SEXUALITY — THE MISSING LINK IN WOMEN'S HEALTH

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INTRODUCTION

Many Primary Health Care (PHC) Programmes function without sufficient consideration of the sexuality of their clients and the impact this has upon their health.[1]

Contraceptives are often provided as medical products unconnected to the feelings or sexuality of recipients or providers. Sexually transmitted diseases are treated with injections but without practise in discussing or using condoms. Young people are taught about AIDS, 'family life' and biology, without reference to the complex issues of sexuality each of these implies.

Women's sexuality represents the interface between two of the most potent and insidious forms of oppression — gender and sexuality. The reluctance to address sexuality potentially limits the effectiveness of programmes in women's health, family planning and the prevention and control of sexually transmitted diseases including AIDS.

In this article we outline some of the ways in which women are particularly vulnerable to risk in relation to their sexuality, and suggest how PHC programmes could begin to address the impact of sexuality on health in a holistic and gender specific way.

SEXUALITY — PLEASURE AND DANGER

Potentially sexuality signifies pleasure and danger to women and men. In reality women tend to bear the brunt of the danger. While their biology makes women vulnerable to the negative consequences of sexuality, it is their lack of sexual self-determination which poses such a profound threat to their health and well-being.

The most obvious and recognised sexual risk for women is that of pregnancy. If the pregnancy is unwanted and safe abortion unavailable, the woman is at risk of injury, infection and death from an unsafe abortion. The outcome of unsafe abortion is the leading cause of death in women in many poor countries. If the pregnancy occurs 'too early, too soon, too often or too late', the woman is at risk of complications with resultant ill health, injury or death.

The second major physical danger is the risk of sexually transmitted diseases (STD), some of them potentially fatal and others causing chronic ill health. HIV is the most recent of these, but cervical cancer, pelvic inflammatory disease (PID) and syphilis are also potentially fatal without correct treatment.

All STDs, including HIV, are more easily transmitted from men to women than from women to men. This results from the differing anatomy of men and women. Semen remains in the vagina for many hours, in an environment which is favourable to the survival and transportation of pathogens through the vaginal wall or cervix, particularly when there are lesions on the genitals. When these lesions are internal, women are unlikely to be aware of them. Even when women experience symptoms, they may not seek medical attention because of embarrassment, fear or the belief that these problems are the normal lot of women.

Many STDs do not produce symptoms in women until the pathogen has caused serious damage to the reproductive organs. For example, chlamydia and gonorrhoea infections can cause scarring of the fallopian tubes resulting in infertility or ectopic pregnancy which is itself potentially fatal. In many societies, women who are infertile experience severe discrimination and rejection. This can result in further health risks if they are then forced to survive through the exchange of sex for money or goods.

In addition to these physical dangers, sexuality can result in serious mental ill-health in women. Genital mutilation, sexual abuse, rape within and outside marriage, sexual harassment in the workplace, and other forms of sexual violence can all cause physical and psychological trauma which last a lifetime. In cultures where sexual satisfaction is highly prized, an unhappy sexual life can cause anxiety, low self-esteem and misery.

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[1] Primary Health Care aims to make essential health care universally accessible to all members of the community in an acceptable and affordable way. PHC is a balanced concept of promotive, preventive, curative and rehabilitative services which is shaped around the life patterns of the population it serves. Local people are actively involved in formulating health-related activities so that they meet local needs and priorities and link up with other sectors such as agriculture, education and human rights. All health interventions are carried out at the most peripheral and practical level by workers trained in these activities. PHC requires that the resources allocated to the primary level and underserved communities are increased.

Men also face risks in the expression of their sexuality. STDs can result in infertility, ill-health and death. Antibiotic resistant strains of STDs, untreated syphilis and AIDS have severe consequences for men as well as women. In some societies younger men are vulnerable to sexual abuse, and in many societies the pressure on all men to conform to rigid masculine stereotypes and ideals of sexual potency can be devastating for those who find these impossible to achieve.

Those women and men whose sexuality is at variance with traditional sexual norms (for instance those involved in same sex relationships) often experience untold suffering because of violence, prejudice and discrimination.

CULTURAL DETERMINANTS OF SEXUAL EXPRESSION

Sexuality is often perceived to be among the most natural, universal and private aspects of human life. And yet like gender, sexuality is a social phenomenon. Beliefs about male and female bodies and the pleasurable potential of each, reproduction, gender roles, relations between and within the sexes, and marriage, all differ widely across cultures.

Women are most vulnerable than men to sexual risk because in most societies their sexuality is more strictly regulated and controlled by others. Sexual norms and rules are often defined by men and the likelihood of conformity and compliance encouraged by the assistance of older married women, for whom the unrestrained sexuality of younger and/or unmarried women may represent a significant threat. Thus women may support repressive action against the sexuality of other women, for example by supporting the practice of female genital mutilation.

In most societies, the control of a woman's sexuality and her reproductive capacity is acquired by the huband and his family upon marriage. In parts of the Arab world and Asia, when a woman marries she has to prove her virginity on pain of rejection or even death, whilst the man is expected to have gained sexual experience outside marriage. The fear of any doubt being cast upon her purity makes it impossible for a woman to raise the topic of contraception or the risks of infection with STDs including HIV infection. Once married, a woman is expected to provide sexual services on demand and the fear and stigma of divorce ensures her cooperation.

SEX AS ECONOMIC SURVIVAL

Perhaps few economic planners are sensitive to the ways in which their policies limit people's choices for survival and progress. As economic options shrink, men are forced into labour migration and marriage is delayed as the accumulation of bride price takes longer to achieve. Taken together with expectations upon men to be sexually active, these factors can indirectly encourage men to place themselves at considerable risk of STDs including HIV infection. At the same time, with fewer options for employment and access to resources available to them, women are forced increasingly into using sexual exchange as an economic strategy.

Thus a woman's sexuality may also represent an economic asset. To the extent that the woman herself is able to control the use of her sexuality, this can represent a source of power and influence and can enable her to pursue short and long term goals for herself, her children and her family. She will also be better able to protect herself from unwanted pregnancy, infections and violence.

When women's sexuality is used by others for economic reasons, the woman is far more vulnerable to risk. For example, if she is owned by a brothel or a pimp, or if she is expected to bring a large dowry to a marriage.

For example:

Initially the Thai government, like many others, was reluctant to acknowledge the extent of the HIV epidemic, partly because the tourist industry is a major source of foreign exchange. In Thailand, agricultural society is being transformed by industrialisation and 'modernisation'. Diminishing economic opportunities in rural Thailand combine with an increasing need for modern agricultural inputs and a desire for a less austere lifestyle.

Many young girls leave their impoverished homes in the small rice farming villages in Northern Thailand.[2] After completing schooling to the age of 12, girls go to work in Bangkok or the Southern towns. Almost always, they go with the consent of their parents, who receive advance payment for their daughters' work. Why do parents sell their daughters to be sexually violated at the whim of a stranger?

> 'I didn't sell my daughter. She saw me suffer and she wanted to help. It was when we were about to lose our ricefields because of the drought that my daughter decided to go. I couldn't stop her. I have nothing better to give her.'

It is now considered virtuous in some villages for a

[2] See Sanitsuda Ekachai, 'Behind the smile: voices of Thailand' Thai Development Support Committee, 530 Soi St. Louis 3, South Sathorn Road, Bangkok 10120, Thailand.

daughter to sacrifice herself for her family. The 'deal' is understood between the girls, their parents and the brothel owners. The girls are bonded to the brothel. They must pay back double the amount that their parents are paid in advance when their daughters first leave the village. The girls themselves receive nothing until they have done so. Then they send money home every week.

> 'She is a good daughter. She takes care of us in our old age.'

In a study in Uganda, Obbo describes how women migrants in Kampala used their sexuality to improve their social status and income through a series of relationships with lovers.[3]

> N moved in with her first lover after she failed school at the age of 13. They managed to build a house and have three children together. Then the man married another woman and threw N out, leaving her with nothing, not even her children. Eventually N got a job in a factory, and took five married lovers who provided her with enough income to save as well as pay for clothes, food and rent. When she had a second child with a 60 year old lover he bought her a plot of land and built her a house. Another lover found her a job in a telephone exchange and places for her children in a good school. At the age of 28, N had managed to secure a future for herself through her own employment and a series of sexual relationships with men who gave her financial support and helped her in her career. Both her sexual and her reproductive ability were important in her progress.

Sexual exchange can occur on a full, part-time or seasonal basis. Women may work from hotels or bars or sell local beer and food as well as sex from their own homes. Women from rural areas may travel to plantations or towns on a seasonal basis or when they know that a foreign ship is arriving. They may visit the neighbouring country to save for a dowry or a business. Single women in urban areas may be partly or wholly supported by lovers. Girls may exchange sex with older sugar daddies or teachers in exchange for gifts, sweets or pocket money.

The degree of control which women have in a relationship will seriously affect whether they feel able to talk to their partner about safer sex, and those who are economically or emotionally dependent will find it more difficult.

LESSONS LEARNED FROM THE FIRST DECADE OF AIDS

AIDS has become a priority health problem in ways that other sexually transmitted diseases never achieved. Informed by sexual prejudice, the popular perception of the epidemic in its early stages as a problem primarily of gay men led to a response characterised by blame, prejudice and apathy. Even when its potential wider significance was recognised few of the lessons learned in community health and PHC were applied to AIDS programmes.

The Global Programme on AIDS (GPA) was established to coordinate and control HIV prevention activities on a global scale. GPA encouraged each country to establish a National AIDS Committee (NAC) and develop a medium term plan for HIV prevention and control. These tended to be dominated by male doctors and focused on testing the blood supply while surveillance and education campaigns were targeted towards so-called 'high risk groups'. The campaign 'messages' were generated by the NACs with little or no involvement of intended audiences. They tended to be 'fear arousing', moralistic and more often than not blamed women for the epidemic. The GPA has recognised some of these problems and is encouraging the NACs to 'de-medicalise' their programmes.

NGOs working outside the government programmes were obliged to submit their education programmes and materials to the NAC for approval. Ostensibly, this was to prevent discriminatory and inaccurate messages and to ensure that messages from different sources reinforced one another rather than confused. Programmes or messages which appeared to challenge the boundaries of sexual norms as defined by the NAC were rejected, delayed or edited to the point of irrelevance.

Because of the strength with which sexual values are held, these 'gatekeepers' imposed their own values on the health options being offered to different populations to a greater degree than in programmes dealing with less sensitive areas. In some parts of the world this sexual conservatism is reinforced, rather than challenged, by NGOs with a strong religious basis. For example, young people may be warned that sex is deadly and told to wait until they marry a faithful uninfected partner for life. This message is likely to be irrelevant and harmful to many young people because it takes no account of the social, economic and sexual realities of this group.

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[3] C. Obbo, 1980, *African Women: Their Struggle for Economic Independence*, London: Zed Press. Quoted in 'Sexual behaviour in sub-Saharan Africa; a review and annotated bibliography' prepared for the ODA by Hilary Standing and Mere Kisekka.

Most of the programmes which have been successful are based on many of the premises of PHC. Groups are involved in designing their own education programmes, looking for ways of practising safer sex which are consistent with their particular values and needs. Working in groups, people support each other in behaviour change and develop educational materials for others based on their experience.

FINDING THE WAY TO SAFER SEX

Safer sex will mean different things to different people depending on their personal 'risk landscape'.

Safer sex education targeted at women often fails to take sufficient account of their relative lack of control and bargaining power within relationships. Furthermore the differences in the ways in which men and women view sexuality and safer sex are often given insufficient consideration.

For example, safer sex to a woman might mean avoiding pregnancy and infection. The use of condoms and non-penetrative sex can achieve both these desires simultaneously, while other contraceptive methods will achieve one but not the other. On the other hand, the woman might reject the use of a condom because of the fear of violence or contamination, religious beliefs or the worry that the condom might get lost inside her. If she considers non-penetrative sex to be a perversion, she may feel that this is also more risky than pregnancy or infection. For a woman to whom sex is a painful and unpleasant chore devoid of any pleasure, celibacy might seem an attractive option.

In terms of reducing the risks of sexually transmitted disease, including HIV infection, people are presented with three options:

1 Stay with one uninfected faithful partner for life.
2 Use condoms for vaginal, anal or oral sex.
3 Engage in sexual activities which do not involve penetration of the vagina, anus or mouth by the penis. For example, masturbation, kissing and massage.

However these options implicitly challenge the perceived norms of heterosexual sex which exist in many cultures and which reflect male sexual desire for penetration, orgasm, and a variety of sexual partners. When a woman suggests monogamy, the use of condoms or non-penetrative activities, she may be implicitly challenging fundamental notions of gender and sexuality.

For example:

> In Rwanda, penile/clitoral stimulation and exchange of 'gifts' (copious bodily fluids) and reciprocity are important in sexual expression for both men and women. The loss of this satisfaction makes people reluctant to use condoms.[4] In other cultures, the vagina is considered to be a sacred place and putting the condom — a foreign body — into it is regarded profane.[5] In many cultures, the possibility of conception makes sex a moral act demonstrating commitment and respect for the woman.[6] This makes it difficult for men to use condoms with regular partners or their wives because they are associated with uncommitted, immoral sex.

In any discussion of safer sex, it is essential to consider the context in which sexual behaviour occurs because safer sex almost always requires more time, resources, privacy, intimacy and skill than unprotected intercourse. This may be a bonus when partners enjoy mutual trust and pleasure and have the necessary time and space. For people in less ideal situations, safer sex can present serious disadvantages as the following examples show:

> For a sex worker, clients taking more time to 'come' is a disadvantage. Oral sex with a condom may take 15 minutes instead of three minutes without and also taste disgusting.
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> For an unaroused married woman who resents her husband's demands, and for whom the experience of sex is akin to rape, a condom prolongs the act and the discomfort. Some women use passive resistance to maintain some control over their sexuality and would not be willing to take an active part in safer sexual activities.
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> For any woman who is providing sex as a duty or paid service rather than as an expression of her own sexuality, more intimate kissing and touching may be unacceptable.
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> For inexperienced and shy young people, quick intercourse behind the school wall may be all that their courage and their opportunities will allow.
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> For a couple sharing a room with their children, quick intercourse with the minimum of noise and movement may be all that they feel free to do. Even putting on and disposing of a condom may be problematic in these circumstances, never mind pleasuring each other in more creative ways.

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[4] See Taylor, C. C., 1990, 'Condom and cosmology: the 'Fractal' person and sexual risk in Rwanda'. Social Science and Medicine, Vol 31 No 9: 1023-1028.

[5] Personal communication with IPPF francophone AIDS Programme Officer, Eugene Kpade.

[6] See Worth, D., 1989, 'Sexual decision-making, and AIDS: why condom promotion among vulnerable women is likely to fail', Studied in Family Planning, Vol 20 No 6: 297-306.

OBSTACLES AND OPPORTUNITIES — PUTTING SEXUALITY INTO PHC

There are a number of possible explanations for the absence of sexuality as an explicit component of planning, training or implementation of most PHC programmes. First and foremost, in many societies explicit discussion of sexual matters is taboo and sexuality is avoided within PHC because of the fear of opposition. Second, sexuality is often considered to be essentially a private matter and as such an inappropriate area for health intervention. Third, programmes dealing with sexuality are often perceived as 'luxuries' more appropriate in wealthier countries.

Programmes which do attempt to deal with sexuality bring into sharp focus questions relating to the distribution of power within a community, and demonstrate the ways in which personal values and experience influence the implementation of policies on the ground.

For example:

Some family planning programmes will have a stated policy of providing contraceptives to married people only. This is a result of the values of the policy makers and fear of the opposition who might accuse them of encouraging immorality. At the level of service delivery, some workers will give contraceptives to young unmarried women 'under the counter' while others will advise them to wait until they are married before having sex, depending on their personal values. A community worker might not give out condoms to young people because she would lose her credibility in the eyes of the parents who make up the most of her clientele and therefore income.

We are all sexual beings with strongly held values, attitudes and feelings about sexuality, living in specific cultural and political environments. Both the personal values of the policy makers and the environment will shape and control programme policies. Furthermore, the personal attitudes and values of individual workers will influence how policies are implemented. In many programmes, policy makers are older and better off men (and sometimes women), often doctors or administrators, while those interacting with clients are usually younger and poorer women.

For example:

In many countries, the majority of staff working in the community in health education or MCH and family planning are women. In a participatory PHC programme, these workers are often expected to do extra work at inconvenient hours and to focus on interpersonal communication. However, the economic and social climate affects them in the same way as other women. They may have two or three jobs which allow them to survive, and leave them no time for extra health work. They may resort to part-time sex work, or submit to sexual harassment at the workplace in order to keep a job or gain promotion. If women workers are forced to compete for male favours, they are less able to support each other in a common struggle against sexual oppression. They may feel anxious about their own sexual vulnerability and prefer to push the problem out of their minds rather than bring it up with other women in a similar situation. Workers' feelings about condoms and safer sex will also impinge on how they talk about these topics with others.

Many issues related to sexual health are emotionally charged and controversial. People who want to empower sexually oppressed groups and expand the range of sexual choices for everyone in the community are often in a minority, and people who suffer most as a result of oppressive sexual norms and behaviour are often those with least power.

A PHC programme that espouses community participation and empowerment in the context of health promotion will have to be clear about which groups in the community they are supporting and who is to set the agenda and the objectives, Is it an individual manager or worker, the organisation, a government or a donor, community leaders or a particular group in the community?

For example:

Programmes funded by USAID are not permitted to address abortion in their programme in any way. Although some workers will quietly give clients advice on where to get a safe abortion, the organisation itself cannot provide the menstrual regulation requested by its clients nor support campaigns for safe abortion services.

A worker in one branch of a Family Planning Association works with a group of gay men, uncertain as to whether the executive level of the association will allow her to continue.

The elderly male leaders of the community design messages on AIDS which portray women as the transmitters of HIV and try to motivate young people to abstain from sex through fear of shame if they are 'caught out' with an STD.

EXPLORING HOW SEXUALITY RELATES TO HEALTH

The first step in putting sexuality into PHC would be to make a comprehensive study of how sexuality relates to health in different groups and to what extent different PHC workers are already addressing sexuality in their work. Many women's health projects have found ways to address sexual issues in their work and PHC programmes could begin by seeking their advice.

Discussing sexuality is a sensitive area and workers will have to find imaginative ways of helping people to talk freely about their sexual lives and feelings. They might begin with themselves in small, single gender groups.

A detailed knowledge of people's needs in relation to their sexuality can only be gained through sensitive work with individuals, couples or small groups using the skills of active listening, open questions and non-judgemental attitudes. Trust and confidentiality are essential.

PHC workers may be able to link up with already existing networks where people talk freely about sex. These almost certainly exist in all cultures, whether in the smoke sauna, the Turkish baths or the beer bar. Usually women will talk to women and men with men, and people of the same age or marital status.

Sometimes a particular person will act as an informal sexual confidante and counsellor for a group. For example, in Morocco, the woman who collects the money at the Turkish baths will often be privy to women's sexual lives, and will listen and offer advice.[7]

In small group discussions, everyone involved in the PHC programme, from TBAs, traditional healers and chemical sellers to cleaners and managers can talk about how sexuality relates to their work and their perceptions of what is needed as well as their own feelings about sexual issues.

The study could also involve talking with key people in the community and the local services; talking to people in informal networks and tuning into 'gossip'; keeping eyes and ears open for what is going on in relationships; and visiting local health services and examining health statistics.

When the study has been completed, a comprehensive plan can be developed to meet priority needs. These will fall into different categories, some of which can be relatively easily put into place without any disagreement, and some of which may require a commitment to significant changes in policy and programme direction and a commitment to the welfare of minority or politically powerless groups.

TRAINING

Some PHC workers may be talking with people about sexuality, but would be helped by having this work validated and actively supported.

All PHC staff and community workers would benefit from in-service training to enable them to talk comfortably about sexuality, to be aware of their own anxieties and prejudices so that these do not impinge on their work in unhelpful ways, and to help others to talk about their sexual needs and practises. This training requires a participatory, experiential approach which allows people to explore their feelings and attitudes in a safe atmosphere and discuss what HIV means in their own professional and personal lives. Many trainers are used to a more factual, lecture-based approach to training and will need to develop their skills in working with groups in a more interactive way.[8]

FAMILY PLANNING

Contraception has been the responsibility of women since the advent of 'reliable' female methods and MCH and family planning services are seen as places for women. Contraception has been dominated by a male medical model, rarely taking into account how women actually feel about the methods on offer or the implications of their use. Side effects and complications are not taken sufficiently seriously and most programmes are more interested in the number of 'acceptors' and 'couple years of protection' from pregnancy than in women's satisfaction. In fact, acknowledgment of clients' feelings and sexuality at the family planning clinic could increase women's use of both the clinic and contraception.

With a few notable exceptions, condoms have been the 'poor relation' in contraception because they are used by men at the time of intercourse and are often in practise less reliable than the pill or IUCD. These disadvantages are linked to the belief that men are irresponsible and driven by an overwhelming sexual need and therefore cannot be expected to use condoms consistently and correctly. However, the use of condoms for contraception and infection prevention would enable women to plan their pregnancies without invasive methods and would make it easier for women to ask men to use condoms because the implication of infidelity does not arise.

Since the advent of AIDS, family planning programmes are increasingly asking women to persuade their partners to use condoms. Recognising the limited power of women, some programmes are developing 'seduction skills' or assertiveness training workshops to help them to do this. While these activities may be helpful to women in a general way, ultimately they reinforce gender roles as they relate to sexuality with

[7] Personal communication with Malika Ladjani, Medical Consultant, IPPF, London.

[8] IPPF has designed one, three and five day experiential training courses which are designed to familiarize staff with sexuality issues as well as HIV and STDS and to help them to interact with clients in a sensitive and non-judgemental way.

women being encouraged to take responsibility for men's sexual behaviour.

COUNSELLING

Counselling is often thought of as a highly skilled, time-consuming and emotionally demanding activity and as such, beyond the reach of a PHC programme. However, all PHC workers can learn to use basic counsellling skills to help individuals, couples and small groups to talk about problems related to their sexuality. Simply giving people space and permission to talk, offering basic information and options and suggesting other sources of help can achieve a surprisingly large step forward. Even one meeting with a group of young women can set into motion ripples of change which spread out to relatives and friends.

THE DISTRIBUTION OF CONDOMS

Education on safer sex becomes unethical when people are encouraged to use condoms but when at the same time condoms are either unavailable or unreliable. PHC programmes can develop distribution systems which reach all communities, and include education in the correct use and disposal of conditions. Social marketing programmes have the advantage that some of the cost is recovered, there is a commercial incentive to reach remote communities and advertising can promote positive images of condoms. PHC programmes could also work with local chemical sellers, young peer educators, and a range of health workers based in the community to ensure that different groups have access to condoms.

STD PREVENTION AND CONTROL

The stigma attached to having a sexually transmitted disease and the potential upset to relationships makes confidentiality a crucial issue in developing acceptable programmes. In many parts of the world, men treat themselves for STD using drugs purchased from a chemical seller living outside their community. Often they do not take the correct course of treatment because they cannot afford it or the seller prescribes incorrectly. This maintains confidentiality, but increases the growth of resistant strains of pathogens and usually leaves female partners unconsidered and untreated.

PHC workers can be trained to screen, diagnose and treat STDs using protocols without a laboratory. Enquiring about genital problems and taking a sexual history in a sensitive way can increase the rate of diagnosis and effective treatment for STDs. However, even good training and supervision may not remove concerns surrounding confidentiality in small communities. Discussions with different people in the community can help to identify helpful approaches. For example, training people who are trusted such as traditional healers or finding 'safe' locations for men and women. A distribution system for generic essential drugs covering underserved areas is needed to reduce the cost of drugs. People with STDs need counselling on the importance of correct treatment for themselves and their partners, options for safer sex and acceptable ways of achieving these goals.

COMMUNITY PARTICIPATION, HEALTH PROMOTION AND SEXUALITY

The majority of HIV prevention programmes aim to reduce the transmission of HIV by helping as many people as possible to practise safer sex.

To achieve this, many health educators design HIV prevention messages from their offices based on their personal view of the problem and its solution. This can result in messages which reflect the ideal rather than the reality of sexual behaviour. In the same way that women are usually blamed for sexually transmitted diseases, abortion and infertility, AIDS messages have tended to portray women as transmitters of HIV. Many AIDS posters advise men to avoid 'easy' women and show a girl getting into car, sex workers in bars, or a man surrounded by eager women.

Other programmes seek the 'participation' of the intended audience in order to develop more persuasive media which put across the 'messages' of the programme.

For example:

> Programme managers or staff believe that the only moral and acceptable way to reduce HIV transmission among young people is to promote abstinence. They encourge groups of young people to talk freely so that they can learn about their feelings, sexual activities and aspirations. They use this knowledge to produce a powerful drama which frightens audiences with its story of tragic consequences following a first sexual experience.

In a genuinely participatory programme, workers, as far as they are able, suspend their own values and listen with an open mind to what the different young people themselves have to say about their sexual needs generally and their options for safer sex. The programme might then respond to a range of needs including information, accessible services, condoms for those who are sexually active and the recognition and acceptance of sexual diversity, including abstinence, non-penetrative sex and same gender relationships. The young people themselves might produce a series of sketches which raise these issues, enabling other young people to discuss them more easily and become aware of services.

In this programme, staff may consider their programme successful if people have had the opportunity to explore the situation and make their own decisions about the importance of safer sex for themselves, even if some people decide that HIV prevention is not the most important consideration in their sexual lives. In this instance, it is the process which is of immediate importance rather than the behavioural outcome. In this case, the aims are concerned with empowering young people through participatory learning events to make their own informed decisions, explore their values and practise skills.

This type of programme requires a management system which is flexible, supportive of the sexual rights of less powerful groups and willing to risk opposition.

INTERSECTORAL WORK AND COMMUNITY DEVELOPMENT

In many cases, the health problems arising from sexuality can only be addressed effectively through a community development approach which operates at a number of levels and involves activities outside the normal remit of the health sector. This is particularly clear when women are obliged to exchange risky sex for economic reasons.

The wider cultural and political context of commercial sex is a major determinant of whether safer sex can be practised. In places where sex workers operate independently and can form associations, women are able to insist on safer sex, and to support each other without pressure from brothel owners or pimps. In many places, programmes will have to decide whether their objective is simply to minimise the spread of HIV in whatever way possible or to address the issue of women's human rights.

For example:

> Dr Sundara Raman Swaminathan was studying stress among prostitutes in Madras in 1986 when he became drawn into HIV prevention work by the rapidly increasing prevalence of HIV in this group. After several months he was able to have conversations with prostitutes about their needs. He quickly discovered that these girls are better described as 'sex slaves' rather than 'sex workers' because they have absolutely no control over their lives. In some brothels, each sexual encounter must be completed in under seven minutes, otherwise the girl is beaten. Safer sex invariably takes longer than unprotected intercourse, so even if a customer were to agree to safer sex, the girl might be fearful and reluctant. To ask these women to insist on safer sex with their clients would be adding to their stress and oppression.
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> Dr Swaminathan then began to work with the potential clients of the prostitutes. These men associated condoms with contraception rather than infection prevention, and were more likely to use them with their wives. Men visited prostitutes precisely so that they could engage in unprotected sex, and in some cases anal sex, for maximum friction. They also believed that AIDS as a sexually transmitted disease can be cured like any other. The programme focused at this point on educating men on the nature of AIDS, and the benefits of condoms both for contraception and STD prevention. However, it will also be necessary to work with the brothel owners to change the working environment. This will generate resistance unless a benefit such as customers preference for a 'clean' brothel can offset loss of income.[9]

This type of programme does not address the underlying denial of the human rights of the women in the brothel, many of whom were sold to the owner and are properly described as slaves. When women are subjected to violence or coercion, a range of interventions including legal action, advocacy, safe houses, forming networks of support groups for women, literacy and alternative income generation programmes are required. For PHC programmes, this will involve working with other organisations, particularly those concerned with the status of women and with particular expertise in these areas.

One such organisation is the Society for Women and AIDS in Africa (SWAA), a Pan-African organisation which is particularly concerned with gender issues and which aims to slow the spread of HIV infection in Africa.[10]

It is important that managers help workers to define their roles and limitations in any situation and to identify collaborators with the necessary skills and resources. This will require training which prepares workers for intersectoral collaboration and regular meetings to discuss and solve problems.

Income-generating programmes have been most successful when they seek to increase women's economic options and control over their lives rather than aim to 'rehabilitate' women so that they leave an 'undesirable' occupation.

> Sex workers in Zimbabwe have started gardens and other forms of income generation, so that they are not obliged for financial reasons to accept a violent

[9] 'Introducing Condoms in Madras', 1991, AIDSWATCH No 13 1st Quarter: 6.

[10] The address of SWAA is Dr Eka Williams, PO Box 2470, Calabar, Nigeria.

customer who refuses to use a condom.[11] In Thailand, EMPOWER has helped sex workers to read and write, and develop skills such as hairdressing. The sex workers have formed a theatre company which tours bars to educate customers, bar owners and sex workers about safer sex.[12]

In Eastern Nigeria, brothel owners, sex workers, health workers and researchers have been working together on an HIV prevention project which combines group discussions, awareness-raising, free condom distribution and STD services and infection control measures in the brothels.[13]

SEXUALITY WORK WITHIN THE COMMUNITY

In many situations it will be helpful to work with families and the whole community to identify options for promoting sexual health. Most people will be concerned about the protection of fertility and the strength and survival of the family and community.

Men and women of all ages need access to basic information, health care and low-cost condoms through existing PHC networks. As men are more likely to be in a position of social, economic and sexual power, there is a particular need to increase their awareness of their responsibility and infuence in the practise of safer sex.

Often it will be helpful to work with groups of men and women separately to understand their differing needs and perceptions. On the basis of this work, programmes can then be developed to facilitate a dialogue between the two groups.

The majority of people in a district will be vulnerable to some health problems relating to their sexuality and, with the advent of HIV, the commonplace enjoyment of sexuality can have fatal consequences. However, within a district, some people may be in situations which put them at greater risk than others. Often this is because of their relatively powerless status and lack of resources, but it may also be related to a particular culture. For example, people at risk might be sex workers owned by men; sexual cultures which result in frequent partner change, men living away from home or people without access to affordable STD treatment. PHC programmes may decide to work with such situations as a priority, recognising that this will require a heavy commitment of resources.

PHC staff could work with teachers, youth workers and family members who traditionally provide sex education. Working together with young people, they could develop a sex education programme for all young people in the district. If necessary, they could train peer educators to reach other young people with basic information about sexuality and health, and activities to help young people develop confidence and skills. This work could lay the foundation for a new understanding and equality in sexual relationships as well as the acceptance of safer sex as normal behaviour.

CONCLUSIONS

Integrating sexuality within PHC in the explicit ways suggested in this article could have profound and far-reaching consequences. If nothing else, it would highlight the ways in which existing power relations between men and women, generations, and people with different sexual orientations have severely detrimental effects upon the health of the whole community.

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[11] Wilson, D., 1990, 'Unpublished paper presented at FHI/IPPF meeting on HIV prevention and marginalised groups held at Regent's College, September 1990.

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