies, the proportion of seats held by women in Parliament reflects a gender bias and continued resistance to entry of women at higher levels of politics.

Apart from the heterogeneity of women themselves (rural, urban, class, age), the response of the hegemonic masculinity of the state and society to changes has resulted in an era of contradictions. Thus while there is persistence of early marriage and early childbirth women are also emerging as breadwinners and controlling income; women are increasingly mobile and more visible in the public arenas; there is a rising demand for working/income earning women as wives, but escalating violence against women, increased agency and control has brought with it greater responsibility for protecting and caring for their body, but without the necessary resources or social support. It is these contradictions and contrary notions in the identity, role, attitude and behaviour that are posing real challenges to women's bodily integrity.

6 Conclusions

India has seen a significant transformation in the perception and images of women's body, in the notions of control over women's body, in the ways women care for their body, in the level of bodily insecurity and vulnerability faced by women, and in the struggles and movements around women's bodily integrity. The impact of these changes on women and on the embodiment of women has neither been fully satisfactory nor homogeneous.

Women's bodies have been the site of intense debate in the Indian context. The dichotomy between their mental and physical selves and non-recognition of women's emotional, mental, psychological, spiritual and physical expressions persists irrespective of regional locations and has led to a restriction of spaces and constant violation of their bodies and bodily integrity.

Recognising the integration between women's minds and physical bodies, there is a need to challenge societal construction of women's bodies, viz, women's bodies are for procreation, women's bodies are for men's enjoyment, and thus sexual agency on the part of women threatens the social order, and women's bodies are for repositories of men's honour, linked to the honour/shame of the community and society.

Women's bodies thus still remain a contested arena where new and changing power relationships are played out. How can women consolidate the gains of movements and struggles and build alliances with men and other groups in society? What is needed to bring about structural transformation in the society and economy so that women are not devalued or commodified in new ways? What is needed to alter the male psyche and make new ways of doing and

thinking more acceptable? It is critical to delve into some of these areas.

Alongside there is a need to redraw the map of women's bodies and create spaces for women to enable them to experience a new sense of the self. Respect for bodily integrity would thus allow women to encounter their body and manipulation of it in terms, which are seen by them as essential for both their physical and emotional well-being.

NOTES

- 1 Similar claims on the women's body are also laid down by Christian and Islamic religious texts.
- 2 A 1976 amendment to the Child Marriage Restraint Act raised the minimum legal age for marriage from 15 to 18 for young women and from 18 to 21 for young men.
- 3 Upper caste women have a greater burden of honour and shame.
- 4 The government introduced a bill to amend the existing law on rape in 1983. The bill was largely devoted to defining the category of custodial rape, and treating it as a more heinous crime than other forms of rape. The category itself was now fairly widely defined, as consisting of state functionaries, employers, and immediate superiors: it also added the categories of mass and gang rape to that of individual rape. The bill further lay down that for cases of custodial rape there was to be a mandatory punishment of 10 years imprisonment, trial would be in camera, and the onus of proof would be shifted onto the accused. The bill thus codified distinction between different categories of rape in a fairly radical way, though it refused to include familial rape in custodial rape [Kumar 1993].
- 5 WDP is a programme of the government of Rajasthan initiated in 1984.
- 6 As defined in the guidelines, sexual harassment includes such unwelcome sexually determined behaviour such as physical contact, a demand or request for sexual favours, sexually coloured remarks, showing pornography and any other unwelcome physical, verbal or non-verbal conduct of a sexual nature.
- 7 Sex ratio between zero and six years.
- 8 The female life expectancy at birth was 62.5 for the period 1995 to 1999, which has increased to 65.16 in 2005. The male life expectancy at birth was 60.8 for the period 1995 to 1999, which has increased to 63.57 in 2005 [GoI 2003].
- 9 QS is a non-surgical, permanent method of sterilisation by the synthetic anti-malarial chemical quinacrine. When quinacrine pellets are inserted into the uterus through an intra-uterine device, they dissolve, form scars and block the fallopian tube to prevent fertilisation.
- 10 The government of India established the NCW in 1992 as a National apex statutory body to review the Constitutional and legal safeguards for women, recommend remedial legislative measures, facilitate redressal and grievances and advise government on all policy affecting women.

REFERENCES

- Agnes, F (1992): 'The Anti-Rape Campaign: The Struggle and the Set Back' in C Datar (ed), *Struggle against Violence*, pp 99-150, Stree Publications, Calcutta.
- (1996): 'Advancing the Human Rights of Women: Using International Human Rights Standards in Domestic Litigation' (mimeo), Commonwealth Secretariat, Hong Kong.
- Agnihotri, A and V Majumdar (1995): 'Changing Terms of Political Discourse, Women's Movement in India, 1970s-1990s', *Economic & Political Weekly*, Vol XXX, No 29, July.
- Bal, V, L Murthy and V Subramanian (1999): 'Population Control and Coercive Controls: Case of Injectable Contraceptives', *Economic & Political Weekly*, No 34 (39), September 25-October 1.
- Baxi, P (2001): 'Sexual Harassment', *Seminar*, 505, September.
- Behrman, Jere R (1988): 'Intra-Household Allocation of Nutrients in Rural India: Are Boys Favoured? Do Parents Exhibit Inequality Aversion?', *Oxford Economic Papers*, 40(1): 32-54.
- Bharat, S (2003): 'Capacity Building for Research in Sexual Behaviour and Sexuality: The Indian Experience' in G Herdt, di Mauro, R Parker (eds), *Handbook of Sexuality Research Training Initiatives*, Social Science Research Council, New York.
- Browning, M and R Subramaniam (1994): 'Gender Bias in India: Parental Preferences or Marriage Costs?', Discussion Paper No 9415, Department of Economics, St Salvator's College, University of St Andrews, Scotland.
- Chakravorty, S (1998): 'Mainstreaming Gender in the Police: The Maharashtra Experience', *Development in Practice* 8(4): 430-38.
- Chatterjee, M and S Wallia (1998): 'Health Issues Related to Life Styles and to Home and Work Environment', unpublished.
- Coonrod, C (1998): 'Chronic Hunger and the Status of Women in India', www.thp.org/reports/india/wom
- Das Gupta, M (1987): 'Selective Discrimination against Female Children in Rural Punjab, India', *Population and Development Review*, 13: 77-100.
- Dasgupta, R (2005): 'Quinacrine Sterilisation in India: Women's Health and Medical Ethics Still at Risk', *Differentials*, No 34, Spring 2005.
- Datar, C (1998): 'Reflections on the Anti-Rape Campaign in Bombay' in S Wieringa (ed), *Women's Struggles and Strategies*, Institute of Social Studies, Hague.
- Gandhi, N and N Shah (1992): *The Issues at Stake: Theory and Practice in the Contemporary Women's Movement in India*, Kali for Women, New Delhi.
- Gongoli, G (1998): 'The Regulation of Women's Sexuality Through Law: Civil and Criminal Laws', *Economic & Political Weekly*, Vol XXXIII, Number 10, March.
- Gopalan, S and M Shiva (ed) (2000): *National Profile on Women, Health and Development, Country Profile – India*, Voluntary Health Association of India, World Health Organisation, April.
- Gopalakrishnaiah, V (1997): 'Reflections on Anti-Arrack Movement: Past and Present' in B Sarveswara Rao and G Parthasarathy (eds), *Anti-Arrack Movement of Women in Andhra Pradesh and Prohibition Policy*, Har Anand, New Delhi.
- Gol (1994): Handbook of PNDT Act, Department of Family Welfare, Government of India, New Delhi.
- (2002): 'Mahila Samakhya (Education for Women's Equality) (Tenth Plan Document)', Government of India Press, New Delhi.
- (2003): 'SRS Analytical Studies Report Number 3 of 2003', Registrar General of India, New Delhi.
- Gupte, M (2003): 'A Walk Down Memory Lane: An Insider's Reflections on the Campaign against Sex-Selective Abortions', Co-Convenor, Mausam, Pune, India, August.
- Haq, M (2000): *The Gender Question, Human Development in South Asia 2000*, Human Development Centre, Oxford University Press.
- Harper C, R Marcus and K Moore (2003): 'Enduring Poverty and Conditions of Childhood: Life Course and Intergenerational Poverty Transmissions', *World Development*, Vol 31, Number 3.
- IDSJ (1998): 'Exploring Possibilities – A Review of Women's Development Programme Rajasthan', *IDSJ Research Report*, No 15, Institute of Development Studies, Jaipur.
- Jandhyala, K (2001): 'State Initiatives', *Seminar*, 505, September.
- John, Mary E and J Nair (1999): 'Sexuality in Modern India: Critical Concerns, Voices for Change', *A Journal on Communication for Development*, April 3(1), p 4-8.
- Kabeer, N (1992): 'From Fertility Reduction to Reproductive Choice: Gender Perspective on Family Planning', IDS Discussion Paper, No 299, Institute of Development Studies Brighton.
- Kelkar, G (1992): 'Stopping the Violence against Women: Fifteen Years of Activism in India' in M Schuler (ed), *Freedom from Violence: Women's Strategies from Around the World*, pp 75-99, OEF International, Washington DC.
- Khan, M E et al (1983): 'Women and Health: A Case Study in Sex Discrimination in Proceedings of the ICMR – Ford Foundation', Workshop on Child Health, Nutrition and Family Planning, Bangalore.
- Mahila Samakhya UP, Annual Report (1992-93): UP Mahila Samakhya Society, Lucknow.
- Mathur, K (2004): *Countering Gender Violence – Initiative towards Collective Action in Rajasthan*, Sage Publications, New Delhi, Thousand Oaks.
- Mathur, K and S Rajagopal (2006): 'Tracing the Journey: Reflections on Doing Women's Studies and Influencing the Developmental Agenda' in IDSJ Silver Jubilee Volume on Rajasthan – *The Quest for Sustainable Development* (forthcoming).
- Misra, G and R Chandiramani (eds) (2005): *Sexuality, Gender and Rights – Exploring Theory and Practice in South and South East Asia*, Sage Publications, New Delhi, Thousand Oaks.
- Murthy, L (2002): 'The Cost of Harassment', www.boloji.com/wfs/wfs066.htm, August 11.
- NFHS-II (2000): 'India 1998-99', National Family Health Survey, International Institute for Population Sciences, Mumbai.
- Ray, B (ed) (2005): *Women of India: Colonial and Post-Colonial Periods*, History of Science, Philosophy and Culture in Indian Civilisation (General editor – D P Chattopadhyaya), Vol IX, Part 3, Introduction, Sage Publications, New Delhi.
- Sarkar, B (2005): '[India] Domestic Violence Bill Passed', *The Telegraph*, July 3.
- Sharma, J and D Nath (2005): 'Through the Prism of Intersectionality: Same Sex Sexualities in India' in Misra G and R Chandiramani (eds), *Sexuality, Gender and Rights – Exploring Theory and Practice in South and South East Asia*, Sage Publications, New Delhi, Thousand Oaks.
- Shastri, J L (ed) (2000): *Manusmriti with the Sanskrit Commentary of Manavata-Muktavali of Kulluka Bhatta*, Motilal Banarasidas, p 346.
- Sheth, Surabhi D (1992): 'Women's Sexuality: A Portrayal from Ancient Indian Literature', *Manushi*, No 71, July-August, pp 14-23.
- Sooryamurthy, R and K D Gangrade (2006): NGOs in India: A Cross-Sectional Study, Rawat Publications, Jaipur.
- Vishwanath, K (2001): 'Whose Body Whose Health?', *Seminar* 505, September.
- Visweswaran, K (1990): 'Family Subjects: An Ethnology of the Women's Question in Indian Nationalism', PhD thesis, Stanford University.