WORK IN PROGRESS

Building sexuality into programs on reproductive health, human rights, HIV/AIDS, and women's rights

CREA

making human rights relevant

CREA IS A WOMEN'S HUMAN RIGHTS ORGANIZATION. CREA EMPOWERS WOMEN TO ARTICULATE, DEMAND AND ACCESS THEIR HUMAN RIGHTS BY ENHANCING WOMEN'S LEADERSHIP AND FOCUSES ON ISSUES OF SEXUALITY, SEXUAL AND REPRODUCTIVE RIGHTS, VIOLENCE AGAINST WOMEN, HUMAN RIGHTS AND SOCIAL JUSTICE.

CREA NEW DELHI

7 Mathura Road, 2nd Floor, Jangpura B, New Delhi 110014, India

Tel 91 11 2437 7707, 24378700, 24378701 Fax 91 11 2437 7708

crea@creaworld.org

CREA NEW YORK

116 East 16th Street, 7th Floor, New York NY 10003

Tel 1 212 599 1071 Fax 1 212 599 1075

mailcrea@verizon.net

www.creaworld.org

CONTENTS

WHY SEXUALITY?

Although human beings have always had sex, sexuality has largely been ignored in the global discourse of human development. Where it has been considered, it has been considered in a limited way. The discourse of women's rights, for instance, has focused on violations related to sexuality – or sexual violence. The field of public health has focused on those aspects of sexuality that are linked to heterosexual reproduction – contraception, maternal mortality and so on. The domain of human rights has explored sexuality as torture. Even the world of HIV/AIDS – an obvious one, given that 80% of HIV is caused by sexual transmission – has only looked at sexuality in the context of safe and unsafe sex.

But what of sexuality as a whole – as gestalt, a phenomenon that is greater than the sum of its parts? Sexuality does not equal sexual violations + heterosexual reproduction + sexual torture + safe sex. It is much more. Surely all of us are sexual beings, with our own aspirations, desires, likes, orientations and preferences? We are straight, gay, lesbian, transgender, bisexual. And this can change from time to time. Surely we do not have sex only to reproduce; pleasure is as vital a part of the sexual equation. Yet "whom one is permitted to have sex with, in what ways, under what circumstances, and with what specific outcomes are never random; such possibilities are defined through explicit and implicit rules and cultures of specific communities, and by underlying power relations." [1]

Even though we often think of sex as a private act, sexuality cannot be seen as a private domain. And even though we think of individuals having sex, sexuality is socially constructed. It is shaped and regulated by the same power structures that shape other aspects of human existence, and manifested in social institutions and arrangements ranging from law, media, and community to family, marriage and gender. "Sexuality is at the very least about health, pleasure, bodies, violence, rights, identity and employment," writes Gautam Bhan. "In its various spaces, languages, and forms, it is no longer willing to quietly function as a lesser politics, but instead is demanding to be heard and have its connections with other politics acknowledged."[2]

Organizing around sexuality started in the 1960s, with emerging feminist, gay and lesbian movements creating an impact on academic disciplines, research agendas and legal and policy domains. But it remained at the margins until the 1990s, subsumed within larger agendas. It was only with the United Nations conferences on population, women's rights and human rights at Cairo, Beijing and Vienna that sexuality moved tentatively onto the stage. Cairo saw sexual health as an integral part of reproductive health, affirming that people should be able to have a satisfying and safe sex life as well as decide if, when and how often to reproduce. Beijing acknowledged that women are sexual beings as well as reproductive beings, with the right to freely decide about their sexuality. Vienna finally brought the 'sexual' into human rights language.[3]

Even so, the sexual and the reproductive remained firmly intertwined, like a couple that has pledged never to part. "The conflation of sexual rights with reproductive rights has, by and large, caused sexual rights to be viewed as a subset of reproductive rights," wrote Ali Miller in 2000 in Health and Human Rights.[4] This subset status has "disappeared" an array of people who are 'sexual but not reproductive' – including non-heterosexual identities, and non-reproductive sexual practices – from the domains of health and rights and their protections, fulfillments and entitlements.

Even when evoked without its reproductive partner, sexual health and rights continues to be formulated as a negative, not a positive, rooted in sexual violations rather than affirmations. "Why is it so much easier to gain consensus for the right not to be abused, exploited, raped, trafficked or mutilated in one's body, but not the right to fully enjoy one's body?" asks Roz Petchesky. And if as Carole Vance puts it, sexual pleasure and sexual danger are both powerful intertwined aspects of women's lives, why have we only spoken of violence and oppression and ignored

Sexuality does not equal sexual violations + heterosexual reproduction + sexual torture + safe sex. It is much more.

BUILDING IN SEXUALITY

Since the mid-1990s, several international organizations working on health, rights or gender have started addressing issues of sexuality. This publication showcases the efforts of eight such organizations working on either public health, reproductive and sexual health, human rights, women's rights, or HIV. Collectively, these organizations work on service delivery, advocacy, policy, public education, research, standard setting, technical assistance, and funding. They are both respected and reputed for the work they do, which spans many countries around the world.

Addressing sexuality is a 'work in progress' for most of these organizations. In this context, this publication aims to showcase (not evaluate) this work in progress. Why have each of these organizations found it important to address sexuality? How are they doing so? What are some of the challenges they face? What factors help them in this mission? These are some of the questions each case study answers.

This publication is intended as a resource. It is based largely on interviews with relevant individuals in each organization, supplemented by information from each organization's publications and website. The case studies, while not comprehensive, offer glimmers of how it is possible to integrate sexuality in practice. We hope they will encourage both individuals and organizations to consider the relevance of sexuality in their own field of work – and contribute to expanding understanding, providing conceptual clarity, and linking theory and practice.

THE SEXUALITY AND RIGHTS INSTITUTE

Exploring theory and practice

This publication has been produced by Creating Resources for Empowerment in Action (CREA) as part of its larger objective of expanding discourses around sexuality. CREA, in collaboration with TARSHI, runs the Sexuality and Rights Institute, an annual residential course in India that links theory and practice and equips participants to explore the interface between sexuality and rights. The Institute aims to:

- Develop a conceptual understanding of sexuality and rights, their connections with each other and with issues of gender and health
- Build analytical skills to critically examine how various programs, strategies and practices in the field of sexual and reproductive health affirm or violate rights
- Incorporate concepts from four interrelated fields - gender, sexuality, rights and health - into planning and working on reproductive and sexual health and rights

The Sexuality and Rights Institute's curriculum is based on interwoven core themes, including: sexuality and rights; sexuality, gender and the legal system; sexual and reproductive health and rights; sex work, sexuality and rights; agency and victimhood; sexuality and the nation-state; representations of sexuality; sexual diversities and rights; sexuality and disabilities.

In 2007, a one-week residential Sexuality and Rights Institute was held in the United States. This is expected to become an annual feature.

> "The Sexuality and Rights Institute in India is one of the few places I know where we deal with sexuality as it occurs to adults and children, gay and straight, male and female, without identity and with identity. Going across. Everywhere else, it's more or less carved into pieces."
>
> ***Alice Miller, Faculty Member, Sexuality and Rights Institute***

1. *Richard Parker, Regina Maria Barbosa, Peter Aggleton: Framing the Sexual Subject* (University of California, Berkeley 2000, pg 7)
2. *Gautam Bhan: Sexual Rights and Social Movements in India* (CREA Working Paper, Nov 2006, pg 2)
3. *Rosalind Petchesky: Sexual Rights – Inventing a Concept, Mapping an International Practice* (in Parker, Barbosa and Aggleton: Framing The Sexual Subject, University of California Press 2000, pg 81-104)
4. *Alice M Miller: Sexual but Not Reproductive* (Health and Human Rights Journal, Vol 4 No 2, pg 68-109)
5. *Carole S Vance (ed.): Pleasure and Danger: Towards a Politics of Sexuality* (Routledge & Kegan Paul 1984)

CARE

A SMALL PILOT WITH A LOUD VOICE

INNER SPACES, OUTER FACES (ISOFI)

GOAL
To build a strong foundation for integrating gender and sexuality into CARE's global reproductive health programs.

RATIONALE
Data indicates that both gender and sexuality are among the underlying, but unaddressed, causes of poor sexual and reproductive health and rights.

STRATEGY
In 2004, ISOFI is introduced as an innovation in pilot sites in two countries that CARE works in - India and Vietnam.

APPROACH
Personal transformation is an essential component of programmatic change.

METHODOLOGY
Staff-centered, participatory, process-oriented (not output-based).

PARTNERS
CARE and ICRW.

FUTURE
In phase two, operations research will demonstrate how the integration of gender and sexuality leads to more effective programming in reproductive health.

WHAT DOES sexuality have to do with poverty? Why would a global organization that works to end poverty among more than 45 million people in 70 countries need to address sexuality? Although sexuality has traditionally not been considered a determinant of poverty, it is belatedly being acknowledged as a 'hidden, sensitive dimension of poverty' (Chambers 2005).

In his framework of the multiple dimensions of poverty, leading development specialist Robert Chambers gives several examples of the links between sexuality and poverty. Girls may leave school when they start to menstruate, get pregnant or have early marriages, while bullying of feminine boys is the leading cause of them dropping out of school[1] – lack of education is strongly associated with poverty. Those who diverge from sexual norms are often stigmatized and excluded from access to resources such as education, employment, health services etc.

CARE – which began in 1946 as a humanitarian organization – today works to end poverty by addressing its underlying causes, including poor health. A family cannot be economically healthy if it is not physically healthy. One of the areas that CARE globally works in is sexual and reproductive health. "We decided to reflect what the organization is doing overall by looking at the underlying causes of poor sexual and reproductive health," says Mona Byrkit, Team Leader, Sexual and Reproductive Health.

Data indicates that both gender and sexuality are among the underlying, but unaddressed, causes of poor sexual and reproductive health and rights. This paved the way for the Inner Spaces, Outer Spaces Initiative, a global pilot that was launched in partnership with the International Center for Research on Women (ICRW) in the spring of 2004. Aiming to mainstream gender and sexuality into CARE's reproductive health programs, ISOFI – as it is popularly known – was launched in two countries: India and Vietnam.

"It was not a project with goals, activities, timelines, budgets and plans," says Byrkit. "It was initially focused on CARE staff, recognizing our own value systems and biases might be getting in the way of optimal programming in sexual and reproductive health. It was very much about: How do you get this huge organization to shift its thinking, which will hopefully then impact what it is doing?"

TRANSFORMING INNER SPACES

ISOFI is based on the unusual premise that personal change is a pre-requisite for programmatic or professional change: Who you are within influences what you do outside. Individuals carry their own lived experiences of gender and sexuality – and their values, attitudes, beliefs and stereotypes – along with them to the

professional sphere; these 'inner spaces' then influence and affect programming in gender and sexuality, often acting as unintended barriers. For instance, an imbibed heteronormativity may prevent sexual health programs from reaching men who have sex with men or lesbian women.

"ISOFI is an innovative methodology to actually get NGO workers to think about their lived experience, trust that and mine it for learning," says Sarah Degnan Kambou, Vice President, Health and Development, ICRW. "Then they are able to talk much more honestly and frankly about sex and sexuality and body parts and sexual sites and all that stuff. This is new. This is very unusual."

In keeping with this, gender and sexuality are seen as intertwined concepts that are socially defined and constructed. Social norms, ideologies and institutions (such as marriage) manifest these constructed views of male and female sexuality. Discourses around gender and sexuality have traditionally cast men as predators, women as victims and sex as linked to reproduction, risk, disease and danger.

However, ISOFI relies on a 'sex-positive' approach that sees gender and sexuality as sites of vulnerability and agency, power and powerlessness, pleasure and pain. "Sex is pleasurable," says Degnan Kambou. "We do it for a reason – it's not just about procreation. If we always talk about sex as a vector or related to disease, then we're not helping people deal with the situations which they find themselves in."

BRINGING IN SEXUALITY

When the project was introduced, CARE staff in both countries was somewhat resistant. "Gender was conceptually accepted, but there was a practical difficulty implementing," says Jesse Rattan, Sexual and Reproductive Health Advisor. "With sexuality, the conceptual link was missing." In India, where sexuality issues had already started surfacing in gender analysis exercises, staff felt they had received enough training on gender – why not train their implementing partners, they suggested?

The process was launched with an intensive experiential four-day workshop, in which participants explored what they meant by sexuality, what they believed about other people's sexuality, and what they considered the 'right sexuality'. "There was a lot of emphasis on analyzing power," says Veronica Magar, former Sexual and Reproductive Health Advisor.[2] "We looked at how we both have it and don't have it."

As the process got underway, fragments of the missing link between sexuality and health became explicit. In India, for instance, participants understood that women were often not sent to the health center out of a fear that they might sexually stray or be violated. "They were able to understand that restrictions and control of women's sexuality had very much to do with not getting to the health center," says Rattan. In Vietnam, where prostitution and homosexuality are considered social evils, young health workers realized that "it's not so bad," says Rattan. "People have a right to their privacy and they are not harming anybody, so they approached it that way."

In both countries, participants' 'inner spaces' started changing as newfound knowledge challenged conventional wisdom. "I am 40 years old and I have been married for many years," reported a female CARE participant from Vietnam. "This is what I have learnt from ISOFI: I have the right to refuse sex, and I have the right to ask for sex." A male CARE participant from India acknowledged that he sometimes beat his wife because of ego problems. Awareness of one's needs and rights in the context of marriage and seeing pleasure as fundamental offered CARE employees a way to reinterpret their own roles as sexual partners. As one participant recalled, "ISOFI has melted a stone."

CARE

CHANGING OUTER FACES

The transformation in these 'inner spaces' gradually showed up in the 'outer faces' of programming – in designing surveys, creating information materials, training new staff. In Vietnam, young health workers scripted and performed plays around teen pregnancies. "The reality is that even in indigenous tribal communities, people are having sex," says Rattan. "And there are pregnant girls that are sent away in shame. And the boys are freaking out, and all this stuff is happening. ISOFI allowed them to deal with this."

In India, health workers started organizing 'couple picnics' for husbands and wives to get to know each other and communicate better. "We feel we are in love again," one couple reported. In other villages, staff decided they would accompany men having sex with men (whom they earlier shunned) in public. "It is small but significant," says Geetika Hora, Gender Advisor, CARE India. "They became sensitive to heterosexuality being a norm rather than a natural state of being."

Perhaps the biggest factor leading to this change was the unique ISOFI methodology, which created safe spaces for reflection and dialog at all levels. "It was an open space to try things, learn things, make mistakes, learn from the mistakes," says Magar. Staff used to very structured projects with monthly reports and concrete deliverables suddenly tasted freedom – and its frustrations. No guides, no goal posts. "The fact that it was process-centered and not deliverable-driven somehow created an enabling environment."

CREATING A BUZZ

Institutional factors also paved the way for ISOFI: CARE's shift from a needs-based to a rights-based organization; decentralization and autonomy in program planning at the country level; program portfolios that included sex workers' rights at the country level; and the presence of champions of gender and sexuality within the organization.

Other factors simultaneously acted as barriers. Within the organization, sexuality remained project-dependent, rather than being part of a program. The 'missing middle' (program managers) did not always see the relevance of sexuality. Outside the organization, a conservative political climate posed a deterrent for CARE, which receives significant funding from the US government. While some staff explored issues of sexuality, others could not even mention condoms, let alone sexuality.

Key CARE staff, including leadership within the Asia region – where the project was piloted - were kept abreast of project developments through reports, brown bag lunches and conference presentations. Such dissemination strategies are critical: How do you make staff across a large organization aware that that this is not just a small project, but a pilot with relevance across programs?

"Many saw its relevance but did not see it as important," remembers Rattan. "We are here to do avian flu – how high does this rate on

our priority list?" Others accepted a piecemeal version of sexuality – without the right to pleasure. "They don't have a right to clean water. How are you going to tell them they have a right to pleasure?" was an oft-asked question. "Is it really a valid, honorable subject of discourse in development agencies – the right to pleasure?"

Despite such misgivings, ISOFI has managed to create an incredible buzz around sexuality at CARE. "It was a small pilot, but it had an incredible voice within the organization," says Usha Kiran, RACHNA Program Director, CARE India. "It raised serious questions for us: Are we diverse enough? Or are we missing out on some perspectives? Are our organizational policies geared towards marriage as an institution? What happens when someone is single and has a partner – will our policies cover that?"

MOVING AHEAD

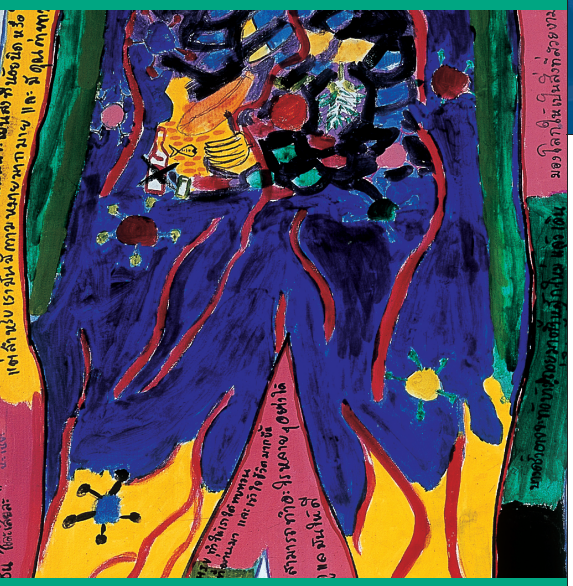
As it moves into its next phase, the challenge is to show how ISOFI's learnings can translate into more effective programming at CARE. How will maternal and child health improve with the infusion of gender and sexuality? An operations research study will compare reproductive health programs with and without gender and sexuality to pinpoint the difference, while a similar ISOFI pilot is being launched in Bosnia-Herzegovina.

"If we're saying this is going to make a health program better, well other than having testimonials and anecdotes about better communication with your husband or decreased violence in the home, what about those more 'traditional' health outcomes the donors are asking for?" asks Byrkit. "Are they actually better? That's what the next phase is about."

The ISOFI methodology consists of a structured iterative loop that includes opportunities for reflection/learning, action/experimentation and analysis/assimilation through:[3]

- **Portfolio reviews and needs assessments** to identify where gender and sexuality are present or absent in project content, strategies, activities, monitoring and evaluation, staffing or evaluation.
- **Gender and sexuality trainings** to deconstruct people's perspectives on these issues and challenge preconceived norms around gender roles, sexual norms and sexual identities.
- **Collective reflective dialogs** to assess how gender and sexuality are being integrated into project strategies and interventions.
- **Individual personal learning narratives** to enable reflection on the effect of gender and sexuality on their own lives.
- **Participatory learning and action** to apply learnings to ongoing interventions.

1. *IDS Policy Briefing* (Institute of Development Studies April 2006)
2. Veronica Magar is no longer with CARE
3. *Walking the Talk: Inner Spaces, Outer Faces – A Gender and Sexuality Initiative* (CARE and ICRW May 2006)



HUMAN RIGHTS WATCH

RECOGNIZING ABUSES BUILT INTO DAILY LIVES

"I was nineteen and this was the most terrible thing that had happened in my life. I understood that I was a criminal; and I saw, too, that my only crime was myself."

Florin Hopris, 19, Romania, May 1993[1]

"Sometimes on the street I pass one of the policemen who beat me that night, and I remember how they called me a cocksucker and a pervert, how they laughed at me, how they stuck my head down the toilet…"

Radu Vasiliu, 18, Romania, July 1997[2]

IN 1998, Human Rights Watch (HRW) published a report showing how gays and lesbians in Romania were routinely denied some of the most basic human rights guaranteed by international law. "From their first criminalization in 1936, homosexual *acts* were punished in Romania lest they give rise to homosexual *identity* and *community,*" noted the report, *Public Scandals: Sexual Orientation and Criminal Law in Romania.*

In the human rights firmament, a Human Rights Watch fact finding report is not just a report. Neither is it only evidence of abuse, however well recorded. It is also a sign of recognition, a marker that *this abuse* is an abuse of internationally-guaranteed human rights, that *this violation* is a human rights violation, that this *issue must* be addressed and acted on as a human rights issue – along with issues of arms, business, counter terrorism, children's rights, international justice, prisons, refugees and women's rights.

"Every time we put out a 50-100 page report showing multiple patterns of abuse, we're saying – these people exist," says Scott Long, Director, Lesbian, Gay Bisexual and Transgender Rights Program, who researched the Romania report. "At that time, human rights organizations believed that these abuses did not happen. They felt that they were so sporadic and so insignificant that no one should pay attention to them."

So what made the Watch start watching – or paying attention? Partly a combination of internal and external advocacy. "There were outside actors coming in saying it would be useful if we did a report on an issue and internal actors who cared about these issues," says Rebecca Schleifer, Advocate, HIV/AIDS and Human Rights Program. Partly circumstance; it shared office space with the International Gay and Lesbian Human Rights Commission (IGLHRC), with whom *Public Scandals* was jointly published.

The women's rights division shone another, somewhat tangential spotlight, on sexuality. Investigating abuses such as those faced by women in prisons meant exploring underlying issues - women's sexualities, how they deployed them, their appearance, their gender conformity. At the same time, a growing body of international jurisprudence was talking about the responsibility of the State

Human Rights Watch is the largest human rights organization based in the United States.

1978
Helsinki Watch set up to monitor the compliance of Soviet bloc countries with the Helsinki Accords

1980s
Americas Watch set up to monitor human rights abuses by both sides in the war in Central America

1988
All the 'Watch' committees are united to form Human Rights Watch

Today, Human Rights Watch tracks developments in more than 70 countries through a team of more than 150 dedicated professionals at its New York headquarters and nine other offices.

to reign in abuses by non-state actors. "A lot of abuses against women and LGBT persons take place in the home and the family," says Schleifer. "This made it easier to support things institutionally, because there was jurisprudence outside to which people could point."

In 1993, Human Rights Watch adopted a formal policy against discrimination on grounds of sexual orientation. During the early 1990s, Sarah Lai and Regan Ralph of HRW wrote about sexual autonomy and human rights, while several reports touched on aspects of sexuality, directly or indirectly.[3] One report documented the sexual abuse of women in US prisons,[4] another challenged the imposition of virginity control exams on women by police and other state agents in Turkey,[5] and another documented the use of large-scale sexual violence as a weapon of armed conflict in Rwanda.[6]

The Rwandan report showed that "rape was extremely widespread and that thousands of women were individually raped, gang-raped, raped with objects such as sharpened sticks or gun barrels, held in sexual slavery (either collectively or through forced 'marriage') or sexually mutilated." Reports such as this exemplify what it means to take sexuality seriously in the context of documenting gross human rights violations.

But these were all still baby steps; early, sporadic attempts to address abuses that fit the mandate of human rights violations, rather than to broaden its gaze. "It was a process of starting very slowly, very incrementally to do the documentation," recalls Long. "It was still a few isolated points of light who got it."

LGBT RIGHTS PROGRAM

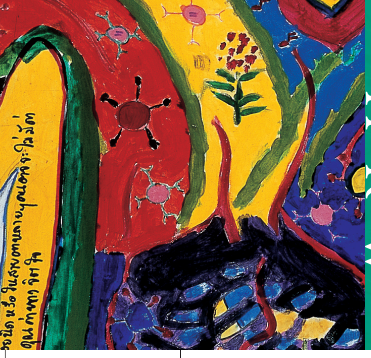
As people in more than 50 countries today mark the International Day against Homophobia, Human Rights Watch named to a "hall of shame" five public officials who have actively promoted prejudice against lesbian, gay, bisexual and transgender people in their countries. Human Rights Watch also pointed to five recent advances that give hope for a future free of hatred and homophobia.

Press Release, New York, 17 May 2006

In 2004, an LGBT Rights Program was started at Human Rights Watch, a milestone in the field. "Addressing sexuality at Human Rights Watch came primarily through an identity framework, through looking at discrimination based on sexual orientation," says Scott Long, who started the program. The question then was: Should it be called the LGBT Rights Program or the Sexual Rights Program? "It was fairly clear that the bulk of the work we would be doing then would be around sexual orientation and gender identity," says Long. "So we would get called on it if we were doing LGBT work and calling it sexual rights work."

Another factor was funding. The organization had already faced a funding dilemma trying to set up the LGBT Rights Program. In those days, it did not have credibility as a player in the LGBT rights field to attract queer-specific funding. But neither did it have the funding to start the program that would give it the credibility. "I knew from my earlier work at IGHLRC that funding in this area was identity-based," says Long. "Most funders had no idea what a sexual rights program was."

The LGBT Rights Program currently focuses on three aspects: fighting bad laws and policies, promoting positive protections, and fighting moral panics and fundamentalisms. It does this through the Watch's well-honed arsenal of fact finding investigations, reports, publications, letters and publicity, often in collaboration with other programs at Human Rights Watch and on-the-ground coalitions with local LGBT groups.



"The groups we work with are underfinanced, marginalized and often illegal as groups," says Long. "And they're often marginalized by the human rights communities in their own countries. We're constantly having to bridge this gap between different kinds of discourses, and between the people we work with and the human rights movements in their own countries." Two 2004 reports brought these constituencies together to condemn Egypt's crackdown on homosexual conduct and violence against HIV-positive and gay men in Jamaica.[7]

In 2007, Human Rights Watch stepped in to protest interference with lesbian and gay rights demonstrations in Moldova, which are protected under European freedom of assembly and non-discrimination provisions. It condemned the Polish government's proposed legislation to censor all discussion of homosexuality in schools and other academic institutions – an action that would violate freedom of speech and impede free access to information. In 2006 it challenged Moscow Mayor Yuri Luzhkov's promise to ban the city's first-ever gay pride parade as a threat to civil liberties and civil society.

WORKING ACROSS PROGRAMS

All the above are joint actions of the LGBT Rights Program and the Europe/Central Asia Division. "A thematic division looks very specifically at one issue and serves that community," says Rachel Denber, Deputy Director, Europe/Central Asia. "But the regional division has to look at the whole region and the whole spectrum of problems. Sometimes it is very difficult to say which one should be prioritized."

The Europe/Central Asia division has traditionally worked on state repression of civil and political rights, religious persecution, and the humanitarian violations that were hallmarks of the armed conflicts related to the breakup of the Soviet Union. "We have to articulate our strategy very clearly," says Denber. "Why is it that we're working on LGBT issues in country X or why is it that we're not in country Y? We have to make our position clear to both sets of communities – unfortunately we're still talking about two communities."

Sometimes it's a question of timing. In 1999, when a new war broke out in Russia, a campaign on any other issue may not have made sense – be it gay rights or orphanages, says Denber. "We have to be able to articulate to our partners why this makes sense at this time. But it's a two-way street. Had we not done the report on Gay Pride in Russia in 2006 it could be that the LGBT program's partners in Russia might have thought that Human Rights Watch was really amiss."

Can LGBT be a sort of Alice in Wonderland looking glass for mainstream human rights movements, so the question becomes: How strong are your fundamental human rights structures? Do you really have freedom from torture and arbitrary arrest for everyone? Or is it only as strong as it is for mainstream acceptable persons?

JESSICA STERN

Well, in my experience, when mainstream human rights organizations understand LGBT abuses, they understand the mainstreamness of the abuse, eg police violence, not the failure to protect everybody. I hope over time they really get that our structures are not protecting everybody.

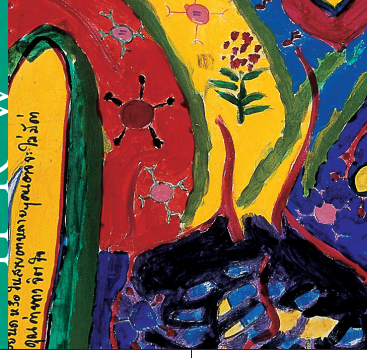
REBECCA SCHLEIFER

But let's be fair. Part of the problem is that protection does not work for anybody. In Jamaica, everybody gets subjected to police violence. In Egypt, everybody gets tortured. In South Africa, everybody gets raped. So what we're really talking about is understanding the particular vulnerabilities of people in a situation where everybody is vulnerable – but for different reasons.

SCOTT LONG

I think there are two ways of developing the methodological understanding of how to do this work – our issues are just like yours, and our issues are different than yours. We need to get to the place where there's a capacity for understanding both.

JESSICA STERN



The children's rights division also collaborates to visibilize discrimination based on sexual orientation and gender identity. "LGBT youth are marginalized in a way that ordinary people would recognize as discrimination," says Michael Bochenek, Deputy Director. "Some of them face violence, some don't. Girls who don't conform and boys who don't conform face violence – and among those categories, transgender youth are the group that is the most marginal." A 2001 report[8] showed how LGBT youth in public schools in the United States are relentlessly harassed and sometimes physically attacked.

"We need to make it clear that embracing a full spectrum of human rights and embracing the notion that human rights are, in fact, indivisible, means taking up these cases," says Jessica Stern, Researcher, LGBT Rights Program. "I wonder if LGBT issues can be a sort of Alice in Wonderland looking glass for mainstream human rights movements, so the question becomes: How strong are your fundamental human rights structures? Does everyone really have freedom from torture and arbitrary arrest? Or are human rights protected only for people who are considered 'mainstream'?"

THE HIV/AIDS AND HUMAN RIGHTS PROGRAM

"Even when he was HIV-positive he still wanted sex. He refused to wear a condom. He said he cannot eat sweets with the paper [wrapper] on."

Sules Kiliesa, Uganda, December 2002[9]

"I like to have plenty of condoms in my bag, but if I see the police, I throw my bag away."

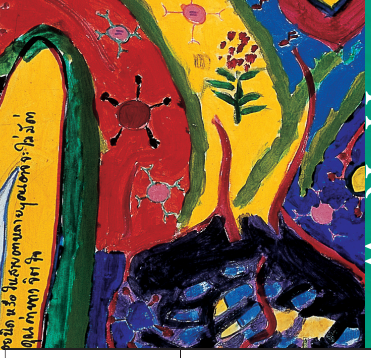
Jessica R, sex worker, Philippines, January 2004[10]

Government failures in the fight against AIDS in Zimbabwe. Police abuse of drug users in Ukraine impeding HIV prevention efforts. Stigma and discrimination against HIV-positive mothers and their children in Russia. Sex, condoms and the human right to health in the Philippines. Restrictions on AIDS activists in China. These are just some of the panoply of human rights issues that the HIV/AIDS Program has highlighted since it started work a few months after 9/11.

"Unlike hot issues like counter terrorism, to get newer issues on board we first need to persuade some of the organizations with which we work that these issues have something to do with what they recognize as human rights issues," says Rebecca Schleifer, Advocate, HIV/AIDS and Human Rights Program. "Torture's obvious. But when you're trying to make an argument about the right to accurate health information - that takes more effort."

The rights of drug users is another such issue. "It takes a while for people to understand what the rights of drug users have to do with human rights," says Schleifer. "Government officials ask me all the time: Are you saying people should have the right to use drugs? I have to say – 'That's not what we're talking about here. People have a right to protect their health. These rights are guaranteed by international treaties.'"

An equally contested issue is sex work. "Many colleagues ask me to come and talk about sex workers' rights," says Schleifer. "I have to tell them that sex workers are people. They have human rights just like the rest of us." The program has documented several rights violations of sex workers including violations of their right to housing, their children's right to education, their right to health, freedom from violence etc.



But positioning violations of sex workers' rights as legitimate human rights violations remains a challenge. When a sex worker in Ukraine complained of being raped the cops, refused to accept her complaint because she had been paid for having sex. "I was asked to consider taking this example out of the report," says Schleifer, "not because it was not seen as a credible example, but because colleagues thought that people in Ukraine would not understand this as a violation or problem."

THE WOMEN'S RIGHTS PROGRAM

Although Human Rights Watch does not have a policy position on sex work, many people within the organization see prostitution as amounting to violence against women. "The HIV/AIDS program has been talking about moving towards advocating for the legalization of sex work as an at least partially effective measure to protect sex workers' human rights and personally I agree with that," says Marianne Mollmann, Advocacy Director, Women's Rights Program. "But I can see how that would be problematic for some of the organizations we work closely with."

Women's rights groups that partner with Human Rights Watch sometimes challenge the use of the term 'sex worker' and what it implies. "My response is: 'If women call themselves sex workers, we call them sex workers," says Mollmann. "If they call themselves women in prostitution, we call them that. However they choose to self determine, we respect that. I don't feel a tension within Human Rights Watch on this issue, but I do feel a tension with some of our partners."

The Women's Rights program, which started in 1990, works on several issues within which sexuality surfaces – domestic violence, trafficking, rape in conflict, abortion rights. "We work on reproductive and sexual rights, but we've not actually been able to do as much on sexual rights as we wanted to," says Mollmann. "We sometimes clarify that we have done research on reproductive rights and not on sexual rights because we don't want to misrepresent what we're doing – and what we have been doing is focused on the reproductive."

Two recent reports focused on the situation of women in Argentina, where abortion is illegal[11] and Mexico, where abortion is allowed only in circumstances such as rape.[12] "We were trying to show that in this context of criminalization of abortion, there's this generalized prejudice and stigma against abortions for any reason, so even rape victims can't get abortions that are legal," says Mollmann. "Women are really afraid or they don't know or they feel they're being bad women."

The Women's Rights Division is planning to do more research on women's sexuality regardless of orientation, says Mollmann. "It does underlie several issues and it does come out in the background of our existing research. Young girls will say to me that they know about condoms or hormonal contraception but they can't ask for it – because that's like accepting to themselves that they are sexually active persons. Women are just not supposed to be sexual."

INSTITUTIONALIZING SEXUALITY

Historically, women's rights, children's rights, LGBT rights and HIV have been the four programs that have taken on sexuality the most at Human Rights Watch. Without a programmatic emphasis, sexuality may not have gotten much attention. "It's very difficult to get existing divisions to take up issues that are outside their traditional sphere of work," says Long. "You need dedicated staff to take an issue forward." Adds Schleifer: "Divisions have their own portfolio, their hands full and no funding, resources of staff to take on new stuff."

The LGBT and HIV programs continuously advocate for including sexuality in other programs as part of an ongoing strategy to institutionalize the issue. "I see no reason why business and human rights or refugee rights should not work on this issue," says Long. Injecting the other divisions with enthusiasm for sexuality-related issues is a key aspect of the job. Says Schleifer: "We spend a lot of time on internal advocacy even though it's not what we get credit for."

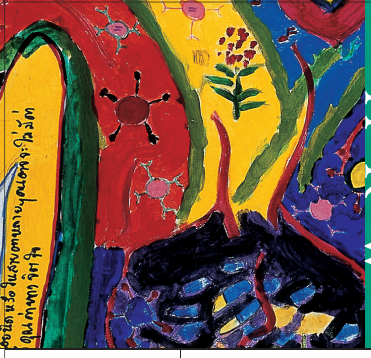
Putting out a high-impact report is one strategy to build enthusiasm for any issue. "A report that gets a lot of publicity and makes other researchers feel that this is not a career backwater for them," says Long. "This really helps." Putting political pressure is another strategy. "We have to find LGBT cases that are critical and make clear that these issues are worth exploring in human rights terms," says Stern. "I'll feel we have successfully institutionalized our issues when at least one researcher in every division has done a report on them."

Over the years, there has been a recognition that these programs are putting legitimate issues on the table and opening up spaces in diverse countries to discuss them. But demonstrating impact still remains a challenge, partly because creating social change is a slow, ongoing process. "Doing political work takes time," says Long. "We're not going to be evaluated by the number of sodomy laws we got rid off!"

"In general, for the last 15 years, we have come up against what I think of as the 'humanitarianization' of human rights: the fact that you have either these vast, intractable problems like the continuing re-legitimation of torture, or vast intractable crises that involves multiple zeroes stringing across the figures of those abused, like Darfur, or Bosnia, or Chechnya. In that kind of environment, it's very difficult to make a case to researchers, funders and organizations for taking up cases of people who seem to be isolated individuals who are suffering abuse for what they do with their bodies.

I often find myself saying that Darfur, Bosnia, Chechnya are horrible – but they are still exceptions in the framework of human life on the planet. What makes them horrible is the fact that these are such a vast disruption of the texture of life. Whereas women who are abused or raped on the street or in the home because of how they look or how they act, men who are beaten up because they are not acting the way men should, these are everyday occurrences. These are part of the normal fabric of social policing for more than half the world's population. To recognize the abuses built into the fabric of the everyday is what we are doing."

Scott Long, Director, Lesbian, Gay Bisexual and Transgender Rights Program



Other challenges are gradually being addressed. "There's a classic question we've been discussing in the LGBT Program," says Stern. "Why is it so hard to document the violations and lives of queer women using a human rights framework? I think that part of the answer is that an LGBT specific framework really fails queer women. A lot of people's lives don't exist within identitarian constructs." Similarly, says Stern, HIV in LGBT communities is constructed as a problem of men having sex with men. "Queer women just drop off the map."

A broader conceptual challenge is the lack of an organizational policy on sexual autonomy – the right to do what one wants with one's body as long as there is no harm. "It is one thing to look at discrimination jurisprudence and say that sexual orientation is an immutable characteristic on the order of religion and so one should not be forced to change it," says Long. "It is quite hard to lay out a conduct jurisprudence in international law which establishes that you have the right to consensual conduct that does not harm anybody. But in order to speak as Human Rights Watch, we have to be coming from a jurisprudentially sound position."

The work on LGBT rights, drug users, sex workers and HIV is helping inch the organization towards this understanding, says Long. "We are laying a groundwork for saying that there are people who are persecuted because of what they do with their bodies. When you do things with your body that the State and society disapprove of, you get punished. But we see the State's response as disproportionately severe because we have a general, emerging idea of bodily freedom – the body independent of the family, community, State. That's the kind of argument we're intuitively moving towards."

"Working on sexuality really requires a methodological shift that a lot of human rights organizations have not been so willing to do. It's a shift from a purely 'violations' model to a 'lived experiences' model. When you're talking about the right of young girls and women to be free from forced marriage, what right do you work on? Is it about her right to live on her own, outside of a parental or marital home? Is it about the right to have an education so that she can provide for herself? Or is it about rights for women across the board – so that she can be an autonomous person?

Recognizing these nuances requires that human rights organizations say: We don't actually take as a norm that human rights violations won't happen. They must say: We look at the government, we look at the community, we look at the family – and we see how human rights violations are embedded in all these structures. And when it comes to issues like sexuality, particular populations are constantly being targeted. The system of patriarchy is invested in a deprivation of sexual autonomy."

Jessica Stern, *Researcher, Lesbian, Gay, Bisexual & Transgender Program*

1. *Public Scandals: Sexual Orientation and Criminal Law in Romania* (Human Rights Watch and International Gay and Lesbian Human Rights Commission 1998)
2. ibid
3. One of the first to do so was a chapter in a report on Georgia, USA, before the 1996 Olympics; the chapter addressed Georgia's sodomy law
4. *All Too Familiar: Sexual Abuse Of Women In U.S. State Prisons* (HRW 1996)
5. *A Matter Of Power: State Control Of Women's Virginity In Turkey* (HRW 1994)
6. *Shattered Lives: Sexual Violence During The Rwandan Genocide And Its Aftermath* (HRW 1996)
7. *In A Time of Torture: The Assault on Justice in Egypt's Crackdown on Homosexual Conduct* (HRW 2004) and *Hated To Death: Homophobia, Violence and Jamaica's HIV/AIDS Epidemic* (HRW 2004)
8. *Hatred in the Hallways: Violence and Discrimination against Lesbian, Gay, Bisexual and Transgender Youth in US Schools* (HRW 2001)
9. *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda* (HRW 2003)
10. *Unprotected: Sex, Condoms and the Human Right to Health in the Philippines* (HRW 2004)
11. *Decisions Denied: Women's Access to Contraceptives and Abortion in Argentina* (HRW 2005)
12. *The Second Assault: Obstructing Access to Legal Abortion after Rape in Mexico* (HRW 2006)

WORLD HEALTH ORGANISATION

PUBLIC HEALTH IS A HUMAN RIGHTS ISSUE

IN 1975, way before sexuality had entered the global discourse around health, a World Health Organisation (WHO) expert group described sexual health as the "integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love." It also stated that "fundamental to this concept are the right to sexual information and the right to pleasure."[1]

Despite this early start, sexual health vanished from WHO's public health agenda – till it resurfaced amid discussions around women's rights. From 1991, a series of dialogs were held between women's health advocates and the scientific community. "At that time, there was a lot of criticism by women's groups of population control policies and the development of new contraceptive methods that were perceived as being unsafe or inappropriate," recalls Jane Cottingham, Team Coordinator for Gender, Reproductive Rights, Sexual Health and Adolescence in the Department of Reproductive Health and Research (RHR). But the then Director of the Special Programme of Research, Development and Research Training in Human Reproduction (which later became part of RHR) was convinced that it was important to listen to the voices of women's health advocacy groups. "It was really one individual at WHO who happened to be very open."

As the dialogs moved from research on contraception to the broader terrains of reproductive and sexual health, they also threw up the need to consistently include women's perspectives in sexual and reproductive health. (Women's perspectives was then the buzzword, not women's rights). This need was met through the formation of a Gender Advisory Panel in 1996.

"The panel helped to bring in many issues, including controversial and cutting-edge issues," says Cottingham. With Beijing, Cairo, and Vienna providing enabling environments, it became more pressing to articulate human rights dimensions of health. "Gradually we started focusing on human rights more explicitly," says Cottingham. "And sexuality was one of the issues that emerged at many different levels."

REPRODUCTIVE HEALTH AND RESEARCH

Not only did Cairo expand the discourse around reproductive and sexual health and rights, it also provided a basis for creating programs on these issues. In 1996, WHO established the Reproductive Health and Research Department, which brought together the research program mentioned above with the reproductive health technical support division. The Department includes sexual health as part of its portfolio.

When diplomats met to form the United Nations in 1945, one of the things they discussed was setting up a global health organization. WHO's Constitution came into force on 7 April 1948 – a date we now celebrate as World Health Day.

WHAT WHO DOES

WHO is the directing and coordinating authority for health within the United Nations system. The World Health Assembly is the supreme decision-making body for WHO. It meets each year in Geneva, and is attended by delegations from all 193 Member States.

WHO'S CORE FUNCTIONS

- Providing leadership on matters critical to health
- Shaping the research agenda
- Setting norms and standards
- Articulating ethical and evidence-based policy options
- Providing technical support, catalyzing change, and building institutional capacity
- Monitoring the health situation and assessing health trends

Reproduction, sexuality, rights and gender are interwoven in its work. "Looking at these from a woman's point of view is absolutely key," says Cottingham. "All diseases have rights dimensions, of course, but sexuality and reproduction are embedded in relationships, where there are gender and rights disparities. This needs special attention."

In 2002, the Department convened a consultation of international experts on sexual health as part of a process to revisit its own work. This working group challenged RHR's own understanding of 'reproductive and sexual health' as one 'block', noting that sexual health is actually a broader concept. It highlighted best practices of working in sexual health from Thailand, in the context of HIV; Sweden, where sexual health education was transforming the way people think about sex and sexuality; and South Africa, where an advocacy campaign had integrated several elements of sexual health and rights. It identified a number of rights-based values and principles that must underlie work on sexual health. And it provided working definitions of sex, sexuality, sexual health, and sexual rights, which though not official WHO definitions are widely used in the field at an informal level.

The working group's recommendations have also spawned efforts in many directions. Research has been commissioned on:

- Programs in which sexuality counseling has been integrated into sexual and reproductive health services
- Services that have included the treatment of victims of domestic violence
- Gender, sexuality and vaginal practices in South Africa, Mozambique, Indonesia and Thailand
- Decision-making dynamics related to female genital mutilation on the Senegal-Gambia border
- Different aspects of sexual health in Chile, India, Nigeria, China, and Nepal

"We're looking at programs where sexuality counseling has been consciously injected," says Cottingham. "What are some of the measurable outcomes? Does it improve people's feelings about services? Sexual health includes not only sexual ill-health, where it is STIs or violence, but also the positive side - sexual wellbeing."

Among other things, the Department has also teamed up with the World Association for Sexology on a global effort around sexual health. It has also published an edited volume entitled *Sex Without Consent: Young People in Developing Countries*, evaluated the impact of a program in China promoting safe sex behavior among unmarried young people, and conducted courses including sexual health as a component for researchers from developing countries.

From November 2006, the reputed British medical journal, *The Lancet* started publishing a series of articles on sexual and reproductive health. Coordinated by RHR, the papers show that despite the ICPD commitments, the Millennium Development Goals do not mention sexual and reproductive health. The burden of sexual and reproductive ill-health remains enormous, noted one paper.[2] Unsafe sex is the second most important risk factor for disease, disability and death in the poorest communities and ninth in developed countries.

Sexual and reproductive health for all is an achievable goal, the series concluded,[3] if cost-effective interventions are properly scaled up, political commitment is revitalized, and financial resources are mobilized, rationally allocated, and effectively used. But does the will exist, both financially and politically?

PUBLIC HEALTH AND HUMAN RIGHTS

The move to place gender and sexuality on WHO's agenda accompanies a move to address public health as a human rights issue. Before the UN conferences at Beijing, Cairo and Vienna, many of WHO's 193 member-

states felt public health had nothing to do with human rights – the two were separate domains, despite the fact that the WHO Constitution, established in 1947, clearly articulates everyone's "right to the highest attainable standard of health". Many felt WHO should focus on public health, while the UN Commission on Human Rights should focus on human rights. In 1997, UN Secretary General Kofi Annan issued a statement saying that all UN organizations should integrate human rights into their work. This provided global agencies like WHO a much-needed mandate to start working on this issue.

"At WHO, we believe we should not do only advocacy," says Ezster Kismodi, Human Rights Advisor. "We feel that WHO's comparative advantage is in finding out how human rights can be integrated in policy and program development." Building human rights into different national health systems across the world is easier said than done, especially since many governments view 'human rights' as a threat. WHO works with governments using a dialogic progressive realizations approach, rather than a violations-based one. "Because our aim is to help to change, not only to point out the violations," says Kismodi. "It's more like how can we help you revise or modify your policies, programs and laws?"

Working with governments – or ministries of health – often means that human rights issues have to be translated into public health terms or language. "Sometimes it doesn't work to say human rights, human rights, human rights," says Kismodi. "We have to talk about rights in the context of unmet needs, put it in the context of ICPD, the constitution and the laws. When it's really very specific, when it's technical, then countries are not really reluctant to take it on."

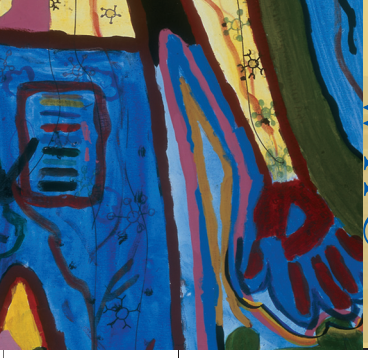
A HEALTH AND HUMAN RIGHTS TOOLS

In order to examine legal and regulatory barriers to maternal and newborn health, WHO and the Harvard School of Public Health have developed a Maternal and Neonatal Health and Human Rights Tool. It aims to create a multi-stakeholder, participatory process that uses a human rights framework to examine the government's actions to meet its human rights commitments to maternal and newborn health made through the international treaties it has ratified and consensus documents it has signed. Such actions may include the examination of laws, elaboration of regulations and of policies, and formulating and implementing standards of care, among others.

The Tool is also grounded in the human rights principles of non-discrimination, participation and accountability. Using a participatory process involving many different stakeholders, it has been field tested in Brazil, Indonesia and Mozambique. The process is intended to be undertaken by health ministries as a reflective exercise to strengthen its own maternal and newborn health programs with technical assistance from WHO and/or other partners familiar with human rights and legal and policy issues related to health.

In Indonesia, for instance, the Ministry of Health became the entry point. Other stakeholders included the ministries of justice, women's affairs, empowerment, and education, commissions on human rights and violence against women, associations of doctors and nurses, universities and non-government organizations. "It was very difficult because different ministries traditionally don't work with each other," says Kismodi. "Ministries are often reluctant to work with NGOs, and different sectors do not think of each other as equal partners. But it *can* work. WHO is in a position to facilitate such a process."

The Tool is designed to collect public health data in relation to maternal and newborn health and other aspects of women's reproductive health, along with information on laws and other regulations, policies and



health system standards that affect maternal and newborn health. These data are compiled according to different relevant human rights, such as the right to life, the right to health, the right to decide the number and spacing of one's children, the right to education and information; and the right to non-discrimination.

Once the data is collected, an analysis is conducted by the multi-stakeholder group. This consists of identifying gaps and discrepancies in the legal, regulatory, policy and health systems related to specific aspects of maternal and newborn health. Gaps and discrepancies may occur if national laws and policies do not deal with the public health problem but also if they are not consistent with international, regional and national human rights standards.

The analysis also highlights whether laws, policies and programs are addressing the needs of vulnerable groups, thus systematically identifying whether the right to non-discrimination is protected and fulfilled. For instance, a law that sets the age of marriage at 16 years is conflicting with human rights standards. If a country does not have a clear strategy on adolescents' sexual and reproductive health, it is ignoring not just adolescents' health needs, it is also ignoring international/regional, possibly national human rights standards.

Once policy barriers are identified, recommendations are made to remove these. For instance, in some countries, national laws explicitly exclude unwed women from reproductive and sexual health services – these laws are violating international human rights standards set by CEDAW or CRC that the country may have ratified. As a result of the application of the Tool the country may revise its laws and policies in order to provide reproductive health services for all, without discrimination.

INDICATORS FROM A HUMAN RIGHTS PERSPECTIVE

A related effort is that of developing indicators on sexual and reproductive health from a human rights perspective. The Department is working closely with Paul Hunt, United Nations Special Rapporteur on the Right to Health, who is developing 'right to health indicators'. For instance, the Department has assisted Hunt to develop right to health indicators related to maternal mortality. "But we are not sure that addressing sexual and reproductive health issues exclusively in the context of the right to health is proper," says Kismodi.

"We believe that human rights are interrelated and the application of civil and political rights to maternal mortality, such as the right to life, set by ICCPR is as important as the application of the right to health, set by ICESC," says Kismodi. Making the claim that maternal mortality violates the right to life is as powerful as saying that it violates the right to health. "It is powerful to invoke both together. What indicators is it important to look at from the perspective of protecting and fulfilling human rights?"

The Reproductive Health and Research Department also strengthens the links between sexual and reproductive health and human rights through other efforts. Interaction with various treaty monitoring bodies is one such effort. The unit coordinates the interactions with CEDAW and provide information on sexual and reproductive health issues to other international treaty monitoring bodies. It usually provides information to countries in which WHO has a presence, where solid data is available and where sexual and reproductive health problems occur.

"Looking at specific health data in the context of different conventions may build capacity in the committees as well," says Kismodi. "We wouldn't say it's the result of our work, but we see an increasing tendency where,

besides CEDAW, other committees are taking up sexual and reproductive health issues. Like the Committee on Economic, Social and Cultural Rights, the Human Rights Committee, the Committee on the Rights of the Child."

THE CHALLENGE OF NEW CONVENTIONS

Participating in the development of new conventions is another such effort. The Department contributed to the inter-agency discussions around the Convention on the Rights of Persons with Disabilities, which has been signed by 100 countries since 30 March 2007. During negotiations, WHO among others, pointed out that sexual and reproductive health should be discussed in the context of health and not in the context of 'families', so the Convention should not give less recognition to human rights related to sexual and reproductive health in this convention than in other international treaties. "We cannot go backwards after ICPD," says Kismodi. "The convention is calling for equality and non-discrimination for disabled people. But we can't discriminate in the area of sexual and reproductive health."

Including the Disability Convention, there are now seven international human rights treaties and conventions in place. The Office of the High Commissioner for Human Rights is working on the reform of the treaty monitoring bodies. One of the models would be a unified treaty monitoring body, possibly different chambers established according to the different conventions. Under this new plan, a country would report on all its treaty obligations at once (instead of reporting at different times under each convention). This new structure may jeopardize the possibility of specific issues, such as health, and specifically sexual and reproductive health being discussed in length, as has been done increasingly in the past couple of years.

The RHR unit is participating in this process and trying to ensure that sexual and reproductive health does not get left out of the fray. "Imagine if one country is reporting in two days on everything from mass human rights violations in terms of terrorism, torture, violence, displaced populations," says Kismodi. "And maternal mortality is not so high in this country, but it's still high. And there is HIV. When could a unified treaty monitoring body consider sexual and reproductive health in the middle of all these issues?"

The confusion related to sexual rights is a big challenge in positioning sexual and reproductive health as human rights. That is why the Department is embarking on a project that may help to clarify the content and meaning of 'sexual rights'. This project will involve different human rights and public health experts and will examine how international, regional and national courts have applied human rights related to sexual health. It is important to recognize that one issue, for instance abortion, may be addressed in the context of the right to health, when safe abortion services are denied from certain population groups, but also in the context of the right to be free from inhumane and degrading treatment when services are denied to the victims of rape. It is important to clarify what is the content of sexual rights and which issues should be considered under this.

The Department is working with various partners on this and will produce some studies and guidelines in the near future with this regard. "The content is not clear," says Kismodi. "Where do we put abortion? If we put it in reproductive rights and sexual rights, it's important to say why abortion can be both. It is always related to the right to health, but its also related to the right to freedom from inhuman treatment when denied to rape victims. Where do we place it? What is sexual health in the context of the right to life? What is sexual health in the context of non-discrimination? Someone has to have the knowledge around this."

Dr Peter Weis is Medical Officer, Office of the Assistant Director-General, Family and Community Health. The team he is part of tries to bring many worlds together – sexual and reproductive health, adolescent health, gender and health on the one hand; and HIV/AIDS on the other.

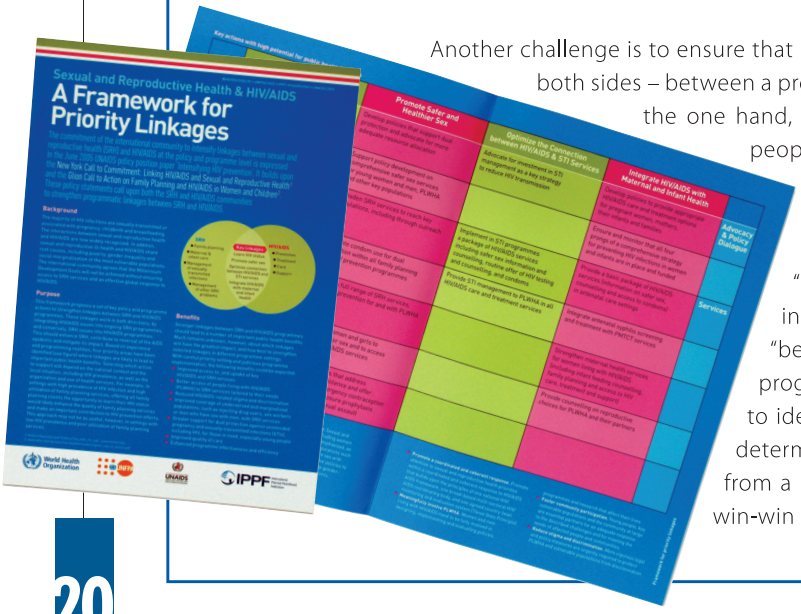
"We need to ensure that the health sector response to HIV considers these issues," says Weis, "and vice versa – that HIV is part of these issues too. Many family planning providers are not really prepared to deal with issues of clients who are HIV-positive, and vice versa. We need to train at both ends."

A related issue is that of dual protection. While the family planning world deals with contraception, it discounts condoms which have lower efficacy rates than other contraceptives. Conversely, the HIV community focuses largely on condoms as the sole means of preventing the sexual transmission of HIV. "What clients need, men or women, are both," says Weis. "We try to bridge that gap."

Four priority linkages have been identified between sexual and reproductive health on the one hand, and HIV/AIDS on the other:

- Promotion of learning one's HIV status and access to services
- Promotion of safe and healthy sex
- Optimizing connections between services for STIs and HIV
- Integrating HIV with maternal and child health and vice versa

WHO, in collaboration with UNFPA, UNAIDS and IPPF is promoting these linkages within their respective constituencies. But there are several challenges. One of the biggest: providers already feel overburdened with the list that is always getting longer. On the upside, case studies in Kenya, Haiti and Serbia show how this is possible – and provides real benefits to clients.



Another challenge is to ensure that sexuality does not get left out of the fray on both sides – between a programmatic focus on reproductive health on the one hand, and a conceptual frame that does not see people with HIV as sexual beings. Sexual violence, for example, is yet another area of overlap that needs programmatic attention.

"We are not advocating that everything be integrated with everything else," says Weis, "because there are huge universes of policies, programs and services. What we say is you need to identify the most important linkage areas and determine which linkages are feasible, make sense from a public health perspective and will lead to a win-win situation."

SEXUALITY AND HIV

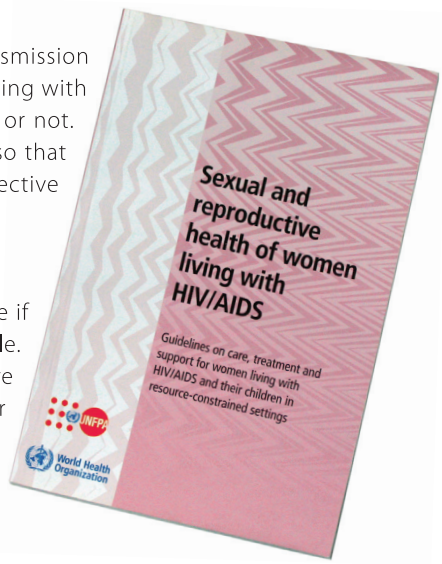
Dr Kevin O'Reilly and Dr Donna Higgins work in the Department of HIV/AIDS at WHO. In a context where 80% of HIV worldwide is transmitted through unsafe sex, they discuss how sexuality, gender and rights interact with their work in prevention, treatment and care.

Q: How do you address the links between sexuality and HIV in your work?

A: The guidelines for essential care for people living with HIV includes prevention of opportunistic infection and onward transmission. It would be very useful to treat people living with HIV/AIDS (PLWHA) as if they are vectors of disease. We are very careful not to do that but to realize the full sexual and reproductive health and right of PLWHA. They have the full right to continue being sexually active individuals, and they need assistance so that they can indulge in the full range of sexual expression with as little fear of infecting their partners as possible. It's a sex-positive orientation as opposed to a sex-negative one.

Q: How does this apply to reproductive rights?

A: The same thing is true of the prevention of mother-to-child transmission (PTMCT) guidelines, which is again based on the premise that women living with HIV/AIDS have the full right to choose whether they wish to reproduce or not. But to do that, individuals need to be armed with enough information so that they can make informed choices. And they need to be provided effective services and care so that they can act on these choices.



Q: Any other examples?

A: We have issues that are specific to women, such as the risk of violence if they disclose, which is very small from the studies that we have available. The other thing around sexuality is that we're really pushing for more couples to be tested, and for a woman to bring in her partner, or vice-versa. There is pretty good evidence that when counseling is done in the context of a couple, its more effective. It helps facilitate the kind of conversation that a couple should have about sexuality, but its tough.

Q: What about prevention of HIV among sex workers?

In our work on prevention of transmission in sex work settings, which is not based on the premise that all women in sex work are being trafficked and exploited, but on the premise that a lot of women choose to go into sex work for reasons of their own. It may not be a completely free choice, they may not have a whole range of opportunities open to them, but it is a free choice in that they are not coerced into it by someone forcing them to do it.

In that context, they have the right to freely engage in sex work if they choose to do so, but they need to be assisted to prevent themselves from being infected. That's the first step. And then subsequently to prevent other individuals as well from getting exposed. Again, it's all based on the right to choose and information that enables people to make informed choices.

1. *Education And Treatment In Human Sexuality: The Training Of Health Professionals* (WHO Technical Report Series No 572, 1975)
2. *Anna Glasier, A Metin Gülmezoglu, George P Schmid, Claudia Garcia Moreno, Paul FA Van Look: Sexual and Reproductive Health: A Matter of Life and Death* (The Lancet, Volume 368, Issue 9547, Pages 1595-1607)
3. *Mahmoud F Fathalla, Steven W Sinding,Allan Rosenfield, Mohammed M F Fathalla: Sexual and Reproductive Health for All: A Call for Action* (The Lancet, Volume 368, Issue 9552, Pages 2095-2100)

GUTTMACHER INSTITUTE

EVOLVING AS THE FIELD HAS EVOLVED

Premarital sex is nearly universal among Americans. Nicaragua votes to ban all abortions. People living with HIV do not lose their desire to have sex and bear children.

THESE ARE headlines from the website of the Guttmacher Institute, a United States-based organization that advances sexual and reproductive health worldwide through research, policy analysis and public education. Ten years back, the Guttmacher Institute focused predominantly on pregnancy, fertility, contraception, family planning services, abortion, and birth planning – issues linked to reproduction. Since then, the S word – sexuality – has entered the fray.

"We're trying to take on more and more the sexual health aspect of people's lives as well as the reproductive health aspects," says Heather Boonstra, Senior Public Policy Associate. "We're now further along the continuum where sexual health is more part of our agenda."

The Institute's shift towards including sexual health is part of an expanding discourse in reproductive health and rights. Writes Geeta Rao Gupta: "Up to the International Conference on Population and Development in Cairo,…family planning programs worldwide managed to function without somehow acknowledging the central role sexual behavior played in contraception."[1] Reproduction and sexuality were seen as different worlds, with reproduction dominating the discourse. "I used to joke that in the old days our study of contraception was so divorced from sexuality that it was as if we had the mindset that people had sex so that they can use a method," says David Landry, Senior Research Associate.

CAIRO: A COMMITMENT TO SEXUAL HEALTH

The 1994 Cairo conference was the first of its kind to explicitly mention sexual health, committing governments to ensuring that "women and men have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities."[2] The Cairo Program of Action affirmed the rights of individuals "to have a satisfying and safe sex life" and noted that the purpose of sexual health is "the enhancement of life and personal relations."[3]

Governments and organizations responded to this in many different ways. Among other things, the Guttmacher Institute started looking at how family planning agencies deliver non-reproductive health services around sexually-transmitted diseases and infections. A special publication called *Testing Positive* focused on STDs, a stretch for an organization that had till then placed STDs at the periphery of its work. "It was kind of a slow recognition that reproductive health does not exist on its own," says Landry.

WHAT GUTTMACHER DOES

The Guttmacher Institute advances sexual and reproductive health worldwide through an interrelated program of social science research, public education and policy analysis. For nearly four decades, Guttmacher has demonstrated that scientific evidence — when reliably collected and analyzed, compellingly presented and systematically disseminated — can make a difference in policies, programs and medical practice.

PROGRAM AREAS

- Protecting the Next Generation: Adolescent sexual and reproductive health
- Adding it Up: Sexual and reproductive health services and financing
- Rights and Responsibilities: Healthy pregnancies, contraception and abortion
- Healthy Sexuality: Relationships, intimacy and sexual behavior

The Institute was named to honor a distinguished obstetrician-gynecologist, author and leader in reproductive rights, Alan F. Guttmacher.

If Cairo catalyzed an interest in sexual health, the rise of HIV/AIDS also focused attention on underlying issues of sexuality. "It made you think: What are the conditions in people's lives that puts them at risk of disease?" asks Boonstra. Another factor was the changing face of public health research. "A lot of the questions had already been answered," says Jennifer Nadeau, former Director of Communications.[4] "For instance, unintended pregnancy has already been measured again and again. To better understand what's really happening in women's lives, you have to ask a new question or ask the question in a different way."

In choosing which research question to focus on, the Guttmacher Institute has typically focused on those questions that have policy relevance. For instance, the Institute's work contributed to the creation of the Title X ("10") program in the United States, which provides low-cost contraceptive services to low-income women. "Research is the backbone of the Institute, but we have always had a focus on policy," says Boonstra. "We see it as a spiral relationship where policy and communications inform research, and research findings come out and are translated into policy action."

BEYOND CAIRO: EXPLORING THE LINKS BETWEEN S AND R

Since Cairo, the Institute has increasingly explored the links between sexuality and reproduction, without losing its core interests in contraception and abortion. "The way people express themselves sexually is more central to our work, and is seen as a component rather than just a sidebar to a health outcome," says Boonstra. "There is a desire to think more about how relationships affect contraceptive use or people's decision-making. To get there, you have to get more into not just sexual behaviors, but also into sexual relationships."

For instance, the single-biggest research project at the Institute is *Protecting the Next Generation,* a four-country study in sub-Saharan Africa that focuses on protecting young people from HIV and unintended pregnancy. The survey includes questions on romantic relationships, family relationships, what young people know and want to know about sex, transactional sex, coercive sex etc. "It's going far beyond looking at sexual behaviors to situate risk within the context of young people's lives," says Nadeau. "It's not a strictly public health focus but more of a sexuality framework."

Ongoing work also increasingly focuses on issues underlying reproductive health, such as gender-based violence. A 2004 issue of the Institute's influential peer-reviewed journal, *International Family Planning Perspectives,* was devoted exclusively to this, with papers exploring the relationship between intimate partner violence and unintended pregnancy; the experience of sexual coercion among young people; how infidelity, violence and forced sex are associated with HIV; and socio-economic factors and processes associated with domestic violence. "This is yet another example of pushing the boundaries of how we define ourselves," says Nadeau.

In 2006, the Guttmacher Institute published a policy brief that underscores not just the reproductive health needs of people living with HIV, but also their sexual health needs. The brief, published in collaboration with several organizations,[5] is based on the premise that people living with HIV are sexual and reproductive beings - they do not lose their desire to have sex and bear children just because they have HIV. Building on this, the brief identifies factors that can limit positive people's access to sexual and reproductive health services such as weak health care systems, taboos around sex, gender inequalities, stigma and discrimination.

BUILDING THE SEXUAL INTO THE REPRODUCTIVE: CHALLENGES

The move to gradually build sexual health into its reproductive health portfolio has come with its own set of challenges, including political opposition. "Today, we're confronted with a kind of ideological conservatism," says Boonstra, "where decisions about what kind of information people should be receiving is based more on beliefs than on best practices in public health." Within the US, the Institute is working with members of Congress to change the dialog around 'abstinence-only programs' to prevent HIV – which it sees as a narrow approach to pregnancy and disease prevention. "We're making more connections between domestic and international sexual and reproductive health," says Landry, "including monitoring the export of abstinence-only efforts overseas."

In 1984, the Institute opposed the Global Gag Rule or the Mexico City Policy that was introduced during the Reagan era, rescinded by Bill Clinton and reinstated by George Bush, calling it "anti-family planning" and "undemocratic". This policy mandates that no US family planning assistance can be provided to foreign NGOs that use funding from any source to perform abortions or provide information and counseling on them. More recently, the Institute has filed an amicus brief in opposition to the Bush administration's policy on the 'anti-prostitution pledge'. This provision disqualifies foreign and domestic NGOs from eligibility for US HIV funding unless they have a position that opposes prostitution.

"Ideological opposition is just as strong in other countries that we work in as it is in the United States," says Nadeau. "If we're doing work on abortion and we say that women will die if abortion is illegal and unsafe – that's very powerful everywhere. But to say that by restricting women's access to contraception, we're not allowing them to express themselves sexually, well who cares?"

Political opposition also ensures that issues are framed as 'sexual health' issues rather than as 'human rights' issues. "We feel that a lot of our work involves human rights but we don't necessarily make the explicit connection to it," says Landry. "The right wing has somehow made human rights seem like it's a dirty word or something." At the Institute, abstinence is seen as a violation of the right to information, abortion restrictions are seen as violations of the right to one's own reproductive health, and people with HIV are seen as having the right to sex and to bear children if they wish. "But at the political level, it doesn't work in the United States to talk about rights," says Boonstra. "We have to talk in terms of sexual health and the evidence of impact on health, even though incorporated in that is a rights-based approach."

THE UMBRELLA: REPRODUCTIVE HEALTH OR SEXUAL HEALTH?

In 2005, a vigorous debate was launched within the Institute after the board proposed that sexual health become the umbrella for all Guttmacher's work, including reproductive health. "We felt that's where the field is moving and we wanted to be part of that movement," says Nadeau. Perspectives differed. Some felt sexual health is part of reproductive health (not vice-versa) and that shifting to a sexual health umbrella could be interpreted as a narrower focus. Others equated sexual health with STDs and HIV and "we didn't want people to think we are moving away from our core interests in contraception and in abortion," says Nadeau. Many staff persons had emerged from the reproductive rights movement and felt uncomfortable at the prospect of losing this emphasis. Eventually, the status quo remained.

However, more than a decade after the Cairo conference, sexual health is very much part of Guttmacher's constellation of concerns. "I think sexual health is firmly embedded," says Boonstra, "because at least at the political level, many of the issues that we face are not really about teen pregnancy or HIV – they're about sex and who's having sex and control over sexuality. You can't talk about one without the other. There's no divide."

1. *Geeta Rao Gupta: Gender, Sexuality and HIV/AIDS: The What, The Why and The How* (July 12, 2000 Plenary Address XIIIth International AIDS Conference Durban, South Africa)
2. International Conference on Population and Development (ICPD) Program of Action para 7.36b
3. ICPD Program of Action para 7.2
4. Jennifer Nadeau is no longer with the Guttmacher Institute
5 The policy brief was published jointly by the Guttmacher Institute and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in collaboration with EngenderHealth, the Global Network of People Living with HIV/AIDS (GNP+), the International Community of Women Living with HIV/AIDS, the International Planned Parenthood Federation, the United Nations Population Fund (UNFPA) and the World Health Organization

IPPF

GOING BEYOND WORDS ON PAPER

WHAT IPPF DOES

Founded in 1952, IPPF is both a service provider and an advocate of sexual and reproductive health and rights.

IPPF'S FIVE PRIORITY AREAS

- Adolescents
- HIV/AIDS
- Abortion
- Access
- Advocacy

WHERE IPPF WORKS

IPPF works through 150 Member Associations (MAs) and is active in 182 countries. These countries form six regions, each with a regional office: Western Hemisphere, Africa, South Asia, Arab World, East & South-East Asia & Oceania; Europe.

Each MA is an autonomous legal entity with its own board that may or may not be funded by IPPF. As a member of the federation, MAs must abide by common principles and put these into practice. IPPF provides technical support to all MAs, financial support to some, and ensures that MAs abide by agreements through an accreditation process.

"IPPF envisages a world in which…sexuality is recognized both as a natural and precious aspect of life and as a fundamental human right…"
Our Vision, IPPF Strategic Framework 2005-2015

WHAT HAPPENED THEN? How did an international federation providing family planning services around the world since 1952 come to incorporate sexuality into its overall vision, a vision that binds its 150 Member Associations? Why does a network focusing on global contraception delivery decide to reposition itself as "the strongest global voice safeguarding sexual and reproductive health and rights for people everywhere?"[1] What compels an organization primarily concerned with birth control for half a century to envision a world where "women, men and young people have control over their own bodies and therefore their destinies…a world where gender or sexuality are no longer a source of inequality or stigma."[2]

"Sexuality has been an implicit part of our reproductive health work for the last 15 years or so," says Angela Heimburger,[3] former Senior Program Officer - Access, Western Hemisphere Region. "But I still think it's the *one* issue that we are still so scared to address on so many levels." The paradigm shifts at the International Planned Parenthood Federation (IPPF) are reflective of the field as a whole: the move from family planning in the 1980s to reproductive health in the 1990s, the subsequent inclusion of reproductive rights, then the linkage with sexual rights and the entry of sexuality in the 2000s.

Organizations like IPPF are continuously shaping and being shaped by the field in a series of dialogic encounters. "The Cairo and Beijing agendas crystallized a lot of thought and solidified an international movement," says Heimburger, "but IPPF was already working on it. The conferences lent legitimacy and maybe a bit more momentum."

GENDER: A PLATFORM FOR SEXUALITY

Within IPPF, windows for incorporating sexuality had popped up from the late 1980s, with gender integration providing one such platform. The struggle to integrate gender paved the way for looking at sexuality. As the federation grappled with a male-dominated governing structure, a strategic plan[4] noted that women's empowerment was one of the six key challenges facing the organization.

This resulted in strategies to integrate gender at all levels – policy, program, services. Women were appointed in key positions of power and leadership on board and staff. Gender advisory panels were created at the highest levels.

Special internships enabled feminists to work inhouse at IPPF. Alliances were built with women's health networks. "That was radical," says Nana Otoo-Oyortey, Technical Officer, Gender and Rights. "Now we have more than 50% women's representation at IPPF. That 50% is now like policy. Everyone accepts it."

At the program level, the Quality of Care initiative became a pivotal point to integrate gender. Using Judith Bruce's model, the IPPF Western Hemisphere region developed indicators to evaluate and strengthen the relationship between clients, mostly women, and providers of family planning services. The initiative helped understand and address the uneven power relations under which women, especially grassroots women access contraception, write Adriana Ortiz-Ortega and Judith Helzner.[5] "It revealed some of the shortcomings of conventional family planning programs while also translating feminist concerns into programmatic and operational concepts."

Gender training simultaneously tried to ensure that gender perspectives were integrated into service delivery at the clinical level. "But if you're talking about gender, you have to talk about sexuality," says Otoo-Oyortey. "It's so linked. It's the basis for women's vulnerabilities in so many situations." Practices like female genital mutilation and child marriage are some early indicators of this link. "Why do you have to undermine women's sexuality right from the time they are babies? Or marry them off at an age when they are not able to make decisions?" asks Otoo-Oyortey. "And then when they come to the clinic, you only address the reproductive. You're not seeing the total woman."

A CHARTER ON SEXUAL AND REPRODUCTIVE RIGHTS

If gender provided one platform to look at sexuality, rights opened another window. Although family planning organizations have not always used rights-based approaches, IPPF's framework on 'the rights of the client' created a base. Quality of care cannot be ensured unless clients have the right to information, access to services, choice, safety, privacy and confidentiality, dignity and comfort, continuity of services, and opinion.[6] "This forms very much a basis at the service level," says Otoo-Oyortey. "We try to translate that into real action. We're not doing these people a favor. We're there because it's their basic entitlement."

Another layer was added to this base when the IPPF Charter on Sexual and Reproductive Rights was developed in 1995. Using international human rights instruments, the Charter[7] showed how sexual and reproductive rights are key human rights issues. "For instance, we took the right to life, which Amnesty International has been phenomenally successful in associating with capital punishment," explains international development consultant Karen Newman, who worked on the charter. "We said, sure, that's an important issue, but what about women who are dying needlessly day in and day out from sexual brutality? Is that not also a human rights violation?"

Similarly, the Charter showed how female genital mutilation and sexual harassment violate the internationally-guaranteed right to liberty and security; how discrimination based on sexual orientation violates the right to equality and freedom from discrimination and the right to privacy; and how a lack of sexuality education violates the right to information and education. "At the time when we had to produce it, it was radical and new," says Newman. "We were one of the first people to do that systematically."

GENDER, SEXUALITY, RIGHTS: CROSS-CUTTING ISSUES

A decade after the charter was developed, gender, sexuality and rights are seen as cross-cutting issues to be integrated in programs and services across IPPF's five As – adolescents, AIDS, abortion, access, and advocacy. "In terms of gender, there's been some success, or at least attempts that seem more tangible in terms of how gender inequalities or violence against women is dealt with," says Carmen Barroso, Regional Director, Western Hemisphere. "And rights is also something that people buy into. And then there's sexuality, which is sort of like a stepchild in a corner, going 'I'd like to participate, but how?'"

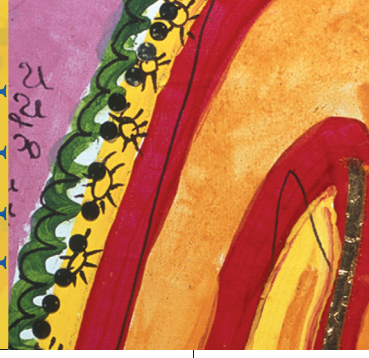
The barriers to integrating sexuality at IPPF are common to those that others face.

- **It's too private.** Service providers at clinics are often wary to step into a domain that is considered intimate, personal, an individual matter, and therefore outside of the professional realm. "People may be afraid of showing some kind of attitude they consider unprofessional," says Kate Rath, Program Coordinator – Access, Western Hemisphere.
- **It's too nebulous.** Even when sexuality is conceptually taken on board, program staff grapple with applying it to their work. "It's conceptual. How do you plug it in?" asks Rath. "How do you make it practical?"
- **It's an add-on.** Staff see sexuality as yet another program to be added on to their bulging portfolios, or more work. "It's not taking on more," says Rath. "It's just a shift in how you address questions or deal with clients. It's not going to make your session longer, just frame it differently."
- **It's seen as not basic.** Sexuality is often seen as an interesting concept but not one that is as basic as contraception or human rights. "People can't contracept effectively if they cannot address the issues that surround their sexuality," says Rath. "They can't really have their human rights unless they address that. We have to be champions of not letting sexuality be seen as a luxury item."
- **It's value-laden.** Providers bring deeply-held values around same-sex relationships, sexual behaviors, HIV etc to their work. "The whole idea that hangs over us as a field is the idea of promiscuity," says Rath. "What's right, what's wrong, what's too much, what's too little. That's a constant struggle with contraception or HIV or abortion or anything else."

Despite these barriers, IPPF has made numerous strides in integrating sexual health into its portfolio. In 1992, IPPF published a guide for trainers in sexual health that is still used in the region. In 2001, a groundbreaking symposium on Power and Sexual Relations was held in collaboration with the Population Council. IPPF's Canadian MA recently changed its name to the Canadian Federation for Sexual Health, and their programs and activities justify the name. Some of IPPF's associations in Latin America and elsewhere have excellent sexuality education programs, as for instance the one in the Dominican Republic. And IPPF's associations in Sweden, Holland, Belgium and Denmark are leaders in the field.

WORKING WITH MEMBER ASSOCIATIONS AROUND THE WORLD

For a federation that works with 150 Member Associations (MAs) and is active in 182 countries, championing sexuality brings other challenges. Some MAs, specially in Latin America and Europe, have integrated sexuality more deeply into their work, while others are struggling. Sexual orientation is a topic that only a few MAs have incorporated. For instance, the Brazilian MA has a project on gay and lesbian youth. Colombia's Pro Familia has a program called *Hombre Mas Hombre* with special clinics for men and special attention paid to gay men. "*Hombre mas Hombre* means more of man and man plus man," says Barroso.



Many countries in which IPPF works have laws and policies that restrict contraception, abortion, same-sex relationships and other sexual and reproductive health issues. In certain government circles, the use of the term 'sexual and reproductive health' is taboo. In some Caribbean countries, contraception is not allowed below the age of 16, even when sex is permitted at the age of 14. In parts of Latin America, the Catholic church is funding smaller church groups to launch powerful campaigns against sexuality in the same vicinity as IPPF Member Associates.

"Sometimes MAs are funded by the government, so it is difficult for them to challenge restrictive policies," says Otoo-Oyortey. While some Member Associations have contributed to changing the policy climate in their countries[8], others cannot or do not. "We're trying to get MAs to engage more with the policy environment," she says, "either by directly engaging with policy makers or by being at the awareness raising level and creating a momentum for change." Where MAs play a largely service provision role, IPPF is helping them use their positions to take on an advocacy role.

Policies such as the Global Gag Rule[9] pose another set of challenges for IPPF. MAs that have signed the Global Gag Rule are allowed to remain members but cannot get IPPF funds. US government pressure to use abstinence as an HIV-prevention tool has forced IPPF to ask itself the big question: Should IPPF have the same messages around the world? Says Otoo-Oyortey: "We're developing an advocacy tool for our members to think about abstinence-only and abstinence-till-marriage programs and how that reflects an anti-sexual thinking."

SEXUALITY – THE WEAKEST LINK AT THE CLINIC

Do providers assume that all clients are heterosexual? Do service providers treat clients of both genders the same way when dealing with topics of abstinence, monogamy and multiple sexual partners? Does the clinic have some kind of protection against or compensation for discriminatory practices that may occur? These are just three of the 200-plus questions that are part of IPPF's self-assessment tool for identifying if gender, sexuality and rights have been integrated into the clinic – the lynchpin of IPPF's service delivery system, where all principles must ultimately percolate down into good practices.

The self-assessment tool clearly indicated that sexuality is the weakest link in programs and services. "A multitude of things from different parts really brought out the fact that we need to focus on sexuality," says Otoo-Oyortey. "For instance, a young boy may come to a clinic run by a Member Association and say, "I'm a homosexual". They have no clue what to do. They don't know how to deal with this situation." Or a question in the exit box at a clinic might say the same thing. "There is shock," she says. "They didn't think homosexuals exist in their country."

The search is on for innovative, sustainable mechanisms to build sexuality into service provision. Several clinics have found a way to address domestic violence among their clients through simple but effective means. Some providers wear buttons saying, "You can talk to me if you have experienced violence," a small change that can really open up the clinical environment. "It's a tool that ensures that from the waiting room onto the clinician you feel comfortable talking, asking questions," says Rath. This feeling is reinforced through other mechanisms, such as the clinical history form which now includes questions to identify a client undergoing domestic violence, who is then referred.

"Providers have found it to be extremely helpful in their professional consultations with women because it directly impacts their health, their sexuality, their wellbeing and the health of their kids," says Rath. Bringing domestic violence into clinical practice has shown how services can be strengthened without having to add to the workload or build new expertise – this also offers a roadmap for integrating sexuality into the clinic. "We're going to open up that window and say, 'You can talk to a lesbian or a man having sex with men as a provider. You don't have to be an expert or a sexpert to do that."

PUTTING SEXUALITY INTO THE YOUTH BASKET

One basket into which sexuality has snuggled is IPPF's youth or adolescent program. "You know, the adults reproduce without having sex, but the youth, they are just sex," says Barroso. "They are nothing else but sex. That's what is behind the fear of youth sexuality." Integrating sexuality into the youth program has meant "pushing and pushing and pushing," says Doortje Braeken, Senior Adviser/Theme Leader for Young People/Adolescents. "You have to talk about sexuality. Otherwise we are totally missing the point."

Part of the push came from a young people's manifesto at IPPF that demanded three rights for teens: the right to access information, the right to be active citizens of their countries, and the right to enjoy their sexuality. "This created major confusion and anger among IPPF's governing council," says Braeken. "They said they don't want young people to have sex. As if sexuality is only about having sex."

A factor that aided the recognition of young people's sexuality is the fact that 20% of IPPF's governing council is below 24 years. Another hook was the need for sexuality education in the era of HIV/AIDS. "You cannot just boom! talk about sexuality," says Braeken. "You need the right hook." Along with Population Council, IPPF is developing guidelines for comprehensive sexuality education using gender, sexuality, rights as an entry point, rather than biology. The guidelines talk about sexual rights, sexual abuse, homosexuality etc. "It's a whole new way of looking at sexual citizenship."

An innovative aspect of this is the attempt to reclaim language from the sex industry. "We have absolutely no connection with the sex industry," says Braeken. "We look down upon them. But who do young people want to listen to? Why don't we learn what they are doing right? Because they can talk about sex, about enjoyment, about orgasms."

Side by side, IPPF is also re-assessing its peer education program to ensure that this is rights-based and empowering, rather than a tool for behavior change. Child protection policies are being introduced across the federation. "For example, if a peer comes in and says she is getting married to someone older but does not want to, what is the MA doing about it?" asks Braeken.

Other moves are afoot. Three youth working groups are looking at sexuality, sexual orientation and sexual diversity. Condoms are being re-assessed, not from the perspective of HIV/AIDS, but as dual protection against pregnancy and HIV. "We want to make condom use much sexier and link it with pleasure," says Braeken. "How can we address the sexuality of young men and not just look at them as predators?"

FULLY INTEGRATING SEXUALITY: A KEY CHALLENGE

Full integration of sexuality into IPPF is still a work in progress. The key to doing so is a combination of the right strategy and the presence of individuals who see the relevance of sexuality. "Individuals have made a big difference," says Heimburger. "Whoever is in power can dictate where funds go and how we frame things."

Many strategies are being used as part of this struggle. An assessment of existing materials: are they gender-equity promoting, rights-based and sex-positive? An award for integrating sexuality. An Innovations Fund to support cutting-edge work. A new monitoring division. A review to tease out 'sexual health' and 'sexual rights' elements from the five As. "Sexual health is more our focus because this is a medical organization at heart," says Heimburger. "The sexual rights is what we are trying to develop more explicitly now." A bill on sexual rights is in the works and is expected to provide impetus to this effort.

One ambitious plan aims to offer bronze, silver and gold packages on sexuality. MAs opting for the basic bronze package might add questions on sexuality and place posters on sexual rights at the clinic. The silver package might add sensitivity training for staff to this. "There are different levels of incorporation," says Rath. "We can start at one level and give people recognition for growing."

Another strategy to integrate issues such as sexual orientation, which get left out, is staffing and board membership. Three out of 44 MAs in the Western Hemisphere region have gay and lesbian individuals on their board, a policy that influences programming. "I think sexual orientation is very important," says Barroso. "If we want to reach out to groups that are leading a movement for sexual rights and for combating HIV, we need to have on our board elements of those groups."

Building alliances is another key mechanism. A recent IPPF program to prevent child marriage has built alliances with a new set of actors: Oxfam, Womankind International, Anti-Slavery International. "We're reaching out," says Otoo-Oyortey. "And that for me is the dimension of having to work on sexuality."

Reaching down – to the clinic and the community – is perhaps the biggest challenge that still remains. "When it comes to the service provision level, we need to do a lot more work around sexuality," says Otoo-Oyortey. "We need to become a safety net for people." Until that happens, sexuality will still remain an unrealized intention, a work in progress, a word that still has to leap off the page.

1. *Who we are, IPPF's Strategic Framework 2005-2015*
2. *What we believe, IPPF's Strategic Framework 2005-2015*
3. Angela Heimburger is no longer with CARE
4. The strategic plan Vision 2000 was presented in 1992 when Halfdan Mahler was General Secretary of IPPF
5. *Adriana Ortiz-Ortega & Judith F Helzner: Opening Windows To Gender* (IPPF/WHR Working Paper No 1 June 2000)
6. *http://www.ippf.org/en/What-we-do/Quality+of+Care+programme.htm*
7. This charter is endorsed by all Member Associations and has been translated into more than 20 languages
8. For instance, the Ethopian MA contributed to changing a restrictive abortion law
9. This prohibits organizations in receipt of US funds from using their own money to provide abortion information, services and care, or even discussing abortion or criticizing unsafe abortion

OPEN SOCIETY INSTITUTE

BRINGING THE MARGINS TO THE CENTER

IN MAY 2006, a federal judge ruled that the US government's 'anti-prostitution pledge' violates the First Amendment. The ruling was in response to an Open Society Institute (OSI) lawsuit against USAID, challenging its policy of requiring grantees to sign a pledge opposing prostitution. OSI argued that the loyalty oath was unconstitutional and flew in the face of sound public health. That the oath falsely cast sex workers as part of the problem rather than acknowledging their role in developing and implementing successful HIV/AIDS prevention strategies.

It is unusual for a donor to intervene so forcefully in public policy, but then, OSI has always constituted itself somewhat differently. Since 1993, when it started, OSI's programming core has been composed of those at the margins. Sex workers. Drug users. The Roma people. Those who are gay lesbian or transgender. Those who are stateless. Or invisible. Or forgotten. The unmentionables.

At the heart of OSI's work is an attempt to address social exclusion - marginalization from employment, income, social networks such as family, neighborhood and community, decision making and from an adequate quality of life.[1] Social exclusion gradually distances and places persons, groups, communities and territories in a position of inferiority in relation to centers of power, resources and prevailing values.[2]

If social exclusion is one of the hallmarks of a closed society, an inclusive society goes hand in hand with the concept of the Open Society – where nobody has a monopoly on the truth, where different people have different views and interests, and where institutions protect the rights of *all* people.[3]

"Open societies have to encompass all people," says Sue Simon, Director, Sexual Health and Rights Project (SHARP). "And there are the people that haven't had any attention or resources, and their voices aren't the voices that are being heard. So from the public health program perspective, we need to put them on the agenda."

WHAT OSI DOES

The Open Society Institute, a private operating and grantmaking foundation, aims to shape public policy to promote democratic governance, human rights, and economic, legal, and social reform.

WHEN OSI STARTED

OSI was created in 1993 by investor and philanthropist George Soros to support his foundations in Central and Eastern Europe and the former Soviet Union. Those foundations were established, starting in 1984, to help countries make the transition from communism.

WHERE OSI WORKS

OSI's two main offices are in New York City and Budapest, but OSI and the Soros foundations network are active in more than 50 countries around the world.

REDUCING HARM, PROTECTING RIGHTS

Sexuality is inextricably linked with social exclusion and with public health. In all societies, heterosexuals, couples and the married form the sexual elite, while sex workers, drug users (many of whom are sex workers), the HIV-infected, and LGBT individuals form the sexually and socially marginalized. They have the least amount of control over their environment and tend to be most vulnerable to HIV and other sexually transmitted diseases. They face a wide range of human rights abuses and don't have access to health or HIV/AIDS services.[4]

At the same time, these groups are often excluded from or marginally included in donor portfolios, networks and communities formed around related issues – women's rights, public health, reproductive rights etc. "That was what prompted SHARP as a place within OSI to take on the needs of these populations," says Simon. SHARP works with sex workers; gay, lesbian, transsexual, and transgender persons; prisoners; Roma community members; injecting drug users; and people living with HIV/AIDS in Africa, Southeast Asia, Central and Eastern Europe, and the former Soviet Union.

Many of these groups overlap with one another. "At SHARP, we really focus on sex workers and LGBT because there are no other places doing that from within a public health framework," says Simon. "So we thought it was really important that the 'health' and the 'rights' be combined, rather than having those be separate streams."

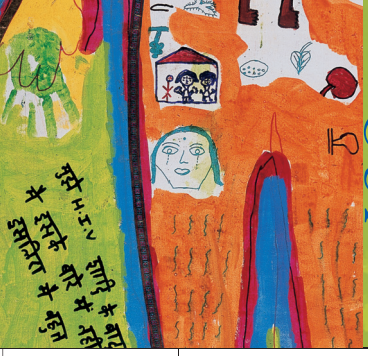
Unlike efforts based around morality or value judgements, the public health program, within which SHARP is located, frames its work around pragmatic achievable goals. Reducing harm. Protecting rights. The aim is not to get sex workers *out* of sex work, but to protect their rights *within* it. The aim is not to get drug users off drugs, but to reduce their potential for harm, including HIV, while upholding their rights and dignities.[5]

Ensuring the centrality and voices of marginalized groups is a key program ethic. "Our biggest goal is to ensure that sex workers are the ones who are leading any kind of service development or policy efforts around the issues that affect their lives," says Simon. "I actually think there's no other way to do it. Who am I to tell sex workers in India what they want or what they need?"

In line with this thinking, SHARP supports groups such as the International Committee on the Rights of Sex Workers in Europe to help develop a rights-based movement of European sex workers and their allies; the Hungarian Civil Liberties Union to promote and protect the health and human rights of sex workers; and the Asia Pacific Network of Sex Workers to build the capacities of sex workers and their organizations.

The program also advocates that donors use a rights-based approach. "We've done donor mapping," says Simon, "and pointed out that there isn't much funding there. Or a lot of the funding isn't coming from a rights-based perspective." A SHARP publication asserts that at a minimum, the rights-based approach should:

- Put a stop to an abuse
- Change the conditions that give rise to the abuse
- Increase the accountability between states and the people affected, first for ending the abuse, and second for creating conditions for greater justice.[6]



Endorsing a 2003 *Lancet* editorial that encourages public health practitioners to address the *conditions,* not the *nature* of sex work, SHARP cautions that a rights-based approach to protecting sex workers' health and human rights must also confront the harms that emanate from society's response to sex work, not simply from sex work itself.

SHARP's donor advocacy is rooted in the understanding that the anti-prostitution pledge, which is in place outside of the US, will lead to a funding gap. "Donors need to prepare themselves and get ready to plug those holes," says Simon. "In a way, we were well positioned to take on a lawsuit, because if we lost our USAID grant, we could have made up for it with our own funds." The lawsuit was filed jointly with its affiliate, the Alliance for Open Society, which was awarded a USAID grant in 2002 to implement an HIV prevention program among drug users, many of whom are in sex work.

"We feel that if people really understood what the prostitution pledge was, they would not support it. How is it that we keep getting creamed in the media?" asks Simon. "Why is it that the messages advocates are putting out do not necessarily resonate with the public or with donors or with politicians? How do we need to frame these arguments?"

As part of its advocacy around this, OSI has supported an initiative to develop effective communication around shared advocacy goals, a five-country study and a video showing how the pledge has affected service providers and sex workers' groups. Efforts are also afoot to demonstrate the efficacy of sex worker-led programs through best practice case studies in Thailand, South Africa, Russia, Slovakia, Romania and the United States.

Law is an important aspect of SHARP's work, simply because laws influence the equitable distribution of public health services and information. Laws that attempt to regulate sexual conduct such as prostitution, sodomy, sex outside of marriage and laws criminalizing transmission of HIV have a profound impact on people's ability to protect their health and seek health services[7]. SHARP is supporting studies in Canada, India, South Africa, Australia, the Netherlands, Senegal, Brazil and Thailand to explore jurisdictions with specific legal and regulatory environments on prostitution and the impact of these policies on sex workers' health and human rights.

"If we think things are bad for sex workers, they're equally bad for LGBT folks around the world," says Simon. "Particularly in places like Africa where your health and safety would be very much at risk if you took the basic step of making yourself known or coming together with other LGBT people."

LGBT issues cut across many themes and geographies at OSI; while SHARP addresses these from a public health perspective, the Human Rights and Governance program works on LGBT rights in eastern Europe and the former Soviet Union. The Middle East and North Africa program has also made LGBT-related grants, while an LGBT Working Group has been set up inside the organization. In 2006, the International Gay and Lesbian Human Rights Commission took a group of South African LGBT activists to testify before the African court – the first time this had ever been attempted. This initiative was supported by SHARP in collaboration with the Network Women's Program.

Despite such groundbreaking efforts, realizing sexual rights for marginalized groups remains a huge challenge. "In many places around the world, it doesn't work to come at things from a rights-based perspective," says Simon. "In some places, people aren't even allowed to congregate. We have to be really mindful of

the dangers that people face and the fact that people have to fight for themselves. We don't have the anticipation that they can start talking rights language or organize HIV services because it's just not feasible in a lot of places. We're just trying to find ways to grab whatever openings exist and support people wherever they are to at least make those small beginning steps."

TALKING SEXUALITY, CHALLENGING CULTURE

Sexuality also finds a place in the International Women's Program (formerly known as the Network Women's Program). Started in 1997, the program initially focused on women's human rights, violence against women, women's health and education. "We were working in a region just coming out of the Soviet experience," says Debra Schultz, Director of Programs. "Many of these countries had very conservative sexual cultures and sexually repressed discourses. I went to Russia in 1996 and was told there were no lesbians in Russia, which seemed highly unlikely."

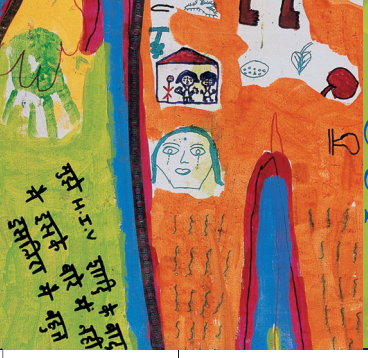
The first programming link with sexuality was via trafficking, when the women's program supported a video documenting how Russian women were being trafficked to the United States, and organized a follow-up seminar in Budapest. "That was really a moment before huge agencies like IOM and USAID had jumped on the trafficking bandwagon," says Schultz. "International agencies have co-opted the issue, which now gets embedded in very complex security agendas."

By the late 1990s, the program had stopped work on trafficking, given its politicization. However, anti-trafficking work remained a priority in the region, with many women's rights advocates in central and eastern Europe disagreeing with the emerging discourse around 'sex work'. "Local autonomy is a strong principle at OSI," says Schultz. "So it was challenging to respect what local women felt should be the approach. But we didn't feel we could make the most constructive intervention with our resources."

A stronger programmatic link with sexuality emerged when 13 young Roma women started discussing the constricting nature of community norms around virginity before marriage. "They felt this was very demeaning and wanted to challenge not only this practice," says Schultz, "but the whole community's lack of realistic conversation around sexuality."

These discussions led to the Virginity Project, which combines attitudinal research, advocacy and public education. From its start in Macedonia, the project has gone on to Hungary, Slovakia, Bulgaria, Monte Negro and Ukraine. It has opened up questions beyond sexuality, such as questions around Roma assimilation into the larger culture. The model is also being adapted and used to discuss other sexuality-related issues in central Asia, such as bride kidnapping in Kyrgyzstan.

Culture is always a challenge for activism around women's rights, especially in the intimate terrain of sexuality. "Sexuality is very personally confrontative to a lot of people," says Schultz, "since it gets dangerously close to cherished notions of culture. It was hard when Roma women advocates started raising issues of domestic violence, trafficking, prostitution. It's a minority community embedded in a racist society that is looking to demonize it. So women's rights advocates felt they were contributing to a negative image of a community that had already been stereotyped."



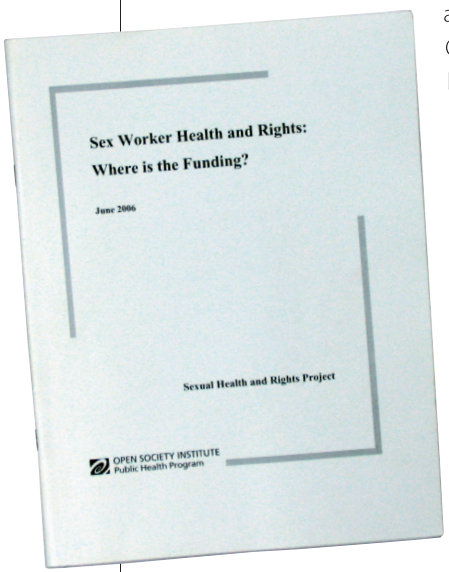
The women's program has also raised sexuality issues in collaboration with other OSI initiatives, such as the Justice Initiative, which works on international justice. The two programs raised the issue of sexual violence at the International Tribunal for Rwanda. "There are so many women's rights issues we would love to see on that agenda," says Schultz. "But that's kind of an entry point issue. Everybody gets it."

In general, women's rights programs do tend to raise rights violations more than affirmative rights, partly because of a tendency to see women as victims more than agents. "We hope to see more of a balance with positive sexual rights," says Schultz. "We're a long way off from really powerful images of women as sexual beings."

FIGHTING STATELESSNESS, PROMOTING CITIZENSHIP RIGHTS

As cross-cutting issues, both gender and sexuality intersect with other OSI programs, as they should in an organization that works to erase the exclusion of the marginalized. An interesting example is that of the Equality and Citizenship Program that is part of the Justice Initiative. Unlike other programs at OSI, the Justice Initiative is not a grantmaking program, but one that implements projects in partnership with NGOs.

The program deals with discrimination and citizenship issues arising in the context of migration. "The vulnerability of migrants has a lot to do with citizenship," says Julia Harrington, Senior Legal Officer, Equality & Citizenship. "There are a lot of people who should have citizenship, but don't. Lot of minority groups don't get access to citizenship. It's a way of enshrining discrimination under the guise of law."



Take the Nubians in Kenya. Or Biharis in Bangladesh. Nepali speakers in Bhutan, Rohinga in Thailand, the Roma in Russia, the Russians in Estonia, or those of mixed ethnic background in Croatia. No matter how long they've been there – and some of these groups have been there for thousands of years – they're still not citizens. Neither are they citizens of countries where they ethnically originated. They're stateless.

"It's not forbidden under international human rights law to deny citizenship to people on grounds of their ethnicity," says Harrington. "From a discrimination lawyer's perspective, this is grotesque because you couldn't do it with respect to access to housing or access to employment or education or right to freedom of expression or political participation. You could not say that people of this ethnic and linguistic background have these rights, while people of that ethnic and linguistic background do not. It's ridiculous. But 'legal status' is part of state sovereignty and has never been challenged."

Women often face unequal citizenship provisions in certain contexts. In Egypt, for example, the birth of a boy is usually registered, but not the birth of a girl. A married woman gets added on to her husband's identity card; in case of divorce, she is left with no legal proof of her identity, making her ineligible for social security, housing support or other benefits. In such situations, women become 'stateless' in their own countries.

Sexuality too intersects with citizenship. When drug addicts – many of whom are sex workers – go to prison or to treatment centers in the former Soviet Union, their identity cards are taken away but not returned. "They will become stateless," says Harrington. "They may not be able to get health care in future." AIDS orphans in Africa who lose their parents at an early age may not have documents. "Legal identity affects groups that have public health problems," says Harrington. "It's both a result of the marginalization of this group and it also entrenches and legalizes further marginalization."

Sex workers who migrate to other countries often become part of the stateless. Some sex workers remain stateless even when they do not migrate – for instance, red-light areas in India are often not counted during the census or when voter identity cards are distributed. "Sexual minority cases of statelessness may exist, but in small numbers," says Harrington. "Anybody who's a little on the margins, it's so easy for them to lose that legal identity – and then they're really in the soup."

Like gender and sexuality, legal identity hovers below many other issues – from public health to freedom of expression – without being adequately recognized. "It's very basic and nobody else is working on it," says Harrington. "We try to make links between human rights, which everyone accepts, and statelessness, which is not seen as a human rights issue. We want to position this as an issue that is central to human rights." ■

1. *www.kerrycdb.ie/meitheal/glossary.htm*
2. *www.ilo.org/ciaris/pages/english/frame/r1-3.htm*
3. *http://www.soros.org/about/faq*
4. *http://www.soros.org/initiatives/health*
5. Harm reduction does not deny the value of helping people become drug free, or the desirability of abstinence as an eventual goal. It simply recognizes that for many drug users these are distant goals and that services to reduce the risk in the interim are therefore essential if personal and public health disasters are to be avoided. Recognizing the reality of drug use, harm reduction programs measure success in terms of individual and community quality of life and health and not in relation to levels of drug use.
http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/articles/what_20010101
6. *Sex Worker Health And Rights: Where is the Funding?* (SHARP June 2006)
7. *http://www.soros.org/initiatives/health/focus/sharp/about#wa_lawhealth*

AMNESTY

RAISING A TOAST TO FREEDOM

MORE THAN four decades ago, the story of two Portuguese students sentenced to seven years in jail for raising a toast to freedom horrified British lawyer Peter Benenson. He wrote to the British newspaper, *The Observer,* calling for an international campaign to bombard authorities around the world with protests about the "forgotten prisoners". On 28 May 1961, the newspaper launched his yearlong campaign, Appeal for Amnesty 1961, calling on people everywhere to protest against the imprisonment of men and women for their political or religious beliefs – 'prisoners of conscience'.

Within a month, more than a thousand readers had sent letters of support, offers of practical help and details about many more prisoners of conscience. Within six months, a brief publicity effort was being developed into a permanent, international movement. Within a year, the new organization had sent delegations to four countries to make representations on behalf of prisoners and had taken up 210 cases. Its members had organized national bodies in seven countries.[1]

That was the start of the movement that we now know as Amnesty International.

WHAT AMNESTY IS

Amnesty International is a worldwide movement of people who campaign for internationally recognized human rights. AI's vision is of a world in which every person enjoys all of the human rights enshrined in the Universal Declaration of Human Rights and other international human rights standards.

WHAT AMNESTY DOES

In pursuit of this vision, Amnesty's mission is to undertake research and action focused on preventing and ending grave abuses of the rights to physical and mental integrity, freedom of conscience and expression, and freedom from discrimination, within the context of its work to promote all human rights.

Amnesty is independent of any government, political ideology, economic interest or religion. It does not support or oppose any government or political system, nor does it support or oppose the views of the victims whose rights it seeks to protect. It is concerned solely with the impartial protection of human rights.

THE 1970s: GETTING ONTO THE RADAR

At its 1979 International Council Meeting, Amnesty International affirms that people imprisoned for advocating homosexual rights are Prisoners of Conscience.[2]

Outfront Timeline, Then and Now

As Amnesty International (AI) celebrated its first decade, sexuality was nowhere on its radar. But sexuality started creeping into the Amnesty agenda from the early 1970s under the rubric of gay rights. That was the Stonewall era in the United States, when an act of defiance against police repression in New York City became a call for LGBT liberation, resulting in the first ever Gay Pride Parade in 1970.

At the same time, social movements forming in different parts of the world around the rights of people with different identities started putting pressure on human rights organizations to incorporate their issues. At Amnesty, the issue emerged as the question: Could someone imprisoned for being gay be a prisoner of conscience? This had a subtle alternative: Could someone imprisoned for advocating gay rights, rather than for being gay as such, be a prisoner of conscience?[3]

In this burgeoning dialog between sexuality and human rights, many rights activists saw 'homosexuality' (as it was then called) as an 'aberration' along with bestiality, prostitution and S&M. Homosexuality was also seen as 'genetic',

as 'not a choice'. "Some of the early studies involved gynecologists and other doctors to figure out if this is a choice," says Meg Satterthwaite. Joining Amnesty as a student-member, Satterthwaite was one of the small group of members who formed AI Members for Lesbian and Gay Concerns. She chaired this group from 1991 to 1996 and is now on the board of AIUSA.

An issue then was the near-total absence of human rights jurisprudence dealing with sexuality-related issues. "The human rights standards were so behind that we didn't have a set of things to point to," says Satterthwaite, "to say this has all been interpreted to support us."[4] Within Amnesty, some opponents used the discourse of cultural diversity to argue that taking up LGBT issues would hurt the development of AI in the global South. Such arguments were countered through research, including anthropological data that showed the prevalence of same-sex behavior across cultures – and the prevalence of rights violations targeted at people engaging in those behaviors.

Despite these barriers, Amnesty moved forward one cautious step in 1978 on affirming that anyone imprisoned for advocating gay rights is a prisoner of conscience. "Amnesty's focus endlessly was: For what things should the State not be able to lock you up?" says Ali Miller, who joined Amnesty's staff in 1988 and was part of the group that fought for LGBT issues to be included in its agenda. "And they weren't clear on sex, but they were clear on peaceful opinion. So peaceful expression of opinion was fine, but actually doing the thing you talked about was not fine."

The irony was that Amnesty would intervene if you were locked up for promoting gay rights, but not if you were having gay sex.

> **"I got involved when I realized Amnesty did not take on prisoners of conscience jailed because of sodomy laws. And that just enraged me. I could not believe it. I wrote a letter to the section and got a reply saying that this should be a resolution. They put me in touch with other members who felt the same way."**
>
> **Meg Sattherwaite, *member, Amnesty International***

THE 1980s: STRUGGLING FOR A FOOTHOLD

"For AI to get into the field of sexual behavior would be to enter into matters so different from those we work on now that it will make people question all our activities."

Research Department in response to 1986 study by the Dutch section of Amnesty[5]

Unlike other organizations working on human rights, Amnesty International is in a class by itself in terms of size, success and resources[6] – it has more than 2.2 million members, supporters and subscribers campaigning for human rights in over 150 countries and territories.[7] "It's an extraordinary experiment in participatory democracy," says Susana Fried, a member who is part of the coordinating team for AI's International LGBT Network. "It really does work in a way that attempts to give membership the power to guide the policy and the direction."

Sexuality, for one, may not have gotten onto the Amnesty agenda if it had not been for a group of interested members. "We had to force the decision within the methods and spaces of Amnesty decision-making," says

Cynthia Rothschild, who joined Amnesty as a student-member. One of the early members who pushed LGBT issues into Amnesty's consciousness, she has been part of both domestic and international membership task forces on LGBT issues and was on the AIUSA board.

"We needed the entry points," says Rothschild. "And some of the entry points are about going to the top. At least within AIUSA, one of us had to be on the board of directors." The strategy of this group was to move the movement from within. "How do you integrate a very specific agenda into a membership-based organization and within the policy framework of a very bureaucratic human rights organization?" asks Rothschild. "For me, it was about strategic volunteer activism within an institution."

In the 1980s, there were instances of people being tortured, killed or disappearing because of their sexual identity. A 1986 study by a Dutch member of Amnesty documented actual cases of people imprisoned because of their homosexuality.[8] "But how do you agree that's a valid issue of human rights for this institution to be taking on?" asks Rothschild. "How do you affect the consciousness of an institute that is membership-based, where you access your mainstream Amnesty member off the street, or in a high school group or in college?"

One tactic was to build common ground – or consensus. "Very few people were talking about sexuality and rights at that point," recalls Miller. "It was a tactical decision to go for a task force rather than a vote of the membership to change policy at that time. It gave us time to figure out how to make the arguments. And then to make sure that the arguments came up as consensus-building as opposed to voting. This was not supposed to be about some sections imposing gay identity on the rest of the world."

A linked strategy was to educate everyone at Amnesty – staff and membership, researchers and programmers. Through every opportunity that existed or had to be created. Newsletters produced in members' kitchens on near-zero budgets. Workshops. Regional conferences. National conferences. International conferences. "How do you ensure that you're dividing your small little team up so that your voice is heard in as many places as possible?" asks Rothschild. "It has been a strategic venture to claim every entry point to get the information out and the point across."

Parallel efforts to place gender on the Amnesty agenda provided another channel for sexuality. A staffer went through all Amnesty reports to see how many prisoners of conscience were women, and how many were imprisoned for gender-specific abuses. Amnesty members started raising questions on female genital mutilation and domestic violence. A task force was set up to look at women's issues. "Because a bunch of us were gay on that task force, we started to think about that," says Miller. "But there was total confusion. Was the women's task force going to take on sexual harassment? Are gay and lesbian issues gender issues or sexual issues? There was no clarity."

Outside Amnesty, newly formed gay and lesbian groups were publicly taking Amnesty to task.[9] Conceptually, this meant that LGBT groups were deciding that a human rights umbrella would be useful. But practically,

> "Policy work and staff work would not exist if not for activist work. If not for the energy of people who were turning out potential cases for the International Secretariat to adopt. Or doing research. Or doing the newsletters in our kitchen so that they could be distributed at the conference the next day. Or creating the resolutions. Or presenting them at the conferences. There would not be the momentum."
>
> **Cynthia Rothschild, *member, Amnesty International***

it was a time of NGOs campaigning against other NGOs and raising money on it. "It was a very difficult time," remembers Miller. "It was very personal and very mean. I remember being called a token lesbian cunt."

More pointed advocacy was aimed at Amnesty's researchers, who have traditionally been its lynchpin, given its focus on individual cases. In his book of the same name, Stephen Hopgood refers to Amnesty's researchers as 'keepers of the flame', those who would like Amnesty to remain what it was, a moral authority working to liberate forgotten prisoners in *other* countries.[10] Hopgood describes a larger struggle within Amnesty between this section of staff and 'reformers' who want Amnesty to work towards more openly political ends, and are as concerned about the human rights of women, minorities, the poor, and non-heterosexuals *in their own societies* as about POCs.[11] Those who want Amnesty to be no more a sentinel, but a player.

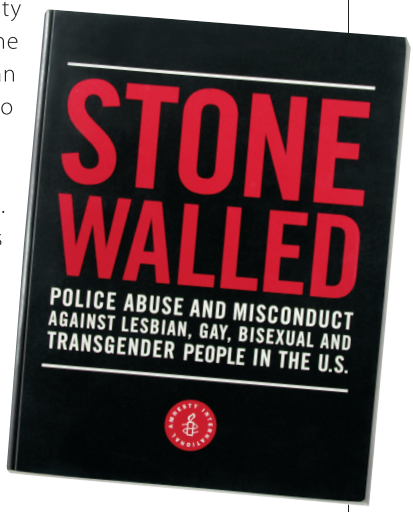
"We were trying to prove to the research section in London that the cases existed. Each section was having internal conversations about whether to advance the issue and voting internally before voting on an international level," says Miller. "But as we got closer and closer to the Amnesty International Council Meeting in Yokohama in 1991, the researchers start to go, 'Oh! These cases, we don't know what to do with them.' So torture and killing cases got taken off the agenda because they were around gay people as if that was outside the mandate. It was a horrible moment."

THE 1990s: A TURNING POINT

In 1991, at its International Council Meeting in Yokohama, Amnesty International decides to adopt as 'prisoners of conscience' people who are imprisoned solely because of their homosexuality, including the practice of homosexual acts in private between consenting adults.

Outfront Timeline, Then and Now

The irony is that heterosexuals jailed for sexual behavior could not count on Amnesty support until the 2000s, but that's another story. "The queer people got on the agenda ahead of the straight people," says Fried, "but it's really the question of an interested minority membership that was prepared to do advocacy. There was no constituency for straight people on this particular issue."



It's one thing to change policy. It's another to put it into practice – or into programs. Even though the 1991 resolution opened the door for researching cases, it was agreed that sections could move slowly on acting on those cases for fear that "too public advocacy" would generate political fallout, and even shut down Amnesty in some countries. Training and research guidelines around doing gay and lesbian case work got put on the slow track. "There was this endless tension between how things got moved – staff, volunteers, major vote…" recalls Miller.

Research and the resulting cases are at the heart of Amnesty International's work. "It's this very personal connection that Amnesty makes between people in one place who can write letters or do advocacy and people in another place who are imprisoned or persecuted," says Fried. Amnesty issues more LGBT individual cases now than ever before. "Although we have gotten better at doing LGBT case work, it remains the single most contested issue that we as a coordinating team

deal with." There is always a demand from AI LGBT activists for more opportunity to work on cases, or on individuals' behalf. Yet the systems are not always in place to meet the demand by generating new cases, and it remains true that the cases that do exist are not always integrated into the campaigning of all the sections on an international level.

Is this partly because all issues don't lend themselves equally to casework? For instance, laws are not always used to imprison LGBT people but also to blackmail or harass them – addressing these may require different methodologies than traditional casework designed to release prisoners. A related issue is that of gender. "Lesbians are always pretty much disappeared," says Miller. "Most women are not in prison for lesbianism and the laws don't cover them. And researchers will look at the laws first when they're looking into whether a case should be issued."

Despite the casework dilemma, LGBT rights has rooted itself at Amnesty in different ways. Through campaigning. In 1994, the *Breaking The Silence* campaign launched by AIUSA spoke out about a range of LGBT human rights abuses in different countries. It was the first time a mainstream human rights organization had taken on this issue. "It was huge," recalls Satterthwaite, who joined the AIUSA staff to direct the campaign. "It went out to all of Amnesty's high school and college groups. A number of high schools needed permission from the parents."

A few years later, the Outfront program was launched at AIUSA with staff, board and volunteer member support. Gay and lesbian issues went from being a volunteer-led initiative to a real program with staff, budgets and organizational resources. Like other programs at Amnesty, Outfront raises issues through campaigns, reports, thousands of online members, and membership actions.

Egyptian men imprisoned in 2002 for being gay received letters from Amnesty members. "They said they had got thousands of letters," says Michael Heflin, Program Director, Outfront. "High school students would send them postcards with decorations on them. People loved it." Recent membership actions have protested threats and assaults against LGBT rights activists in Kosovo, El Salvador, the Honduras; challenged homophobia in Poland, Latvia and Uganda; demanded that the US investigate transgender women's allegations of abuse; and urged the Philippines to pass an anti-discrimination bill.

Membership actions are an important component of campaigns - particularly international campaigns, which represent an organizational commitment to an issue. A 2001 Amnesty worldwide campaign against torture included cases of those tortured because of their sexual orientation or gender identity. "Apart from individual cases that form part of a campaign, we try to address systemic issues, such as police brutality," says Heflin.

As part of the campaign following the release of AIUSA's 2005 report, *Stonewalled,* activists asked police departments to sign a pledge to take concrete steps to end targeting of LGBT individuals for police abuse and misconduct. Six major metropolitan police departments took the pledge. Campaigns are also really important at an organizational level, says Ariel Herrera, National Field Organizer, Outfront. "Campaigns by their nature inform and shape policy. It's a kind of dialectics that happens."

GENDER: A PARALLEL STORY

"I would describe the environmental movement as a very female movement. If you had to give it a gender you would say it was feminine. Human rights is very male."

Staff member, Amnesty International[12]

The story of gender at Amnesty is somewhat of a parallel to that of sexuality. Both were late entrants who found footholds at Amnesty due to membership initiatives and task forces; although both got institutionalized as programs in the late 1990s, they have yet to find their full places in the sun. Gender was pushed into the fray by women's rights advocates inside Amnesty at the same time that international conferences at Beijing and Vienna were redefining women's rights as human rights.

In 1994, Amnesty launched a major international campaign, asserting that human rights are women's rights but the campaign focused on its traditional issues, where the state could be held responsible – torture, state violence, abuses during armed conflict, and disappearances – as they affected women.[13] Issues like domestic violence were absent. It was only in 1997 when Amnesty resolved that it would work on violence perpetrated by non-state actors (and not just state violence) that domestic violence came on the agenda.

The first report resulting from this decision was on Pakistan,[14] which addressed imprisonment, violence and imprisonment for sex outside of marriage (or *zina*). This report was AI's first not only on non-state perpetrators of violence against women but also exposed severe and violent punishment particularly for women exercising their sexuality. "We've been talking about violations of the right to bodily integrity eg forced marriage, female genital mutilation - issues that go directly into the area of sexuality," says Sheila Dauer, Director, Women's Rights Program, AIUSA. "But it is new to name it sexuality as such."

Women's rights issues at Amnesty span migrant workers, torture, refugees and internally displaced women, discriminatory laws and traditions etc. They include issues as diverse as stoning in Iran, rape as a war crime in Darfur, Zina laws in Pakistan, acid blindings in Bangladesh, sexual assaults against women prisoners in the US, and disappearances of human rights defenders in Latin America. Amnesty International now states clearly that it opposes the criminalization or condoning of violent punishment by non-state actors of sexual acts between consenting adults.

The international *Stop Violence Against Women* campaign, which Amnesty launched in 2004 acknowledges that violence against women is a human rights scandal. The campaign – which runs till 2010 – shows that violence against women violates women's rights to life, physical and mental integrity, to the highest attainable standard of health, to freedom from torture and sexual and reproductive rights. Many forms of violence are brought under this umbrella,

including forced abortions and sterilizations, forced and child marriage, and discriminatory maternal health services that let women die. "The Stop VAW campaign has really had a pretty consistent focus on sexuality-related issues," says Fried. "Those of us who were involved really pushed the issues."

Despite this, several women's rights advocates feel that violence, sexuality and gender issues are not properly integrated – either into the campaign or in Amnesty's work. "It's a very narrow concept of human rights," says one women's rights advocate. "Although some cases of domestic violence are seen as torture, violence against women per se is not seen as akin to torture. Although some cases of rape in conflict situations may be seen as war crimes, not all are."

"There are still very basic arguments about what is violence against women," says Gita Sahgal, the first director of the Gender Unit at Amnesty's International Secretariat, which was set up through a team effort in 2002. "Is virginity testing violence against women? Of course it's violence against women. We need to argue that states shouldn't use these practices anymore." Other forms are not considered violence. The spread of dress codes, fundamentalist onslaughts and attacks – such issues are rarely taken up by human rights organizations, even though they violate women's rights.

Part of the problem is history and methodology. It is not enough to logically demonstrate that something is a human rights violation even when it is blindingly obvious as one. It must be recognized as a violation in the formal discourse of human rights – treaties, conventions, instruments etc. "It gets there in fits and starts," says Sahgal. "The formal language can be read and interpreted – and there are some really admirable cases of this at Amnesty. But it's a contested field which is still evolving."

Abortion rights remains one such contested issue at Amnesty, which does not uphold abortion as a right per se – but advocates for access to safe and legal abortion services in certain cases: where unwanted pregnancy is a result of rape, sexual assault or incest; or in cases of grave risk to her health or life. Amnesty also holds imprisonment or other criminal sanctions for seeking, having or providing an abortion as a violation of women's reproductive rights and a health provider's human rights. Amnesty recently called for decriminalization of abortion, a major milestone in its work on gender.

It's a tough balancing act for an organization caught between the new claims of women's rights and the expectations of some of the conservative oldtimers, who yearn for individual cases rather than systemic issues. "We're kind of having to educate the membership," says Dauer. "It's very important in terms of how we move into the sexuality arena, but it's a very small part of the totality of women's reproductive health and rights."

"There's been a lot of movement at the policy level. There's even been a fair amount of movement at the program level. The regional and thematic teams are mandated to look at LGBT issues and figure out how to integrate that. It's uneven, but many of them are doing it with increasing consistency. The campaigning has gotten better, the policy debates have gotten much better, and even some of the legislative advocacy. But what still doesn't happen is the casework."

Susana Fried, *member, Amnesty International*

BREAKING DOWN THE WALLS

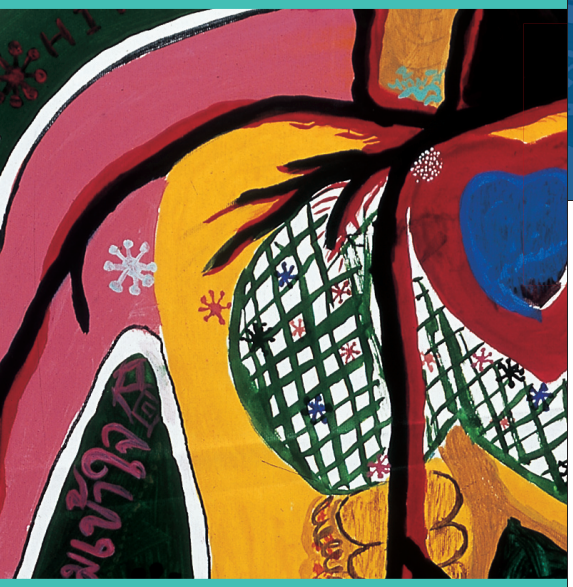
"We've been breaking down the walls around the human rights box. For us, it has been about saying that sexuality work is fundamental to human rights work. We at Amnesty have been part of an international movement that has said that the human rights paradigm needs to be expanded. We have played a role in advancing the discourse of human rights and sexuality. That feels significant to me."

Cynthia Rothschild, Member, Amnesty International

Sexuality and gender sit in different pots at Amnesty, like they do in other organizations – largely in programs on LGBT rights, women's rights, and HIV. The challenge remains to ensure that these issues do not get ghettoized, but seep into the rest of Amnesty's work. "It's always part of the discussion now," says Heflin of LGBT rights. "It's not gone off the agenda. Nor are we at risk of being seen as extra-budgetary."

Sexual orientation has rooted itself more firmly than gender identity. However, the focus on gender-based violence is offering space for issues, for instance, of transgender people facing police violence and torture – Amnesty's core work. "What you see is 20 years of work," says Fried. "Right now these issues are there because we did the advocacy. But as LGBT and sexuality issues get more well-integrated, then the level of backlash and discomfort will increase. My feeling is that there's going to be a lot of discomfort."

1. These two paragraphs are reproduced almost verbatim from *www.amnesty.org/faq*
2. In 1979, AI also called for the cessation of forced or involuntary 'medical' treatment for people in detention aimed at altering their sexual orientation.
3. *Stephen Hopgood: Keepers of the Flame:Understanding Amnesty International* (Cornell University Press 2006 pg 116)
4. In 1981, the European Court of Human Rights ruled in *Dudgeon v. UK* that sodomy laws criminalizing consensual homosexual conduct between adults in private violated the right to privacy protected under the European Convention on Human Rights.
5. *Hopgood pg 117*
6. *Hopgood pg 141*
7. *www.amnesty.org/faq*
8. *Hopgood pg 117*
9. IGLHRC, ILGA and ACT UP launched a campaign to get LGBT issues on Amnesty's agenda before the 1991 International Council Meeting in Yokohama
10. Until recently, AI members were not allowed to work on issues in their own countries, partly in order to protect individuals who were advocating or expressing dissent. However, this contributed to the "legacy of witnessing, testifying, the inner light of conscience, speaking truth to power, and non-violence". (Hopgood pg 8) "All these contributed to Amnesty International's sense of itself as a moral authority." (Hopgood pg 11)
11. *Hopgood pg 11*
12. *Hopgood pg 147*
13. *Hopgood pg 152*
14. *Violence against Women in the Name of Honour* (Amnesty International 1999)



ICRW

SETTING THE AGENDA FOR CHANGING WOMEN'S LIVES

WHAT ICRW DOES

ICRW's mission is to empower women, advance gender equality and fight poverty in the developing world. To accomplish this, ICRW works with partners to conduct empirical research, build capacity and advocate for evidence-based, practical ways to change policies and programs.

ICRW'S RESEARCH AREAS

- Adolescence
- HIV/AIDS
- Nutrition & Food Security
- Poverty Reduction & Economic Growth
- Population and Social Transitions
- Violence against Women
- Women's Rights

WHERE ICRW WORKS

ICRW is headquartered in Washington, DC and has a country office in New Delhi, India. Project offices are located in Andhra Pradesh, India, and Kampala, Uganda. ICRW collaborates with individuals, governments, businesses, foundations and communities in more than 40 countries throughout Africa, Asia, and South and Central America.

"Life without sex is like a meal without salt."

Respondent in Understanding Sexuality:
An Ethnographic Study of Poor Women in Bombay, India

IN JULY 1994, the International Center for Research on Women (ICRW) launched a pioneering study on women's sexual behaviors.[1] Many of its key findings are now conventional wisdom, but were then startlingly new. Above all, the study showed how women lacked social and sexual power in heterosexual relationships. Women said they had been married for their sexual services and to fulfill their husbands' sexual needs. Their first sexual experience often took place without consent and was unpleasant, traumatic, and painful. However, some women's sexual experiences and views changed over time, with one woman finding sex as necessary as salt.

Six years later, ICRW president Geeta Rao Gupta provided radically new insights at the 13th International AIDS Conference. "An important first step…is to recognize, understand and publicly discuss the ways in which the power imbalance in gender and sexuality fuels the epidemic," Rao Gupta said in July 2000 in Durban, South Africa[2]. "…[There is] an increased acknowledgement of the role that gender plays in fueling the epidemic. Unfortunately, aside from a few exceptions, public discourse on sex and sexuality is still invisible."

In her historic presentation, Rao Gupta discussed how norms of gender and sexuality make men and women more vulnerable to HIV. Feminine ideals around virginity, motherhood, silence around sex, passivity and economic dependency collude to make women ignorant and vulnerable to infection. Masculine ideals of domination, invulnerability, and being knowledgeable about sex encourage the denial of risk and run counter to the notion that men should protect themselves from potential infection.

"I locate sexuality as one of the core themes in ICRW's work which branches out into all our other work," says Joy Deshmukh-Ranadive, former Country Director, India.[3] In some of ICRW's programs - Adolescence, HIV/AIDS, Violence Against Women, Reproductive Health & Population, Women's Rights – the link with sexuality is clear. But programs like Nutrition & Food Security – or Poverty? How does sexuality fold into these?

ECONOMICS AND SEXUALITY – STRANGE BEDFELLOWS?

In India, ICRW is currently building a research portfolio around micro-finance. Many micro-finance programs that lend to groups of poor women use repayment rates as indicators of success. This is not necessarily the right indicator, and ICRW hopes to demonstrate how micro-finance can be more empowering for women. "Women have used micro-finance services to generate income, develop skills and improve their families' standard of living," says Rao Gupta.

Unfortunately, many micro-finance programs are kept at the level of small loans that don't allow growth and keep women 'ghettoized' in micro-credit. Micro-finance programs should measure their success by the size of women's loans over time and whether a substantial proportion of women borrowers graduate from microcredit to formal credit channels and from micro-enterprise to small- and medium-sized businesses.[4]

"Micro-finance, which provides credit and resources for those excluded from the formal banking system, can play a major role in reducing women's vulnerability to HIV and AIDS by strengthening their economic stability and enabling them to cope without turning to risky behaviors such as selling unsafe sex," says Rao Gupta.[5]

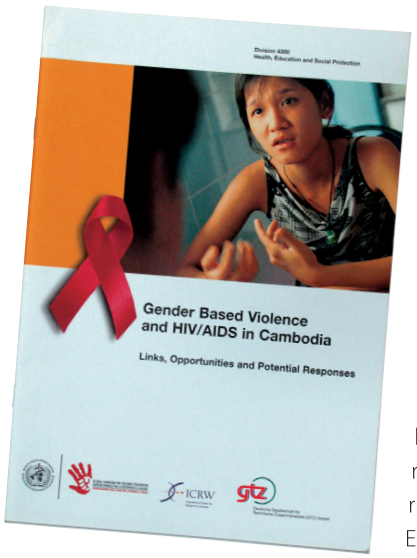
Several ICRW studies explicate the links between economics, gender and sexuality:

- **Studies show** that child marriage not only puts girls at risk of maternal death and injury, it also curtails their educational opportunities, and hence their ability to access economic opportunities.[6]
- **Studies show** that poverty encourages risky livelihood measures, such as enduring an abusive relationship, or engaging in unsafe sex in exchange for money, housing, or food.[7] A study in Zambia shows that poverty can precipitate and exacerbate stigma due to HIV.[8]
- **Studies in** India show that women's property ownership is linked with a substantially lower risk of marital violence.[9] Preliminary evidence in sub-Saharan Africa shows that property rights reduce women's vulnerability to domestic violence, unsafe sex, and other AIDS-related risk factors.[10]
- **Studies show** the direct and indirect economic costs of domestic violence. In Canada, the direct cost of goods and services to prevent violence and treat victims is estimated at $1 billion (Canadian). Violence also affects the economy by reducing women's labor market participation and productivity, resulting in lower earnings, savings and investment.[11]

GENDER AND SEXUALITY – ARTIFICIALLY DIVIDED?

While sexuality and economics may seem like different domains, gender and sexuality have traditionally been viewed as going hand in hand. Women's empowerment, gender mainstreaming, violence against women, and sexuality are all cross-cutting themes at ICRW, says Aparajita Mukherjee, a researcher in gender and sexuality. "We see them as interlinked concepts. We don't see them as divided."

Part of the challenge is to remove the artificial barrier that exists between gender and sexuality. "When you are addressing gender, you are inadvertently also addressing sexuality," says Mukherjee, who feels the two concepts have a dynamic relationship. "Through gender, sexuality comes in sometimes. At other times, gender comes in through sexuality."



Gender and sexuality are also seen as dynamic concepts in another sense – they can be seen as separate issues and as cross-cutting issues, says Mukherjee. "It's the same logic as: Do you work with women or do you work on gender? Do you work on violence or do you understand that violence is embedded in many things? There is value in both." The research challenge for ICRW is often about demonstrating the inter-connections. "The challenge and excitement is over the same thing – showing the links."

ICRW is currently mainstreaming gender and sexuality into HIV programming in two sites in India – working in an urban slum setting in south India and with a rural positive persons' group in India[12]. Research has shown that many young men in urban slums have 'auntie sex' – sexual relationships with older married women. "It was a perfectly symbiotic relationship but there was a low perception of risk," says Mukherjee. Existing norms around gender and sexuality influence this risk perception.

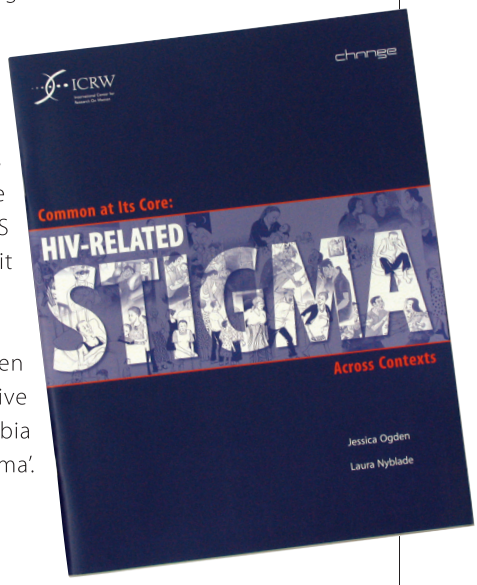
The task ahead is to change these norms via programming – a change that can be measured through indicators. For instance, women who carry condoms are 'loose' or easily available is a common perception influencing risk. But this was something the implementing organization had not considered. "We sometimes see things that other people have not seen," says Mukherjee. "Bringing other people into that fold of seeing is what the work is about."

A simultaneous challenge is to create spaces within the organization, at levels of policy and procedure, to mainstream gender and sexuality. "The lesson has been that mainstreaming gender and sexuality is never complete if it is limited to just the project," says Mukherjee. "Having the buy-in of senior management is absolutely critical."

SETTING THE AGENDA FOR POLICY AND ACTION

At ICRW, research is not seen as an end in itself, but as a critical step leading to policy action and program change. It is action research, but with all the rigor associated with academic research. "We're really interested in cutting-edge issues," says Sarah Degnan Kambou, Vice President, Health and Development. "We're constantly striving to set the agenda on particular themes."

Violence against women is one such theme. In the 1990s, ICRW research conclusively showed that domestic violence rates were too high to be ignored by policymakers.[13] Current research is investigating the social reasons behind violence, measuring the costs of violence on households, communities and the economy, and probing the links between HIV and violence. One study shows that men who perpetrate physical and sexual violence against intimate partners are more likely than nonviolent men to engage in behavior associated with high HIV risk.



Child marriage is another such theme. ICRW's research (which shows that 51 million girls below the ages of 17 are married in developing countries) systematically demonstrates how child marriage is both a human rights violation and a barrier to overcoming poverty. "We have defined child marriage on the US policy landscape as an important issue for consideration in US foreign assistance," says Degnan Kambou. "Now other partners will take it forward. Is there any longer a role for us? Perhaps not."

Stigma is another cutting-edge theme. Although stigma has traditionally been seen as an 'immeasurable' social phenomenon, ICRW has developed quantitative indicators to measure stigma. Studies in Ethiopia, Tanzania, Vietnam and Zambia have isolated common elements of stigma and discrimination, or 'enacted stigma'. These include:

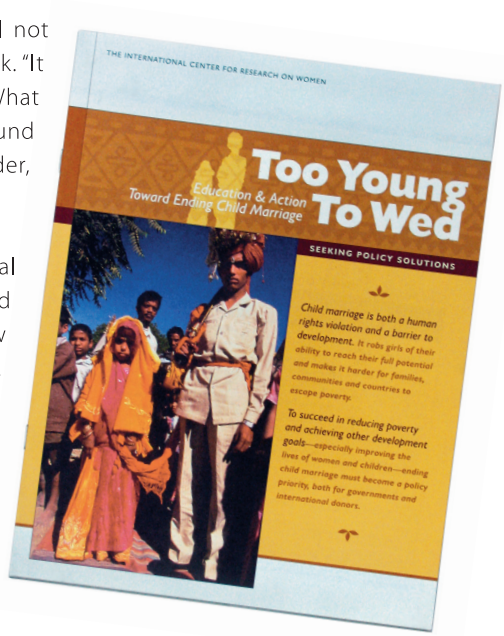
- Physical forms (isolation, violence)
- Social forms (isolation, voyeurism, loss of identity/role)
- Verbal forms (gossip, taunting, expressions of blame/shame, labeling, derogation)
- Institutional forms (loss of livelihood/future, loss of housing, differential treatment in schools, health care settings, public spaces, media campaigns)[14]

"There are core, identifiable elements of stigma across the world," says Degnan Kambou. "It doesn't matter whether you are in Ethiopia or Vietnam. These are common factors." Other studies are demonstrating the impact of stigma. In Botswana and Zambia PMTCT[15] services are not being utilized, not because of access or quality of care, but because of the stigma of approaching such centers. In India, studies are looking at the nexus of stigma and violence. "This has a huge sexuality component."

MOVING AHEAD

In the early 2000s, ICRW teamed up with CARE to understand how the systematic integration of gender and sexuality influences reproductive health outcomes. The Inner Spaces, Outer Faces project, which was piloted within CARE India (and is detailed on page 4) is now being carried out in the Balkans. "We helped CARE set up the iterative, reflective methodology and conduct it," says Degnan Kambou. "Sexuality really came out as key to this project's success."

Although sexuality seeps into many of ICRW's programs, it is still not systematically integrated into the organization's research framework. "It needs to be developed more purposefully," says Degnan Kambou. "What we don't yet have as an institution is a conceptual framework around gender and sexuality. How does sexuality really tie with in with gender, with poverty, with everything else?"



Like many other women's rights organizations, ICRW's conceptual frame remains largely heterosexual. A search using the keyword 'lesbian' in the ICRW website yielded no results; there are a few references to homosexual or same-sex activity in ICRW reports. Cutting-edge issues of pleasure and desire are now emerging given ICRW's research in the Balkans on masculinities, violence and vulnerability as well as its emerging program of work conducted in collaboration with Promundo. "We have just begun to talk about pleasure and desire and sexual identity," says Kambou. "These are things that we are on the cusp of developing. There are exciting times ahead at ICRW!"

1. The study, *Understanding Sexuality: An Ethnographic Study of Poor Women in Bombay, India* by Annie George and Surinder Jaswal analyzed how women's sexual and reproductive health behaviors put them at risk of sexually-transmitted infections and HIV, and looked at the economic and socio-cultural realities influencing these behaviors
2. *Geeta Rao Gupta: Gender, Sexuality and HIV/AIDS: The What, The Why and The How* (July 12, 2000 Plenary Address XIIIth International AIDS Conference Durban, South Africa)
3. Joy Deshmukh Ranadive is no longer with ICRW
4. According to Rao Gupta, the effectiveness of micro-finance is being measured by the wrong yardstick - their typically high loan repayment rates. *http://www.news.harvard.edu/gazette/2006/11.02/01-roe.html*
5. *http://www.icrw.org/docs/speeches/8-15-06-toronto-womenhivpoverty.pdf*
6. *Geeta Rao Gupta: Unlocking the Power of Women: Is Education the Key?* (Speech, Harvard Graduate School of Education, 25 October 2006)
7. *Women and HIV/AIDS, ICRW Fact Sheet*
8. *Common At Its Core: HIV-related Stigma Across Contexts (ICRW and CHANGE 2005)*
9. *http://www.icrw.org/docs/2005_brief_mdg-property.pdf*
10. *To Have And To Hold: Women's Property and Inheritance Rights in the Context of HIV/AIDS* (ICRW Information Brief June 2004)
11. *Violence Against Women Must Stop: ICRW Millenium Development Goal Series (JCRW 2005)*
12. *Project partners are APAC* and *BROSICA (Chennai)* and *AVERT* and *Amich Aamchi (Sangli)*
13. For instance, ICRW studies showed that 40% of women in India experience domestic violence
14. *Common At Its Core: HIV-related Stigma Across Contexts* (ICRW and CHANGE 2005)
15. Prevention of mother to child transmission

HOW SEXUALITY?

Between the idea
And the reality
Between the motion
And the act
Falls the Shadow
TS Eliot, The Hollow Men, 1925

Sexuality has been understood, expressed and explicated in many ways. Within the development discourse, Paul Hunt, United Nations Special Rapporteur on the Right to Health sees it thus: "Sexuality is a characteristic of all human beings. It is a fundamental aspect of an individual's identity. It helps to define who a person is."[1] Write rights advocates Susana Fried and Ilana Landsberg Lewis: "Sexuality…is composed of gender identity, sexual identity and orientation, sexual desire, and sexual practices, which together constitute an individual's sexual subjectivity in society."[2]

That's the idea. In reality, there is little conceptual clarity around sexuality. Between the idea and the reality lie many shadow understandings of sexuality, each looking at this vital aspect of human experience through a differing lens. For organizations working on reproductive health, sexuality = sexual health. For those working on human rights, sexuality = sexual rights. For those working on women's rights, sexuality = sexual violations. And for many organizations in the fields of health, gender or rights, sexuality = heterosexuality.

THE HURDLES

Perhaps the biggest shadow that falls between the idea of sexuality and the reality of how it is put into practice via programs is the lack of a rounded, holistic understanding. More often than not, sexuality is:

- not seen as a whole, but piecemeal
- not seen as an end, but as a means to other ends
- not seen as necessary, but as luxury
- not seen as integral, but as extra
- not seen as public, but as private
- not seen as positive and negative, but only as negative
- not seen as linked to other issues, but in isolation

"Development has generally treated sexuality as a problem, considering it only in relation to population control, family planning, disease and violence," notes Susie Jolly.[3] "But sexuality has far broader impacts on people's wellbeing and illbeing." Other than such conceptual barriers, the eight case studies in *Work In Progress* also show how other factors inhibit programming around sexuality. If external barriers include a growing conservative backlash and fundamentalist influences, internal barriers include workload issues, funding gaps, and staff ambiguity, confusion and resistance.

An imbibed omnipresent heteronormativity is another key challenge to effective programming around sexuality. While it is possible to be heterosexual without being heteronormative, several organizations and programs retain a focus on 'heterosexual reproduction' in their work on sexual and reproductive health. There is rarely mention of sexual behaviors other than the heterosexual – leading to what Alice Miller in another context calls "the disappearance of entire categories of persons – including lesbians, gay men, and others who claim different sexual identities and behaviors for themselves."[4]

If the framing is largely heterosexual, so is it more reproductive than sexual. As Roz Petchesky writes: "The now-mainstreamed elision of the phrase 'sexual and reproductive"…too often buries the sexual, folding it discreetly into marital/heterosexual and childbearing relations." As the field continues to evolve, will the next step be an exploration of not just that which is 'sexual and reproductive', but also that which is 'sexual but not reproductive'? That is the challenge that lies ahead in framing 'sexuality' - not as ally, adjunct or accomplice – but as an autonomous subject of inquiry.[5]

CROSSING THE HURDLES

All the organizations whose work is showcased here have crossed their own hurdles in a number of innovative ways and through diverse mechanisms – by linking sexuality with gender, by using every entry point that exists or can be imagined, by building critical alliances, by becoming champions for the cause, by finding that one individual within the organization who can make a difference, by keeping top leadership abreast, by developing bronze, gold and silver sexuality packages, by instituting awards, by constituting boards, by starting programs, by finding common ground, by building consensus. And by educating, educating, and educating.

Change has come from up and down, within and without, individuals and groups, board and staff, reports and charters. Change has come from likely and unlikely sources, from policy or from strategy, in ways that are planned and unplanned, expected and unexpected. As each of the eight case studies in *Work In Progress* demonstrates, where there is clarity, commitment, strategic competence and an openness to change, it is possible to design, create and run meaningful health, gender and rights programs that take sexuality solidly on board. Not just as an idea, in theory. But as a reality, in practice. Minus the shadow.

1. *Report to the Commission on Human Rights, 16 Feb 2004*
2. *Susana Fried and Ilana Landsberg Lewis: Sexual Rights from Concept to Strategy* (in Women's International Human Rights: A Reference Guide, Transnational Publishers, New York 1998 pg 91-121)
3. *IDS Policy Briefing Issue 29 April 2006*
4. *Alice M Miller: Sexual but Not Reproductive* (Health and Human Rights Journal, Vol 4 No 2, pg 68-109)
5. *Rosalind Petchesky: Sexual Rights – Inventing a Concept, Mapping an International Practice* (in Parker, Barbosa and Aggleton: Framing The Sexual Subject, University of California Press 2000, pg 81-104)

All the images in Work In Progress are from *Our Positive Bodies*, a series of body maps created by HIV-positive women in Kenya, Thailand and India as a way to map their treatments and share their life choices in the context of HIV. *Our Positive Bodies* was initiated by TICAH – the Trust for Indigenous Culture and Health in Nairobi, Kenya.

Work In Progress has been researched and written by Bishakha Datta and designed by Mahesh Padvekar.

Susana Fried and Cynthia Rothschild have been of invaluable help in reviewing and providing feedback on *Work In Progress*.

Many thanks to Caroline Earle, CREA for her assistance during research and to Geetanjali Misra, CREA who dreamed up this publication – and to all those who shared their valuable time and insights with us at Amnesty, CARE, Guttmacher, Human Rights Watch, ICRW, IPPF, OSI, and WHO.

For copies of *Work In Progress*, email crea@creaworld.org or mailcrea@verizon.net. Or contact CREA in Delhi or in New York. Contact information on inside front cover.

CREA