SEXUALITY POLICY WATCH

SPW Country Case Studies
on Sexuality Politics
– Summaries –
Jully, 2006

SPW Country Case Studies on Sexuality Politics

Summaries - 2nd version
July, 2006

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The Sexuality Policy Watch was constituted in 2002 as the *International Working Group on Sexuality and Social Policy* (IWGSSP). In the last four years SPW has been engaged in research and political activism and has been able to produce a series of policy analyses as well as other materials. In August 2006 we met in Toronto to assess and share the outcomes of our main policy research activities. We decided to change the name of the initiative as to more precisely project the image of who we are and what we do.

Table of contents

Introduction

The following documents are based on case studies of sexuality politics in Brazil, Peru, Egypt, South Africa, Poland, Turkey, India, Vietnam, the United Nations and the World Bank. These summaries were presented and discussed in the research meeting organized by Sexuality Policy Watch in Toronto prior to the 2006 XVI International AIDS Conference.

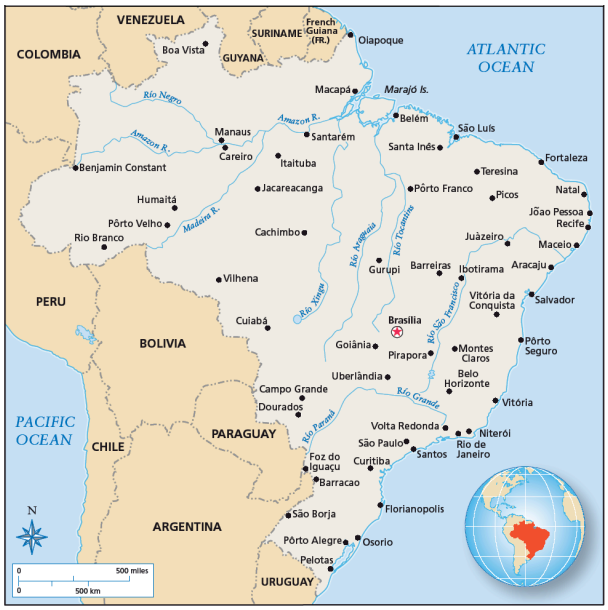
Making these summaries available to the general public is the first step towards sharing the wealth of knowledge generated by the sexuality politics project. Sexuality Policy Watch is releasing these summary findings in acknowledgment of the fact that the conditions prevailing in the world and in national settings with respect to sexuality and politics is not just shifting rapidly but also threatening important gains in sexuality and reproductive rights made in the last two decades

The information collected about major forces at play in the various sites investigated in the research as well as the lessons learned from the experiences examined may provide useful tools of analysis and inspiration for persons involved in sexual politics in many quarters of the world.

We hope you enjoy reading these documents!

Brazil

By Adriana Vianna



Country profile

HDI Rank (2005)[1]	63 of 177		
Population (2005)[3] ***Size*** ***Sex ratio*** (male/100 females) ***% of total population under 15***	186,405,000 97/100 28%	**Demographics**[5] European 53% (Portuguese, German, Italian, Spanish, Polish) Mulatto 38% (mixed European & African) African 6% Asian 1% (Japanese) Middle Eastern 1% (Lebanese, Syrian, Turkish) Indigenous & Mestizo1% (200 small ethno-linguistic groups and mixed European & Indigenous)	**Religions**[5] Catholic 80% Other 20%
Income wealth pyramid (2001)[1] ***Share of income or consumption (%) - Poorest 10%*** ***Share of income or consumption (%) - Richest 10%*** ***Ratio richest 10% to poorest 10%*** ***GINI Index***	0.7% 46.9% 68.0 59.3		
Political and legal system[5]	**Political System**: Federal republic; democratic system Bicameral Legislation **Judicial Branch**: Supreme Federal Tribunal; judges appointed for life by the Senate; Higher Tribunal of Justice; Regional Tribunals; Lesser tribunals **Constitution**: Oct. 5, 1988 **Legal System**: Based on Roman codes; has not accepted compulsory ICJ jurisdiction		
GDP per capita[1]	US$ 7,790 (PPP adjusted)		
Public Health expenditure (2002)[1]	3.6% of GDP		
Total debt service as % of GDP (2003)[1]	11.5%		
Official ODA received for HIV/AIDS ***from Global Fund*** (2005-06) (US $)[6] ***from PEPFAR***[7]			
Life expectancy by gender (2003)[1]	70.5 yrs (gen. pop.), 74.6 yrs (women), 66.6 yrs(men)		

Poverty measures[1]	
% of pop. below poverty line(2003) ***% of pop. living below $1/day***(2003)	17.4% 8.2%
Education by Gender	
Adult literacy rates (2003)[1] ***Enrolment ratio for primary, secondary & tertiary education*** (2002/03)[1]	88.6% (women), 88.3% (men) 93% (women), 89% (men)
Income by Gender	
estimated earned income (PPP US$) (2003)[1] ***Ratio of female estimated earned income to male earned income***[1]	US$ 4,704 (women), US$ 10,963 (men) 0.43/1.00
Female labor force participation[1]	
Economic activity rate (% ages 15 and above) (2003) ***Employment in agriculture (as % of female labor force)*** (1995- 2002) ***Employment in industry (as % of female labor force)*** (1995-2003) ***Employment in service industry (as % of female labor force)*** (1995-2002)	43.7% 16% 10% 74%
HIV infection and AIDS mortality rates[2]	0.7 or 620,000 infected — AIDS Deaths: 14,000 Adults (15+): 610,000 — Orphans: --- Women (15+): 220,000 — Children: ---
Rates of other STIs	
Primary methods for HIV prevention[2]	HIV/AIDS Programs: MTCT antiretovirals Anti-retroviral combination therapy Blood screening
Maternal mortality ratio (2000)[1]	260/100,000 live births
Current abortion laws[4]	Abortion prohibited, except to save woman's life and in cases of rape and incest; punishable 1-3 years (pregnant woman) and 1-4 years (practitioner)
Most contentious laws related to sexuality	

[1] 2005 Human Development Report, United Nations Development Programme (UNDP), http://www.undp.org.
[2] 2006 Report on the Global AIDS Epidemic, UNAIDS, http://www.unaids.org.
[3] Population Division and Statistics Division of the United Nations Secretariat, http://www.un.org.
[4] UN World Abortion Policies 1999, http://www.un.org/esa/population/publications.
[5] CountryWatch, http://www.countrywatch.com.
[6] The Global Fund, www.theglobalfund.org/en/funds_raised /distribution/#sector_recipients.
[7] US Department of State, http://www.state.gov/documents/organization

Brazil

Focal Concern

Since it ratified its Federal Constitution in 1988, Brazil has attempted to promote and strengthen human rights. However, even with government support, the viability of such rights is threatened by racial, ethnic, gender and other social inequalities. The advancement of reproductive and sexual rights, while benefiting from the efforts of progressive social movements, has been curtailed by the influence of conservative lobbies, especially religious-oriented political parties. In this context, abortion and the legal recognition of same-sex partnerships occupy a central position in public debates because of the resistance they provoke from conservative forces.

Historical and Political Context

The 1988 Citizens' Constitution was a historical landmark for Brazil. Not only did it officially end a long period of authoritarianism, it also recognized new social rights along with new social actors who organized themselves around issues of gender, race and sexuality. In this context, healthcare and gender equality were acknowledged as fundamental rights; various forms of family were also given legal recognition. Yet, given the balance of forces, discrimination based on sexual orientation still failed to enter the Constitutional framework, and is now the subject of a Constitutional amendment currently being debated.

Critical Points

- The consequences of illegal abortion are more severe for poor women on two counts: 1) clandestine unsafe abortions endanger women's lives and, 2) in cases of botched operations, women who go to health professionals for help risk being reported to the police.

- In a judicial ruling on foetal anencephalia in 2005, the terminology used was 'therapeutic anticipation of childbirth,' thus strategically moving away from the controversial language of abortion and thereby making the procedure less contentious.

- Access to assisted reproductive technologies is an issue being discussed in the legislature. Proposals regarding ethical norms in the provision of such technologies prohibit the commercialization of gametes and 'wombs for rent'. The heterosexual bias of the proposals, however, is evident in their consideration only of infertile women.

- The greater challenge in the debates on reproductive and sexual rights is the naturalization of categories within the framework of laws, policies and even in social movement demands. In this regard, the destabilizing role of transvestites and transsexuals has been central, raising questions for feminist groups as well as gays and lesbians.

- The successful Brazilian response to HIV/AIDS is built on three principles: a) universal treatment for all, which has made anti-retrovirals accessible to everyone, b) non-discrimination, which emphasizes respect for human rights and enabled the passage of laws giving social benefits, such as welfare payments and retirement pensions, to people with HIV/AIDS, and c) provision of information about sex and sexuality that is not moralistic and condemnatory, which has drawn strong criticism from conservative groups, especially the Catholic Church.

- However, HIV/AIDS-related NGOs have criticized the government's negotiations with multinational pharmaceutical companies, such as Abbott, to reduce prices of medicines. These NGOs urge the government to resort to compulsory licensing instead and to produce their own medicines, arguing that negotiated prices prevent technology transfer and the development of the national pharmaceutical industry which is crucial to sustaining millions of lives.

- But Brazil has shown strength in defending the integrity of its AIDS policies in the face of conflict with US aid policies. Brazilian officials and activists opposed the US Global AIDS Act forbidding the sponsoring of organizations that support the legalization of prostitution and sex trafficking as it threatened to constrain Brazil's AIDS interventions related to sex workers. As a result Brazil renunciation its grants from USAID until the latter relented on the required restrictions.

- HIV/AIDS was instrumental in increasing the visibility of homosexuality and became an important base for the formation of new activist groups, opening up new prospects for political organization and action.

- Although discrimination on the bases of sexual orientation is not addressed in the Constitution, legislators have passed laws promoting the rights of sexual minorities. Law 11.872/02 is worth noting as it deals with the 'promotion and acknowledgment of the freedom of orientation, practice, manifestation, identity and preference as regards sex', which clearly recognizes sexual rights as human rights.

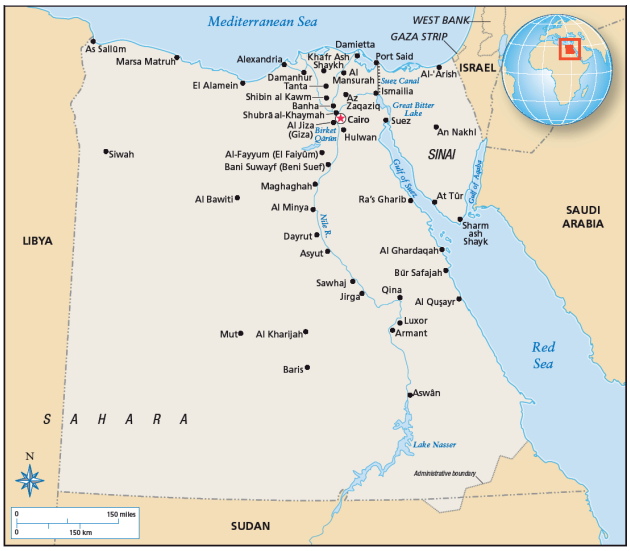
- Although homosexuality and manifestations of homoerotic affection are not crimes in Brazil, conservative groups have mounted campaigns to criminalize 'libidinous kisses in public between people of the same sex'. A Partnership bill emphasizing same-sex couples' property rights also failed to pass in the legislature.

- The close coordination between sexual minorities groups and the government is evident in a joint program, 'Brazil without Homophobia', to combat violence and discrimination against gays, lesbians, bisexuals and transgender persons. However, while the close ties between the State and civil society groups can be viewed as empowering to these groups, this kind of relationship can also curb the critical role of civil society.

- While the GLBT movement has gained much social and political support, it tends to fragment into different identity groups with separate agendas. Competition for public resources exacerbates this fragmentation and creates conflict. It is worth noting that when the law on discrimination against sex orientation was passed in Sao Paulo, a transvestite group was the first to use it to bring a case against a gay nightclub that prohibited transvestites from frequenting the venue.

Egypt

By Hossam Bahgat and Wesal Afifi



Country profile

HDI Rank (2005)[1]	119 of 177		
Population (2005)[3] ***Size*** ***Sex ratio*** (male/100 females) ***% of total population under 15***	 74,033,000 101 34.3%	**Demographics**[5] Eastern Hemitic 99% Greek, Nubian, Armenian, other European 1%	**Religions**[5] Muslim 90% Coptic Christian 10%
Income wealth pyramid (2001)[1] ***Share of income or consumption (%) - Poorest 10%*** ***Share of income or consumption (%) - Richest 10%*** ***Ratio richest 10% to poorest 10%*** ***GINI Index***	 3.7% 29.5% 8.0 34.4		
Political and legal system[5]	**Political System**: Republic Bicameral Legislation **Judicial Branch:** Supreme Constitutional Court; also Courts of General Jurisdiction --Court of Cassation, Courts of Appeal, Tribunals of First Instance, District Tribunals Note: All Courts of General Jurisdiction are divided into criminal and civil chambers. **Constitution:** Promulgated Sept. 11, 1971; amended in 1980 **Legal System:** Based on English common law, Islamic law, and Napoleonic codes; judicial review by Supreme Court and Council of State (oversees validity of administrative decisions); accepts compulsory ICJ jurisdiction, with reservations		
GDP per capita[1]	US$ 1,220 [PPP adjusted - US$ 3,950]		
Public Health expenditure (2002)[1]	1.8% of GDP		
Total debt service as % of GDP (2003)[1]	3.4%		
Official ODA received for HIV/AIDS ***from Global Fund*** **(**2005-06) (US $)[6] ***from PEPFAR***[7]	 -- --		
Life expectancy by gender (2003)[1]	69.8 yrs (gen. pop.), 72.1 yrs (women), 67.7 yrs (men)		

Poverty measures[1] ***% of pop. below poverty line*** (2003) ***% of pop. living below $1/day*** (2003)	 16.7% 3.1%
Education by Gender ***Adult literacy rates*** (2003)[1] ***Enrolment ratio for primary, Secondary & tertiary education*** (2002/03)[1]	 43.6 (women), 67.2% (men) ---
Income by Gender ***estimated earned income (PPP US$)*** (2003)[1] ***Ratio of female estimated earned income to male earned income***[1]	 US$ 1,614 (women), US$ 6,203 (men) 0.26/1.00
Female labor force participation[1] ***Economic activity rate (% ages 15 and above)*** (2003) ***Employment in agriculture (as % of female labor force)*** (1995-2002) ***Employment in industry (as % of female labor force)*** (1995-2003) ***Employment in service industry (as % of female labor force)*** (1995-2002)	 36% 39% 7% 54%
HIV infection and AIDS mortality rates[2]	<0.1 or 5,300 infected AIDS Death: <500 Adults (15+): 5,200 Orphans: --- Women (15+): <1000 Children: ---
Rates of other STIs	
Primary methods for HIV prevention[2]	HIV/AIDS Programs: Anti-retroviral combination therapy
Maternal mortality ratio (2000)[1]	84/100,000 live births
Current abortion laws[4]	Abortion prohibited, except to save woman's life
Most contentious laws related to sexuality	

[1] 2005 Human Development Report, United Nations Development Programme (UNDP), www.undp.org.
[2] 2006 Report on the Global AIDS Epidemic, UNAIDS, www.unaids.org.
[3] Population Division and Statistics Division of the United Nations Secretariat, www.un.org.
[4] UN World Abortion Policies 1999, www.un.org/esa/population/publications.
[5] CountryWatch, www.countrywatch.com.
[6] The Global Fund, www.theglobalfund.org/en/funds_raised/distribution/#sector_recipients.
[7] US Department of State, www.state.gov/documents/organization

Egypt

Focal Concern

Encouraged by the government, al-Azhar, the official religious institution in Egypt, has exercised influence in policymaking related to women's sexuality and reproduction in recent years. While this collaboration between the government and al-Azhar has fended off the further rise of the fundamentalist Muslim Brotherhood, it has only served to deepen the assault on sexual rights of women and other sexual minorities.

Nevertheless, even as public debate on sexuality has been dominated by Muslim conservatives, the daily practices of individual Egyptians have been shown not to conform to this conservative agenda. The prevalence of premarital sex, unorthodox *urfi* marriages, and abortions, especially among young people, are evidence of a silent resistance to conservative sexuality discourses and public policies.

Historical and Political Context

The battle over who was to be the sole legitimate voice of Islam conditioned the relationship between the State, al-Azhar, and the political Islamists starting in the 1960s. To counter the rising popularity of the Islamist movement, the State reorganized al-Azhar and placed the latter within its control in a bid to boost its Islamic credentials. While the cooperation of al-Azhar with the State was criticized by political Islamists as a loss of independence for the religious institution, it is this position which has granted al-Azhar and conservative Muslims leverage over key policies on religious and sexuality-related matters. Thus, while the highest religious authority appears to have been secularized, the State, on the other hand, has not also been free of religious influence.

The transformation of al-Azhar into a major political player was evident during the period of the International Conference on Population and Development (ICPD) in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995. Al-Azhar's actions emboldened other Islamist actors to form the Islamic Committee for Women and Children as an affiliate of a coalition of Islamic organizations around the world under the Grand Imam of al-Azhar, and which is now the public face of the religious institution in UN discussions.

Critical Points

- Al-Azhar, the official Islamic institution, and political Islamic groups, such as Muslim Brotherhood, are the two main forces working against sexual rights in Egypt. These two disagree on issues such as the Islamic character of the State and the role of Islam in the legislative process, but support each other's positions on gender, sexuality, and rights.

- With the entry of al-Azhar into policymaking, legislative proposals on sexuality and gender which ordinarily go directly to Parliament for discussion now have to go through religious authorities for approval, undermining the process of lawmaking in the country.

- Apart from stamping its approval on proposed bills, al-Azhar, with State endorsement, has the power to determine whether particular books and art works should be approved or confiscated according to Islamic principles.

- In 2005, al-Azhar responded to a request from the National Council for Women (chaired by the First Lady of Egypt) for its position on a bill criminalizing female circumcision, asserted that it is a desirable act and must not be criminalized in a Muslim country.

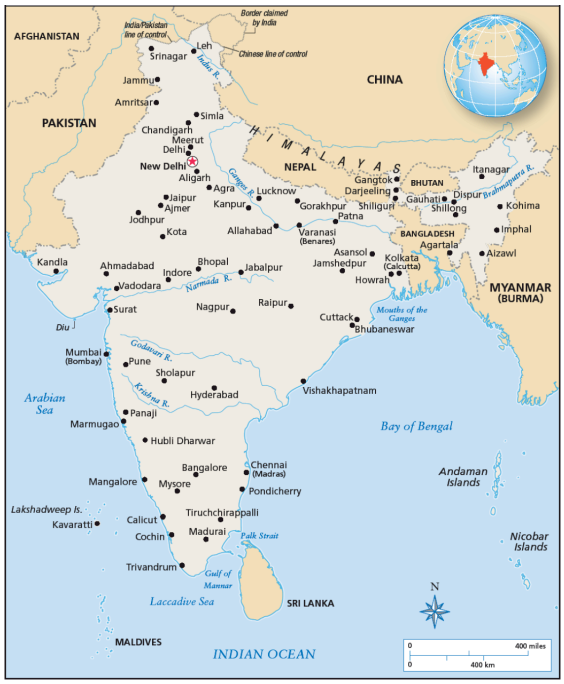
- The success of religious conservatives in dominating the public debate on sexual rights is enhanced by the absence of discussions based on scientific knowledge of sexuality, reproduction and similar issues. According to the Transitions to Adulthood Survey, only six percent of boys and seven percent of girls learned about puberty through school books. A study on Women's Perceptions of Sexuality found that women have limited knowledge of reproduction.

- It is important to note, though, that both religion and scientific knowledge have limited impact on the actual sexual practices of Egyptians. Premarital sex, according to studies, is common; and as of 2005 courts were adjudicating between 14,000 and 21,000 cases of *urfi* marriages, which require only two witnesses and is not sanctioned by religion or the State.

- Abortion exists as a 'semi-legal' practice in the country. It is neither promoted nor controlled, but is still a sensitive topic as demonstrated by issues raised by the religious officials during the ICPD and Beijing conferences. Sidestepping the politically-charged nature of the debates, health activists have successfully campaigned for the incorporation of post-abortion care into the national Safe Motherhood Program, the aim of which was to improve all types of obstetrics care instead of focusing on pushing for a policy change on abortion.

India

By Radhika Ramasubban



Country profile

HDI Rank (2005)[1+]	127 of 177		
Population (2005)[3]		**Demographics**[5]	**Religions**[5]
Size[*]	1,103,371	Indo-Aryan 72%	Hindu 80%
Sex ratio (male/100 females)	105	Dravidian 25%	Muslim 14%
% of total population under 15	32%	Mongoliad, others 3%	Christian 2%
			Sikh 2%
			Buddhist 1%
			Jains 1%
Income wealth pyramid (2001)[1]			
Share of income or consumption (%) - Poorest 10%	3.9%		
Share of income or consumption (%) - Richest 10%	28.5%		
Ratio richest 10% to poorest 10%	7.3		
GINI Index	32.5		
Political and legal system[5]	**Political System**: Federal republic; democratic process; mixed presidential-parliamentary system Bicameral Parliament **Judicial Branch:** Supreme Court; chief justice and 25 additional judges formally appointed by the president on the advice of the prime minister; judges remain in office until the age of 65 **Constitution:** Jan. 26, 1950 **Legal System:** Based on English common law; limited judicial review of legislative acts; accepts compulsory ICJ jurisdiction, with reservations		
GDP per capita[1]	US$ 564 [PPP adjusted US$ 2,892]		
Public Health expenditure (2002)[1]	1.3% of GDP		
Total debt service as % of GDP (2003)[1]	3.4%		
Official ODA received for HIV/AIDS			
from Global Fund (2005-06)[6]	US$ 49,416,900		
from PEPFAR[7]	--		
Life expectancy by gender (2003)[1]	63.3 yrs (gen. pop.), 65 yrs (women), 61.8 yrs (men)		

Poverty measures[1] ***% of pop. below poverty line*** (2003) ***% of pop. living below $1/day*** (2003)	 28.6% 34.7%
Education by Gender ***Adult literacy rates*** (2003)[1] ***Enrolment ratio for primary, secondary & tertiary education*** (2002/03)[1]	 47.8% (women), 73.4% (men) 56% (women), 64% (men)
Income by Gender ***estimated earned income (PPP US$)*** (2003)[1] ***Ratio of female estimated earned income to male earned income***[1]	 US$ 1,569 (women), US$ 4,130 (men) 0.38/1.00
Female labor force participation[1] ***Economic activity rate (% ages 15 and above)*** (2003) ***Employment in agriculture***[8] ***(as % of female labor force)*** (2001) ***Employment in industry***[8] ***(as % of female labor force)*** (2001) ***Employment in trade***[8] ***(as % of female labor force) (2001)*** ***Employment in service industry***[8] ***(as % of female labor force)*** (2001)	 42.5% 76.6% 13.1% 3.2% 7.1%
HIV infection and AIDS mortality rates[2]	[0.4 - 1.3] or 5,700,000 infected Adults (15+): 5,600,000 Women (15+): 1,600,000 Children: --- Orphans: --- AIDS Deaths: est. 270,000-680,000
Rates of other STIs[9#]	Genital ulcer diseases: 15.0% Urethral discharge: 8.3% Vaginal discharge: 39.0% Inguinal swelling: 1.2% Others: 35.5%
Primary methods for HIV prevention[2]	HIV/AIDS Programs: Anti-retroviral combination therapy Blood screening
Maternal mortality ratio (2000)[1]	540/100,000 live births
Current abortion laws[4]	Abortion allowed to save woman's life, based on socio-economic grounds, physical and mental health, and in cases of rape and incest; parental authorization/notification required

Most contentious laws related to sexuality	**Section 377 IPC (1860)** that labels non-heterosexual sex as "unnatural", to be punished with imprisonment for life or imprisonment for ten years and liable to fine. **Immoral Traffic (Prevention) Act 1956** that gives police and courts wide-ranging powers to decide if a person is a "prostitute" and then remove her from "any" place and prohibit her from re-entering it on pain of punishment. This includes power to search and arrest without search/arrest warrants, keep in custody indefinitely, and imprison for between two and five years. An Amendment to Section 5 © of the Act passed in May 2006 criminalizes clients of sex workers in the name of preventing trafficking.

[1] 2005 Human Development Report, United Nations Development Programme (UNDP), www.undp.org
[2] 2006 Report on the Global AIDS Epidemic, UNAIDS, www.unaids.org
[3] Population Division and Statistics Division of the United Nations Secretariat, www.unstats.un.org
[4] UN World Abortion Policies 1999, www.un.org/esa/population/publications
[5] CountryWatch, www.countrywatch.com
[6] The Global Fund, www.theglobalfund.org/en/funds_raised/distribution/#sector_recipients
[7] US Department of State, www.state.gov/documents/organization
[8] Census of India, 2001 (N. Delhi: Govt. of India).
[9] National AIDS Control Organisation (Jan-Dec 2003). Published in Health Information of India 2004, Central Bureau of Health Intelligence, Ministry of Health and Family Welfare, Govt. of India, http://cbhidghs.nic.in
NOTE: These data are very problematic. Available data reflects patients reporting to government STD clinics only, which accounts for 5-10% of the total number of patients, a wide range of providers being the preferred option. Even in these clinics, laboratory confirmation of diagnosis is often absent, further undermining the quality of the information provided.

+ GDI rank (2003): 98 out of 177; GDI is a combination of HDI components plus inequalities in achievement between women and men.
* % population not likely to survive up to 40 years (2000-05): 17% , Human Development Report 2005 (UNDP). In 2001, % of population under 29 yrs: 61.9 and sex ratio of females/1000 males: 933, Census of India (N. Delhi: Govt. of India).
** GINI ratio for per capital consumption expenditure (1999-2000): Rural – 0.258, Urban – 0.341, National Human Development Report 2001 (N. Delhi: Planning Commission, Govt. of India).

India

Focal Concern

The HIV/AIDS epidemic in India poses its greatest challenge to the complicit silence around sexuality on the part of both State and society. By highlighting the sexual vulnerability of women and of sexually marginalized sections of the population, the epidemic has created an unprecedented opportunity for multiple sexuality discourses that question narrowly constrictive constructions of both patriarchal gender relations and heteronormativity, and frame the issue of the sexual rights of those involved. The most focused contestation around sexual and citizenship rights has come from people of alternative sexualities in the form of a Public Interest Litigation that is currently challenging the legality of Section 377 of the Indian Penal Code (IPC) that criminalizes 'unnatural offences'. The struggle to reform the law, however, although extremely significant, opens up new dilemmas - arising out of the limitations of the available public health and legal frameworks - for the onward progress towards sexual rights for the entire spectrum of people of alternative sexualities.

Historical and Political Context

Section 377 IPC, known as the anti-sodomy law, was introduced by the British colonial government in the mid-19th century as part of its civilizing mission, and in deference to similar laws then current in Britain that criminalized all non-procreative sexual behavior, whether homosexual or heterosexual. In an ironic historical twist, Section 377 is now being viewed by the Indian State, religious fundamentalists and political conservatives, as a statute that is in keeping with the fundamental elements of traditional 'Indian culture'. The resort to cultural nationalist language to defend Section 377 and justify attacks on sexual minorities, reflects a discourse that denies the existence of tolerant erotic traditions in ancient Indian sexual culture that permitted a space and role, albeit limited, for diverse sexualities. It is this tolerant tradition that the emerging lesbian, gay, bisexual, *hijra-kothi* and transgender communities are seeking to reclaim, simultaneous with their struggle for their civil and human rights. The clash between, on the one hand, the new-found identity of these groups, now legitimized by the recognition of HIV/AIDS work globally, and on the other hand, the anxieties of conservative forces bolstered by the existing sexual order and legal provisions, has found a platform in the debates on Section 377.

Critical Points

- While the epidemic enabled the visibility of marginalized sexual and transgender communities, it is this visibility of HIV/AIDS work that has incited medical re-stigmatization, violent police reprisals and public discrimination. These negative fallouts take the form of denial of access to affordable and effective health care, summary arrests and public shaming, and repeated dislocation of activist groups operating out of mainstream residential areas, which have acted to prevent these groups from building self confident and stable communities for self-care.

- The contradictory position of these groups is further reflected in the government's acknowledgment, two decades into the epidemic, of the urgent health needs of LGBT individuals and their position as a 'bridge' population for the spread of the virus

into the general population. This peculiar situation has earned for LGBT groups representation in government health and policy making bodies, even as they are rejected by mainstream medical professionals and persecuted by the police under the anti-sodomy law.

- The various actions by LGBT and HIV/AIDS groups to respond to repression were instrumental in the process of consolidating the disparate alternative sexualities groups into a national-level 'community'. At the same time, the legal reform campaign, while serving as a mobilizing tool for developing a common ideology and strategy, needed this organized movement on which to anchor its strength and legitimacy as it engaged with the State.

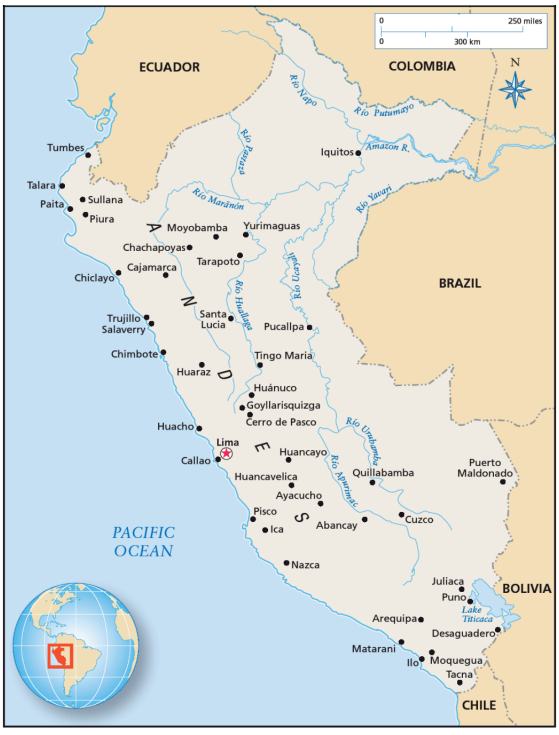
- The legal challenge to Section 377 has revealed a basic tension between the practical necessity of calibrating arguments according to the narrow assumptions of the law, and the ideal trajectory of the movement toward broadening rights. The petition to exempt private consensual adult sex from the law was criticized by several LGBT groups because it had the effect of discriminating against poor LGBT persons, the majority of whom perforce engage in sex in 'public'.

- The 'legalization' of the struggle for LGBT rights on the one hand, and the movement to the 'center' from the margins gained by acceptance of the sanitized identity of 'MSM', on the other, also throw into sharp relief the problematic role of class and self-identity in influencing the political configurations within the incipient LGBT community, the relative legitimacy of different groups in relation to the State, and the movement forward of a broad-based rights agenda.

- A market-led embryonic discourse of sexual rights based on pleasure and personal freedom is currently underway; this discourse privileges heterosexuality and metropolitan consumption values and its vehicles are the English language print and electronic mass media, films and fashion. The debate on the anti-sodomy law, although still at the margins and conducted through postings carried by dedicated AIDS email groups and receiving only occasional coverage in the English press is, nevertheless, evidence that this alternative sexualities movement is coming of age, at least in the metropolitan cities and among the better-off English-speaking classes.

Peru

By Carlos Cáceres, Nancy Palomino and Marcos Cueto



Country Profile

HDI Rank (2005)[1]	79 of 177		
Population (2005)[3] ***Size*** ***Sex ratio*** (male/100 females) ***% of total population under 15***	27,968,000 101 32%	**Demographics**[5] Indigenous 45% Mestizo 37% European 15% Black, Japanese, Chinese, other 3%	**Religions**[8] Roman Catholic 79.2% Evangelic, Pentecostal or non-Catholic Christian 12.8% Adventist, Jehova Witness or Mormon 3.7%
Income wealth pyramid (2001)[1] ***Share of income or consumption (%) - Poorest 10%*** ***Share of income or consumption (%) - Richest 10%*** ***Ratio richest 10% to poorest 10%*** ***GINI Index***	 0.7% 37.2% 49.9 49.8		
Political and legal system[5]	**Political Systems**: Constitutional republic; predominantly presidential system Unicameral Congress **Judicial Branch:** Supreme Court of Justice or Corte Suprema de Justicia (judges are appointed by the National Council of the Judiciary) **Constitution:** December 1993 **Legal System:** Based on civil law system; has not accepted compulsory ICJ jurisdiction		
GDP per capita[1]	US$ 2,231 [PPP adjusted US$ 5,269]		
Public Health expenditure (2002)[1]	2.2% of GDP		
Total debt service as % of GDP (2003)[1]	4.2%		
Official ODA received for HIV/AIDS ***from Global Fund*** (2005-06)[6] ***from PEPFAR***[7]	 US$ 15,718,354 --		
Life expectancy by gender (2003)[1]	70 yrs (gen. pop.), 72.6 yrs (women), 67.5 yrs (men)		
Poverty measures[1] ***% of pop. below poverty line*** (2003) ***% of pop. living below $1/day*** (2003)	 49% --		

Education by Gender ***Adult literacy rates*** (2003)[1] ***Enrolment ratio for primary, secondary & tertiary education*** (2002/03)[1]	 82.1% (women), 93.5% (men) 88% (women), 87% (men)
Income by Gender ***estimated earned income (PPP US$)*** (2003)[1] ***Ratio of female estimated earned income to male earned income***[1]	 US$ 2,231 (women), US$ 8,256 (men) 0.27/1.00
Female labor force participation[1] ***Economic activity rate (% ages 15 and above)*** (2003) ***Employment in agriculture (as % of female labor force)*** (1995-2002) ***Employment in industry (as % of female labor force)*** (1995-2003) ***Employment in service industry (as % of female labor force)*** (1995-2002)	 35.6% 6% 10% 84%
HIV infection and AIDS mortality rates[2]	0.5 or 93,000 infected Adults (15+): 91,000 Women (15+): 26,000 AIDS Deaths: 5,600 Orphans: --- Children: ---
Rates of other STIs	
Primary methods for HIV prevention[2]	HIV/AIDS Programs: Anti-retroviral combination therapy Blood screening
Maternal mortality ratio (2000)[1]	410/100,000 live births*
Current abortion laws[4]	Article 119 of the Penal Code: Only therapeutic abortion is permitted, in order to save the mother's life or to prevent severe and permanent harm to her health.
Most contentious laws related to sexuality	

[1] 2005 Human Development Report, United Nations Development Programme (UNDP), www.undp.org.
[2] 2006 Report on the Global AIDS Epidemic, UNAIDS, www.unaids.org.
[3] http://unstats.un.org/unsd/demographic/products/socind/health.htm Population Division and Statistics Division of the United Nations Secretariat, www.un.org.
[4] UN World Abortion Policies 1999, www.un.org/esa/population/publications.
[5] CountryWatch, www.countrywatch.com.
[6] The Global Fund, www.theglobalfund.org/en/funds_raised/distribution/#sector_recipients
[7] US Department of State, www.state.gov/documents/organization
[8] From study performed by the Instituto Bartolomé de las Casas and a public opinion survey conducted by the Catholic University of Peru (El Comercio Journal, Perú, 14 April 2006

NOTE: The oficial statistics for Peru (2002) present significantly different statistics on maternal mortality, putting the figure at 164 maternal deaths per 100,000 live births, http://www.minsa.gob.pe/estadisticas/estadisticas/SalaSituacional/04_Mortalidad.pdf

Peru

Focal Concern

A critical examination of how Peruvian governments since 1990 have addressed reproductive rights, HIV/AIDS prevention and treatment, and sexual diversity rights, reveals that abortion and contraception consistently generated the deepest public controversies and debates. HIV/AIDS issues too received considerable attention as the epidemic was often portrayed as having the potential to affect everyone. Public discussions of the epidemic included calls for concern and sympathy for those affected that directly challenged stigma based on fears of contagion or moral judgments. Sexual diversity rights, perceived as a demand made by "others", were generally trivialized and disdained by politicians, officials and the general population. As a result of these differences in visibility and approach, advocates and activists achieved some success in advancing HIV/AIDS-related rights. Positive changes also occurred with respect to sexual diversity rights as long as the issue was given a low political and institutional profile. The highly public controversies over reproductive rights and the growing conservatism internationally threatened not only to stall progress but to reverse past gains.

The analysis of policy making and program implementation in these three areas reveals that: 1. Weaknesses in national institutional frameworks concerning reproductive health made it possible for governments to adopt two very different (even contradictory) approaches to the issue within the past 15 years; 2. Policies were presented as rights-based in order to garner political legitimacy when, in fact, they evidenced a clear disregard for the rights of individual citizens; and 3., By favoring low-profile "public health" discourses and marginalizing "the sexual" in official policies related to sexuality, advocacy groups sometimes created opportunities for legal changes but failed to challenge conservative powers opposing the recognition of sexual and reproductive rights and the full citizenship of women and sexual minorities.

Historical and Political Context

Peruvian society has been shaped by the Roman Catholic Church's official power and influence over cultural values, the conservatism of its ruling elites, and the rise and fall of anti-authoritarian movements. Since colonial times, the Church, through its control of, among other things, property, education, health care, and social institutions such as marriage, has exercised considerable influence in Peru. The Church has also maintained close ties with the country's political elite over the centuries. In the 20th century the growth of a middle class and rapid urbanization, in conjunction with the formation of workers' unions and populist political parties, led a rise of popular demands for rights and services. The priest Gustavo Gutierrez founded the liberation theology movement during this period, initiating a crisis within the Church that threatened its relations with the country's political elite. A protracted period of crisis followed, characterized by aggressive clashes between populist groups and the authoritarian State. In the 1980s and early 1990s, while governed by democratic regimes, the country experienced hyperinflation, recession, rampant unemployment and grave human rights violations. This deterioration was exacerbated by the actions of the militant groups, the Maoist Shining Path and the Túpac Amaru Revolutionary Movement, and the military came to play an increasingly prominent role in the day-to-day running of the country. The election in 1990 of Fujimori initiated a period of neoliberal and authoritarian policies. Fujimori's autocratic policies were seconded by Juan Luis Cipriani, an Opus Dei provincial archbishop,

later named cardinal of the country, who dismissed any "human rights" considerations in the fight against terrorism. Fujimori's economic shock treatment and radical free market policies included a coercive population and reproductive health program to address poverty. It was also during this time that a progressive HIV/AIDS program was put in place which included the participation of LGBT groups. Following Fujimori's resignation in 2000, President Toledo initiated a re-democratization process. This, however, involved surrendering the Ministry of Health to far-right conservative Catholic groups, which had supported Toledo's candidacy. Citing the human rights violations committed by the previous regime in implementing a reproductive and health program, the new health officials proceeded to ban modern contraceptives and post-abortion care as well as removed 'gender', 'sexual and reproductive right' and 'sexual orientation' from official documents.

Critical Points

- Reproductive rights, HIV/AIDS, and sexual diversity rights have achieved different levels of progress in Peruvian society in the past 15 years. Among these issues, reproductive rights have always been accompanied by considerable public attention and deep controversies, which inevitably hamper their advancement. HIV/AIDS, on the other hand, has been easier to push forward as it is seen as a problem that deserves sympathy and action from government. Positive changes in the area of sexual diversity rights, however, were possible only when LGBT groups maintained a low profile in public.

- Although there was public support for the campaign by feminists and progressive physicians and artists to decriminalize abortion in cases of rape, political pressure from the Catholic Church and professional lawyers' association prevented the approval of the proposed legislation in 1991. The introduction into the Constitution of a provision 'recognizing the unborn child' in 1993 has made it more difficult to relax the law regarding abortion. The possibility of decriminalizing abortion presents critical challenges given its extremely sensitive and controversial nature in the public debate. Church representatives and conservative forces seem to be not only inflexible regarding possible progressive changes, but to permanently seek opportunities for conservative changes.

- The apparent paradoxical transition from an extreme neo-Malthusian policy during Fujimori to a Catholic fundamentalist health program during Toledo illustrates the lack of recognition for citizenship rights by both secularist and religion-backed regimes. For these governments, the notion of rights could be manipulated to serve their broader political agendas, such as attempting to gain the support of civil society in order to fuel their political ascendancy.

- Both the Fujimori and early Toledo governments used pro-women's rights rhetoric to justify, respectively, their excessive population policy and fundamentalist health program. While the former purported to support contraceptive choice but in practice coerced poor women to get sterilizations, the latter denounced the violations against women's bodies and used this to impose religious doctrine on health programs.

- The radical changes in the reproductive health program from Fujimori to Toledo's first 30 months in power and the ease with which programs had been dismantled from one government to another exposed the weak institutional system within Peru's health sector. This has undermined whatever advancement in reproductive health and rights had been achieved in previous years, in favor of momentary dominant political interests.

- The collaboration of members of civil society movements with government was crucial in the success of the progressive and relatively comprehensive national

HIV/AIDS control program in the mid-1990s. However, this had the effect of blunting the political aspect of HIV/AIDS activism. The short-lived collaboration also dramatized the fact that health programs operating as isolated visionary projects within authoritarian regimes are unsustainable.

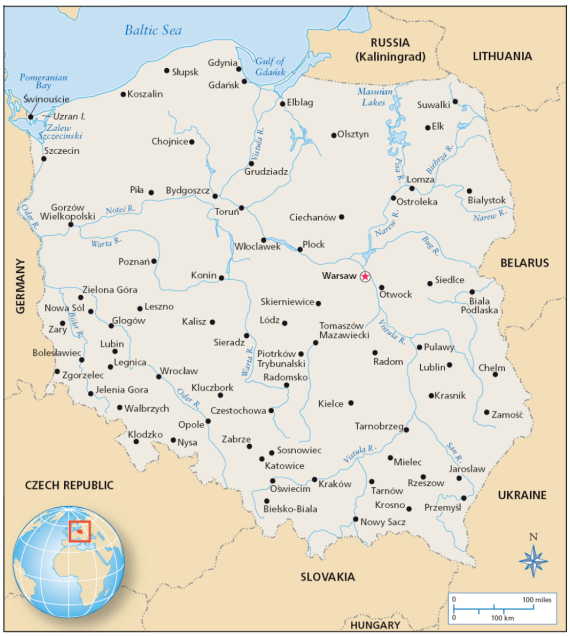
- Shifting the focus from prevention to treatment access proved to be a boon for HIV/AIDS as it mobilized broad support from persons living with HIV/AIDS, activists, and even the Catholic Church. While the "right to health" was at the core of the campaign, consensus with religious conservatives was bridged from a charity viewpoint, thus making possible the passage of an AIDS law.

- The re-emergence of social movements towards the end of Fujimori's government and during Toledo's presidency also established the basis for a renewed diversified LGBT movement, with more groups being formed. These groups, however, have distanced themselves from HIV/AIDS in order to separate the political activism around sexual diversity rights from the less-political approach of HIV/AIDS work.

- In 2005, Congress approved a new Code of Constitutional Procedures, which included a provision protecting citizens from discrimination based on sexual orientation. Moreover, the Constitutional Tribunal, in a historical judgment, declared unconstitutional the Military Code which defined homosexual activity while on duty as a crime.

Poland

By Wanda Nowicka



Country Profile

HDI Rank (2005)[1]	36 of 177		
Population (2005)[3] ***Size*** ***Sex ratio*** (male/100 females) ***% of total population under 15***	 38,529,000 94 16%	**Demographics**[5] Polish 97% German 1% Ukrainian 1% Byelorussian 1%	**Religions**[5] Roman Catholic 95% Eastern Orthodox, protestant, other 5%
Income wealth pyramid (2001)[1] ***Share of income or consumption (%) - Poorest 10%*** ***Share of income or consumption (%) - Richest 10%*** ***Ratio richest 10% to poorest 10%*** ***GINI Index***	 3.1% 26.7% 8.6 34.1		
Political and legal system[5]	**Political System**: Republic; parliamentary system Bicameral national assembly **Judicial Branch:** Supreme Court; judges appointed by the president on the recommendation of the National Council of Judiciary for an indefinite period. Constitutional Tribunal, judges chosen by the "Sejm" for a nine-year term. **Constitution:** An interim "small constitution" came into effect in December 1992, replacing the communist-imposed constitution of July 22, 1952. The National Assembly adopted a new democratic constitution on April 2, 1997, subsequently passed by popular referendum on May 25, 1997. **Legal System:** Mixture of Continental (Napoleonic) civil law and holdover communist legal theory Changes being gradually introduced as part of a broader democratization process. Limited judicial review of legislative acts. Court decisions can be appealed to the European Court of Justice in Strasbourg, France.		
GDP per capita[1]	US$ 5,487 [PPP adjusted US$ 11,379]		
Public Health expenditure (2002)[1]	4.4% of GDP		
Total debt service as % of GDP (2003)[1]	9.1%		
Official ODA received for HIV/AIDS ***from Global Fund*** (2005-06)[6] ***from PEPFAR***[7]	 -- --		
Life expectancy by gender (2003)[1]	74.3 yrs (gen. pop.), 78.4 yrs (women), 70.3 yrs (men)		

Life expectancy by gender (2003)[1]	74.3 yrs (gen. pop.), 78.4 yrs (women), 70.3 yrs (men)
Poverty measures[1] ***% of pop. below poverty line*** (2003) ***% of pop. living below $1/day*** (2003) ***% of pop. living below 50% median income*** (1990-2000)	 -- -- 8.6
Education by Gender ***Adult literacy rates*** (2003)[1] ***Enrolment ratio for primary, secondary & tertiary education*** (2002/03)[1]	 99.7% (women), 99.8% (men) 93% (women), 88% (men)
Income by Gender ***estimated earned income (PPP US$)*** (2003)[1] ***Ratio of female estimated earned income to male earned income***[1]	 US$ 8,769 (women), US$ 14,147 (men) 0.62/1.00
Female labor force participation[1] ***Economic activity rate (% ages 15 and above)*** (2003) ***Employment in agriculture (as % of female labor force)*** (1995-2002) ***Employment in industry (as % of female labor force)*** (1995-2003) ***Employment in service industry (as % of female labor force)*** (1995-2002)	 57% 19% 18% 63%
HIV infection and AIDS mortality rates[2]	0.1 or 25,000 infected Adults (15+): 25,000 Women (15+): 7,500 AIDS Deaths: <1000 Orphans: --- Children: ---
Rates of other STIs	
Primary methods for HIV prevention[2]	HIV/AIDS Programs: Anti-retroviral combination therapy
Maternal mortality ratio (2000)[1]	13/100,000 live births
Current abortion laws[4]	Abortion allowed to save women's health, and in cases of incest, rape and fetal impairment; parental authorization/notification required
Most contentious laws related to sexuality	

[1] 2005 Human Development Report, United Nations Development Programme (UNDP), www.undp.org
[2] 2006 Report on the Global AIDS Epidemic, UNAIDS, www.unaids.org
[3] Population Division and Statistics Division of the United Nations Secretariat, www.un.org
[4] UN World Abortion Policies 1999, www.un.org/esa/population/publications
[5] CountryWatch, www.countrywatch.com
[6] The Global Fund, www.theglobalfund.org/en/funds_raised/distribution/#sector_recipients
[7] US Department of State, www.state.gov/documents/organization

Poland

Focal Concern

Debates about whether access to abortion is a right or should be limited by the state have been used by political parties, the Catholic Church, the liberation movement and the nascent women's movement to express competing visions of Poland's national character and the nature of its post-communist democracy.

Important political players, including the conservative Solidarity trade union and related political movements, advocated the banning of abortion and limiting other reproductive rights and efforts by the women's section of Solidarity to oppose its anti-abortion position resulted in the dissolution of the Women's Section of the trade union. The Catholic Church, greatly strengthened as a political actor following the end of the communist era, also actively campaigned against abortion. The Church's authority was further magnified by the symbolic power and deliberate actions of Pope John Paul II (the "Polish Pope"). All public opinion polls show that the majority of the populous, despite being predominantly Catholic, does not support legislation restricting abortion. Nevertheless, the comparatively new and still weak democratic system in place in Poland has enabled the conservative minority to prevail.

The emerging and still relatively small Polish feminist movement has campaigned against restrictions on abortion but has yet to develop effective strategies to effectively influence the public debate on women's reproduction, sexuality and rights.

Historical and Political Context

From 1932 to 1956, abortion was allowed in Poland if a woman's pregnancy resulted from a 'crime' or if it placed the woman's life or health at risk. In 1956, the law was further expanded to allow abortion for socio-economic reasons. After the communist regime was toppled, the new Parliament in 1993 introduced restrictions to the law, such as eliminating justification on socio-economic grounds. A reversal of this position in 1996 was declared unconstitutional in 1997. In 2004-05, another attempt undertaken by women's groups to liberalize the law on abortion and introduce a law on responsible parenthood failed.

Critical Points

- The legality of abortion for forty years under communism was based on an instrumentalist and needs-based materialist approach to a prevalent social problem affecting poor women and not in recognition of Polish women's autonomy and right to sexual and reproductive self-determination. Because legal abortion was 'handed' to and did not have to be fought for by women, this made it easy for Catholic fundamentalist groups to contest this right in later years.

- In the absence of a women's movement under communism, a discourse on reproductive choice did not develop until the late 1980s. It was the issue of abortion that was instrumental in the development of a Polish feminist movement.

- The symbol of 'Heroic motherhood', exemplified by the image of "Mother Pole" who reproduces both children and national culture, demands the subordination of women's individual needs to that of family, religion and national identity. This ideology diminishes Polish women's role in the historical struggles for freedom and independence while foregrounding their capacity to reproduce for the nation.

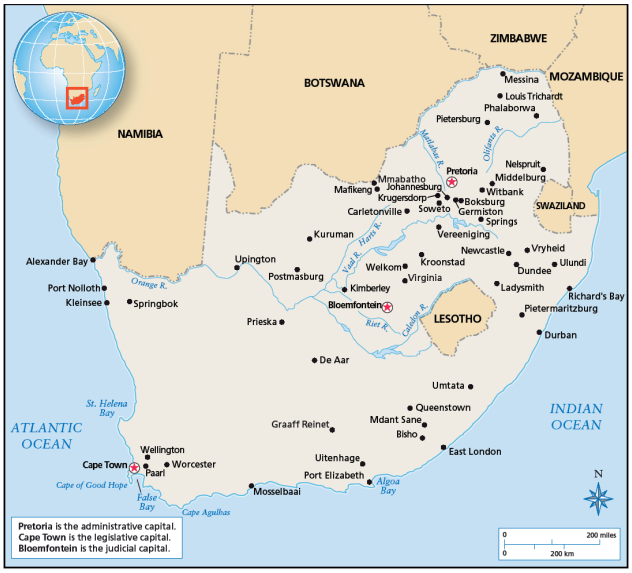
- Conservatives described liberal abortion laws as a remnant of the communist regime and one of the elements of that oppressive history to be abolished if in the transition to democracy is to be successful. This construction is mirrored in calls for the "moral revival" of the nation which, using terms borrowed from Pope John Paul II, requires that the nation move from the *civilization of death* that was in place under the communist regime to a *civilization of life* under democracy, terms that have directly influenced public debates on abortion.

- Many young women (18-25) consider abortion a moral issue primarily and thus support laws limiting women's access to abortion, while many older women (30-45) view the issue as primarily a question of rights and are critical of restricting access. This generation gap on abortion mirrors the shift in the status of abortion from the communist to the post-communist period.

- Abortion is a highly tabooed issue and no women have stepped forward to provide a public face for abortion rights struggles. The majority of women also consider abortion a private matter and are reluctant, therefore, to act outside the private realm by participating in public debates about abortion and publicly sharing their experience of having abortion.

South Africa

By Belinda Beresford and Helen Schneider



Country profile

HDI Rank (2005)[1]	120 of 177		
Population (2005)[3] ***Size*** ***Sex ratio*** (male/100 females) ***% of total population under 15***	 47,390,900 96/100 33%	**Demographics**[3] Indigenous African 37 662 900 Asian/Indian 1 163 900 White 4 365 300 Coloured (mixed) 4 198 800	**Religions**[5] Christian 98% Indigenous 29% Muslim 2% Hindu 2%
Income wealth pyramid (2001)[1] ***Share of income or consumption (%) - Poorest 10%*** ***Share of income or consumption (%) - Richest 10%*** ***Ratio richest 10% to poorest 10%*** ***GINI Index***	 1.4% 44.7% 33.3 57.8		
Political and legal system[5]	**Political System**: Republic; Bicameral Parliament **Judicial Branch:** Supreme Court **Legal System:** Based on Roman-Dutch law and English common law; accepts compulsory ICJ jurisdiction, with reservations **Constitution:** 1996; this new constitution was certified by the Constitutional Court on December 4, 1996 and was signed by then President Mandela on December 10, 1996,and entered into effect on February 3, 1997; it is being implemented in phases		
GDP per capita[1]	US$ 3,489 [PPP adjusted US$10,346]		
Public Health expenditure (2002)[1]	3.5% of GDP		
Total debt service as % of GDP (2003)[1]	2.7%		
Official ODA received for HIV/AIDS ***from Global Fund*** **(**2005-06)[6] ***from PEPFAR***[7] (2004-06)	 US$ 70,903,651 US$ 369,700,000		
Life expectancy by gender (2003)[1]	48.4 yrs (gen. pop.), 50.2 yrs (women), 46.8 yrs (men)		
Poverty measures[1] ***% of pop. below poverty line*** (2003) ***% of pop. living below $1/day*** (2003)	 -- 10.7%		

Education by Gender ***Adult literacy rates*** (2003)[1] ***Enrolment ratio for primary, secondary & tertiary education*** (2002/03)[1]	 80.9% (women), 84.1% (men) 78% (women), 78% (men)
Income by Gender ***estimated earned income (PPP US$)*** (2003)[1] ***Ratio of female estimated earned income to male earned income***[1]	 US$ 6,505 (women), US$ 14,326 (men) 0.45/1.00
Female labor force participation[1] ***Economic activity rate (% ages 15 and above)*** (2003) ***Employment in agriculture (as % of female labor force)*** (1995-2002) ***Employment in industry (as % of female labor force)*** (1995-2003) ***Employment in service industry (as % of female labor force)*** (1995-2002)	 47.3% 9% 14% 75%
HIV infection and AIDS mortality rates[2]	21.5% or 5,500,000 infected AIDS Death: 320,000 Adults (15+): 5,300,000 Women (15+): 3,100,000 Children: 240,000 Orphans (0-17): 1,200,000
Rates of other STIs[8]	Syphilis: 10% women attending antenatal and family planning clinics. 24%-42% in sex workers and men with urethritis. Chacroid: accounts for over 50% of genital ulcer disease in men. Herpes simplex virus type 2: 50% in men with urethritis, over 80% in commercial sex workers Gonorrhoea: 5% in women attending family planning and antenatal clinics. Chlamydia: less than 20% of male urethritis cases Bacterial vaginosis and candidiasis: between 20%-40% for STI clinic attenders and sex workers
Primary methods for HIV prevention[2]	HIV/AIDS Programs: MTCT anti-retrovirals Anti-retroviral combination therapy Blood screening
Maternal mortality ratio (2000)[1]	230/100,000 live births

Current abortion laws[4]	Choice of Termination of Pregnancy Act, 1996 – Abortion allowed 1) upon request of woman, first 12 weeks, 2) from 13-20 weeks with medical practitioner's opinion, 3) if it poses injury to woman's physical, mental health, 4) if there is substantial risk fetus would suffer severe physical, mental abnormality, 5) in cases of rape and incest, 6) based on socio-economic grounds, and 7) after 20 weeks, if it endangers the woman's life, or if there is injury to and malformation of the fetus
Most contentious laws related to sexuality	Immigration Act, 2001, enshrined the rights of South African citizens non-South African partners to obtain permanent residency in South Africa. In July 2002, the High Court of South Africa in Bloemfontein ruled that to deny same-sex couples the right to marry equally is discriminatory and thus unconstitutional. On November 30, 2004, yet another court ruled in favour of same-sex marriage when the Supreme Court of Appeal of South Africa declared that under the Constitution, the common law concept of marriage must be changed to include partners of the same gender. Education Laws Amendment Act, 1999 and South African Schools Act, 1996 – widely interpreted as permitted progressive sex education in schools making it possible, for example, for Planned Parenthood to train South Africa's life skills teachers. Alteration of Sex Description and Sex Status Act, 2003 – provides for the alteration of the sex description of persons in the National Population Register whose sex organs have been altered surgically or by other medical treatment. Sexual Offences Amendment Bill would reduce the age of consent from 19 years to 16 years but would also criminalize non-disclosure of STI in circumstances where there is a risk of transmission. SA Law Commission is working on legislation to de-criminalize commercial sex work in South Africa.

[1] 2005 Human Development Report, United Nations Development Programme (UNDP), www.undp.org.
[2] 2006 Report on the Global AIDS Epidemic, UNAIDS, www.unaids.org
[3] Statistics South Africa, http://www.statssa.gov.za/
[4] UN World Abortion Policies 1999, www.un.org/esa/population/publications.
[5] CountryWatch, www.countrywatch.com.
[6] The Global Fund, www.theglobalfund.org/en/funds_raised /distribution/#sector_recipients.
[7] US Department of State, www.state.gov/documents/organization
[8] Johnson, LF., Coetzee, DJ. And Dorrington, RE. (2005) Sentinel surveillance of sexually transmitted infections in South Africa: a review. Sexually Transmitted Infections, 81: 287-293. There are no nationally representative microbiologicalstudies of STIs in South Africa, but there are many sentinel surveillance studies. The results of these studies are difficult to compare, because of differences in populations sampled and differences in diagnostic methods used. Almost all of the studies are conducted among users of public health facilities, and there are very few studies of SIT prevalence in individuals of higher socioeconomic status.

South Africa

Focal Concern

South Africa's post-apartheid democratization process has provided a legislative and legal environment that supports sexual and reproductive rights. Despite gains on the constitutional front, however, homosexuality, abortion and HIV/AIDS remain contentious issues for the general public, revealing a schism between the emerging rights-based framework of the State and the 'morals of the nation'. In conjunction with reactionary forces within South Africa, various international aid initiatives, such as those governed by the current US administration, have served to weaken domestic HIV/AIDS and reproductive health programs and threaten to undermine the progressive potential of the constitutional principles.

Historical and Political Context

The 1996 South African Constitution, with its comprehensive Bill of Rights and strong anti-discrimination provisions, has been hailed as the most progressive in the world. For example, it was the first national constitution to prohibit discrimination based on sexual orientation, pregnancy, conscience, and place of birth. Following this constitutional breakthrough, the courts since 1999 have ruled on ground-breaking cases recognizing the right of homosexuals to equal protection, equal spousal benefit, and to adopt children. Marriage defined as a contract between a 'husband and wife' has also been stricken from the law. A law recognizing same-sex marriages is expected to pass by the end of 2006. Abortion was likewise legalized in 1996 through the Choice of Termination of Pregnancy Act. All these advances in sexual and reproductive rights have been accompanied by public resistance, either in terms of their legality or implementation.

Critical Points

- While sexual and reproductive rights have been institutionalized, the legal expression of these rights has to be consolidated by supportive constituencies who employ these rights to entrench changes in access to resources. Seventy eight percent of adult South Africans disapprove of homosexuality, especially, black male homosexuality. Between 56 and 70 percent disapproved of abortions performed because of socio-economic difficulties or serious birth defects. Health practitioners can also refuse to perform the procedure, and according to surveys, large numbers of health care workers actively oppose these laws.

- While South Africa strives to protect and erect its rights and freedoms, threats to its agenda have not only come from within but also from outside. With the US policy mandating that no US family planning assistance will be given to NGOs that use funding from other sources to provide, advocate or promote abortion, funding has been directed to faith-based organizations and abstinence-only efforts in the region. This has directly affected HIV/AIDS programs for vulnerable groups whose health rights are supposedly guaranteed by the Constitution.

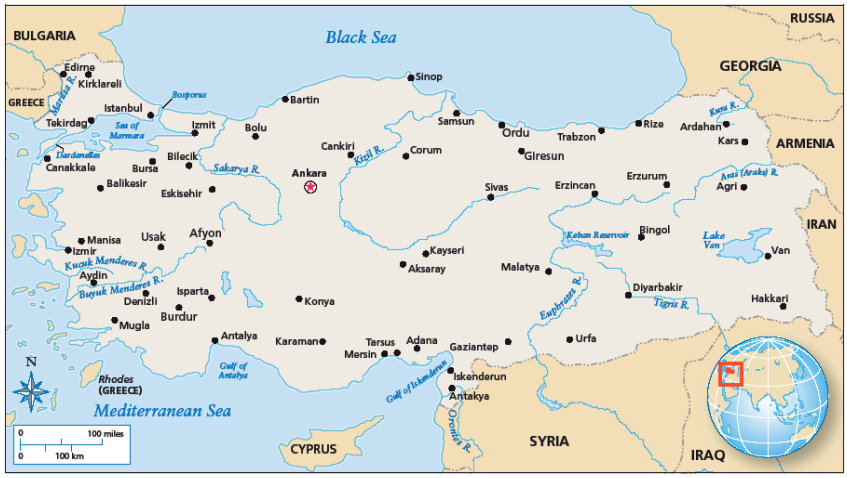
- As focus on HIV/AIDS treatment continues to dominate health care, this has diverted attention from other epidemics and health programs such as those promoting reproductive and sexual health.

- Donor policies have provided a means by which faith-based groups can unduly influence people who need their help; it has also sustained the idea that the church has a right to pressure people about their sexual lives and rights.

- This has also meant that health providers and researchers have had to find ways of 'creatively' implementing programs and conducting studies so as to neutralize the constraints imposed by donor policies.

Turkey

By Pinar Ilkkaracan



Country profile

HDI Rank (2005)[1]	94 of 177		
Population (2005)[3] ***Size*** ***Sex ratio*** (male/100 females) ***% of total population under 15***	 73,192,000 102/100 29%	**Demographics**[5] Turkish 80% Kurdish 20%	**Religion**[8] Muslim 98% Christian, Bahai and Jewish 2% [
Income wealth pyramid (2001)[1] ***Share of income or consumption (%) - Poorest 10%*** ***Share of income or consumption (%) - Richest 10%*** ***Ratio richest 10% to poorest 10%*** ***GINI Index***	 2.3% 30.7% 13.3 40.0		
Political and legal system[5]	**Political System**: Constitutional republic Mixed presidential-parliamentary system Unicameral national assembly **Judicial Branch:** Constitutional Court; High Court of Appeals (Yargitay); Council of State (Danistay); Court of Accounts (Sayistay); Military High Court of Appeals; Military High Administrative Court **Constitution:** Nov. 7, 1982 **Legal System:** Derived from various continental legal systems; accepts compulsory ICJ jurisdiction, with reservations		
GDP per capita (2003)[1]	US$ 3,399 [PPP adjusted US$ 6,772]		
Public Health expenditure (2002)[1]	4.3% of GDP		
Total debt service as % of GDP (2003)[1]	11.7%		
Official ODA received for HIV/AIDS ***from Global Fund*** **(**2005-06)[6] ***from PEPFAR***[7]	 US$ 1,616,854 --		
Life expectancy by gender (2003)[1]	68.7 yrs (gen. pop.), 71.1 yrs (women), 66.5 yrs (men)		
Poverty measures[1] ***% of pop. below poverty line*** (2003) ***% of pop. living below $2/day*** (2003)	 -- 10.3%		

Education by Gender ***Adult literacy rates*** (2003)[1] ***Enrolment ratio for primary, secondary & tertiary education*** (2002/03)[1]	 81.1% (women), 95.7% (men) 62% (women), 74% (men)
Income by Gender ***estimated earned income (PPP US$)*** (2003)[1] ***Ratio of female estimated earned income to male earned income***[1]	 US$ 4,276 (women), US$ 9,286 (men) 0.46/1.00
Female labor force participation[1] ***Economic activity rate (% ages 15 and above)*** (2003) ***Employment in agriculture (as % of female labor force)*** (1995-2002) ***Employment in industry (as % of female labor force)*** (1995-2003) ***Employment in service industry (as % of female labor force)*** (1995-2002)	 51.2% 56% 15% 29%
HIV infection and AIDS mortality rates[2]	<0.1% or 2,254 infected AIDS Deaths: --- Adults(15+): 2,104 Orphans: --- Women(15+): 591 Children: ---
Rates of other STIs	
Primary methods for HIV prevention[2]	HIV/AIDS Programs: Anti-retroviral combination therapy
Maternal mortality ratio (2000)[1]	70/100,000 live births
Current abortion laws[4]	Abortion allowed to save the woman's life, preserve woman's physical and mental health, in cases of rape and incest and fetal impairment, based on socio-economic grounds and on request.
Most contentious laws related to sexuality[9]	**Art. 99 of Penal Code** criminalizes abortion after the first 10 weeks of pregnancy and requires imprisonment for the medical practitioner, with or without the consent of the woman. In the campaign to reform the Turkish Penal Code, women's groups tried to push the limit to 12 weeks but were unsuccessful.

(cont.) **Most contentious laws related to sexuality**[9]	**Art. 104 of Penal Code** criminalizes consensual sexual relations of young people between 15-18 yrs upon complaint. **Virginity testing** is a common tradition. Although Art. 17 of the Constitution states that bodily integrity of individuals may not be violated, relevant authorities have used various provisions in the law to justify enforced virginity testing. **Art. 287 of Penal Code** has a provision on 'genital exam' which cannot be performed without proper authorization from a judge or prosecutor and carries a sentence of 3 months to one year. The law, however, fails to explicitly name and ban virginity testing. It also does not require the woman's consent. Although **Art. 9 of Penal Code** states that the reduction of sentence for honor killings may no longer be applied, this is not the case in all honor killings, thereby still granting room to legitimize human rights violations. A new article in the Penal Code **criminalizes the publication of obscene material** thereby threatening freedom of expression and legitimizing discrimination based on sexual orientation.

[1] 2005 Human Development Report, United Nations Development Programme (UNDP), www.undp.org.
[2] Brief Summary of HIV/AIDS Situation in Turkey, UNAIDS Turkey.
[3] http://unstats.un.org/unsd/demographic/products/socind/health.htm - Population Division and Statistics Division of the United Nations Secretariat, www.unstats.un.org
[4] UN World Abortion Policies 1999, www.un.org/esa/population/publications
[5] CountryWatch, www.countrywatch.com
[6] The Global Fund, www.theglobalfund.org/en/funds_raised/distribution/#sector_recipients.
[7] US Department of State, www.state.gov/documents/organization
[8] See http://www.factrover.com/people/Turkey_people.html
[9] For more information on contentious laws related to sexuality in Turkey, see www.wwhr.org/images/CivilandPenalCodeReforms.pdf

Turkey

Focal Concern

In 2002-2004, "The Campaign for the Reform of the Turkish Penal Code from a Gender Perspective," spearheaded by a broad coalition of women's organizations and LGBT groups, succeeded in realizing a groundbreaking reform of the penal code. This reform, achieved despite Turkey's ruling religious conservative government, radically transformed the code's underlying philosophy and the state's conception of sexuality in Turkey. Major accomplishments of the campaign include the transformation of the underlying philosophy of the law so as to recognize *all* women's autonomy over their bodies and sexuality; a radical shift from "the law as the protector of the nation's morality" to "the law as the protector of people's sexual and bodily integrity," and the removal of all references to traditions such as morality, chastity, honour or virginity in the Code.

The public debate generated by the campaign underlined the tension between the traditional nationalist and religious conservatives' use of sexuality as a major tool of constructing national or religious identities in Turkey and the efforts of feminist or LGBT groups to re-construct notions of sexuality.

The three-years of wide-spread and intensive national debate concerning the re-construction of sexuality in Turkey triggered by the campaign entered international political arenas when, shortly before the reforms were to be accepted in the parliament, the religious conservative government attempted to re-criminalize adultery. This initiative drew sharp criticism of the European Union (EU), from whom it was seeking membership, and triggered the biggest crisis between Turkey and the EU since the start of the accession talks. This event illustrates how sexuality issues may function as sites for trans-national and even global political conflicts and debates.

Historical and Political Context

In 1923, the Turkish Republic was founded under the rubric of the 'Kemalist revolution,' which referred to a set of social and political reforms that abolished the religious (i.e., Islamic law) and adapted European laws, secularized the State, and introduced 'Western' clothing and rights to women. But far from promoting the actual liberation of women in everyday life, the new Republic positioned women as the 'emblem' of secularism and modernity in the same way that conservatives and Islamists used women as the symbol and protector of family values. Under this modern regime, customary and religious laws and norms were translated into a new language subsumed under a new notion of public morality. Citizenship rights of women were then constructed around values such as honor, purity, chastity, shame and obscenity, which were entrenched in the 1926 Penal Code.

Critical Points

- The unique brand of secular republicanism in place in Muslim Turkey has led to a complex transformation and conflation of religious and nationalist arguments to defend the political/ legal regulation of women's bodies and oppose sexual rights for

women and young adults. This is seen in the way religious conservatives employed 'national values' and 'national identity' to align themselves with the constitutional principle of secularism, while gaining the support of secular liberal conservatives to oppose sexual rights during the campaign.

- In their commitment to defend secularism against religious customary practices, such as early religious marriages, progressive Turkish legislators have criminalized sexual relations among young adults. In the Turkish case, the law's mandate to protect secularism seems to be in conflict with its responsibility to broaden rights. It also shows the absolutist approach of the law, which makes legal reforms a very complicated process of gains and losses.

- The meaning of 'honor' is far from being uncontested and is being redefined by the Turkish public. The debates around honor during the campaign shed light on the complex transformation of the traditional notion of honor in post-modern secular Turkey. While social-democrats in the parliament wanted all references to 'honor' removed from the law, religious conservatives differentiated between 'honor' as a sacred value and 'custom' as a negative value. This distinction is important as it justified killings motivated by a desire to protect honor but not killings in the name of custom. To bring legal sanctions against honor killing would be an act against honor itself, an argument that put pressure on the more progressive legislators.

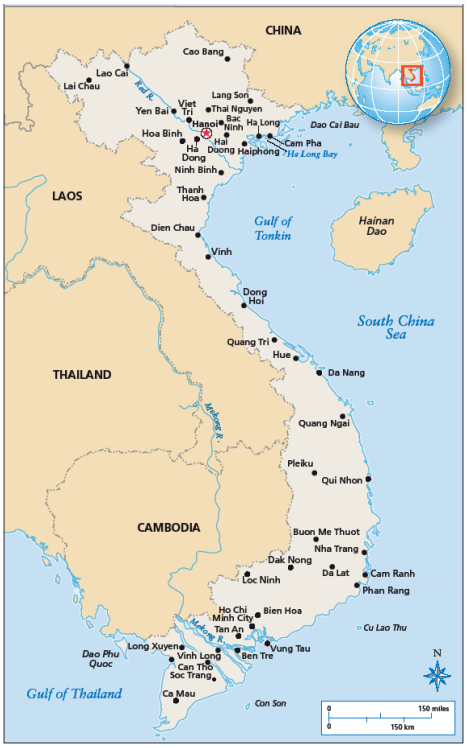
- Despite the failure of the campaign to criminalize discrimination against sexual orientation, the public discussion around the issue has prompted other parts of the judicial system to be responsive to LGBT rights. The attorney-general was later to declare that "being homosexual does not mean being immoral" and affirmed the "notion of freedom of will."

- As the government made a last attempt to defend religious conservative values by re-criminalizing adultery, in an effort to counterbalance the victories of the campaign, they were confronted with the pressure of the European Union, which in fact had remained silent on matters related to sexuality in the Turkish Penal Code until then.

- A lesson from the Turkish case is that, although the realization of sexual rights within the legal system entails not only revising criminal law but also reviewing the Constitution and civil law, the reform of the criminal law might be a very significant step in transforming the state's conception of sexuality, especially in countries where the criminal law has played a considerable role in defining notions of gender, sexuality and the so-called public morality in a country.

Vietnam

By Le Minh Giang and Nguyen Thi Mai Huong



Country profile

HDI Rank (2005)[1]	108 of 177		
Population (2005)[3] ***Size*** ***Sex ratio*** (male/100 females) ***% of total population under 15***	 84,239,000 100/100 30%	**Demographics**[5] Vietnamese Chinese Muong Tai Meo Khmer Cham	**Religions**[5] Buddhist Taoist Roman Catholic Indigenous beliefs Islam Protestant Cao Dai Hoa Hao
Income wealth pyramid (2001)[1] ***Share of income or consumption (%) - Poorest 10%*** ***Share of income or consumption (%) - Richest 10%*** ***Ratio richest 10% to poorest 10%*** ***GINI Index***	 3.2% 29.9% 9.4 37.0		
Political and legal system[5]	**Political System**: Communist state Unicameral national assembly **Judicial Branch:** Supreme People's Court, chief justice is elected for a five-year term by the National Assembly on the recommendation of the president **Constitution:** Revised and promulgated April 15, 1992 **Legal System:** Based on communist legal theory and French civil law system		
GDP per capita[1]	US$ 482 [PPP adjusted US$ 2,490]		
Public Health expenditure (2002)[1]	1.5% of GDP		
Total debt service as % of GDP (2003)[1]	2.1%		
Official ODA received for HIV/AIDS ***from Global Fund*** (2005-06)[6] ***from PEPFAR*** (2004-06)[7] ***from World Bank*** (2005-11)[8] ***from DFID, Norway*** (2004-06)[9]	 US$ 23,285,869 US$ 78,900,000 US$ 35,000,000 UK£ 17,500,000		
Life expectancy by gender (2003)[1]	70.5 yrs (gen. pop.), 72.6 yrs (women), 68.6 yrs (men)		
Poverty measures[1] ***% of pop. below poverty line*** (2003) ***% of pop. living below $1/day*** (2003)	 50.9% --		

Education by Gender	
Adult literacy rates (2003)[1]	86.9% (women), 93.9% (men)
Enrolment ratio for primary, secondary & tertiary education (2002/03)[1]	61% (women), 67% (men)
Income by Gender	
Estimated earned income (PPP US$) (2003)[1]	US$ 2,026 (women), US$ 2,964 (men)
Ratio of female estimated earned income to male earned income[1]	0.68/1.00
Female labor force participation[1]	
Economic activity rate (% ages 15 and above) (2003)	73.3%
Employment in agriculture (as % of female labor force) (1995-2002)	--
Employment in industry (as % of female labor force) (1995-2003)	--
Employment in service industry (as % of female labor force) (1995-2002)	--
HIV infection and AIDS mortality rates[2]	0.4 or 210,000 infected AIDS Deaths: 13,000 Women (15+): 84,000 Orphans: --- Children: ---
Rates of other STIs[10*]	Estimated: 1 million cases per year, including: 150,000 syphilis 150,000 gonorrhea 500,000 chlamydial infections 200,000 other STIs
Primary methods for HIV prevention[2]	HIV/AIDS Programs: Various, pilot harm reduction programs Life-skills based HIV education primary/secondary Anti-retroviral therapy Blood screening
Maternal mortality ratio (2000)[1]	130/100,000 live births
Current abortion laws[4]	Abortion allowed to save woman's life, preserve woman's physical and mental health, in cases of rape and incest and fetal impairment, based on socio-economic grounds and on request
Most contentious laws related to sexuality	Ordinance on Prevention and Control of Prostitution (final version includes a clause on punitive measures for clients, and yet issues with implementation) Ordinance on Population (which approves the rights to decide on the number of children, and yet not fully realized)

[1] 2005 Human Development Report, United Nations Development Programme (UNDP), www.undp.org.
[2] 2006 Report on the Global AIDS Epidemic, UNAIDS, www.unaids.org.
[3] http://unstats.un.org/unsd/demographic/products/socind/health.htm - Population Division and Statistics Division of the United Nations Secretariat, www.unstats.un.org.
[4] UN World Abortion Policies 1999, www.un.org/esa/population/publications.
[5] CountryWatch, www.countrywatch.com.
[6] The Global Fund, www.theglobalfund.org/en/funds_raised /distribution/#sector_recipients.
[7] US Department of State, www.state.gov/documents/organization
[8] Data from World Bank, Vietnam Office, http://www.worldbank.org.vn/
[9] Data from DFID, http://www.dfid.gov.uk/countries/asia/vietnam.asp
[10] Data from the 2000 Consensus report on STI, HIV and AIDS Epidemiology in Vietnam, WHO, Ministry of Health, http://www.wpro.who.int/NR/rdonlyres/5E7E8481-C40C-457F-BFBD-FC1D4F9583ED/0/Consensus_Report_VTN_2000.pdf

* Data on STIs in Vietnam are extremely limited and not updated frequently

Vietnam

Focal Concern

Since the late 1990s, Vietnam's social and health priorities have shifted from a narrow focus on fertility control to a broader reproductive health and HIV/AIDS agenda, evident in the increased media coverage about the issues and funding for HIV/AIDS prevention and treatment. This shift, however, is in tension with the nation's drive toward modernity as population targets (low fertility and small population size) are still seen as markers for progress as well as an essential foundation for development and prosperity. Furthermore, issues that have plagued family planning and population programs in the past continue to undermine present HIV/AIDS and reproductive health programs. Among these issues are the lack of a strong civil society to advocate for more sustained change in policies and the persistent effort by the State to focus on women's bodies and sexualities as vehicles for its project of nation building.

Historical and Political Context

As the prospect of economic success after Reunification failed to materialize, the Vietnamese State embarked on swift policy reforms meant to move the country from a centrally planned economy to a 'socialist oriented economy under State management.' Known as Doi Moi, or Renovation, this ushered in a period of more privatized investments and less State control in some areas of the economy. While hailed as successful, the neo-liberal policy measures introduced at the time transformed Vietnam's near universal health care system into a poorly regulated system with serious consequences for access, equity and efficacy.

Doi Moi also marked an era characterized by the loosening of State control in some areas of social life, which was expected to involve a loosening of State regulation over women's reproduction. The progressive ideals of reproductive health and rights were introduced into the government agenda and were expected to materialize in this context. This looks far from being the case, however. A 'population surge' caused panic in the early 2000s as it was seen by government officials to threaten the achievements of the two-child policy and the progress of Vietnam towards development and modernity.

The State has realigned 'private' matters such as intimacy, sexuality and reproduction according to its nation-building project and has made women's sexuality and bodies a domain of the State. It has accomplished this by harnessing the tools of neoliberalism, and with the help of public health and medical expertise developed through the population and family planning era until the current period of HIV/AIDS,

Critical Points

- In the post-*Doi Moi* era, two major actors are shaping the field of reproductive and sexual health in Vietnam. On the one hand, UNFPA and other international agencies such as Pathfinder and the Population Council played a major role in supporting Vietnam's shift from a family planning and demographic focus to the provision of a more comprehensive reproductive health package. Working through government agencies and mass organizations, the efforts of these organizations enabled State approval of policies on reproductive health and rights in early 2000s.

- On the other hand, the Vietnamese State has continued to find new ways of governing its citizens, one of which is by cultivating citizens who live by the 'rule of law', aspire for market-driven goals and still conform within the boundaries set by the State. In terms of family planning, the 'rule of law' was meant to signify a shift from 'birth according to plan,' which mobilizes all direct bureaucratic means to achieve targets, to 'birth according to law,' which is meant to leave the fertility regulation to social and market pressures.

- From 1999 to 2005, government funding for family planning and population activities has declined while international grants (mainly from UNFPA) have increasingly shifted to reproductive health. HIV/AIDS funding from international donors (including all major global players like the US Administration's PEPFAR Program, the Global Fund, the World Bank, and the UK Government's Department for International Development), on the other hand, have significantly exceeded government funding. This situation is reversed for family planning, as since the mid-1990s government funding has always been higher than international funding. Funding from international donors for HIV/AIDS currently exceeds funding for reproductive health.

- HIV/AIDS prevention has been strongly linked to the eradication of the 'social evils' of drug abuse and prostitution, which is reflected in the formation of the National Committee for Prevention and Control of AIDS, Drug Use and Prostitution. This emphasis on 'social evils' arguably reflects the State's anxiety over the turbulent transformations after Doi Moi. Despite recent changes in policies and national strategy that favor harm reduction approaches, HIV/AIDS prevention will continued to be hampered by police activities aimed at busting drug abuse and prostitution.

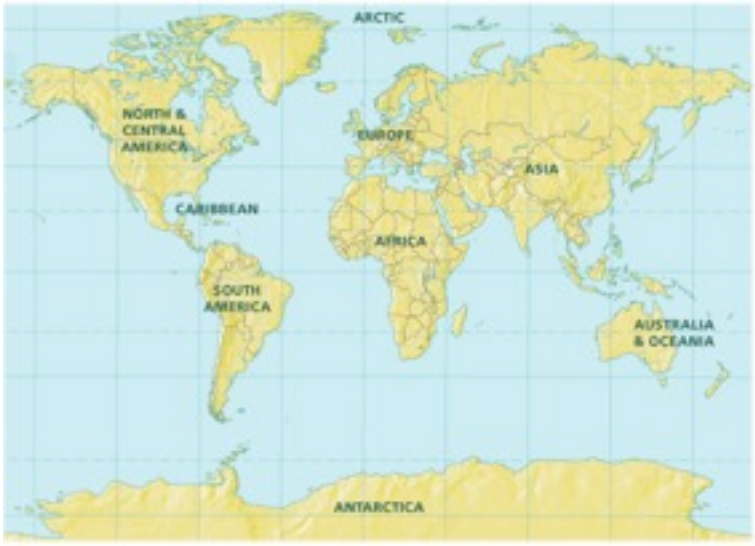
- Government policy on people with HIV/AIDS recognizes the latter's right to be protected from discrimination. PLWHA are guaranteed care for opportunistic infections but this is not the case for antiretrovirals since government funds are mostly spent on prevention and supplies of donor-paid ARVs are far below the demand. There has been a move from a needs-based to a rights-based approach to dealing with PLWHA in recent years. However, the low socioeconomic status, lack of education, and marginalization of many PLWHAs because of their illegal activities limits their participation as decision-makers in programs. Moreover, the public perception that the care for PLWHA is merely voluntary, humanitarian and charitable undermines the obligation of the State to ensure PLWHA rights.

- The ascendancy of HIV/AIDS as a social and public health priority that compete for attention and resources with reproductive health raises concerns over what it takes to hold the state and donors accountable for the promises for a comprehensive agenda for reproductive health and rights. In the discussion of issues around population and HIV/AIDS, the State and the international donor community emerged as the main political actors, leaving a gap in which non-State and non-donor voices should have been heard. This is because of the lack of a legal framework that would allow citizens, such as PLWHAs and couples who decide to have a third child, to form their own associations and advocate for their own interests. Such individuals are required to associate with State-sponsored mass-organizations, but these lack credibility because they are viewed as State agents. Many so-called local NGOs have been established during the years after Doi Moi as research and service organizations and have burgeoned at the windfall of resources for HIV/AIDS. While they have made pioneering efforts in many areas, compensating for the shortfalls in government and donors efforts, it is too early to tell whether their contributions can be sustained as they are largely dependent on donor resources that are not direct accountability to those most vulnerable and marginalized.

- While women as housewives and family caretakers have been at the core of family planning policies, they have been subsumed under 'community', 'general population' and 'the family' in HIV/AID policies and programs. In the fight against HIV/AIDS, however, middle-class women are charged with maintaining the 'happy and prosperous family' of the post-*Doi Moi,* which should be free from the devastation of HIV transmitted supposedly by prostitutes. Yet, the vulnerability of housewives to HIV has, ironically, received little attention. Furthermore, the State continues to focus on women, whether they are female sex workers or housewives, as vehicles to achieve its goals in controlling the spread of HIV/AIDS. Although HIV/AIDS has opened new opportunity to challenge women-centered approach to reproductive and sexual health and turn the attention to men, it remains to be seen whether and how this opportunity will be taken up by various actors in the scene.

United Nations

By Françoise Girard



United Nations

Focal Concern

Foucault argues that as a political issue sex is, "located at the point of intersection of the discipline of the body and the control of the population." In sympathy with this observation the analysis of key UN events over the past decade illustrates how, in spite of efforts to foreclose discussion of it, sexuality has emerged as a focal issue of discussion in UN-sponsored population and development debates.

At the Fourth World Conference on Women in Beijing in 1995 and recent meetings of the former UN Commission on Human Rights (CHR), governments and civil society organizations have debated what norms on sexuality and gender should guide their actions at national and international levels. During the Beijing meeting, government delegates debated the merits of paragraph 96 (the right of women to control their sexuality) and whether to name sexual orientation in the Platform for Action – ultimately choosing the former but not the latter. In 2003 and 2004, government delegates to the UN Commission on Human Rights refused to consider a resolution proposed by Brazil to condemn discrimination on the basis of sexual orientation. These debates afford critical insights into how: 1. UN events function as sites for the shaping of discourses; 2. UN frameworks on sexuality and gender are evolving; and, 3. different views of sexuality are affirmed and contested by the diverse constituencies convened under the auspices of the UN.

Historical and Political Context

Before 1993, the words 'sexuality' or 'sexual' had never appeared in an intergovernmentally agreed document at the international level, with the exception of the 1989 Convention on the Rights of the Child's provisions on protection from sexual exploitation and abuse. Sexuality was addressed implicitly within the context of heterosexual marriage through the right to marry and found a family, to choose a spouse, to practice family planning and to determine the number and spacing of one's children.

Feminists, health activists and LGBT groups, during the round of UN conferences of the 1990s, battled conservative governments and religious fundamentalists to get issues of sexuality integrated into the discourse of international human rights. These groups first campaigned for the recognition of violence against women as a violation of human rights, and then advocated for reproductive and sexual rights and for non-discrimination on the basis of sexual orientation. The latter claim was further pursued in the early 2000s at the UN Commission on Human Rights. Activists achieved significant advances and experienced some setbacks with each campaign.

Critical Points

- Foucault's insights into the creation and use of Western discourses on sexuality highlight the pressing need to combat the pathological stereotype of the "homosexual" and the discrimination that it gives rise to; but it also calls for rejecting the entire edifice of "sexuality" and the strategies used by multiple sites of power to control it – something that the drive for universal sexual rights sought to achieve at the UN, if unsuccessfully,

- Mobilization was key to the successes in Beijing and will likely be a key element of future successes at the new UN Human Rights Council and elsewhere. North-South alliances, while not free of internal conflicts, are especially important to combat the arguments of culture and religion that constitute the main obstacles to the advancement of rights related to sexuality. The leadership provided by Southern activists effectively counters the claim that these are Northern/Western issues.

- To advance a progressive agenda on sexuality, multiple parallel strategies are needed. Claims for mention of sexual orientation need to be complemented by claims for sexual rights in a range of areas, such as education, labor, housing, etc. Negotiations over language in UN and other multinational settings must be complemented by ground work, alliance-building and careful preparation of arguments, all of which were crucial in Beijing and at the Commission on Human Rights.

- Sex, gender, and sexual orientation remain viable terms of engagement but they cannot be taken as universal, immutable terms. Sexual orientation and identity politics, for example, have shown relatively less resonance among activists in the South, where in many places people do not identify as gay and are arrested for what they do and not for who they are. This requires consideration of other frameworks upon which to anchor sexual rights.

- The experience of negotiating the resolution on sexual orientation in the Commission on Human Rights has pushed advocates to rethink the strategic value of the non-discrimination framework. Some activists now think that anti-discrimination may be a narrow framework that only invites contestation, especially around marriage, when universality of rights, which many states still do not recognize, might be the core issue.

- This rethinking is calls for new perspective on par. 96 on sexual rights of the Beijing Platform for Action. This paragraph, initially considered by some to be a poor substitute for a provision on sexual orientation, is now viewed by many activists as proposing a broader conception of sexuality that includes control over and decision on sexual matters, and freedom from coercion, discrimination and violence.

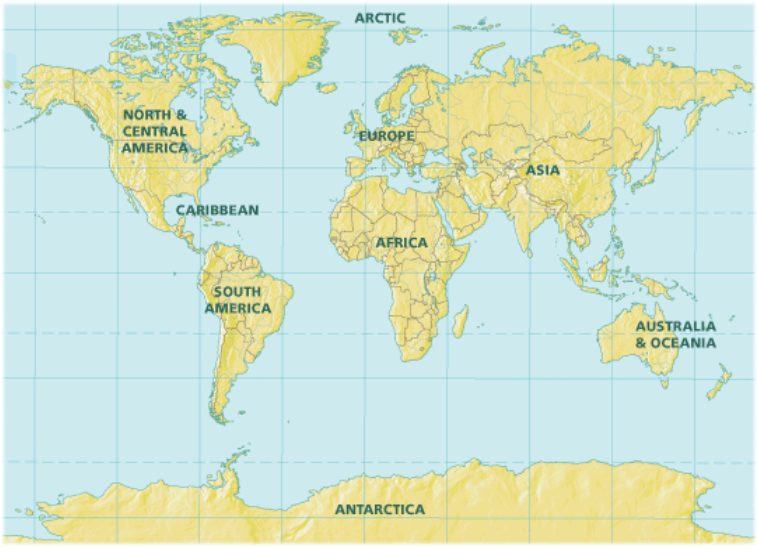
- However, advocates must still ensure that campaigns on sexual rights do not reinforce heterosexism. Advocacy in the Beijing conference emphasized the 'sexual rights of women,' leaving sexual orientation and other sexual and gender diversities out of the picture. Likewise, advocacy on sexuality must guard against the temptation of framing issues solely in terms of avoiding violence and disease, thereby silencing pleasure.

- Tensions between gender and sexuality surfaced during the campaign at the Commission on Human Rights, both in terms of analysis and strategy. Some LGBT advocates did not see the immediate relevance to their interests of resolutions that would support comprehensive sexuality education, or access to sexual health services for all.

- Advocates for sexual rights have consistently taken the lead in putting their issues on the table at the UN. Yet the tactics of the Vatican, of the US (under Bush) and of other religious fundamentalists at the UN have stifled negotiations on sexuality. This was evident in the discussions on the Brazilian resolution on sexual orientation at the CHR, where even progressive governments proved reluctant to pursue a discussion that would rouse strong opposition from conservative governments and forces.

World Bank

By Kenneth de Camargo and Rubem Mattos



World Bank

Focal Concern

Institutions and those who work in them are guided by how issues of concern are conceptualized and theorized. For institutions like the World Bank, which have the power to set the agenda for global public policies, this intellectual work frames how problems are understood, what constitutes solutions to problems, and what strategies are employed to put proposed solutions in place. It is important to acknowledge that this work is conditioned by a shared commitment to maintaining the Bank's financial credibility and intellectual authority. Through their actions, then, World Bank staff circulate, both intentionally and indirectly, conceptual and theoretical frameworks, and in so doing either advance new areas of debate on some of the most pressing issues of our time or significantly curtain critical discussions.

Given the Bank's authority to determine what kinds of health and development programs are established in the developing world, it is in a unique position to influence approaches to issues of gender and sexuality. An analysis of the Bank's documents reveals, however, that rather than addressing these fundamental components of some of the most pressing health emergencies of our time, its economic rationality and technocratic viewpoint has effectively silence and sanitize the discourse on sexuality, thereby limiting what sexuality and gender-related issues can be tackled in the context of Bank sponsored programs, and constraining efforts to advance fundamental sexual rights.

Historical and Political Context

Over the last ten years, the World Bank has consistently demonstrated a commitment to take into account gender issues and support HIV/AIDS. Despite a much-maligned reputation among developing countries, it has also shown itself to be sensitive to pressure from organized civil society-based movements. In the effort to preserve both its neo-liberal economic rationale while remaining relevant to cutting edge debates concerning development, rights and globalization, the Bank has engaged in the struggle over some of the key ideas of our times. This has underscored the paradoxical image of the Bank as an institution that is responsible for destructive structural adjustment policies in poor countries yet also capable of responding positively to grassroots politics.

Critical Points

- The World Bank frames gender inequalities as obstacles to development. However, these inequalities are discussed in terms of men/women relationships in households, reducing these into mainly economic relationships and reinforcing the hetero-normative view of the family while desexualizing gender.

- In discussions on sexual-reproductive rights, sex is often dropped from the text to emphasize reproductive health. Yet, reproductive health as a concept remains to be tied to 'population control' thinking, which still sees birth control as a means of reducing poverty instead of the other way around. Reproductive health is also conflated with family planning, which reinforces the traditional notion of sexuality as inseparable from reproduction.

- 'Sex-as-risk' is a theme found in Bank documents, as reflected in discussions on sexually transmitted diseases and HIV/AIDS prevention under the general heading of sexual and reproductive health. Despite references to diverse sexual orientations in some Bank texts, these appear only in the less relevant institutional documents. And while identifying education as a strategy in disease prevention, the Bank still falls into a pattern of withholding information from the youth.

- There is a strong tendency in Bank documents to medicalize sexuality, particularly its HIV/AIDS programs and policies. This is part of the overall technocratic approach to health taken by the Bank. This approach views health as primarily the absence of disease, which takes precedence over any considerations of rights or pleasure and gives medical doctors and health economists the authority to determine what is best for individuals and society.

- Because of the silencing of sexuality in the Bank's public discourse, what is reinforced is the essentialist, biological conception of sexuality that de-legitimizes any claims based on rights. This means that the public discourse of the Bank is yet another important arena where an affirmative notion of sexual rights has to be fought for, potentially with repercussions on a global scale.

Glossary and Definitions

HDI (Human Development Index) Rank

A composite index measuring average national achievement in three basic dimensions of human development – health (life expectancy), education (literacy and school enrolment) and standard of living (per capita GDP). 1 represents the highest development accomplishment and 0 the lowest. The 2005 Human Development Report draws on 2002-2003 data in each of these categories and ranks 177 countries with Norway ranked 1st, with an index of 0.963, and Niger ranked 177th, with an index of 0.281. The world average is 0.741, which the Maldives and Turkmenistan approximate most closely.

GINI Index

A measure of the unequal distribution of income (or consumption) among individuals or households within a country. The index is expressed as a measure of the extent to which income deviates from a perfectly equitable distribution across all persons within a country. A Lorenz curve plots the cumulative percentages of total income received against the cumulative number of recipients, starting with the poorest individuals or household. A value of 0 represents perfect equality, a value of 100 represents absolute inequality. [NOTE: the GINI Co-efficient was developed by the Italian statistician Corrado Gini and published in his 1912 paper "Variabilità e mutabilità" ("Variability and Mutability"). The **Gini index** is the Gini coefficient expressed as a percentage, and is equal to the Gini coefficient multiplied by 100.]

GDP (Gross Domestic Product)

This is one measure of the size of a country's economy. It represents the total value added by all resident producers in the economy plus any product taxes (less subsidies) that are not included in the valuation of output. It is calculated without making deduction for depreciation of fabricated capital assets or for depletion and degradation of natural resources. Value added is the net output of an industry after adding up all outputs and subtracting intermediate outputs. GDP per capita is calculated by dividing the total annual GDP figure by a country's mid-year population.

ODA (Official Development Assistance)

ODA is a category of development aid, representing primarily flows of aid to developing countries and multilateral institutions provided by official agencies, including state and local governments, or by their executive agencies. The main objective of the aid is economic development and welfare of developing countries. Such aid is usually includes concessions and contains a grant element of at least 25%. In 2004, according to the Organisation for Economic Co-operation and Development, the G7 countries donated US$56,686 billion and the European Union countries US$42,919. The United States donated US$18,999 billion, the smallest contribution as a precentage of GNP (0.16%), while Norway donated US$2,200 billion, the largest contribution as a percentage of GNP (0.87%).

PPP (Purchasing Power Parity)

A rate of exchange that accounts for price differences across countries, allowing international comparisons of real output and income. At PPP US$ rate (as used in the Human Development Report), PPP US$ 1 has the same purchasing power in the domestic economy as $1 in the US.

Poverty Measures

- *National Poverty Line* – this is the poverty line deemed appropriate for a country by its authorities. National estimates are based on population-weighted subgroup estimates from household surveys. Poverty rates are usually expressed as the percentage of the population living below the specified poverty line. Because the definition of poverty differs from country to country this indicator is of limited use when conduction comparisons across countries.

- *Population living below US$2.00 per day*. These data are adjusted for PPP (Purchasing Power Parity) and therefore allows country comparisons because it is based on the same (adjusted) measure.

Share of Income or Consumption

The shares of income or consumption accruing to subgroups of population indicated by deciles or quintiles based on national household surveys covering various years. Consumption surveys produce results showing lower levels of inequality between poor and rich than do income surveys, as poor people generally consume a greater share of their income. Because data come from surveys covering different years and using different methodologies, comparisons between countries must be made with caution.

Ratio of Richest 10% to Poorest 10%

The data shows the ratio of the income or consumption share of the richest group to that of the poorest group, or what the richest consume in comparison to what the poorest consumes. Example: a measure of 13.3 indicates that the richest 10% consume 13.3 times more than the poorest 10% in society.

Ratio of Female to Male Estimated Earned Income

This is derived from the ratio of female non-agricultural wages to male non-agricultural wages, the female and male shares of the economically active population, total female and male population, and PPP adjusted per capita GDP.

Female Economic Activity Rate

Percentage share of the female population ages 15 and above who supply, or are available to supply, labor for the production of goods and services.