Sexuality and Health – A Background Paper

Voices Against 377

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors. (from the WHO draft definition, 2002)

We understand the right to health, through broadening, not only our concept of 'health', but also of 'rights'. Rights include freedom fro discrimination as well as a positive, affirmative articulation of the right to sexual and other expression. The right to health is closely related and dependent upon he realisation of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, education, work, human dignity, life, non-discrimination, equality and the prohibition against torture, privacy, access to information and an the freedoms of association, assembly and movement. We advocate an approach to the right to health that sees all forms of injustice as an impediment to that right.

In considering the intersectionality between sexuality and health, we are interpreting the right to health' as ranging from a right to be free from disease to mental and physical ell-being, made possible only through freedom from violence, stigma and marginalisation. A disease-based notion of health is impoverished in a situation where same sex desire is more often than not associated with fear, guilt, shame, repression and low self esteem, borne out of homophobia. As of now, any way of perceiving sexuality that falls out of the heteropatriarchal norms is seen as 'deviant' and as a threat to existing hierarchies of sexual practices and identities. Section 377 of the Indian Penal Code which was drafted in 1862 during British rule, criminalizes all sexual activity that is seen to be 'against the order of nature' which includes all forms of sex that are not peno-vaginal. : It reads *"Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life……"*

The invisibilisation, marginalisation and criminalisation of people based on their sexualities is a impediment to the realisation of a right to health in terms of lack of access and an absence of well-being. Even when health care is formally available, prejudices and misconceptions about sexuality can, and do often exacerbate the cycle of discrimination and reinforce existing heteropatriarchal norms. Single women, widows, women who desire other women, sex workers - all those whose behaviour might be seen as a threat to the existing social order experience a range of violations. These include limitations on their mobility, ability to exercise choice (for example, whether, whom, when and if to marry) social stigma as well as physical/sexual abuse. it is not only women that we need to be concerned with. Stigma is also faced by men who do not fit

into the image of a `manly man' whether in terms of the ability to perform sexually or in terms of looking and behaving in a manner that is `masculine'.

Let us take two instances to illustrate this point.

Case study 1

A 35-year-old married woman, a slum dweller with five children, goes to a government hospital for abortion. Unaccompanied and after changing three buses & spending Rs.12/-, she finally reaches her destination. This is her first visit to a hospital or a dispensary. Once there, it is a long wait before she is able to see the doctor. While taking her history, the doctor learns how many children she has. He comments as a matter of fact, *"kaam karte waqt bahut maza aya hoga.....ab ayee ho girane. Family planning kyon nahi karte ho."* This leaves her feeling very humiliated. She vows never to go back to a govt. set up for anything. She is happier going to the quack who has set up shop in her slum.

In this case the doctor's preconceived notion of acceptable sexuality i.e. sex for procreation being the only acceptable form of sex has prompted his insensitive remarks. This in turn has serious repercussions on the quality of health care that the woman accesses and ultimately on the health of the woman.

Case study 2

The following case study from Delhi, also provided by Narrain and Khaitan, localizes this discussion of the interface between same-sex sexuality and the right to health.

"A petition was filed in the case of a patient from the All India Institute For Medical Sciences (AIIMS) who was being treated by a doctor at AIIMS psychiatry department for the past four years so as to cure him of his homosexuality. The patient himself noted that , "Men, who are confused about their sexuality, need to be given the opportunity to go back to heterosexuality. I have never been confused but was nevertheless told that I had to be 'cured' of my homosexuality. The doctor put me on drugs which I had been taking for four years." The patient went to Naz Foundation India (an organization working on MSM issues) , and the coordinator of the MSM Project, Shaleen Rakesh filed a complaint with the National Human Rights Commission(NHRC) alleging psychiatric abuse involving a patient at the All India Institute of Medical Sciences (AIIMS). The treatment reportedly involved two components: counseling therapy and drugs. During counseling therapy sessions, the doctor explicitly told the patient that he needed to curb his homosexual fantasies, as well as start making women rather than men the objects of his desire. The doctor also administered drugs intended to change the sexual orientation of the patient, providing loose drugs from his stock rather than disclosing the identity of the drug through formal prescription. The patient reports experiencing serious emotional and psychological trauma and damage, as well as a feeling of personal violation. The moment the petition was filed there was a wide mobilization of the sexuality minority community and a number of letters were written to the NHRC urging

the NHRC to protect the rights of the sexuality minority community. The NHRC after admitting the complaint(No. 3920) finally choose to reject it. Informal conversations with the Chairman of the NHRC revealed that the Chairman believed that till Sec 377, Indian Penal Code1 went nothing could be done and anyway most of these organizations were foreign funded and there was no real grass roots support. According to another NHRC source, "homosexuality is an offence under IPC, isn't it? So, do you want us to take cognizance of something that is an offence?"(The Pioneer, Thursday, August 2, 2001)."

In this case, the doctor's attempt to change the sexual orientation of the man is a direct result of his belief that same sex desire is 'abnormal'and that homosexuality is a disease that can be 'cured'. The treatment he prescribes is disastrous for the health of the man . The man is unable to take recourse to the NHRC because the Chairman believes that the existence of a law that criminalizes same sex desire had tied his hands. The doctor's and the NHRC chairman's understanding of sexuality has caused tremendous damage to the physical, mental and emotional health of the man .

There is a need to focus on how gender, caste, class, ability, and religion interact with sexuality to strengthen the barriers to access. Fears and inhibitions relating to sexuality on the part of individuals and certain communities negatively impact access as well as the ability to act upon any suggested course of action. The sexual violence, in many cases resulting even in death, faced by Muslim women in Gujarat are a painful reminder of how women's sexuality is used by forces of religious fundamentalism to attack the `other' community. In both the case studies the class , caste and religious background of the person are crucial factors. One can imagine what the doctor's reaction in the first case would have been if the woman who came to him was Muslim, or if instead of a slum dweller she was from an upper middle class family.

The aim of this interaction is to highlight the links between sexuality and health so that it is useful for you as health activists and community workers in your area of work. For instance , if you came across instances like the two cases that we cited would you provide contraceptives to a woman who approaches to you, irrespective of her marital status or in the second case, would you as avoid making the assumption that person who experiences same sex desire is 'diseased'. We hope that this is the first of many occasions where we explore the relation between sexuality and health and how this would impact your work.

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[1] s. 377, IPC has been used to criminalize even consensual sexual relationships between people of the same-sex. It reads thus: *"Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life....."*