The Right to Health and Sexuality

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First Published in March 2007

By
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Website : www.cehat.org

ISBN : 81-89042-49-1

Printed at :
Satam Udyog
Parel, Mumbai-400 012.

FROM THE RESEARCH DESK

Health and Human rights has explicit intrinsic connections and has emerged as powerful concepts within the **rights based approach** especially so in the backdrop of weakening public health system, unregulated growth of the private sector and restricted access to healthcare systems leading to a near-total eclipse of availability and accessibility of universal and comprehensive healthcare. A rights-based approach to health uses International Human Rights treaties and norms to hold governments accountable for their obligations under the treaties. It recognises the fact that the right to health is a fundamental right of every human being and it implies the enjoyment of the highest attainable standard of health and that it is one of the fundamental rights of every human being and that governments have a responsibility for the health of their people which can be fulfilled only through the provision of adequate health and social measures. It gets integrated into research, advocacy strategies and tools, including monitoring; community education and mobilisation; litigation and policy formulation.

Right to the highest attainable standard is encapsulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights. It covers the underlying preconditions necessary for health and also the provisions of medical care. The critical component within the **right to health** philosophy is its realisation. CEHAT's main objective of the project, *Establishing Health as a Human Right* is to propel within the civil society and the public domain, the movement towards realisation of the right to healthcare as a fundamental right through research and documentation, advocacy, lobbying, campaigns, awareness and education activities.

The Background Series is a collection of papers on various issues related to right to health, i.e., the vulnerable groups,health systems, health policies, affecting accessibility and provisions of healthcare in India. In this series, there are papers on women, elderly, migrants, disabled, adolescents and homosexuals. The papers are well researched and provide evidence based recommendations for improving access and reducing barriers to health and healthcare alongside addressing discrmination.

We would like to use this space to express our gratitude towards the authors who have contributed to the project by sharing their ideas and knowledge through their respective papers in the Background Series. We would like to thank the Programme Development Committee (PDC) of CEHAT, for playing such a significant role in providing valuable inputs to each paper. We appreciate and recognise the efforts of the project team members who have worked tirelessly towards the success of the project ; the Coordinator, Ms. Padma Deosthali for her support and the Ford Foundation, Oxfam- Novib and Rangoonwala Trust for supporting such an initiative. We thank Satam Udyog for printing the publication. We hope that through this series we are able to present the health issues and concerns of the vulnerable groups in India and that the series would be useful for those directly working on the rights issues related to health and other areas.

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ABOUT THE AUTHOR

The Right to Health and Sexuality

Akshay Khanna is a queer activist presently pursuing a PhD in Social Anthropology at the University of Edinburgh. His doctoral research relates to the emergence of sexuality as a political object in people's movements and civil society formations in India. An aspect of this research relates to the engagement of activism relating to health with issues of sexuality. Akshay is a founder member of Prism - a queer activist forum based in Delhi which carries out dialogue on sexuality with various progressive groups and movements and has earlier worked as a human rights lawyer focusing specifically on issues around health, HIV/AIDS and sexuality.

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Introduction

Recent years of activism around health have brought about a conceptualisation of the relationship between health and various social, economic, political and cultural factors. Unfortunately, for the large part, the politics of sex and sexuality have not figured in these conceptualisations except in so far as they relate to either the HIV/AIDS epidemic or to reproductive health. The manner in which the politics of sex and sexuality combine with these factors to marginalise people, to preclude access and indeed, to engender violence against them, has, in other words, remained unspoken. This paper is an attempt to start filling this gap in the activism and language of movements interested in the right to health.

The paper is not limited to the examination of experiences of people who *identify* as gay, lesbian, transgender, bisexual, kothi, hijra and the like. Intends to demonstrate the fact that the politics of sex and sexuality needs to be considered as central to the issue of health. This paper, in other words, hopes to highlight equally, how much the politics of sex and sexuality play a significant role in the health status of so called 'normal' people. The first objective is thus to bring about a recognition that these aspects affect what in the language of epidemiology and public health is called the 'general population', as much as it is to highlight the experiences of those who are most obviously marginalised in the process.

Through the paper there is an attempt to highlight the manner in which the conceptualisation of the sexuality of the 'general population' as heterosexual, monogamous and marital, acts as a mechanism of exclusion and violence against those whose realities do not fit this framework.

These observation/experience are supported through evidence. Interaction it explores the range and depth of the interaction between the queer body and the public health system, from a human rights perspective.

1. Conceptualising Sexuality

'What is sexuality?'. While this may seem like a simple question, there are a range of possible answers. For a large section of population, 'sexuality' is understood as homosexuality as a peculiar type of sexuality, based on an idea that there is something in each person, or about each person, that can be called a 'sexuality', and that this 'thing' can be of different types – homo-, hetero- or bisexual. Further, this leads to an understanding that depending on the nature of a person's sexuality, she

or he can be classified into a type of person. Finally, this understanding leads to the recognition of political identities such as gay, lesbian, transgender and bisexual.

But perhaps this is too simplistic an understanding[1]. To start with, there are many people who have same-sex desires, and who do not either identify as gay or lesbian, or who do not think of themselves as any different from others around them, based on these desires. In other words, those who identify as gay, lesbian, bisexual, kothi and the like, are only a small subset of people who have same-sex desires and sexual relationships.

Second, this understanding is based on a rigid two-gender/sex system eith the presumption that all people are either male or female, or are making a transition between these two categories. In the Indian context there are many identities and realities that cannot be understood within the meanings of these terms. The hijra identity, for instance cannot be considered simply a 'sexuality identity', or even simple 'gender identity'. Its is simultaneously a cultural, political, economic and linguistic reality[2]. The same can also be said of other realities such as kothi, aravani, aali, jogappa and zenana. These realities demand that we look beyond a two-gender/ sex system and indeed re-open the questions 'what is gender'? And 'what is sex'? These are socio-politically constructed categories that form the basis exclusion and marginalisation.

A third limitation of such an approach is that it makes the issues that arise out of the politics of sex and sexuality 'someone else's' problem, as though people who do not identify with any of these categories are unaffected by the politics of sex and sexuality. This makes it easy to deal with the complexity of sexuality at a distance, in an 'antiseptic' manner so that the structures and hierarchies that bring about marginalisation are not shaken up.

Finally, this understanding fails to recognise the role of the medical establishment and discourse in constructing the idea of the homosexual, of 'normal' and 'natural'.

At the outset, thus, it is important to question this understanding and open up the meaning of 'sexuality'. The definition of sexuality by World Health Organisation:

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. (WHO draft working definition 2002)

The significance of this definition lies in the recognition of the social, political,

[1]For a more detailed analysis of the political implications of this understanding, see Khanna 2005 and 2006 (forthcoming)
[2]For an interesting ethnogarphy see Reddy 2005

economic and cultural aspects of sexuality. At the same time, its limitation lies in the fact that it continues to treat sexuality simply as an aspect of personhood that is regulated through socio-political mechanisms, rather than seeing it as simultaneously an aspect of society itself, and as a series of organising principles and mechanisms.

Here, it is important to bring the ideas of 'heteronormativity' (Warner 1991) and 'compulsory heterosexuality' (Rich 1994 (1986) and Menon 2005). These ideas provide a larger political context, and a loose structure, within which to understand the processes through which the categories of heterosexual 'woman' and 'man', come to be seen as 'natural' and 'normal'. The understanding here is that these categories are maintained as 'normal' and 'natural' through constant and vigorous enforcement, through political, economic and cultural practices of institutions that define the 'norm'. This 'norm' is, to put it simplistically, that the heterosexual, monogamous, marital, procreative, same-caste, religion and class coupling is the only form of legitimate sexual relationality. That which falls outside of this norm must face social and political sanction, be marginalised and excluded, or be subjected to intervention that will bring the deviant back within the norm. In other words, our participation in the economy, in political and cultural domains and in social life in general, our access to resources and rights, is mediated by our status in a heteronormative framework. And the enforcement of this norm, the process of exclusion and inclusion, is through the coordinated action of various institutions and discourses, i.e. 'institutions of heteronormativity' – the family, law, medicine, religion, caste, class and the like. This is where the conceptual tool – intersectionality is introduced. The basic argument here is that these institutions, and the 'identities' that they generate, function in tandem with each other, and in such a manner as to constitute each other[3]. The approach of intersectionality is an attempt to address the limitations of identity based understandings of politics, which presume that all those who fall within a given category form a homogeneous group affected by the workings of power in the same way. Here the focus lies on the manner in which these various identities and categories constitute each other. In other words, the objective is to understand how caste identity is as much a sexual identity as, say, sexuality identities are constituted by class hierarchies. As such, the approach in

[3]The approach of intersectionality, in some sense is a development from the tensions between traditional Marxist and Feminist imaginings of the world – where traditional Marxism sees class as structurally definitive hierarchy, traditional feminism places gender in that place. For Marxism, gender and sexual hierarchies become variants of the class hierarchy, and for feminism, class is one mode through which the 'gender divide' is maintained. In practical terms, the problem with both these approaches is that they escape the nature of power *per se* – for instance, the Marxist argument that patriarchy and caste domination can only be dealt with after the socialist revolution rings empty as the 'socialist revolution' in its fulfillment will yet again be based on a structure of power where it shall be upto the upper-caste male to address gender, caste and sexuality hierarchies. And in terms of the traditional feminist position, the tensions centering activism around the category of 'woman' is most obvious in conflicts over the women's reservation bill, where Dalit feminists have argued that the broad identity category of 'woman' is in essence constructed around the experience of upper-caste women.

this paper seeks to go one step further than the approach of 'multiple identities' in that it brings the constitution and negotiations of these identities into focus, as a constant process, and in relation to each other. The focus of the next part of the paper is on the role of medical discourse in these processes.

2. The Bio-medical[4] Construction of Sexuality

The bio-medical understanding of sexuality as being of types, i.e., of homosexual and heterosexual, is a little more than a century old. It is only in the late 19th century that bio-medicine appropriates to itself the right to speak the truth about desire, pleasure and the body. This is around the time when the body became something that could be mapped and through which disease became subject to new rules of classification. This, French philosopher Michel Foucault argues, is the period where three interconnected processes are in action (Rabinow 1984). First is the emergence of 'dividing practices' – where the normal and the abnormal were categorised and separated, often in very physical ways (the creation of asylums for the 'insane', prisons for the 'criminal' and clinics for the diseased, for instance – (Foucault 1988, 1977 and 1975). In the context of sexuality, this division came to be in terms, first, of a 'normal' heterosexual and an abnormal 'homosexual', and second, through multiple distinctions within the context of heterosexuality itself. The second process was the emergence of authoritative discourses and pseudo-sciences such as biomedicine, psychiatry and criminology, through which there is a delineation of who may speak the 'truth' about the human condition and from what location. Finally, is the emergence of processes through which people are called upon to recognise themselves in terms set by such discourses. This 'call to recognise one self' (Foucault 1988a) is an essential part of the way in which populations came to be regulated in the modern nation-state. This is to emphasize that, once a person thinks of herself as being subject to a given norm, she starts regulating herself – there is no more need for a coercive state or society to stand with a whip to behave in certain way, to play a certain role in the economy.

The particulars of these processes as they relate to sexuality, need to further be understood in the context of changes in role of family in the economy in the Euro-American capitalist transformation. Johnathan Ned Katz suggests that:
"the transformation of the family from producer to consumer unit resulted in a change in family member's relation to their own bodies; from being an instrument primarily of work, the human body was integrated into a new economy, and began more commonly to be perceived as a means of consumption and pleasure (Katz 1990:10)

It is in this context, argues Katz, that doctors, (upwardly mobile professionals,

[4]The terms 'bio-medical' and 'bio-medical', in this paper, refer to postivist apporoaches to the body and to health. These understandings are based on a Cartesian dualism of the mind and body, which makes the 'body' available to positivist/scientific scrutiny and intervention as though it stands outside of social, political, economic and cultural processes and construction. In simple terms, bio-medicine' here refers to what is generally called allopathy as well as to the avatars of other systems of health, such as ayurveda, siddha and unani which are rapidly being transformed into variants of allopathy.

reaping the benefits of rise in power and prestige) prescribed a new sexual ethic as if it were a morally neutral, medical description of health. And over the years, medical discourse has come to prescribe this 'sexual ethic' in precise and restrictive ways. For instance, the ICD-10, or the International Classification of Diseases identifies most diversions from a heteronormative understanding of the world, 'non-conformities' as diseases – transsexualism, 'fetishes', and in some cases homosexuality are some examples. Interestingly, the ICD-10 also recognises 'too much' and 'too little' sexual desire as diseases[5]. In other words, the medical discourse has taken upon itself the job of laying out the exact nature, content and volume of 'normal' sexuality.

The idea of 'abnormal sexuality' finds its origins in the workings of various traditions of thinking in bio-medicine including sexology, psychology and psychiatry. One starting point of this history is Viennese psychiatrist Richard Krafft-Ebbing's influential *Psychopathia Sexualis* (1894), wherein human sexual behaviour was framed as a collection of loathsome diseases. "Deviations" from the "normal" pattern, in other words, were viewed as perversions, including sadism, masochism, necrophilia, urolagnia, fetishism, nymphomania, satyriasis, homosexuality, voyeurism and exhibitionism (Brecher cf. Chandran and Narrain, 2005:3). Over the course of the century this framing of sexuality – in terms of diversions rather than diversities – has dominated bio-medical engagement, intervention and research in the context of sexuality. This includes surgical experimentation - such as castrations (Stienach[6]) and hypothalomotomies (Roeder[7]). Apart from these, there have also been attempts to treat homosexuality using hormones based on the theory that "homosexuality means that the men are inadequately masculine and the women are overly masculine". The most common bio-medical response in today's context is that of behavioural therapy, something we shall discuss in greater detail later in this paper.

A recent research in the context of India, carried out by Chandran and Narrain suggests that this understanding of sexual diversity as *perversion* forms the basis for some of the most violent interventions and 'treatments' meted out by medical practitioners more than a century after *Psychopathia Sexualis*. This is also reflected in medical text books and the like dealing with sexuality. For instance, Chandran and Narrain bring our attention to a 1995 text book on 'abnormal psychology' prescribed by Bangalore University for graduate and postgraduate studies. The chapter on sexual perversions, notes
"...it is a wrong notion with some persons that homosexuality is characteristic of only

[5]Section F52 of the ICD-10, titled Sexual dysfunction, not caused by organic disorder or disease, includes both 'excessive sexual drive' and 'lack of sexual desire' in the category of 'mental and behavioral syndromes'.
[6]Stienach in 1917 was the first to use a surgical technique to "cure" homosexuality. He performed a unilateral castration on a homosexual man, and then transplanted testicular tissue from a heterosexual man into the castrated patient, in the hope that he would be cured. "At least 11 men were operated on from 1916 to 1921. The experiments were not successful. "(Silverstein 1991:107, cf Chandran and Narrain)
[7]Roeder in 1962, experimented with hypothalamotomies, something that at least 75 men considered 'sexually abnormal' have been subjected to since. Most of these men had either been imprisoned or involuntarily committed to medical institutions. (Silverstein 1991:107, cf. Chandran and Narrain)

children and adolescents. In fact, this perversion may be found in any person at any age and in both the sexes. Innocent children and adolescents pick up this habit through association with perverted persons. Homosexuality in women may be found in those who are either unmarried, widows or deserted by or separated from their husbands on certain grounds. Such women seek partnerships with other such women who also desire their sexual gratification through the same process..." (Chaube 1995: 438-9, cf. Chandran and Narrain).

This framing of sexual diversity as perversion has also meant a continuous search for an explanation of homosexuality – as though desire and the sense of self are things that are available to a scientific gaze, which can be understood, intervened in and explained. And this search has meant a range of psychosocial, hormonal, physiological and genetic theories. The weight carried by each of these explanations has ofcourse changed alongside shifts in dominant bio-medical paradigms – for instance, presently, where the genetic theory of the body holds sway, an unending search for the 'gay gene' is deemed to deserve much allocations of resources and media attention. This paper does not examine any of these theories in any great detail, but it is significant to emphasise three points in this context. First, that the bio-medical construction of sexuality has taken place through the collaboration of various strand of thinking and explanatory frameworks in bio-medicine. Second, that the negotiation of these constructions are explicitly political – for instance, the exclusion of homosexuality *per se* from the Diagnostic and Statistic Manual (DSM) of the American Psychiatric Association (APA) was through a series of closely contested votes[8]. And for the large part, these politically negotiated process move towards the expansion of medicalisation to a wider range of experiences. For instance the definition of 'infertility' has, over the years expanded substantially. Whereas at an earlier time, the definition required atleast 5 years of sex without contraception, today, it has expanded to just one year. Finally, and what is perhaps most significant here is that these multiple articulations of the 'abnormal' have actually been the articulation of the 'normal' – that is to say, rather than seeing the history of bio-medical engagements with sexuality simply as a process through which the 'perverse' has been identified, we need to see this history of one through which the idea of the 'normal' was created in bio-medical terms. As Jefferey Weeks argues *"...the negative side of this classificatory enthusiasm was a sharp reinforcement of the normal...the debates over the causes of the perversions and the eager descriptions of even the most outrageous examples inevitably*

[8]The first time that the status of homosexuality as a disease, since its conceptualisation in the late 19th century, was brought into question was during negotiations of the second edition of the DSM. It was finally in 1973 that the Board of Trustees of the APA approved the deletion of homosexuality as a disorder. This decision was opposed by the larger body of the APA and finalised after a referendum. It is significant to note here that this significant 'scientific' debate was resolved politically. Presently, the ICD 10 classifies 'egodystonic sexual orientation' as a disorder. This is where "The gender identity or sexual preference (heterosexual, homosexual, bisexual, or prepubertal) is not in doubt, but the individual wishes it were different because of associated psychological and behavioural disorders, and may seek treatment in order to change it. "Significantly, it also states that "Sexual orientation by itself is not to be regarded as a disorder". For a detailed analysis see Narrain, 2004.

worked to emphasize their pathology, their relationship to degeneracy, madness and sickness, and helped to reinforce the normality of heterosexual relationships." (1981:71)

What this implies is that the presumption of heteronormativity remains unquestioned in the structure of the health care system, and in public health policy. For instance, even though none of the main national policies relating to health – the present National Health Policy, the National Population Policy or the National AIDS Prevention and Control Policy even mention the terms sexuality once, they are based on certain ideas about sexuality in society. While each of these may be seen as distinct from each other, owing to the focus they pertain to, there are some commonalities and some peculiarities that need to be highlighted. The next part of this paper briefly examines these.

3. Sexuality in Public Health Policies

The Public Health Policies in India imagine that the population is heterosexual, monogamous and married. All other realities are treated as aberrations, and most often as 'problems'. For example, the National Population Policy, while being seen as making a shift from 'Population Control' to 'Reproductive and Child Health', (in keeping with shifts in the international health industry, as articulated in the ICPD at Cairo), focuses almost exclusively on the population in the 'reproductive age group'. As such, the right to sexual and reproductive health is limited to the those who have reproductive capacities, and in the policy these are almost necessarily married heterosexual people. In particular, the focus is on a certain heteronormative sexual relationship, moving away from sex within marriage on occasions that are few and far between. And the understanding of this relationship is overtly heteronoramtive. Men are imagined as the natural decision makers with respect to these relationship. For instance, the policy states that men's 'cooperation and participation' is necessary for 'program *acceptance*'. This is reflected in the incentives approach to sterlisation, which, rather than addressing gendered inequalities within the relationships, presumes the heterosexual couple as an unproblematic unit.

This rather narrow focus implies the exclusion of non-procreative sex, be it in the context of same-sex desire, or otherwise, including between female sex workers and male clients. In other words, the sexual health concerns of all those who fall outside of the heteronormative ideal are excluded. And this is reflected in practice as well, where even those queer folk who do access sexual health services are presumed to be heterosexual and married and must negotiate a long series of prejudices to get services that are relevant to their realities and problems.

The one apparent exception to the square focus on married heterosexual couples is that of adolescents. The policy suggests that the special requirements of adolescents, especially in rural areas, comprise information, counselling, population education, and making contraceptive services accessible and affordable, and enforcing the Child Marriage Restraint Act. Although this shift provides challenges to the hitherto strictly heteronormative constructions of sexuality ('in India we only have sex after marriage'),

the references to adolescent sexuality continue to be framed, largely, in the context of marriage. The presumption seems to be that if the Child Marriage Restraint Act is enforced, adolescents will cease to be sexually active. As a result, first, adolescent sexuality is framed as a *problem*, and second, the problem is addressed without shaking up the heteronormative construction of sexuality that the policy brings about.

The most obvious comment on sexuality in the National Health Policy is the framing of HIV/AIDS as a 'lifestyle disease', which can therefore be dealt with through strategies for 'behaviour change', such as information education communication or 'IEC'. One aspect of the framing as 'lifestyle disease' is that it is morally loaded and an effective way of placing the 'blame' on either the individual or her/his circumstances. The complexity of sexual economies is collapsed into 'lifestyle'. The second aspect to note here is that the focus of the NHP in such a case is to bring about 'behaviour change', and how exactly is this planned? The policy prescriptions in this regard are two fold. First, the policy suggests that school health programmes can "gainfully adopt specially designed modules in order to disseminate information relating to 'health' and 'family life'", on the basis of the idea that school and college students are the "most impressionable targets for imparting information". The second is more interesting – the policy states that where behavioural change is an essential component, the success of the initiatives is crucially dependent on dispelling myths and misconceptions pertaining to religious and ethical issues. It goes on to suggest that "community leaders, particularly religious leaders, are effective in imparting knowledge which facilitates such behavioural change". In effect, the politico-moral negotiations related to sex that the State seeks to carry out are framed, firstly, as apolitical, and second, in terms of a longstanding colonial tradition that presumes that 'Indian society' is divided into neat and pre-existing, natural 'communities', that each 'community' has a natural 'leadership', which represents the community's interests, and which, therefore, can be the basis for liberal politics (Spencer 1997).

Finally, lets look at the National AIDS Prevention and Control Policy, which is the only state policy to recognise non-heteronoramitive realities. The key building blocks for the epidemiological model being followed are three categories of people: those in the 'general population', the 'high-risk groups' and those who apparently relate these two groups – the 'bridge population'. These are categories essentially based on an imagination of sexual behaviours of these 'groups'. The idea here is that the 'high-risk behaviour' is practiced by 'high-risk groups', and not in the 'general population' – that except for a particular group of people, all sexuality is heteronormative, (with the additional category of the 'bridge population', typically seen as clients of sex workers, bisexual men and sexual partners of injecting drug users). This limited imagination dominates not just the structure of the AIDS control program and the services it attempts to provide, but the very understanding of the epidemic. For instance, Sentinel Surveillance is based on anonymous testing of blood samples collected at a certain number of sites, for a

certain number of months every year. These sites include STD clinics, antenatal clinics and a certain number of sites where data is collected from 'high-risk groups' that are accessible to the surveillance system. This methodology excludes the large proportion of the population. For instance, the surveillance carried out on the 'general population' is typically carried out at sites that have both STD and antenatal clinics, which are available only in the relatively larger hospitals in urban and sub-urban areas. That is to say, the sample that is being tested for HIV prevalence is a certain section of the population, which accesses these particular services of the public health system. Evidence suggests that the majority of people in the country do not access government services, but private health care and that only a very small number of women access ante-natal services or health care related to STDs (NFHS 2, 1998-99, Bharat et al 2003). The reasons for this situation are complex and involve particularities of local sexual economies, along with factors such as accessibility of services, their geographic location, time required to access these services, and the fact that there is the co-existence and mingling of multiple cultural understandings of health and health care systems (Khanna, 2004). At the same time, the methodology ensures that those systematically excluded from access to public health due to discriminatory attitudes, those who resist this particular heteronormative framing – adolescents who cannot access sexual and reproductive health services, hijras, same-sex desiring people, women who do not access public health services, male and female sex workers, the urban poor who have limited access to public health facilities – are excluded from the data through which the epidemic is traced. The implication of this is that the segment of the population that comes within the purview of the surveillance mechanism consists of people who are urban/sub-urban, in a position and willing to access reproductive health services in the public sector, and significantly, almost always presenting in their reproductive roles. A very small proportion of people, those who, in some sense, fit the state's heteronormative construction come to represent the 'general population'. At the same time, the surveillance carried in 'high-risk' populations is as exclusionary. For instance, the surveillance amongst 'MSM' or men who have sex with men, is typically carried out by NGOs and through 'support groups', i.e. amongst males who are accessible to NGOs and who are willing to identify with categories, such as kothi, around which support groups are structured. Needless to say, this is a limited number of people, those who choose to access services based on identities relating to sexual desire or gender. Those who do not identify with these identities – including the sexual partners of those who do, are thus excluded from the epidemiological equation.

4. The Right to Health and Exclusion on the Basis of Sexuality

The Alma Ata declaration looks at health as not merely the absence of disease, but a state of "complete mental, physical and social well-being". If we consider this as the definition, the health status of same-sex desiring people is a matter of both interactions with the health care sector and

of the mental, and often physical effects of a culture of silence, violence and homophobia. For example, the family is usually the first site in which a lesbian woman, a gay man, a transgender person, or others who fall outside of the heterosexual norm will be faced with pervasive (even if unspoken) homophobia. Becoming aware of antipathy towards homosexuality and same-sex desiring people, or knowing from an early age that heterosexual marriage is compulsory for them, are some of the primary factors underlying the psychological stress of marginality and invisibility. This psychological stress is compounded by other players in society, most of whom assume and reinforce heterosexuality as being the only acceptable way of being. Second, is the fact that a large number of same-sex desiring people and people whose gender identities do not fit in the strict categories of 'man' and 'woman' are excluded from support structures and networks of family and community that otherwise provide the conditions for well-being, care and support. For instance, the large number of hijras are thrown out of homes and communities and must fend for themselves, often from a young age in a society that is already aggressively violent against them. Ensuring a right to health therefore entails transforming wider social mores regarding sexuality in order to create the space in which individuals can define and express their sexuality free from stress and fear. Only then can the conditions for mental and emotional well-being be fulfilled.

4.1 Access to Health Care

We also need to take into account how the stress of keeping important aspects of one's life a secret is an obstacle to accessing proper health care. Taking the example of a gay man who fears he has an STI, even if there is a sensitive health care professional in the community, the sense of embarrassment or shame about his sexuality might still prevent him from communicating to a doctor important details impacting his health. Lesbian and bisexual women have similar experiences in interactions with not just gynaecologists, but health care in general. A lesbian identified friend who recently underwent dental surgery was asked by the dentist whether she was married. On hearing that she wasn't the next question was 'oh, then do you have a boyfriend?' What the dentist was trying to get at was that she needed to abstain from kissing for a day or two, but kissing was apparently only possible in a heterosexual context. While this may not be a particularly troubling example, the point is that in doctor-patient interactions, the presumption is most often that the only sexual activity that could be relevant to sexual health would be heterosexual, and within marriage. To be more precise, the presumption is of penile-vaginal sex as the only form of sex that exists, or that can be spoken about. For instance, it is only in the context of the HIV/AIDS epidemic that anal sex is being brought into the purview of health care. STIs and STDs relating to anal sex are rarely even considered for the purposes of diagnosis or treatment.

At another level is the blatant discrimination in the health care sector, against queer people. One extreme example is the refusal of public health hospitals to provide services to hijras relating to urinary tract infections. The process of castration, often leads to blockages in the

urinary tract, something that is relatively simple to treat, but which can be life threatening in the absence of timely intervention. Refusal to carry out this simple procedure is a shocking manifestation of an extreme form of discrimination, one that is reported to be a common experience in the hijra community. Another common example is the refusal of treatment to men who have sex with men, purportedly on the basis of a fear of HIV infection.

Clearly, simple access to health care is not adequate for the realization of a person's right to health. In a homophobic social environment, in which secrecy about sexuality is the norm, proper and full attention to health needs are impossible. Ensuring a right to health therefore entails entering into a process of educating health care professionals about issues related to homosexuality. Access must be to services that are unbiased, sensitive and supportive of sexual difference, and the particular concerns related to them.

This is at a general level. There are however, some particular instances of the active violation of human rights of same sex desiring people at the hands of the health sector. A case in point is the wide practice of 'reparative' or 'aversion' therapy to 'cure' homosexuality.

4.2 Sexuality and the Mental Health Profession

Three recent research in India (Chandran and Narrain; suggest an intense homophobia in the interactions between queer folk and mental health professionals. This is largely through the use of 'reparative therapies', which aim to change the sexual orientation of a patient through the administration of nausea inducing drugs, shock therapy and/or behavioural therapy. The following quote describes one gay man's experience with reparative therapy.

"I approached a psychiatrist, assuming he would help me. 'Help' he did. 'Its all in the mind', he said. My bouts of depression (which I never realised arose from bottling up gay orientation) he glibly informed was a disease called schizophrenia. 'Your gayness is the cause of delusions and hallucinations.' He prescribed 'Orap' and 'Serenace' which are powerful neuroleptic medications. The nightmare began in earnest, lasting fifteen years, ravaging body and soul. I took an overdose of Orap hoping to die. I did not. I was rescued. As a reward I was given shock therapy which played havoc with my memory for over two years. My moods were always bleak, my senses dull, and my thinking blurred."

Hemant, (quoted in Narrain and Khaitan)

Chandran and Narrain's research, based on interviews with mental health professionals and queer folk in Bangalore suggests that the one fact assumed at the start by mental health practitioners is that heterosexuality is the objective of all sexual development. In this context, they argue that intervention by mental health professionals is based on the understanding:

'...that being a heterosexual is the "natural" thing. And that people are homosexual because of unhealthy fixations, same-sex experimentation, same-sex sexual abuse and peer pressure. Yet again, the norm of heterosexuality is beyond question, and its primacy requires no explanation. Everything outside heterosexuality becomes "different", and therefore, suspect. What is different must

be explained in ways that does not threaten the norm, and hence difference becomes pathologised, and acceptably classified as abnormal under the all-legitimising banner of medicine...Coupled with "scientific"' theories of poor parenting, fixations and habit forming homosexual experiences, and the connections with HIV and other sexually transmitted infections, the counsellors attempt to paint homosexuality as an undesirable as well as dangerous condition.'

The research identifies three modes by which homosexuals are treated in Bangalore. The first is the mode of prescribing behavioural therapy including "shock" therapy. Two examples from the paper:

In (the leading mental health institution in this city) they have behavioural therapy in which they try to suppress the homosexual response by shock therapy. They show pictures of homosexual activity and then give the person a mild shock. They show pictures of oral sex, on seeing which the patient feels happy, and then give him a shock. The idea being that the person associates shock and not pleasure with the activity. I believe in behaviour modification, the positive way. What I do instead is to show a series of pictures of heterosexual activity. Combined with this I teach him how to enhance pleasure by the use of lubricant. I try and introduce him to the idea that a woman feels nice and the pleasures of living together and how sex is the root cause of that. I give him an idea of what is the vagina and how one can masturbate with lubricant so that the organ slides into the vagina. I create a sense of anticipation about the vagina so that when he finally encounters a vagina he feels pleasure. My objective is to replace the feeling of pleasure in homosexuality by pleasure in heterosexuality. This is what I call replacement therapy. - Dr. SB (Sexologist)

The idea is to decrease interest in homosexuality and increase interest in heterosexuality. That apart, we use treatments like orgasmic reconditioning — which is basically a treatment to redirect a person's stimulus for pleasure. For example, if a person can be made to think of a woman instead of a man at the moment of orgasm then we succeed in reconditioning their pleasure in the female direction. We make the person get an erection with physical stimulus, the person is then made to imagine a person of the opposite sex and made to masturbate. We start by showing pictures of the same sex but move towards replacing it with pictures of the opposite sex. As an adjunct to orgasmic reconditioning we also use aversive therapy (10 to 20 sessions). We may follow up with booster sessions, which may be for four to five days consecutively. Dr. CPB (Clinical Pscyhologist)

The research finds that there is a widespread understanding that homosexuality is a 'behaviour' and one can get patients to stop exhibiting that form of behaviour through aversive therapy, positive reconditioning, orgasmic therapy and various other ways in which sexual pleasure is sought to be changed.

The "violence" of these processes, the authors argue, lies not only in the physical pain of a mild aversive shock which increases in intensity going up to 10amps, but in the exposure of ones deepest fantasies to the clinical gaze of judgement. The fantasy is the subject of the doctor's gaze as pleasure is then monitored, calibrated and judged. The clinician's gaze functions not only to capture the

homosexual body in an embrace of power but aims in fact to change desire under its relentless judgmentality. The effect of this, of being told that one's desire needs to be changed, Chandran and Narrain suggest, the patients' sense of self and internal coherence instead of being validated, is deeply challenged. Behaviour therapy gives the patient a low sense of self-esteem as s/he is told through verbal and physical means that what s/he feels and indeed what s/he is has to be changed.

The second form of treatment has been in the context of recent development of religion-based therapy. This therapy, which offers homosexuals, through prayer and belief, the opportunity to become heterosexuals, gained prominence when *Exodus International* visited Bangalore. An organisation whose members have converted from homosexuality to assert heterosexual identities, Exodus International, with the help of local religious groups, organised a series of meetings to speak about how homosexuals can be converted through reparative religious therapy. Their practices are also endorsed internationally by another organisation called NARTH (North American Reparative Therapy for Homosexuals), an association that believes that homosexuality can be cured and offers aversion therapy. In the present context, faith-based support groups operate out of the office spaces of religious groups offering support for people to come out of homosexuality. Significantly, recent developments show that even founders of Exodus International now state that their programmes were "ineffective...not one person was healed." They stated that the programme often exacerbated already prominent feelings of guilt and personal failure among the counselees; many were driven to suicidal thoughts as a result of the failed 'reparative therapy'[9].

The third, and only positive form of treatment that has being provided is the on where counsellors and doctors take a non-judgemental position towards homosexuality. This is where homosexuality is not being considered as a disease, and the focus is on mental health instead. This, the authors suggest is related to the emergence of a gay and lesbian voice, readings in the contemporary history of western psychiatry that have resulted in the taking of a different stand and the recognition through clinical practice, which shows that treatment does not work.

Narrain and Khaitan examine the human rights implications of reparative therapy. These amount to the violation of the dignity of a patient, but also, at worst, constitute forms of torture. They refer to the following case study from Delhi to show up the ways in which mental health, law and culture collude in the violation of the rights of sexually marginalized people.

"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*

[9]Gerald C. Davison, Constructionism and Morality in Therapy for homosexuality, *cf.* John C Gonsiorek *et.al.* , *Homosexuality: Research implications for public policy*, Sage, London, 1991, p 159.

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: counselling therapy and drugs. During counselling 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 Code[10] 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 cognisance of something that is an offence?"(The Pioneer, Thursday, August 2, 2001)."*

What we see here is the collaboration between medical and legal discourses on homosexuality, resulting in a situation were there is no redressal even in the law against such glaring human rights violations, on the basis that same-sex desire is considered 'unnatural' and criminalised.

At another level, even when a mental health professional *is* able and willing to provide a client with support and information, homophobia can still have serious consequences in a counsellor-client relationship. Again, similar to the situation with general health practitioners, a client's impulse to silence around her or his sexuality translates into (perhaps unwillingly) concealing aspects of her or his reality, even from a potentially sensitive therapist . We must be sure to ask, how can a mental health professional help a client to realize well-being in the absence of information about a client's situation? This becomes a matter of concern given that experiences on helplines and in support spaces—as well as fact-finding reports on lesbian suicides, for example—show the range of mental health concerns for same-sex desiring people, to include depression, suicidal feelings, and substance abuse. As several participants

[10]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....."*

noted in a seminar of mental health professionals held by the lesbian and bisexual women's group, Sahayatrika (Trivandrum, November 2002), one of the pervasive points of ignorance in professional counselling is the idea that the lack of mental well-being of same-sex desiring people is directly linked to the "sickness" of that orientation itself. But as several mental health professionals noted that day, it is homophobia that needs to be "fixed" in order to realize well-being, and not the orientations themselves.

5. The Construction of Sexuality Through Public Health Interventions

Thus far we have considered the manner in which heteronormativity in the health sector has implied an abrogation of the right to health of queer people, and some instances of violence. The final part of this paper focuses on the manner in which sexuality is being actively constructed through public health interventions. The material presented here is based on ongoing ethnographic research being carried out at various 'targeted interventions' being carried out in the context of HIV/AIDS, specifically focusing on those interventions targeting men who have sex with men, or 'MSM'.

Responses to the HIV/AIDS epidemic have given rise to the emergence of analysis of 'indigenous' cultural categories and systems of classification that structure and define sexual experience in different social and cultural contexts—with particular stress on the cross-cultural diversity that exists in the construction of same-sex interactions (Khan 1999, Aggleton 1999) and simultaneously, the diapproval of categories such as 'homosexual'. As Shivananda Khan puts it in his examination of 'MSM' in India and Bangladesh:

"...more often than not these descriptions (homosexual, bisexual, heterosexual) are meaningless when used cross-culturally, and we should perhaps pay greater attention to sexual practices as they are understood in local cultural terminologies and contexts" (1999:195)

This has resulted in the proliferation of a multiplicity of 'clear identities' in the HIV/AIDS sector, in queer movements and in anthropology. For example, what was once called the 'LGBT movement' is now often called the 'LGBTKQJHA...movement'[11]. Khan identifies such categories as *do-parantha*, *double decker*[12] and *panthi*[13] in the context of India and Bangladesh. Similar ethnographies may be found of such 'indigenous identities' of *kathoeys* in Thailand (Jackson 1997), *warias* in Indonesia (Boellstorff, 2004), *ponnaya* in Sri Lanka (Ratnapala, 1999), *fletes* in Lima (Cáceres and Jiménez, 1999), *metis* in Nepal, *zenanas* in Pakistan (NFI 2004) and so on.

While it is interesting and significant that the dominant Euro-North American framework of understanding sexuality

[11]'Lesbian, Gay, Bisexual, Transgender, Kothi, Queer, Jogappa/Jogamma, Hijra, Aravani...'
[12]Both terms refer to 'a man who does both – penetrate and get penetrated'
[13]'Panthi', 'Parikh' and 'Giria' are terms used by kothis and hijras to refer to their male identified lovers. Whether this may be considered an 'identity category' is a matter of debate as most often, these are 'otherwise straight' married men.

simply in bio-medical terms is being challenged by the identification of these 'indigenous' categories, what is troubling here is the manner in which these categories are being re-framed in peculiar ways geared towards their placement in epidemiological models and interventions. For instance, the term 'kothi', arguably one with a long and complex history (see Hall 2005, for instance) today means little more than 'the effeminate male who is penetrated in a same-sex encounter between men'. This is related to the 'targeted interventions' approach, which is based on the understanding that there are certain people who are more vulnerable to HIV infection and who cannot be provided optimum services and support through interventions focused on the 'general population'. This ultimately requires that such people be identifiable and intelligible as 'communities', thereby a requirement of the definition of the characteristics of the group, of the identity. The need to establish vulnerability has, in turn, implied that these characteristics have been defined in terms of penetration – it is, in other words, the fact that kothis are penetrated while having sex, that it is possible to demand the allocation of resources and funding towards these targeted interventions. In turn, a complex sociocultural, economic and linguistic reality is collapsed into the sexual act of being penetrated. For instance, the ethnographic research has brought to light a process through which young effeminate males, who are otherwise spoken of in different cultural idioms in different parts of India come to be identified as 'kothi' through interaction with support groups and outreach workers of the HIV/AIDS sector. Over a period of time, the various complexities of being gender transgressive lose significance and the identity comes to be simply about 'being penetrated'.

While this has various psychosocial and political implication beyond the scope of this paper, what needs to be highlighted here is that the interaction between the public health system and queer bodies has been a process of creation of bio-medical and epidemiologically intelligibly entities that are defined in terms of vulnerability. This makes queer bodies available in various ways to the international health industry. For instance at the present moment, there is a drive to carry out large scale 'mapping' of 'MSM'. This is justified in terms of 'evidence based' programming. But as has been seen in the context of other marginalised communities in recent times, such as sex workers in various parts of the world, this 'mapping' makes available these communities for such things as clinical trials for vaccines. Further, in a context where same-sex desire continues to be criminalised, the collation of this information is something dangerous – who will have access to this information and how will that access to information be regulated in such a way as to protect these communities from further abuse and human rights violations? The simple point here is that there is a link between the bio-medicalisation of sexuality identities and the creation of further vulnerability for already marginalised groups.

In this context it is important to recognise that medical discourse is not necessarily benign, but explicitly political, and with some serious consequences. Rather than a drive towards further medicalisation,

further minimalisation of of complex realities into medical categories, we need to constantly bring in political and cultural and social understandings of these realities.

Conclusion

Through the paper it it has been are intention to empahsise the need to recognise sexuality as an important aspect of the right to health. Public health policies are based on certain presumptions about sexuality, though these are largely unstated. These assumptions go to re-inforce a particular idea based on the notions of 'natural' and 'normal', where the only form of sexual relationality that is recognised as legitimate is married, heterosexual, same-caste, class, religion etc. This is 'heteronoramtivity' which are rather than being 'normal' or 'natural', are simply 'compulsory' or enforced on a regular basis. The implications of a heteronormative society in general, of the health care sector in particular fall on all people, whether they identify themselves as heterosexual, homosexual, male, female, or otherwise. The implications of such a heteronoramative context are most pronounced in the context of same-sex desiring people and those whose gender challenges the categories of 'man' and 'woman'. The system works towards exclusion, discrimination and violence against queer folk. These constitute not just violation of the right to health, but of a range of other human rights as well. Access to health services is restricted due to lack of sensitive system that enables free exchange of information necessary for an individual to realize well-being. Such perceptions and biases must be changed also to prevent human rights violations that stem from such active homophobic interventions as reparative therapy. Finally, there is a need to recognise the various implications of the medicalisation of sexuality and to keep medical and epidemiological discourse open to challenge and collaboration with other approaches to sexuality. As such, while there is an urgent need for action at particular sites of discrimination and violence, there is equally a need for the incorporation of sexuality into wider conceptual and political dialogues addressed by the movements relating to the right to health.

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This is one of background papers to the **Establishing Health as a Human Right Project**. It reflects solely the views of the author. The views, analysis and conclusions are not intended to represent the views of the organisation.

ISBN : 81-89042-49-1