Strengthening Alliances for Sexual Health and Rights

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Sexual health and, more broadly, the field of reproductive health, has been the focus of my work for the past ten years. I know my 73-year-old mother will be very proud of me because my talk is on an issue that she has spent the past 10 years of her life educating adolescent girls and their mothers in rural India about—that healthy sexuality and the right to sexual health are fundamental to community health and development.

Up to the International Conference on Population and Development in Cairo, the term "reproductive health" had been used synonymously with family planning, and family planning referred specifically to the use of contraceptives to contain population growth. Because of this narrow definition, family planning programs worldwide somehow managed to function without fully acknowledging the central role that sexual behavior played in conception. As absurd as this may sound, it is a fact that sexuality and sexual health have remained outside the purview of family planning programs and policies worldwide for the past four decades.

It took infection and death—the AIDS pandemic—to force public health officials to focus on human sexuality. Even so, the focus has not been so much on human sexuality in general as on risky individual sexual behavior, without recognition of the complex societal context within which such behavior occurs or its social, cultural, political, or economic determinants. Public health messages to prevent HIV therefore stressed individual responsibility, with messages such as abstain from sex, use a condom, reduce the number of partners and be faithful, without acknowledging that, for many people worldwide, the course of sexual actions and lives is shaped by forces outside individual control.

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This fact has been vividly brought home through research documenting women's sexual lives. Such as, in the findings of the Women and AIDS Research Program of the International Center for Research on Women—a program funded by USAID that has supported 17 studies in 13 countries.[1]

Due to the dedication, commitment, and hard work of research teams in each of these countries, studies have uncovered the reality of women's sexual experiences, including both positive and negative experiences of human sexuality. In almost every instance, this reality has been quite different from what had been presumed to be true.

The findings reflect the words of women, men, boys, and girls from all over the world. They reveal that there are many women and girls who enjoy sex, can express their sexual desires, and are not afraid to voice their need for sexual satisfaction.

> "When one is used to sex, one cannot do without it, and as soon as the man touches me, I feel hot."
> *Adolescent female student from Mauritius*

There are also many adolescent girls in developing countries who, like young women everywhere, view sex as a part of romantic love and whose desire to be loved and to love is one of the principal reasons for having sex.

> "You have sex so that you can strengthen your love."
> *Adolescent female student from Zimbabwe*

And there are others who believe quite strongly that there can be love without sex, if only they could contain their boyfriends.

> "The reason why I don't trust boys is that they don't believe there is love without sex."
> *Female secondary school student from Zimbabwe*

However, far more overwhelming were expressions of confusion, fear, lack of information, and passive participation.

> "Girls of our age, when they get married tell us what the man-woman relationship is all about. They say after marriage, we'll be dressed up, taken to a man, and made to

sleep with him. They tell us not to be frightened, not to shout but to keep quiet."

Adolescent girl in India

Women experienced the double standard of sexuality in which women had to be virgins before marriage and consistently faithful afterwards, while men were not men if they had not had multiple sexual partners.

"It's not nice for a girl to have many boyfriends but for men it's allowed."

Teenage boy from Zimbabwe

For many women, sex was a burden to be accepted quietly, or a commodity to be sold in order to ensure survival or protection.

"I was scared, wondering what he was doing to me...I would tell my mother-in-law that I wished the night never came because at night her son used to come inside to sleep. He never came during the day.... She used to laugh at this..."

An Indian woman who was married before she attained puberty

And for far too many women, sexuality was associated with lack of control, violence, abuse, and above all, resounding silence.

"I would tell him sometimes that I did not want it, and that he came to me (near me) only to have sex. Then, he would get very angry and beat me and say that I did not like him because I was having an affair."

An Indian woman who was married before she attained puberty

Because the studies focused on women, less was learned about male sexuality. There were, however, some fairly consistent and vivid images of the sociocultural construction of male sexuality: men as needing sexual release at all costs—what some have called the "hydraulic model" of male sexuality: men and boys are expected always to be in charge of sexual interactions, to be sexual teachers, to know it all, even though they themselves have very little accurate information and are expected to learn about sexuality on the street. Also, the pressure for men was to live up to a macho image of

control, to make new conquests, and to cross new frontiers as proof of manhood, and above all, to assure they would not be perceived as homosexual.

> "I suffer from poor information about sex. Unfortunately I married as a virgin and waited for my husband to teach me . . ."
> *A woman in Brazil*

> "An older friend explained to me. He told me that you start fondling a girl until she is so weak that she cannot resist."
> *An adolescent boy in Zimbabwe*

> "[Anal sex] is a conquest because women never want to give there. . . .When you do it there, 'he did her over again,' like a virgin again. I got something that is difficult to get."
> *A man in Brazil*

These data and vivid images highlight how prescribed gender roles—and a wide range of economic, social, cultural, and political factors—support an imbalance of power in sexual relations and the extent to which that imbalance shapes an individual's experience of sexuality, as well as his or her vulnerability to sexually transmitted infection. The findings also underscore the need to empower women to take better control of their sexual lives and to redefine male sexuality in a way that puts less pressure on men and emphasizes respect and mutual sexual satisfaction.

Thus to ensure sexual health as well as healthy sexuality, we need to move beyond our preoccupation with individual risk to consider conditions of vulnerability; to move beyond a traditional public health model toward an analysis that includes the role of economic and social development and the opportunities offered by a human rights framework.

Both public health and human rights are concerned with defining and advancing human well-being. To achieve that goal requires us to challenge and transform social, political, and economic structures that prevent individuals from fully realizing their human potential in humane and nondestructive ways. Empowering individuals with the right to choose and shape the course of their own sexual destinies is critical

to ensuring respect for basic human dignity, and lies at the core of human rights efforts to ensure sexual health.

But in order for those of us in the public health and human rights fields to move forward to achieve our common goal, we must tread carefully. We must make sure that our good intentions do not pave the road for disaster, but rather that they are guided by our combined past experience. In particular, we should be careful to ask ourselves four critical questions.

First, how should we state our cause to ensure the sexual health and human dignity of individuals? We must learn from the experience of the international women's human rights movement. Casting women's right to self-determination as an individual right was immediately used to create a discourse of false polarities and dichotomies, a discourse in which we were accused of promoting individual good at the expense of societal harmony, of supporting individualism at the expense of the collective.

We need to be wary of this political ploy as we move forward and be careful to cast individual empowerment not *just* as an individual right for its own sake but for the sake of the collective economic and social good. For this, we would do well to borrow the public health approach that identifies individual health as an essential ingredient for ensuring the health of populations. We need to emphasize that empowerment is not a zero sum game—empowering women, for example, does not reduce the power that men have. Power is not a finite concept—more power to one ultimately means more power to all. This is true at the household level, where research shows that a woman who has access to greater productive resources or education improves the health and welfare outcomes for her children and family. It is also true at a more macro level, where providing women with education and productive resources improves the economic status of communities and countries. In sexual health, too, empowering women to protect themselves, to speak up, and to have access to technologies frees men from stereotypical roles which hold them solely responsible for protection against infection.

Second, how should we define the right to sexual health? We urgently need clarity on what can be protected and pro-

moted using traditional human rights concepts, and whether there are differences in the definitions which can be used in the North and the South. In the North, sexual rights may be defined as greater freedom for sexual expression, while in the South, they are likely to be conceived as the freedom to say no. We need to rethink the terms we use, so as to accentuate our commonalties rather than our differences. Thus, why is the term sexually active, a term popularly used in public health discourse to describe individuals who are having sex, not used to describe women who have actively decided to say no to sex? From a human rights perspective, a woman who chooses to say no is as autonomous as a woman who chooses to say yes—a point that public health needs to acknowledge. Although these seem to highlight key differences in priorities, it should be noted that both definitions share a common vision. Underlying both is the need for respect of human dignity to shape one's own sexual activity and behavior: to be in control. And it is that definition that must guide efforts both in public health and in human rights advocacy.

Third, how does one help to empower an individual to have the right to sexual health? One answer is to deconstruct the components of power to create a framework for action.

There are five essential components of power: information/education; economic resources; mobility/access; perceived social support; and supportive norms, policies, and laws. There is a clear relationship between each of these components, sexual health and vulnerability. The data from the Women and AIDS Program revealed broad areas of vulnerability for women. Many women know very little about sex or reproductive physiology, and their access to this information is severely limited by social norms which dictate that women must remain ignorant and passive about sexual matters. This lack of information compromises women's ability to negotiate safer sex options. The economic vulnerability caused by women's limited access to economic resources restricts their ability to negotiate safer sex or to leave relationships they perceive to be risky, or forces them to sell sex for survival. Women's access to services is greatly constrained by restrictions on their mobility. For many women, distance is an insurmountable barrier, and competing demands on their time increases the opportunity cost of traveling long distances

or waiting for care or information. Women who feel they lack social support of either their parents or the community of other women, perceive themselves to be dependent on men for security and comfort even when a relationship involves violence and abuse. Women's vulnerability is greatly compromised by norms, policies, and laws that do not guarantee basic rights such as the right to property, the right to bodily integrity, or access to education.

Staying with the example of women and HIV/AIDS, let us now ask the final question: How can an alliance between public health and human rights help protect women's sexual health? How can such an alliance promote women's access to each of the five components of power? As a first step, recognizing the role that gender plays in compromising a woman's sexual health, public health can use a human rights framework to address gender inequity and discrimination. Public health can and should do this, for example, by citing appropriate human rights conventions to advocate for technologies and services that are woman-friendly: advocate for the resources to develop a female-controlled technology for prevention, such as a microbicide; provide services at timings that are convenient for women, integrate services so that the time costs to women of using multiple services are minimal; make technologies, such as condoms, and treatments, such as STD treatment, available in places where women can access them without fear of social censure; and wherever possible, provide community outreach services so that distance does not act as a barrier to women's use of services.

Public health and human rights activist communities can also join forces to foster gender equality more proactively by jointly opposing health education efforts that reinforce damaging gender stereotypes for short-term gains. In AIDS education, for example, a predatory, violent, irresponsible image of male sexuality is often perpetuated to increase condom sales. Any gains in condom use achieved by such campaigns are made at great long-term cost to women's human rights and must stop. The gains are unlikely to be sustainable because they erode the very foundation on which AIDS prevention is based—responsible and respectful sexual behavior. Besides, men rarely benefit either—for the macho image of male sexuality puts a lot of pressure on adolescent boys

and limits their ability to speak up about their need for more information or about their doubts and fears.

Public health workers can and should also join with human rights activists to advocate more broadly for measures that will improve women's economic and social status, such as expanding women's access to education. Even though some in the public health community may perceive such a task to fall outside the purview of their mandate, they must recognize that pandemics such as AIDS that bring death to women and their families, provide tragic opportunities to forcefully advocate for such policy changes. In the field of human rights this example underscores the challenge to those who have worked for years to protect civil and political rights to use their expertise in research and advocacy to demonstrate the critical importance of promoting and protecting economic and social rights. By doing so they can create a vision of human rights in which the artificial dichotomy between these rights can finally come to an end.

In order for such collaboration to work, we need to recognize and share the positive values that guide our different disciplines. Public health can bring to this partnership the value of objectivity and the value of basing action on rigorous research. Human rights, on the other hand, can enrich the partnership with its emphasis on the value of inclusion and participation—a value that has often eluded public health with its roots in the top-down approach of medicine.

In conclusion, let me share an exchange that I had with my daughter in 1992, when she was seven years old, an exchange that served to bring home quite forcefully that my work on women and AIDS was work on human rights, not just health. Driving home from work one day, she asked me with considerable fear and apprehension how adults who had sex could protect themselves from HIV. I confess that I began with a lecture on the importance of abstinence, and uncompromising fidelity thereafter, and so on, only to be interrupted with, "Yes, yes, all that is fine, but when I am grown up and want to have sex, what should I do?" So, I gingerly ventured into a description of condoms and their use. "Yes," she said in reply, "but that is what men use, right? What do women do?" "Convince men to use them," I said. To which she burst into tears and said with great anguish, "But that's not fair,

Ma, what if I can't convince the man?" So, I leave you with that thought—there is far too much in our world that is not fair and only if we work together can we make life more fair for all our children.

Notes

1. Women and AIDS Research studies have been conducted in the following countries: Brazil (2), Guatemala, India (2), Jamaica, Malawi, Mauritius, Mexico, Nigeria, Papua New Guinea, Senegal, South Africa, Thailand (2), Zimbabwe (2).

Suggested Readings

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