Chapter 1

Recognize, Promote, Ensure and Protect Sexual Rights for All

*Sexual rights are an integral component of basic human rights and therefore are inalienable and universal. Sexual health is an integral component of the right to the enjoyment of the highest standard of health. Sexual health cannot be obtained or maintained without sexual rights for all.**

Introduction

The placement of sexual rights as the first item in the World Association for Sexual Health's (WAS) declaration Sexual Health for the Millennium is consistent with the growing recognition of human rights as foundational requirements for health (Farmer, 1999; Mann, Gruskin, Grodin & Annas, 1999). Therefore, sexual health cannot be achieved or maintained without respect for human rights (WHO, 2007, in press).

In its Gender and Reproductive Health Glossary, the secretariat of the World Health Organization (WHO) proposes a working definition of sexual rights as "human rights related to sexual health". It thereby places sexual rights securely within the domain of the array of human rights that are already recognized in international treaties and conventions (WHO, 2002a). This working definition states:

* This chapter closely follows the background paper written by Eleanor Maticka-Tyndale and Lisa Smylie. Additional input was informed by the WAS Expert Consultation in Oaxaca, Mexico and feedback from reviewers (see Appendix IV and V).

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive, and impart information in relation to sexuality;
- sexuality education;
- respect for bodily integrity;
- choice of partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when to have children; and
- pursue a satisfying, safe, and pleasurable sexual life.

The working definition concludes that, "The responsible exercise of human rights requires that all persons respect the rights of others" (WHO, 2002a).

Sexual rights as outlined above can be identified as an underlying core element within all of the eight Millennium Development Goals (MDGs) (United Nations, 2005). The availability of quality sexual and reproductive health services, information and education in relation to sexuality; protection of bodily integrity; and the guarantee of the right of people to freely choose sexual partners and spouses to make decisions about child bearing, and to pursue satisfying, safe and pleasurable sexual lives are grounded in and contribute to gender equality and the empowerment of women (MDG 3); to access to primary education, particularly for girls (MDG 2); to reduction of infant and child mortality, especially of female children (MDG 4); to improvements in maternal health and mortality (MDG 5); to decreasing vulnerability to HIV/AIDS, STIs and other health threats (MDG 6); and also to reduction of poverty (especially among women) (MDG 1). Thus, it is evident that achieving sexual rights for all people will not only contribute to sexual and reproductive health, well-being and quality of life but will also advance the MDGs.

Sexual Rights: Some Hurdles to be Cleared

Despite the clear alignment of sexual rights with human rights, the broad international support for numerous human rights treaties and consensus statements (Office of the United Nations High Commissioner for Human Rights, 2004), and the health and development gains of a rights-based approach (Farmer, 1999; Hendriks, 1995; Mann, Gruskin, Grodin & Annas, 1999), attempts to reach international consensus on sexual

rights have faced obstacles (Correa & Parker, 2004; Girard, 2005; Petchesky, 2000) that are, nevertheless, not insurmountable.

Religious and Other Cultural Barriers

As normative statements, international human rights agreements may represent a challenge to the authority of the state, the cultural structures or religious organizations (Cook, 1995). Sexual rights may be particularly contentious because they address aspects of life that are considered to belong in the private and sacred domain and are grounded in cultural and religious beliefs about the nature of human existence and its relation to the fundamental power of life, as well as the nature and perpetuation of core groups such as family and clan. These are set out in cultural and religious belief systems and moral codes that are neither dependent on nor responsive to science or democratic process (Plummer, 2003). Within these cosmovisions, health and development are not prioritized above adherence to cultural or religious beliefs and moral codes. In fact, ill health, suffering, and even death may be viewed as necessary trials or passages, or even as inevitable consequences of transgressions of cultural and religious norms. A sexual rights approach may be seen as violating the nature of humanity as understood in religion and culture. This explains, for example, the vehement opposition from Pakistan's representatives (a stand that was endorsed by other countries) to the inclusion of sexual orientation in a draft resolution to the Commission on Human Rights in 2003, claiming it was an insult to the world's 1.2 billion Muslims (as cited in Saiz, 2004, p. 57) and similar opposition of Roman Catholic and Muslim clerics to inclusion of references to homosexuality in the 1994 International Conference on Population and Development Program of Action (ICPDPoA) (United Nations, 1994), the Beijing Platform for Action (Beijing) (United Nations, 1995) and the United Nations General Assembly Special Session on HIV/AIDS (UNAIDS, 2002) platforms and resolutions (Bayes & Tohidi, 2001; Girard, 2005; Parker, di Mauro, Filiano, Garcia, Munoz-Laboy & Sember, 2004).

Theoretical Concerns

Critical theorists have also challenged a rights and health-based approach to sexuality. They underline the implications of framing sexual rights within a health paradigm as compared to a paradigm of citizenship. Miller (2001) points out that "although locating sexuality with health may liberate it from the strictures of religion, culture and morality, it places sexuality under the normalizing control of health and medicine". Historically (and currently) health and medicine have imposed a tyranny of 'nature' and biological determinism that does not acknowledge the socially constructed nature of sexuality or the capacity of individuals and cultures to find pleasure and 'naturalness' in diverse practices and experiences. Consider, for example, the pathologization of the otherwise universal practice of masturbation or of all same sex adult consensual sexual contact despite historical and contemporary examples of cultures where this is a normatively bound practice. Consider also the relatively recent, and in some circles still contentious,

removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (APA).

Those working in the globalization arena alert us to its more undesirable tactics and consequences. Van Eerdewijk (2001) calls our attention to the ways in which western ethnocentrism leads researchers to take their own circumstances as the "norm," thus applying their own values in interpreting their observations rather than searching out the values of others. Boyle and Preves (2000) draw our attention to political tactics that move a western agenda forward without concern for the preferences, attractions and desires of local people, thereby denying their right to autonomy as a people. Plummer (2003) challenges the relevance of universal and abstract rights devoid of local contexts, histories and stories to creating an ethic for the global world of the 21st century.

Theorists of rights, sexuality and globalization point out that rights doctrines stemming from a health rationale pay little attention to the work of social constructionists and the evolving understandings of sexuality grounded in post-modern acknowledgements of shifting and diverse subjectivities, knowledge and experience (Hawkes, 2004; Richardson, 2000; Weeks, 1989;2000), or the power differentials between genders, groups and nations in determining international agendas and norms. This has led some feminist scholars such as Oriel (2005) to question whether the sexual rights agenda has adequately taken account of women's rights relative to those of men, particularly given the still prevalent power differentials between men and women. Further, Miller (2001) calls our attention to the need to reconcile fundamental incompatibilities between the centering of human rights as compared to public health, particularly if we advance the position that rights are essential to health.

These concerns related to new conceptualizations of sexuality within a health and rights paradigm can perhaps be understood if we acknowledge the inherently dialectical nature of change (Balakrishnan, 2001). Liberation from old forms of oppression brings both new freedoms and new oppressions. Thus, the tyranny of the community is replaced by the tyranny of the individual. Centering the rights of the individual may threaten the well-being and very existence and identity of some individuals, groups or communities. Consequently, opposition to rights may best be understood as a warning that alerts us to the inevitability of competing or conflicting goals and the need to proceed with due caution, being alert to new losses as well as gains and recognizing that the best that may be achieved is a new balance.

The Need for Sexual Rights

Despite these debates, international organizations advocating for the rights of women and children, and of gay, lesbian, bisexual and transgendered persons, such as Human Rights Watch and Amnesty International, as well as Rapporteurs to various UN Committees, have been in the forefront of documenting on-going violations of sexual rights and their consequences for the health, well-being and the very life of men, women and children. To enable all people to enjoy the highest attainable standard of

sexual health, various needs stemming from universally agreed upon ethical principles must be met.

A) The Need for Autonomy in Sexual and Reproductive Health Decision-Making

Women's autonomy in sexual decision-making and their right to sexual and reproductive health care are denied in the legal prohibition of birth control and abortion services that force them to access illegal and often unsafe abortions (WHO, 2004). But even the availability of contraception and safe abortion do not necessarily guarantee women's right to reproductive self determination. Organizations in Latin America have documented the performance of surgical sterilization or insertion of IUDs on indigenous and otherwise marginalized women without their consent in Peru and Mexico (Castro & Ervitie, 2003). Among Mertus'(2001) review of numerous reproductive and sexual rights problems in Central and Eastern Europe was the involuntary sterilization of Romani women in Slovakia. In countries that prohibit sexual activity outside of marriage, sexual and reproductive health services are commonly denied to unmarried women (Amado, 2003; Shirpak, Mohammad, Maticka-Tyndale, et al., 2006, in press).

B) The Need for Guarantees of the Freedom to Seek, Provide, and Receive Sexual Health Information and Education

The sexual information and education needs of women and girls are poorly met in many countries as illustrated, for example, in restriction of much school-based sex education in the United States to abstinence-only programs (Arnold, Smith, Narrison & Springer, 1999; Jones, 2002); inconsistent provision of sex education in Canada (Barrett, King, Levy, Maticka-Tyndale, McKay & Fraser, 2004); absence of or scattered access to sex education in much of Latin America, Africa, the Middle East and Asia. When education for sexual health is available, it may be inappropriate to the needs of many women and girls as evidenced in the ABC (Abstinence, Be Faithful, Condoms) approaches to HIV prevention education that dominate in subSaharan Africa. These assume personal autonomy and control over sexual decision-making and further dis-empower and alienate the vast majority of girls and women who lack such autonomy and control (Van Donk, 2006; Whelan, 1998).

Forms of sexual activity that are pathologized, criminalized, non-normative, or whose existence is ignored or denied are either absent from or portrayed as such in sexual education programs. Often those who practice them have no access to information, education, or services except those that portray them as deviant, perverse, diseased or ill. Thus, in countries where homosexuality is considered a disease, even health care providers, researchers and educators are taught to approach it as illness or crime. Similarly, where polygamy is criminalized, adults in consensual polygamous unions (and their children) lack access to the rights, protections and services afforded to those in legally recognized marital unions (Maticka-Tyndale, 2002, 2003). Where sado-masochistic practices are criminalized, willing participants may be subject to arrest and

criminal prosecution with no consideration of the consensual nature of their practice (e.g., Richardson, 2000, p. 112). In many countries people with disabilities are assumed to have a lack of capacity for sexual decision-making and for sexual activity, and thus have been denied rights to sexual self-determination and to sexual health services to meet their needs (DiGiulio, 2003; Tilley, 2000; Zola, 1988). This is most evident with respect to persons diagnosed with severe mental illnesses or who are mentally retarded (Dybwad, 1976; Zola, 1988). The sexual capacity and interests of the elderly are similarly denied with husbands and wives placed in separate chronic care facilities and the elderly in these facilities not afforded the privacy and respect required to engage in safe, pleasurable and satisfying sexual lives. The right of sex workers to engage in consensual sexual activities is likewise denied through the criminalization of sex work. The absence of information, education and sexual health services is considered to be a contributing factor to poor sexual health including sexually transmitted infections, unwanted pregnancy, sexual violence, sexual dysfunction, poor reproductive health outcomes, and to ultimately jeopardize the right to pursue a satisfying, safe and pleasurable sexual life (WHO, 2007, in press).

C) The Need to Protect People against Violence and Violation of Bodily Integrity

Verbal abuse, harassment, violence, violation of bodily integrity, and murder or capital punishment are commonly used by the state and its agents, and implicitly condoned when used by civil society, to punish men, women, boys and girls who violate cultural norms of sexual conduct. The death penalty may be, and is, imposed for a conviction of homosexuality in countries governed by shari'a (Islamic) law (Amado, 2004; Ottoson, 2006). In Egypt, health professionals in Medical Forensics units violate the bodily integrity of those arrested on suspicion of homosexual activity with forced and repeated anal examinations in an attempt to determine their guilt (Long, 2004). India provides a further example of the collusion of health professionals and police in what Narrain (2004) describes as a Hindu nationalist backlash that has led to "rigorous and harsh policing" with criminal proceedings or forced medical treatment for those discovered in same sex activities. In Zimbabwe, Namibia, Zambia, Botswana and Uganda government leaders have launched campaigns of hate against homosexual people, inciting and condoning civil abuse of expected homosexuals and directing police to aggressively pursue, arrest and prosecute them (Human Rights Watch and IGLHRC, 2003). Homosexual men are harassed, intimidated, and assassinated with the complacency of the society at large in Jamaica and other Caribbean countries. Reports submitted to the United Nations Special Rapporteur on Torture and those prepared by Amnesty International document police torture and rape of gay, lesbian and transgendered persons while in police custody in India, Somalia, Turkey, Afghanistan, Egypt, Mexico, and Venezuela as well as refusal of police to investigate rape and murder of homosexual persons by civilians (Amnesty International, 2005; Long, 2001). In the United Kingdom, Australia, the United States, and Canada a defense of homosexual panic has been successfully used to obtain a lower sentence for perpetrators of violence against gay or transgender men (Howe, 2000).

Violence in the form of rape, sexual torture, honor killings, beatings and disfigurement are also used by agents of the state and members of civil society to control and punish women and girls who have transgressed cultural norms of sexual conduct (Amado, 2004; Abu-Odeh, 2000; Fried & Landsberg-Lewis, 2000; Spatz, 1991; Zuhur, 2005). Most recently, attention has been drawn to the rape, sexual torture, forced childbearing and forced marriage of hundreds of thousands of women as part of armed conflicts in the former Yugoslavia, Somalia, Burma, Kashmir, Sierra Leone, Rwanda, Angola and various Latin American countries (Heyser, 2006; Hughes, Mladjenovic & Mrsevic, 1999; Human Rights Watch, 2003; Human Rights Watch/Africa, Human Rights Watch Women Rights Project, & La Fédération Internationale des Droits de l'Homme, 1996; La Luz, 2000; Mladjenovic & Hughes, 1999). Rape and sexual violence against women and girls have also been documented in U.S. prisons (Human Rights Watch, 1996), refugee settlements, and as part of human trafficking (Blum & Kelly, 2000; Mertus, 2001; Olujic, 1995). Such violence has been linked to unwanted pregnancy, STI and HIV acquisition, poor maternal and infant health, sexual dysfunction, and inability to make sexual choices and negotiate sexual encounters in a way that minimizes a woman's health risks (Garcia-Moreno & Watts, 2000; WHO, 2002b).

Female genital mutilation (FGM) continues to be practiced on girls and women despite the documented threats to health (WHO, 1998) and heightened risks to both women and their infants during childbirth (Banks, Meirik, Farley, Akande et al., 2006). Male infant circumcision, although very different in purpose and nature from FGM, is considered by some groups as an abuse against male infants since, according to their argument; it is an irreversible cutting of genitalia without the consent of the individual (i.e. the infant). This practice is still routinely performed among Muslim and Jewish populations as an essential religious ritual and for the majority of male infants born in the United States, South Korea and the Philippines against the claims of American, Canadian, British, Australian and European physicians' and pediatricians' associations that there is insufficient evidence of health benefits to recommend the routine practice of circumcision among children (American Academy of Pediatrics Task Force on Circumcision, 1999; American Medical Association, 1999; Australian College of Paediatrics (1996); Fetus and Newborn Committee, 1996). Recent studies, it should be noted, demonstrate a protective effect of adult male circumcision on HIV transmission when combined with other prevention tools. Adult male circumcision for HIV prevention, if it is to be ethical, must be safe, culturally appropriate, voluntary, and informed (WHO & UNAIDS, 2007).

D) The Need to Ensure Self-Determination and Autonomy in Sexual Decision-Making

At the most fundamental level, sexual rights embody the right to participate in sexual acts with whom one chooses, if one so chooses, and to pursue one's own route to

sexual pleasure and fulfillment. That is, to self-determination and autonomy free from coercion, force, punishment, or discrimination. At the local level where people live their lives, self-determination and autonomy are both guaranteed and limited by law and social custom. Laws governing age of consent or majority determine, for example, when youth have access to legal guarantees of autonomy as well as when they are held fully accountable and governed by legal limitations to autonomy. Thus, below the age of majority, youth are not granted the right to consent to sexual practices, partnerships, or to access certain services. It is a paradox that marriage, even if not consensual, grants in some places the majority of age to individuals, including the right to engage in consensual sexual activity. In addition to laws governing age of consent, laws in many countries also set limits on the free choice of sexual partners and sexual acts. Often restricted are sexual activities or marriage between people of the same sex, between those who are not married, between partners with certain lineage relationships to each other, as well as sexual activity for immediate material gain and when there are more than two partners involved. These restrictions apply even when there is consent among all parties.

Sexual activity between persons of the same sex is most often regulated through sodomy laws in which anal intercourse (and sometimes other practices such as oral sex) is criminalized. Such laws exist in over 80 countries (Amado, 2004; Khaxas, 2001; Ottoson, 2006; Saiz, 2004; Samelius & Wagberg, 2005). Marriage for same sex couples is likewise restricted in most countries, denying them the well-established health and social benefits that accrue from marriage (Herdt & Kirtzner, 2006). Niveau et al. (1995) further document denial of the right to marriage on the part of transsexuals in countries where, for example, there is no mechanism for changing civil status despite complete surgical and hormonal transformation of biological sex characteristics (e.g. UK, France).

It is not uncommon for heterosexual women to be denied the right to choose their sexual partners, to choose whether and with whom they will marry, to decide whether or not to engage in sexual activity, to be free from sexual activity to which they do not consent, and to expect that their bodily integrity will be respected. For example, in Turkey, where an unmarried woman cannot decide to engage in sexual activity, virginity testing is conducted by state physicians at the request of parents or other community authorities and against the will of women and girls themselves (Girard, 2001; Lai & Ralph, 1995; Tambiah, 1995). Female genital mutilation is used in countries in the Middle East, Northern and subSaharan Africa, and Asia to control the sexual activity and enhance the acceptability and attractiveness of girls and women (Amado, 2004; Bop, 2005; Igras, Muteshi, Wolde Mariam & Ali, 2004; Jaldesa, Askew, Njue, & Wanjuru, 2005; Lewis 1995; Shaaban & Harbison, 2005; WHO, 1999). Women's organizations in Peru and other Latin American countries have documented challenges to women's right to autonomy in sexual decision-making on the part of personnel in public health facilities, particularly when women are poor or members of minority ethnic communities (Comité de America Latina y el Caribe para la Defensa de los Derechos de la Mujer and Center for Reproductive Law and Policy, 1999). In an

attempt to control the spread of HIV, in 2001 the government of Swaziland ordered a five-year ban on sexual relations for unmarried women, including abstinence from even shaking hands with males (Girard, 2001).

Child marriage and early childbearing – below the age at which independent consent is considered possible in international treaties – has been documented in Asia, Africa and the Middle East (Bruce & Clark, 2004; Germain, 2005; ICRW, 2004; Lai & Ralph, 1995; Save the Children, 2004). In countries where the decision of whether, when and whom to marry rests with the father or male relatives, the consent of girls and women is not necessarily sought, constituting forced marriage (Amado, 2004). Once married, women in many countries, particularly in the Middle East, Northern Africa and Latin America, but also in Ireland, cannot leave the marriage, since they are denied access to, or severely limited in their ability to access, divorce (Amado, 2004; Fried & Landsberg-Lewis, 2000; Shephard, 2000).

Finally, while the exchange of sex for immediate material gain (commonly referred to as prostitution, or more usually as sex work), even when there is consent between parties, falls outside the criminal codes in some of its forms in only 12 countries (Australia, Brazil, Canada, Costa Rica, Denmark, Germany, Netherlands, New Zealand, Spain, Sweden, Switzerland, and the states of Nevada and Rhode Island in the United States), UN agencies report the trafficking of hundreds of thousands of women and girls, against their will, from Africa, Asia, and Eastern Europe for purposes of sexual labor (UNDP, 2000; UNFPA 1999, 2000; UNICEF, 2001; United Nations 1994, 1999, 2000).

E) The Need to Recognize, Promote, Ensure and Protect Sexual Rights for All to Achieve the Millennium Development Goals

There is an extensive literature on the close connections among the MDGs. Gender inequities and women's lack of power exacerbate and are at the root of much of the world's poverty and of maternal and child health. Poverty is also a prime determinant of maternal and child health and the three collectively influence access to and completion of primary education (especially for girls). Poverty, health, education and being female create and exacerbate conditions of vulnerability to HIV, AIDS, malaria and other diseases. Collectively, poverty, health, education, and especially HIV/AIDS and malaria, through their effects on individuals, families and communities place greater stresses on the physical environment. Experience has clearly demonstrated that these can only be effectively addressed through a coalition among nations, the eighth MDG.

The remaining chapters in this document address, individually, how the promotion of sexual health in reproductive health programs, the provision of access to universal sexuality education, the promotion of gender equity in sexuality, the eradication of sexual abuse and violence, the recognition of sexual pleasure as a component of well-being, the eradication of STI`s including HIV/AIDS, and combating sexual disease and dysfunction contribute to achieving the MDGs. Official acknowledgement of

sexual rights would set legal and policy guarantees for these recognitions, eradications, access, provisions and promotions which could then be used to develop appropriate programming, service delivery, and legal action. Consequently it is through these mechanisms that sexual rights contribute to the MDGs. Since the debates on sexual rights at ICPD and Beijing, there has been increasing evidence of legal and policy changes that embody the sexual rights listed in WHO's working definition.

F) The Need for Protective Laws and Policies

Violence against women has been addressed in legal reform in 24 countries in the past decade (WHO, 2002b). In Morocco, a new family law passed in 2004 gives women equality in the family (Amado, 2004), and Iran is considering modification to its family law that will place the same requirements on husbands to fulfill the sexual needs of their wives that have been the long-term legal obligation of wives with respect to their husbands (Iran news paper July, 27th 2005). These contribute to gender equity, the experience of a sexually pleasurable and fulfilling life, and to respect for women's right to self-determination in the choice of marital and sexual partners, without fear of punishment.

Women's right to reproductive self-determination is supported by change in abortion laws. Since 1995, fifteen countries have passed laws liberalizing access to safe abortion. Included among these are Benin, Burkina Faso, Chad, Guinea, Mali and Nepal which formerly had some of the most restrictive laws. Five countries, however, (El Salvador, Ireland, Hungary, Poland, Russian Federation, and the United States) have made access to abortion more legally restrictive (Center for Reproductive Rights, 2005).

Respect for women's bodily integrity, and protection of the sexual and reproductive health and the health and life of infants born to them (Shaaban & Harbison, 2005) is evidenced in the passage of laws criminalizing female genital cutting in 9 industrialized and 11 African countries since 1995 (CRIP, 2006; Rahman & Toubiah, 2000). However, as evidenced in examples from several countries, and also experienced in the work of one of the authors (Maticka-Tyndale) in Kenya, such laws have often driven the practice underground (e.g., BBC, 2004a; WHO, 1999) increasing the health risks (BBC, 2004b). As mentioned above, concern for the bodily integrity of boys is evidenced in the policies set by various national medical associations (American Academy of Pediatrics Task Force on Circumcision, 1999; American Medical Association, 1999; Australian College of Paediatrics (1996); Fetus and Newborn Committee, 1996) that discourage routine circumcision of male infants on the grounds of "insufficient evidence of its beneficial health effects".

G) The Need for Positive Rights and Enabling Conditions

Positive rights and enabling conditions are those that speak to the ability of persons to act as they choose and to make their own decisions. There has been a gradual move toward recognition of the right of same sex couples to marry, adopt and raise children, and to benefit from the social and legal status of spouse in a growing number of

countries. As of June, 2006, Belgium, Canada, Netherlands, Spain, and the state of Massachusetts in the United States provided for marriage regardless of the sex of members of the couple (IGLHRC, 2006). In 1994, South Africa became the first country to incorporate nondiscrimination based on sexual orientation in its constitution.

Information, education and sexual and reproductive health services are advocated as sexual rights themselves and also comprise a component of the enabling conditions that make it possible for people to act on other sexual rights. The WHO Conceptual Framework (WHO, 2007, in press) outlines shifts that have occurred in the delivery of sexual and reproductive health services from needs-based to rights-based approaches. Services have been expanded to address the sexual and reproductive health needs of couples as well as women, and of those outside the reproductive years. There are also gradual shifts from addressing merely sexual disease and ill-health to promoting sexual well-being and pleasure, although these are taking longer to be realized (WHO, 2007, in press). Several programs have begun to incorporate programming for men, particularly in relation to gender equity or violence (e.g., Guedes, Stevens, Helzner & Medina, 2002).

An increasing number of countries are moving forward to provide effective HIV prevention programming to youth through schools (see Kirby, Laris, & Rolleri, 2006 for a review) and communities (see Maticka-Tyndale & Brouillard-Coyle, 2006, in press, for a review). The Government of Kenya's mandate in 2001 of one AIDS lesson a week in all primary and secondary school grades supported the rights of children and youth to information and sex education related to HIV and AIDS. The government's adoption, in 2005, of an in-service and pre-service training program for all primary school teachers on HIV/AIDS prevention education further supported that right (Maticka-Tyndale, Wildish, & Gichuru, 2004; Wildish & Gichuru, 2006, in press).

Several organizations in Latin America are working from a sexual rights orientation (e.g., Profamilia, Horizons, Instituto Promundo, the Jamaica Family Planning Association, and the International Planned Parenthood Federation). They have launched interventions designed to establish more gender equitable norms in communities, specifically addressing situations of violence against women in Brazil, Jamaica , Colombia, and Venezuela (Guedes, Stevens, Helzner, & Medina, 2002; IPPFWH 2001a, 2001b; Pulerwitz, Barker, Segundo & Nascimento, 2006). Religious leaders have been mobilized in Uganda (Kagimu, Marum, Webwire-Mangen, Nakyanjo, Walakira, & Hogle,1998), Malawi (Willms, Arratia, Makondesa, 2004), and Thailand (Maund, 2006; Sangha Metta, 2006) to empower youth and adults alike and to deliver information and education for HIV prevention and care that often involves reinterpreting religious doctrine to provide otherwise contentious information (Wolderhanna, Kingheim, Murphy, et al., 2005). In Canada, coalitions of organizations representing sex workers and university-based researchers have used rights-based approaches to research and advocate for legal and policy changes to support the

programmatic work of sex worker organizations that target the health, safety and well-being of sex workers (e.g., STAR, 2005).

Finally, Cabal, Roa and Sepulveda-Oliva (2003) remind us that courts, using international treaties, provide a venue for bringing about change, especially when there is a disconnect between international, constitutional and legislative norms and the realities of people's lives (Cabal, Roa and Sepulveda-Oliva, 2003). Organizations in Latin America have pioneered use of courts and international litigation as strategies to improve national legislation and policies to the benefit of women and girls (see Cabal, Roa and Sepulveda-Oliva, 2003: p. 51-2 for more details).

These illustrations of legislation, policy and programs that promote sexual rights have been developed in the absence of any international treaties or formal recognitions of sexual rights per se. Instead, they have used international human rights conventions or local agreements to advance these initiatives. The existence of a sexual rights dialogue has been sufficient to advance these actions.

Overcoming the Complexities of and Challenges to Sexual Rights

While evidence of the need for and possibilities resulting from a formal acknowledgement of sexual rights appears compelling, the complexity and challenge of achieving such an acknowledgement must be recognized. It is of paramount importance to raise two such challenges:

- The challenge of expanding the domain of a rights-based approach;
- The challenge of developing and establishing a method for reaching international acknowledgement of sexual rights.

The Challenge of Expanding the Domain of a Rights-based Approach

While sexual rights are not explicitly referenced in any UN treaties or conventions, defense of sexual rights is well grounded in the provisions of virtually all existing human rights treaties and conventions and has figured prominently in the debates, resolutions, and reports to UN commissions set up to monitor progress toward realization of treaty provisions. Two examples are the General Comment issued by the commission on the International Convention on Economic, Social and Cultural Rights calling for nondiscrimination based on sexual orientation (CESCR, 2000) and the recent report of Paul Hunt, Special Rapporteur to the United Nations arguing for the recognition of sexual rights (Hunt, 2006). The persistence of violations to human rights related to sexuality, despite wide endorsement of such treaties and conventions and the actions taken by watchdog committees, alerts us to the limitations of such treaties and conventions in advancing a rights agenda. We are reminded by legal scholars and rights

advocates such as Wilets (1997) of three key limitations of such treaties and agreements. First, although most are widely endorsed (Office of the United Nations High Commissioner for Human Rights, 2004), they are non-binding in nature and defer to national laws and customs when issues are in contention. Thus, for example, in states whose medical professionals view homosexuality as a disease whose public expression fosters its spread (as is the case in most Islamic countries), what have been presented in this paper as violations of rights are seen instead as consistent with the right to treatment of people suffering from a disease and the right of the public to protection from the spread of a preventable disease.

Second, treaties and agreements address the responsibilities of states and agents of States, but have little or no influence over civil society. This is illustrated in the examples of Egypt, Kenya and other countries where, despite bans on female genital cutting, it is still practiced. It is also seen in Canada (and other countries) where, despite laws prohibiting hate crimes as well as physical assault, gay men are still the victims of assaults and murder perpetrated by private citizens or vigilante groups (Janoff, 2005).

Third, the legal frameworks accessed through rights agreements are better able to forbid or prevent physical harm than to promote positive rights (e.g., the right to pursue a satisfying, safe and pleasurable sexual life) or to ensure that enabling conditions necessary for the realization of rights are in place. This is particularly salient when we consider that the exercise of many rights is premised on the idea of consent (consensual relationships, sexual acts, marriage). Research in diverse settings has raised the question of whether consent is possible without enabling conditions. Economic and social conditions may, for example, place severe limitations on possible alternatives. Thus, young girls consent to sexual relations or marriage when they have no other way to meet economic needs or to hold a socially endorsed status in their community (Maticka-Tyndale, Gallant, Brouillard-Coyle, et al., 2005; Sanyukta, Greene & Malhotra, 2003). Similarly, widows may consent to sexual intercourse with a male relative or community member in order to maintain their economic and social position in the community (Luginaah, Elkins, Maticka-Tyndale, Landry & Muthui, 2005). The role of economics is also evident in Romania and other countries in Central and Eastern Europe where legal and often free abortions are used for birth control rather than high cost, difficult to access contraceptives (Mertus, 2001; Yamin, 2004) raising the question of whether women have freely chosen methods to control their fertility or have been coerced by economic circumstances.

These limitations illustrate the divide between international treaties and agreements, or even national laws, and the local realities of people's lives where a multiplicity of interdependent conditions influence the actions they take. The consequences of a disconnect between raising awareness of rights and having enabling conditions in place for the actualization of such rights is poignantly illustrated in events reported in Ilam province, Iran. Raising women's "awareness and demands" through education in Ilam province is credited with contributing to a substantial rise in suicide rates among women in the province in 2004. Heyran Pour-Najaf, an advisor to the Ilam governor,

reasoned that women had immolated themselves to protest "appalling family conditions" when they were unable to attain the "rights" of which they had learned (Ilam Suicide High Rate, February 28, 2005). Finally, the at times conflicting goals of human rights and public health are illustrated in global differentials in HIV prevalence and in policies that are credited with either maintaining low or in decreasing incidence. Great care must be taken in interpreting information pointing at the association between positive health outcomes and legislation restrictive of sexual rights. For example, globally, HIV incidence has been lowest in countries with particularly restrictive laws related to sexual autonomy (e.g., Middle East, Senegal) or that have implemented public health measures that restrict human or sexual rights such as in Cuba's early policy of quarantine of HIV-positive people. Similarly, Thailand's decrease in HIV incidence is credited, in large part, to its policy of mandatory condom use in brothels; a policy which violates the right to self-determination and which, on these grounds, was opposed by several wealthy countries and international groups. While gains can be documented with vertical programs and prescriptive and restrictive approaches, especially at the initial stages of a health program or initiative, backlashes may occur as a result of behavioral disinhibition caused by oppressive conditions and attainment of physical health without complete wellness and well-being.

The Challenge of Developing and Establishing a Method for Achieving International Consensus

Sexual rights cut to the core of deeply held beliefs about the nature of being human, individual and group identities, and the moral order. As such, they stir heated debate and resistance that has prevented any movement toward consensus or acknowledgement. Bauman (1993), in Post-Modern Ethics, provides a convincing argument for the need for a novel approach to addressing global ethical dilemmas, such as that posed by sexual rights. Plummer (2003) and Correa and Parker (2004) describe such an approach, consisting of open, reciprocal, communicative dialogue for establishing international codes and consensus. The approach is consistent with what Miller (2001) identifies as a key principle underlying human rights work, i.e. the participation of individuals and groups in defining and resolving the issues that affect them.

Such participatory action approaches are increasingly used in local work with populations that have otherwise been excluded from setting agendas, priorities and designing programs (Horizons, 2002; Maticka-Tyndale & Brouillard-Coyle, 2006, in press). It is also seen in the dialogic projects of the National Issues Forum, the Public Conversations Project, and the Public Dialogue Consortium (Pearce and Littlejohn, 1997) and in the process used by the former Surgeon General of the United States to establish a consensus statement about sexual health (Satcher, 2006). Participatory action is particularly salient in the case of sexual rights where differences exist not only across cultural and religious groups, but also within them. The differences within groups are seen in the example of Islam where despite the opposition of conservative Islamic groups to wording in recent rights-based agreements and programs of action

(Parker et al., 2004; Petchesky, 2000), several Muslim scholars have presented the argument that Islam is consistent with and supportive of a rights-based approach (e.g., An-Naim, 2004; Chase & Alaug, 2004; Senturk, 2005). Similar differences in interpretation of religious doctrine are evident within all faith-communities (see, for example, documents on the website of the Religious Institute on Sexual Morality, Justice and Healing: www.religiousinstitute.org, or Catholics for Free Choice: www.cath4choice.org). This suggests that there is a place for dialogue within faith communities.

Participatory action approaches could be applied internationally to move the global community further in the direction of consensus on contentious sexual rights issues. This would, however, require commitment of all parties to work towards consensus and to engage in critical examination and open communication about their own positions, to accept critical examination of their position from the outside, and to respectfully hear and duly consider the positions of others.

Conclusion

Sexual rights, as with all human rights, are looked to for their liberatory potential. The great hope presented by sexual rights together with the concerns raised by nation-states and theorists alike suggest that work must move forward with humility, i.e. recognizing the profound liberatory as well as the oppressive powers of rights as they change long established and respected social relationships that have been central to the security, as well as the oppression, of individuals and communities alike. This requires work on several fronts.

Government, non-government and multilateral organizations must continue delivering and expanding rights-based sexual health approaches. At the same time, more work is needed in developing a broader, more empowering conception of sexual rights that is capable of cutting across localized divisions and struggles to serve as a foundation for a transformed public health praxis (Parker et al., 2004).

This work must involve multiple partners from different cultural and religious backgrounds as well as from diverse disciplines and sectors. As this work moves forward, it is essential to be alert to both its liberatory and oppressive potentials.

As Collier (2000) suggests in his examination of changes in family law and Plummer (2003) in his discussion of developing an ethics of intimate citizenship, we need to ask whether we are losing an ethic of obligation and care in our focus on rights of the individual.

Sexuality, after all, exists and is experienced not only within the individual, but in relationships: relationships with partners, with children, with parents and with fellow community members. It will be in striking a balance between rights and obligations, between caring for self and caring for others that we will strike the balance and develop

sexual rights that benefit health, well-being and quality of life of entire communities and move nations forward toward achieving the Millennium Development Goals.

Necessary Actions

Three recommendations to move sexual rights forward emerge from the discussion presented in this section:

> 1.1 To effectively advocate for and promote sexual health, it is important that sexual rights are located within existing human rights contexts. Government and international organizations and agencies should be encouraged to endorse the sexual rights agenda through recognizing, promoting, respecting, ensuring, and protecting human rights and fundamental freedoms essential to sexual health. This approach would serve to locate sexual rights within existing treaties and conventions so that sexual rights are included in the monitoring and enforcement mechanisms of these agreements.
>
> 1.2 The promotion of sexual rights requires participatory action and dialogic projects that bring together different cultural, religious, and social perspectives to the issue of sexual health. World Association for Sexual Health (WAS) and World Health Organization (WHO) and other relevant organizations are well placed to foster such dialogue.
>
> 1.3 A system for monitoring and evaluating advances in sexual rights should be established. This system should include the study and evaluation of the implications of changes in policy and law related to sexual rights for long-term outcomes in health and quality of life.

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