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Sexuality: Not Just a Reproductive Health Matter

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Recent activities of the international women's health movement have generated considerable interest in women's sexuality and gender research. The emergence of AIDS and STDs in populations other than 'high risk' groups and the emphasis on preventive efforts rather than curative ones, has sent public health professionals into a frenzied search for clues about 'everyday' sexuality and sexual behavior in relation to HIV/AIDS. This is reminiscent of earlier attempts of the population control movement to understand sexual behavior in relation to fertility including, for example, counting the number of coital acts in relation to contraceptive use, because of fears of a population explosion in the developing world. Similarly, much of the current reproductive health inquiry into women's sexuality is limited to understanding issues of sexual partners and practices, as if understanding these elements alone would reveal major clues' for carrying out successful interventions to prevent disease and unwanted pregnancy.

Ironically, much of the early research conducted on sexuality from Freud to Kinsey to Foucault was focussed, on unraveling the complex relationships between sexuality social, cultural and psychological life, and mainly in terms of sexual pleasure A. These are all dimensions of sexuality that are largely missing in the current reproductive health literature. While most definitions of sexuality reflect a comprehensive list of elements - physical and emotional desire, knowledge attitudes, meanings, practices, behaviors and identities - there is little demonstrated acknowledgement by researchers and practitioners that sexuality is a complex phenomenon.

What are these missing elements? Is it really useful to study sexuality to improve women's reproductive health? How can sexuality be successfully incorporated into programs? By whom? Can health professionals take on the 'sexuality challenge' alone?

There is a tremendous range and diversity of sexual experience, even in groups that are sometimes treated as homogeneous, including adolescents and women. Adopting the view, for example, that all women are victims of sexual violence denies us the opportunity to understand the diversity of sexuality and sexual experiences. Furthermore, every person's sexual experiences can change over their lifetime. Hence, it is important to consider how - and why. Interviews I

conducted a few years ago in rural India illustrate these points well. During the course of one interview, the woman revealed that when she was first married she would run away to a neighbor's house when her husband approached her for sex: he had 'such desire' that she did not know what to make of it. Gradually, she realized that she too had 'desire' and that men and women 'get together to put out each other's fires', not just to have children. Although 'men seemed to have more of an urge than women do', she felt that once she had children and was older, sexual encounters became easier and more pleasurable. She elaborated that she was lucky', as her husband was an understanding man. Several other women spoke of being terrified about what would happen to them when they were newly wed and their husbands first approached them; some of them had not even started menstruating when they had their first sexual encounters.

Current sexuality research in reproductive health (with the exception of research on violence and sexuality) mostly ignores the emotional and psychosocial aspects of sexuality. Researchers and practitioners rarely address the fear and lack of information that sets up negative feelings around potentially pleasurable experiences for many women, and for men as well.

Are applied health researchers and practitioners really interested in expanding the scope of the information they collect? If yes, do they have the resources or the time? Not many do, and perhaps this is partly because developing country health studies do not receive funding to explore sexuality beyond disease and unwanted pregnancy. Additionally, health practitioners in developing countries tend to be biased towards clinical interventions for most health-related issues and are rather perplexed by or unused to the idea of having to address non-clinical aspects of women's health.

Typically, research that does expand the scope of information usually collected tends to be carried out by social scientists or public health academics who embrace the sociological and anthropological dimensions of sexuality. Weiss and Rao Gupta, for example, have coined the '5 Ps of sexuality'- practices, partners, procreation, pleasure and power - from their research on women and HIV/AIDS B. Dixon-Mueller's framework describes the link between sexuality and sexual and reproductive health, distinguishing four elements of sexuality: sexual partners, sexual acts, sexual meanings, and sexual desire and pleasure C. Heise examines the links between violence and sexuality in women's lives D., and others from developing countries such as Hong in Vietnam E. and Correa in Brazil F. are breaking ground with pioneer work on gender and power differentials, and how this affects sexual and reproductive health.

Can researchers and practitioners overcome their own sexual inhibitions and prejudices when faced with the task of collecting such information? Even when

researchers are ready to explore and describe women's sexuality, we rarely admit that we may be uncomfortable with aspects of our own sexuality and hence unable to question or lead others to talk about theirs. The collection of valid data depends not only on who is collecting it but also on the methods used. A one-time survey questionnaire that asks a woman about sexual violence, for example, is less likely to get valid information compared to a series of in-depth interviews where the respondent might begin to trust the interviewer more. While a series in-dept interviews may or may not get people to reveal their sex lives 'completely' an interviewer will be able to draw much more information form the latter, assuming that the interview questions and manner are well designed and carried out.

The site of an interview is critical as well. Not surprisingly, when women feel that they are in a secure environment they are likely to reveal much more information about themselves. Several years ago, while working with an NGO in India on women's illnesses, I realized that the ability to speak in a safe space is absolutely necessary for sexuality research; the interviewees were mostly women living within the strict confines of purdah. To the astonishment of the health workers and myself, during a 'know your body' session with a group of traditional birth attendants, the women were soon leading us on to unanticipated topics of discussion. A part of our strategy was, of course, to talk only as much as was absolutely essential. Intending to cover only reproductive anatomy and physiology, we were unwittingly led in to a full-blown discussion about sexual arousal, masturbation, and women being able to stimulate other women sexually. A few women were even heard to say that women don't really need men to satisfy them sexually. It was striking that within the safe confines of that room, most of the women were able to speak freely about their sexuality. However, once the women left the room, most of this conversation was blown to the desert sand. A number of women said they rarely had a safe space to -discuss these issues in the household; being open about their sexuality threatened their security and sometimes even their daily existence.

Can sexuality data describing desires and fears be realistically incorporated into women s health programs? The already burdened public health service delivery systems in many development countries are unlikely candidates. Moreover, the best use of such data is likely to be in a non-clinical context. Cooperative efforts between NGOs and women's groups may be more successful in initiating work, with women on sexuality issues in the communities in which they already work, and within specific contexts. Our study on women's illnesses in rural India, for instance, led thin NGO we had been working with to focus its efforts on women's and men's groups and councils at the village level to enhance knowledge and understanding about health, and mutual sexual health needs and rights.

Sexuality presents a challenging agenda, far beyond concerns relating to numbers of sexual partners and sexual practices. If health and sexuality research is limited to the descriptions of behaviors, practices and partners, the benefits to women are quite likely to remain limited. Health research and practice should start addressing the social, cultural and economic factors that make women vulnerable to risks and affect the ways women desire sex or refuse it. Sexuality is not just a reproductive health matter. The integration of sexuality issues into health research and practice will remain limited if the 'sexuality challenge' adheres only to the reproductive health paradigm. The challenge for researchers and practitioners is to forge and sustain connections outside the public health arena to seek long-term strategies to tackle sexuality in all its complexity.

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