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1. New Perspectives on Sexual Health

This chapter elaborates on the origin, meaning, and use of the term 'sexual health'. To do this it is necessary to also discuss terms that have been frequently used in texts which include 'sexual health'– namely 'reproductive health', 'reproductive rights', and 'sexual rights'. Distinctions between reproductive health and sexual health, and between sexual health and sexual rights are provided. All four terms –'reproductive health', 'sexual health', 'reproductive rights', and 'sexual rights' – are relatively new in local, regional, national, and international discourse; their use has emerged primarily within the last three decades. In the 1990s these terms became common in international texts but popular use of these words has varied and continues to vary greatly by country and context. After I give a brief history of the origin and meanings of these terms and how they are used here, it will be clear how these definitions determine the content of this book. This chapter concludes with an introduction to aspects of sexual health in Finland and a brief discussion of the implications of a rights approach to sexual issues.

Reproductive Health and Reproductive Rights

According to Correa (1997), members of organisations concerned about population problems and the health of new mothers and their babies in developing countries adopted the term 'reproductive health' in the 1980s and early 1990s. These include women's health organisations, the World Health Organization, family planning organisations and institutions providing maternal care. Women promoted the use of the term 'reproductive health' in order to emphasise an approach to family planning which included considerations of women's needs and views in contrast to the previous approach which focused primarily on population control. Women's activists wanted the interests of women to be taken into account in population policies. For many poor women in developing countries, such policies had failed to acknowledge, for example, the degree to which having children is linked to social status, religious views, and other pressures (Freeman and Isaacs 1993).

Correa (1997) emphasises that the term 'reproductive rights' was adopted by women's groups and other non-governmental organisations in the 1970s and 1980s in their struggle to make and/or keep abortion safe and legal and to promote women's access to safe contraception. In 1978, for example, the Women's Global Network for Reproductive

Rights (WGNRR) was founded with its headquarters in Amsterdam. This organisation is an autonomous network of groups and individuals in every continent, including 113 countries, working for and supporting reproductive rights for women. According to this network, reproductive rights refer to "women's right to decide whether, when, and how to have children. This means the right and access to: full information about sexuality and reproduction, about reproductive health and health problems ... good quality, comprehensive health services that meet women's needs and are accessible to all women; safe effective contraception and sterilisation; safe, legal abortion; safe women-controlled pregnancy and childbirth; and prevention of and safe, effective treatment for the causes of infertility" (Back cover of each WGNRR Newsletter). Articles in the newsletters typically focus on health problems associated with pregnancy, contraception, and abortion. Nevertheless, because of the overlap of issues relating to both sexuality and reproduction, topics that affect women's sexuality are also covered such as female genital mutilation, prostitution, and sexual abuse and assault.

At the 4th International Women and Health Meeting in Amsterdam in 1984 feminists from various parts of the world agreed that the use of the term 'reproductive rights' would promote their goals of improving the reproductive aspects of women's lives throughout the world. After that conference, numerous books and articles with either the term 'reproductive rights' or 'reproductive choice' in their titles were published (e.g., Boland and Rahman, 1997; Cook and Fathalla, 1996; Correa and Petchesky, 1994; Dixon-Mueller, 1993b; Hardon, Mutua, Kabir and Enngelkes, 1997; Hardon and Hayes, 1997; Hartmann, 1995; Hayes and Hardon, 1996; Rahman and Pine, 1996). At this same time, feminist lawyers joined family planning professionals and human rights activists to place women's reproductive health needs within a human rights and health rights framework (Cook, 1993, 1995; Correa, 1997; Packer, 1996).

Although the term 'reproductive rights' was not used, some of the principles of such rights have been acknowledged in documents of the United Nations, starting with the Teheran Declaration. A document written at the 1968 International Conference on Human Rights in Iran states that parents have the basic human right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information. These two rights were extended to individuals in the World Population Conference at Bucharest in 1974. The right to 'control one's own body' was first formally accepted by an international meeting in the 1993 United Nations World Conference on Human Rights in Vienna. In addition, in the Vienna Declaration, violence against women was acknowledged as a human rights abuse.

Major advances in the scope of reproductive rights were also achieved at the 1994 International Conference on Population and Development in Cairo and at the 4th World Conference on Women in Beijing in 1995. Planners and participants of the Cairo conference shifted the focus from one that had been concerned primarily with population control to one that made the well-being of individuals and their rights a priority for

economic development. The use of the word 'rights' was considered an important strategic move that would promote advocacy for and acceptance of more comprehensive reproductive health and education services. This paradigm shift also included a major redefinition of reproductive health. Although traditional services – such as those concerned with maternal health and family planning–were still considered important, the meaning of reproductive health was extended to include health problems and rights related to sexuality. The Programme of Action of the Cairo conference states that reproductive health "implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so" (United Nations, 1996, p.1). The document goes on to say that reproductive health "includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases." (p.1) In the new approach, agreed upon by 184 governments, sexual health is considered a vital part of a person's physical and psychological well being. This was the first time that an international document explicitly acknowledged the importance of sexuality in people's lives.

It is important to note that members of the Nordic delegation to Cairo were major promoters of getting the term 'sexual health' in the Programme of Action. Although they were unable to also have 'sexual rights' included, progress had been achieved when the terms 'reproductive rights' and 'sexual health' were retained. Correa (1997, p. 108) notes that the use of the term 'sexual rights' did not even come up for consideration until "practically the eve of Cairo". In Beijing one year later, the term 'sexual rights' was again discussed but still was not officially incorporated into the conference documents. Nevertheless, important references to women's sexual well-being were stated in the Platform of Action. For example, Paragraph 96 (Correa, 1997, p.109) states, "The human rights of women include their right to have control over and decide freely and responsibly on matters related to sexuality, including sexual and reproductive health, free of coercion, discrimination, and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect of the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences." Thus, the Beijing documents are significant because they mark the first international consensus on recognising the principle of sexual rights.

Since the Cairo and Beijing conferences, international organisations including the World Health Organization, the International Planned Parenthood Association, the United Nations Population Fund, and the World Association of Sexology as well as many national, regional and local organisations have tried to expand upon and implement the programs these conferences endorsed. The United Nations sponsored workshops and supported the publication of a series of reports about the conference issues, including "Reproductive Rights and Reproductive Health: A Concise Report" in 1996.The World Health Organization (WHO) identified sexual and reproductive health as one of its four priorities and provided country and regional co-ordinators with useful guidelines and

information to facilitate needs assessment and service provision. In addition, a meeting attended by regional, national, and international experts in family planning was held on "Operationalising Sexual and Reproductive Health". As a result the following problem areas of sexual and reproductive health were highlighted: aspects of couple relationships, including safer sex practices; unwanted pregnancy; maternal mortality; sexually transmitted diseases, HIV/AIDS; unsafe abortion; infertility; violence against women, female genital mutilation; and special population groups such as adolescents, the poor and marginalised (International Planned Parenthood Federation, 1995). Recommendations involved the following activities: advocacy, information, education, communication, service delivery, evaluation, and research. The United Nations Population Fund (UNFPA) published "The Right to Choose: Reproductive Rights and Reproductive Health" in 1997 which includes sections on rights, empowerment and development; rights for sexual and reproductive health; sexual and reproductive self-determination; and reproductive health and sustainable development. In 1998, ENTRE NOUS, a publication of UNFPA and WHO, added the word 'sexual' to its subtitle, which now reads "The European Magazine for Reproductive and Sexual Health". These examples represent only a small proportion of the recent use in international contexts of the terms 'sexual and reproductive health' and 'reproductive rights.

More needs to be said about the International Planned Parenthood Federation (IPPF). According to its web page (www.ippf.org), IPPF links autonomous national family planning associations in over 150 countries world-wide. IPPF has been an aggressive promoter of the programs initiated in Cairo and Beijing. Soon after these conferences IPPF was quick to supply its regional and national member organisations with materials and information to help them widen the scope of their activities to include health problems and concerns related to sexuality. These materials include "Sexual and Reproductive Health, Family Planning Puts Promises into Practice" (1995), "Charter on Sexual and Reproductive Rights" (1996), and "Sexual and Reproductive Rights, A New Approach with Communities" (1997). Their booklets on sexual and reproductive rights are especially significant because they contain the 12 basic rights IPPF believes are implied by the documents produced by international consensus at the conferences in Vienna, Cairo, and Beijing as well as the 1995 UN World Summit for Social Development in Copenhagen. These are listed in Table 1. The purpose of including the explanation of these rights in a guideline booklet prepared by IPPF is to "increase the capacity of Family Planning Organisations and other non-governmental organisations to undertake effective advocacy within the field for sexual and reproductive health" (Newman, 1997). In order to guide social policy and hold governments responsible for enabling people to exercise their sexual and reproductive rights, the meaning and interpretation of these rights must be clear. The guidelines help clarify these meanings and provide numerous illustrations of how each of the rights is linked to sexual and reproductive health. For example, the 'right to privacy' means that all individuals, including adolescents, have the right to confidentiality when seeking sexual and reproductive health care services. The IPPF guidelines also illustrate how each right can be violated. The prohibition of access to

sex education and information to adolescents is an example of how the 'right to information and education' is violated.

Table 1

SEXUAL AND REPRODUCTIVE RIGHTS as formulated by the INTERNATIONAL PLANNED PARENTHOOD FEDERATION

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1. The Right to Life

IPPF claims that the right to life applies to, and should be invoked to protect, women whose lives are currently endangered by pregnancy.

2. The Right to Liberty and Security of the Person

IPPF claims that the right to liberty and security of the person applies to, and should be invoked to protect, women currently at risk from genital mutilation, or subject to forced pregnancy, sterilisation or abortion.

3. The Right to Equality and to be Free from all Forms of Discrimination

IPPF claims that the right to equality and to be free from all forms of discrimination applies to, and should be invokes to protect, the right of all people, regardless of race, color, sex, sexual orientation, marital status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status, to equal access to information, education and services related to development, and to sexual and reproductive health.

4. The Right to Privacy

IPPF claims that the right to privacy applies to, and should be invoked to protect, the right of all clients of sexual and reproductive health care information, education and services to a degree of privacy, and to confidentiality with regard to personal information given to service providers.

5. The Right to Freedom of Thought

IPPF claims that the right to freedom of thought applies to, and should be invoked to protect, the right of all persons to access to education and information related to their sexual and reproductive health free from restrictions on grounds of thought, conscience and religion.

6. The Right to Information and Education

IPPF claims that the right to information and education applies to, and should be invoked to protect, the right of all persons to access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that any decisions they take on such matters are made with full, free and informed consent.

7. The Right to Choose Whether or Not to Marry and to Found and Plan a Family

IPPF claims that the right to choose whether or not to marry and to found a family applies to, and should be invoked to protect, all persons against any marriage entered into without the full, free and informed consent of both partners.

8. The Right to Decide Whether or When to Have Children

IPPF claims that the right to decide whether or when to have children applies to, and should be invoked to protect, the right of all persons to reproductive health care services which offer the widest possible, affordable, acceptable and convenient services to all users.

9. The Right to Health Care and Health Protection

IPPF claims that the right to health care applies to, and should be invoked to protect, the right of all persons to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.

10. The Right to the Benefits of Scientific Progress

IPPF claims that the right to the benefits of scientific progress applies to, and should be invoked to protect, the right of all persons to access to available reproductive health care technology which independent studies have shown to have an acceptable risk/benefit profile, and where to withhold such technology would have harmful effects on health and well-being.

11. The Right to Freedom of Assembly and Political Participation

IPPF claims that the right of freedom of assembly and political participation applies to, and should be invoked to protect, the right to form an association which aims to promote sexual and reproductive health and rights.

12. The Right to be Free from Torture and Ill Treatment

IPPF claims that the right to be free from torture and inhuman or degrading treatment applies to and should be invoked to protect children, women and men from all forms of sexual violence, exploitation and abuse.

Those attending five-year follow-up meetings to evaluate progress in achieving the goals of the programmes of action of Cairo and Beijing reaffirmed commitments to continue the approaches agreed upon at those mid 1990s conferences. In particular, the humans rights context for sexual and reproductive health and rights was again endorsed. Reports and documents from numerous NGOs revealed that language and concepts considered new and difficult in the original conferences were now generally understood and being used to guide programs in sexual and reproductive health. One of the documents presented at the Cairo follow-up meeting in The Hague was a Nordic Resolution on Adolescent Sexual Health. In this resolution, developed by the five Nordic countries, specific ways to promote the sexual health of adolescents are described and linked to sexual rights. Another paper stressed the need to devote more attention to the enactment of laws that would protect sexual and reproductive rights.

Sexual Health and Sexual Rights

In the examples cited so far, the word ‘sexual’ has almost always been used together with ‘reproduction’, as in ‘sexual and reproductive health’ or ‘sexual and reproductive rights’. In fact, at Cairo, sexual health was defined as part of reproductive health. There are some sexuality and health professionals who have separated the two terms. For example, some educators have used the term ‘sexual health’ since the 1980s, even though the use of this term was popularised only in the 1990s. So now I discuss the use of the terms ‘sexual health’ and ‘sexual rights’ without the addition of ‘reproductive’.

The terms ‘sexual health’ and ‘sexual well-being’ can be found in documents of the WHO from the 1970s and 1980s. The definitions of these terms have been vague and ambiguous. For example, one WHO definition of ‘sexual health’ is “the integration of physical, intellectual, and social factors which enriches and strengthens personality, communication and love“ and that of ‘sexual well-being’ is “the identification of sexual versatility and individuality in the sexual experiences and needs of each society and its members“ (in Advisory Committee on Health Education, p. 27, 1989). Helfferich (1996) states that the aim of such definitions is not to describe a real state of health, but to formulate an ambitious ideal that will encourage governments to create conditions conducive to health, including political and economic empowerment that allow people to make free and informed decisions relating to their health.

After the Cairo conference in 1994 family planning organisations and professionals in the health field have also more frequently used the term ‘sexual health’ in their publications. A review of articles published in five major family planning journals over the 12 year period from 1980 to 1991 revealed that less than 4% of publications discussed topics that related to sexuality and/or gender-power dynamics (Dixon-Mueller, 1993a). Now references to sexuality and gender are common. In 1996 the editor of “Planned Parenthood in Europe“ changed the name of his journal to “CHOICES, Sexuality and Family Planning in Europe“. The theme of a subsequent issue of this journal was “Sexual Health Today“. Also in 1996, the first African conference on sexual health was held in Ghana (Nair, 1997). In 1997, a doctor who specialises in sexually transmitted diseases from the New York University Medical Center launched a new magazine, called SEXUAL HEALTH. The purpose of this magazine is to “provide the best available information about all matters sexual and open a new dialogue about the breadth of human sexuality in an effort to make sex safer and more satisfying for everyone.“ (Premiere Issue, pp.2-3, 1997). At a 1997 symposium organized by the Japan Family Planning Association and the Japan Federation of Sexology, Barbara Axelson from Sweden and president of the IPPF’s European Network, was a major speaker. Her talk included a focus on sexuality and the importance of sexual enjoyment. She emphasised that in Scandinavia, people accept responsible sexual expression as a significant human value for the entire life cycle. She went on to say that the three conditions necessary for an individual’s sexual enjoyment were a loving partner, sexual knowledge and contraceptives. She also said that cultures with supportive rather than restrictive sexual ideologies can best promote sexual health and well-being (JOICEP, 1997). In 1998 the journal “Genitourinary Medicine“ changed its name to “Sexually Transmitted Infections“ – with the subtitle next to it “The Journal of Sexual Health and HIV“. It is advertised as one of the leading journals in the sexual health field and as the oldest journal in the field of sexual health issues.

In addition to the trend for family planning organisations to consider sexual health issues as important, sexuality organisations have increasingly used the terms ‘sexual

health' and 'sexual rights' in their texts. The Swedish Association for Sex Education together with the Danish Family Planning Association published a booklet entitled "Sexual Rights of Young Women in Denmark and Sweden" (Lindahl, Vikorsson and Rasmussen, 1995). The 1998 IVth Congress of the European Federation of Sexology included 'Health, Well-Being, and Sexuality' as one of its five themes for paper topics. The Eastern Region of the Society for the Scientific Study of Sexuality in the USA devoted its entire 1998 eastern region meeting to the topic of sexual health. Additional examples could be cited but we give just one more. The 1997 World Congress of Sexology in Valencia focused on the theme of 'Sexuality and Human Rights'. Major plenaries involved a discussion of sexual rights for special population groups. As a result of this Congress, the Valencia Declaration of Sexual Rights was written. This document, updated at the more recent meeting in Hong Kong, is important for an understanding of sexual health and sexual rights and is presented in Table 2.

Table 2.

Declaration of Sexual Rights of the World Association for Sexology

Sexuality is an integral part of the personality of every human being. Its full development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love.

Sexuality is constructed through the interaction between the individual and social structures. Full development of sexuality is essential for individual, interpersonal, and societal well being.

Sexual rights are universal human rights based on the inherent freedom, dignity, and equality of all human beings. Since health is a fundamental human right, so must sexual health be a basic human right. In order to assure that human beings and societies develop healthy sexuality, the following sexual rights must be recognized, promoted, respected, and defended by all societies through all means. Sexual health is the result of an environment that recognizes, respects and exercises these sexual rights.

The right to sexual freedom. Sexual freedom encompasses the possibility for individuals to express their full sexual potential. However, this excludes all forms of sexual coercion, exploitation and abuse at any time and situations in life.

The right to sexual autonomy, sexual integrity, and safety of the sexual body. This right involves the ability to make autonomous decisions about one's sexual life within a context of one's own personal and social ethics. It also encompasses control and enjoyment of our own bodies free from torture, mutilation and violence of any sort.

The right to sexual privacy. This involves the right for individual decisions and behaviors about intimacy as long as they do not intrude on the sexual rights of others.

The right to sexual equity. This refers to freedom from all forms of discrimination regardless of sex, gender, sexual orientation, age, race, social class, religion, or physical and emotional disability.

The right to sexual pleasure. Sexual pleasure, including autoeroticism, is a source of physical, psychological, intellectual and spiritual well being.

The right to emotional sexual expression. Sexual expression is more than erotic pleasure or sexual acts. Individual have a right to express their sexuality through communications, touch, emotional expression and love.

The right to sexually associate freely. This means the possibility to marry or not, to divorce, and to establish other types of responsible sexual associations.

The right to make free and responsible reproductive choices. This encompasses the right to decide whether or not to have children, the number and spacing of children, and the right to full access to the means of fertility regulation.

The right to sexual information based upon scientific inquiry. This right implies that sexual information should be generated through the process of unencumbered and yet scientifically ethical inquiry, and disseminated in appropriate ways at all societal levels.

The right to comprehensive sexuality education. This is a lifelong process from birth throughout the lifecycle and should involve all social institutions.

The right to sexual health care. Sexual health care should be available for prevention and treatment of all sexual concerns, problems and disorders.

Sexual Rights are Fundamental and Universal Human Rights

Distinctions: Sexual Health vs Reproductive Health and Sexual Health vs Sexual Rights

Long time consultant for the IPPF Evert Ketting (1996) has advocated a separation of sexual and reproductive health areas. He states that the decision in Cairo to incorporate sexual health as an aspect of reproductive health was done in part to legitimise and make less controversial services related to sexuality. Ketting would like to see sexual well being or sexual health considered worthy of attention on its own. Ketting defines reproductive health problems as "medical problems related to pregnancy, childbearing and infancy" (1996, p.1), whereas sexual health involves "helping people to gain full control of their own sexuality and to enable them to accept and enjoy it to its full potential. It is not primarily about diagnosis, treatment, or medical care but about lack of knowledge, self-acceptance, identity, communication with partner and related issues" (1996, p.1). Ketting further states that because of the different nature of sexual and reproductive health problems that health providers can offer more effective services and programs if they are considered separately. In addition, he notes that for much of Europe, maternal and infant mortality and morbidity rates and health complications due to illegal abortions are minimal, whereas sexual problems caused by lack of information, knowledge, and education are common. Areas that especially need attention in Europe involve problems with sexual identity, communication with and empathy toward one's partner, and sexual abuse and coercion. In fact, many European family planning organisations are becoming sexual health institutions. In Finland, the need to deal with sexual health problems has been acknowledged and the name of the former Family Planning Clinic in Helsinki was changed in 1996 to Sexual Health Clinic (Väestöliitto, 1997).

Others have also made distinctions in the definitions of sexual health and reproductive health. For example, Klouda (1996) stated that while sexual health depends on, and always relates to relationships, reproductive health has to do with reproductive organs, fertility, clinical services and illness. WHO's current definition of sexual health is "the integration of the physical, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching, and that enhance personality, communication, and love...every person has a right to receive sexual information and to consider sexual relationships for pleasure as well as for procreation" (www.siecus.org). The Sexuality Information and Education Council of the United States (SIECUS, www.siecus.org) has formulated the following definitions – **Sexually Healthy Adult**: Sexually Healthy Adults appreciate their body, take responsibility for their behaviours, communicate with both sexes in respectful ways, and express love and intimacy consistent with their own values. SIECUS has worked with non-governmental organisations around the world to develop a consensus about this definition and in such different countries as Brazil, Nigeria, Russia and the United States, groups have affirmed a similar vision. **Sexually Healthy Relationship**: A sexually healthy relationship is based on shared values and has five characteristics: it is consensual, non-exploitative, honest, mutually pleasurable, and protected against unintended pregnancy and sexually transmitted diseases including HIV/AIDS. **Sexual Rights**: The rights of individuals to have the information, skills, support and services they need to make responsible decisions about their sexuality consistent with their own values. These include the right to bodily integrity, voluntary sexual relationships, a full range of voluntary accessible sexual and reproductive health services, and the ability to express one's sexual orientation without violence or discrimination.

Based on the background information provided above I now present the definition of sexual health used in this book. I agree with Ketting that sexual health and reproductive health have different areas of focus. Nevertheless, there are areas of overlap between the two. For example, sexually transmitted diseases can impact one's sex life including one's enjoyment of sexuality and therefore one's sexual health. But sexually transmitted diseases such as chlamydia, syphilis, herpes and HIV/AIDS can also have a negative impact on a woman's reproductive health by limiting her fertility or harming the health of her new born infant. The ability to control the timing and spacing of children, an aspect of reproductive health, depends on having access to safe and effective contraceptives. The ability to enjoy one's sexuality, an aspect of sexual health, also depends on being able to experience sex without the fear and worry of an unwanted pregnancy. Because of this overlap there is an argument for combining sexual health and reproductive health. Furthermore, many in the family planning and health fields believe that using the words sexual and reproductive together can widen the scope of and legitimise services and education to include more comprehensive coverage of both sexual and reproductive matters. Nevertheless, the major part of this book includes topics that relate to the forthcoming definition of sexual health. I should also add that an

argument could be made to define reproductive health as part of sexual health rather than the reverse view currently expressed in international documents that sexual health is a part of reproductive health. Sex can be considered to have a variety of purposes and reproduction is only one among several. Indeed, many social scientists have emphasised that the trend in the 20th century was to move from an ideology of procreational sex to one whose purpose is recreation or the promotion of intimacy in relationships (e.g., see Gill, 1977). Most would agree that the majority of sexual acts (including, of course, self-masturbation) are not for reproductive purposes. Certainly, the use of the term reproductive health excludes sexual health issues for gays and lesbians.

Next I present the definitions of sexual health and sexual rights that guided the framework for this book. I use slightly modified definitions prepared by a subgroup of the International Women's Health Coalition with the name HERA, which stands for Health, Empowerment, Rights and Accountability (www.iwhc.org/hera.index.html). This group was active in promoting the agreements reached in Cairo and Beijing and has continued to work together to advocate for and help implement the action programs of these two conferences. **SEXUAL HEALTH** is the ability of women and men to enjoy and express their sexuality and to do so free from risk of sexually transmitted diseases, unwanted pregnancy, coercion, violence and discrimination. In order to be sexually healthy, one must be able to have informed, enjoyable and safe sex, based on self esteem, a positive approach to human sexuality, and mutual respect in sexual relations. Sexually healthy experiences enhance life quality and pleasure, personal relationships and communication, and the expression of one's sexual identity. As stated in a HERA Action Sheet (www.iwhc.org/hera.index.html), "sexual health is fundamental to the development of one's full potential, to the enjoyment of human rights and to an overall sense of well-being. By endorsing sexual health for all, legal, health and educational systems build a strong foundation for preventing and treating the consequences of sexual violence, coercion, and discrimination." **SEXUAL RIGHTS** are "a fundamental element of human rights. They encompass the right to experience a pleasurable sexuality, which is essential in and of itself and, at the same time a fundamental vehicle of communication and love between people. Sexual rights include the right to liberty and autonomy in the responsible exercise of sexuality" (www.iwhc.org/hera.index.html). These statements by HERA of course state ideal generalities and are subject to ambiguous interpretations but we present them here because the value of sexual health and sexual rights has only recently been acknowledged by an international consensus. HERA also provides a more comprehensive and yet still somewhat vague listing of what sexual rights include (see Table 3). The content of the lists of rights by the international organisations – namely by IPPF, the World Association of Sexology, and HERA – provides evidence of the international trend to value sexual relationships with particular characteristics. A list of ten ways to promote sexual health was given by Eli Coleman, current president of the World Association of Sexology, at a plenary talk in Valencia in 1997 (see Table 4). I hope that the

lists concerning sexual rights and sexual health will encourage discussions in educational and health settings. Knowledge of such rights should contribute to efforts to promote the realisation of these rights at both the personal and societal level. In addition, the lists of sexual rights and ways to promote sexual health can be used as the basis for formulating more precise evaluation mechanisms of sexual health services and educational programs for various populations in different geographical areas.

Table 3.

COMPONENTS OF SEXUAL RIGHTS AS LISTED BY HERA

1. The right to happiness, dreams and fantasies.
2. The right to explore one's sexuality free from fear, shame, guilt, false beliefs and other impediments to the free expression of one's desires.
3. The right to live one's sexuality free from violence, discrimination and coercion, within a framework of relationships based on equality, respect and justice.
4. The right to choose one's sexual partners without discrimination.
5. The right to full respect for the physical integrity of the body.
6. The right to choose to be sexually active or not, including the right to have sex that is consensual and to enter into marriage with the full and free consent of both people.
7. The right to be free and autonomous in expressing one's sexual orientation.
8. The right to express sexuality independent of reproduction.
9. The right to insist on and practice safe sex for the prevention of unwanted pregnancy and sexually transmitted diseases, including HIV/AIDS.
10. The right to sexual health, which requires access to the full range of sexuality and sexual health information, education and confidential services of the highest possible quality.

Note. HERA is an international group of women's health activists working together to implement strategies that promote sexual and reproductive rights and health throughout the world

Table 4.

TEN WAYS TO PROMOTE SEXUAL HEALTH BY ELI COLEMAN

1. Offer comprehensive sexuality education throughout the life span.
2. Include comprehensive sexuality education for health professionals and educators.
3. Carry out needed research in child and adolescent sexuality.
4. Overcome homophobia, biphobia, and transphobia.
5. End sexism.
6. End sexual violence.
7. Promote masturbation.
8. Promote sexual functioning.
9. Create better access to sexual health care.
10. Recognise sexual health as a basic human right.

Note. Eli Coleman is currently president of the World Association of Sexology (WAS).

Because most of the new views about sexual health and sexual rights expressed in the aforementioned definitions and lists reached an international consensus largely due to the efforts of women's health and feminist advocates, conference documents provide a more thorough description of sexual health needs and sexual rights issues relating to women than to men. The approach here is to consider issues and problems that concern everyone – men and women. In taking this inclusive approach, it is stressed that there are multiple sources of inequality and that gender is only one such dimension. The needs of many special populations have to be considered, such as the poor and marginalised, non-heterosexuals, ethnic and racial minorities, the disabled and the institutionalised. In addition, the major focus of this book is not on reproductive health where women's health needs require special considerations and resources. Thus, an egalitarian perspective on sexual health and sexual rights is intended here.

I make one final point about sexual health definitions. There are a few who warn against attempts to define 'sexual health'. Helfferich (1996, p.2) emphasises that health is a normative concept and asks whether the term 'sexual health and reproductive health' will become the "new normative straight jacket". She also calls for discussions on the meanings and implications of these concepts and I hope that this book contributes to these clarifications. The German sexologist Gunter Schmidt (Coleman, 1998) believes that these health definitions prescribe what is healthy or proper sex and in that way may be promoting only a certain type of sex that is socially desirable. He notes – and of course is correct – that all definitions are social constructs and that linking the term health to sexuality will encourage people to regard definitions and explanations of sexual health as medical truths.

Sexual Enjoyment and Pleasure as Components of Sexual Health

I want to emphasise an additional aspect of the new approach to sexuality that was endorsed by international consensus. The new view of sexual health recognises the importance of sexual pleasure or sexual enjoyment to a person's well-being and health. What is remarkable is the variety of sources that within a decade came to endorse this point and I give a few examples. In an article entitled "The Sexuality Connection in Women's Reproductive Health", Dixon-Mueller (1993a) proposed an analytic framework which links four dimensions of sexuality to reproductive health. In this framework, sexual enjoyment is one element of sexual health. The importance of sexual pleasure to health is also emphasised by Basso (1993) in a book published by the Pan American Health Organization (PAHO) of the WHO. Basso has been Co-ordinator of joint work in sexual and health education carried out by the PAHO, and she has also been active in Uruguay to formulate national curricula for sex education programs. She has been involved with health care practices, sex education, and working groups of women,

men, couples, and adolescents for more than two decades. Basso believes that sexuality has been relegated to a marginal position in health programs despite the fact that sexuality is an intrinsic part of the life course. Basso (1993, p. 113) writes "As a source of pleasure and well-being, it is personally enriching, and has far-reaching repercussions for the family and society as well." She further notes that sexual expression contributes to one's capacity to love, to bond with others, to communicate feelings, and it is a source of creativity, pleasure, and personal enrichment. She argues for a reciprocal relationship between health and sexuality. In her view, comprehensive health could not be achieved for people without a "harmonious development of their sexuality" and a satisfying sexual development could not be possible if other aspects of physical and psychological health are not attended to.

Canada provides another example. In that country in the early 1990s committees and working groups agreed that there is a great need in their country to make sex education more comprehensive and accessible. In response to this need government funding was provided to produce a booklet to describe the Canadian guidelines for sexual health education. In these guidelines sexual health is acknowledged as a major aspect of personal health that affects people at all ages. The goals of sexual health education are "to help people achieve positive outcomes (e.g., self-esteem, respect for self and others, non-exploitative sexual satisfaction, rewarding human relationships, the joy of desired pregnancy and to avoid negative outcomes" (Ministry of Supply and Services, 1994, p.5). "The terms 'sexual health' and 'healthy sexuality' are widely used in federal, provincial and local health promotion initiatives to support the positive integration of sexuality and the prevention of sexual problems, at all stages of people's lives." (p.4).

Feminist literature also links sexual rights to sexual enjoyment. Correa and Petchesky (1994, p.113) stress that the "principle of bodily integrity or the right to the security in and control over one's body, lie at the core of reproductive and sexual freedom." This means that women need to be protected against policies and situations that involve sexual violence, genital mutilation, denial of access to information and birth control, coerced marriage and child-bearing, and prohibitions against homosexuality. Correa and Petchesky further state that "bodily integrity also involves affirmative rights to enjoy the full potential of one's body – for health, procreation, and sexuality" (p.113). These feminists – one from Brazil and the other from the United States – emphasize that the boundaries among health, sexuality and human rights issues are dissolving throughout the world. They point out that not only in industrialised countries of the North but also in Latin America, Africa and Asia, phrases like 'the right to sexual pleasure' and 'sexual self-determination' appear in policy statements and strategy documents of women's health and family planning organisations. In this regard, it is worthwhile to note that of the 24 active members of HERA almost all were from less developed countries including Bangladesh, Argentina, Peru, Mexico, Cameroon, South Africa, Nigeria, Kenya, Pakistan, and India.

Research Support for Sexuality and Health Linkages

Research findings have supported the connection between sexuality and positive health outcomes. Some of this research was inspired by studies that indicated that touch deprivation causes irreversible damage and even death for young children (Colton, 1983; Montague, 1978). Spitz (1947) reported that good nutrition, medicine and clean surroundings were not enough to ensure the survival of infants and toddlers deprived of touch in orphanages. The studies of Harlow in the United States in the 1960s and 1970s confirmed the negative health consequences of touch deprivation for young monkeys. More recent research has shown that lack of touch causes permanent neurological damage and chemical imbalance, whereas wanted touch has positive health outcomes (Hatfield, 1994). Some researchers (e.g., Prescott, 1975) argue that severe touch deprivation as an infant/young child inhibits one's ability to form healthy intimate adult relationships, hinders the development of empathy, and promotes sexually abusive and assaultive behaviour. These touch studies are relevant here because sexual expression includes touching and many receive pleasure from being held and caressed. Touch therapy is a major technique used by sex therapists to help individuals and couples who come to them for help with sexual problems.

Within the last decade research findings by those in the sexuality and health fields has also found evidence linking sexual behaviour and health. David (1994, p. 345), former Director of the World Health Foundation for Mental Health in Geneva wrote, "research in Denmark and elsewhere has shown that successful fertility regulation heightens adaptive abilities and coping abilities. Good contraceptive control makes for good family health and thus good mental health." Another researcher for the WHO, Odile Frank (1994) reported the results of studies on mental health and female sterilisation in five countries. Women in the sterilisation groups reported improved sexual satisfaction and improved relationships with their husbands due to removal of the fear of unwanted pregnancy. Frank illustrated how sexual behaviour both directly and indirectly influences health. Effects include sexually transmitted diseases, unwanted pregnancies, and emotional and mental problems due to sexual dysfunctions. The results of a longitudinal study reported in the British Medical Journal support the view that sexual activity involving orgasms has a protective effect on men's health (Smith, Frankel, and Yarnell, 1997). Mortality risk from coronary heart disease was 50% lower in a group with high orgasmic frequency compared to one with low orgasmic frequency. Although the researchers in this study acknowledge the complex nature of causal inferences, they emphasize that if the findings are replicated, there would be clear implications for health promotion and prevention programs. Apt, Hulbert, Pierce, and White (1996) found that compared to married women with low sexual satisfaction, married women with high sexual satisfaction reported higher degrees of life satisfaction and fewer symptoms of psychological distress such as somatisation, depression, anxiety, and anger/hostility. Two recently published

books provide additional evidence of the sexuality and health links: "The Science of Love, Understanding its Effects on Mind and Body" by Anthony Walsh (1996) and "Love and Survival, The Scientific Basis for the Healing Power of Intimacy" by Dean Ornish (1998). Walsh, a sociologist and criminologist, focuses on how human neurophysiology, the endocrine system and areas of the brain are affected by touching. He also discusses the ways that love and touch influence physical and mental health and lawlessness. Ornish, a medical doctor, includes a long chapter describing the results of specific studies that support the intimacy and health connection. He states (p .3) "Love and intimacy are at a root of what makes us sick and what makes us well, what causes sadness and what brings happiness, what makes us suffer and what leads to healing. If a new drug had the same impact, virtually every doctor in the country would be recommending it for their patients. It would be malpractice not to prescribe it – yet, with few exceptions, we doctors do not learn much about the healing power of love, intimacy, and transformation in our medical training. Rather, these ideas are often ignored or even denigrated." In this discussion, there is the danger of overvaluing relationships and perhaps encouraging people to stay in abusive or unhappy ones. If sexual relationships become a symbol of health, then people preferring single lifestyles may feel stigmatised by this choice. In addition, some may argue that the stressful aspects of relationships, including break-ups, often contribute to serious mental health problems. Nevertheless, for the majority of people, healthy sexual relationships do add significantly to the quality and happiness of their lives, at least for major life periods.

Finland's Approach to Sexuality

For the past three decades Finland has taken a health rather than a moralistic approach to social problems that relate to sexual behaviour. Health care is recognised as a right in Finland, and thus many sexual health services are readily available to its citizens. The authorities contributing to this book illustrate how their country has attempted to improve the quality of its sexual health information and services. Co-operation and co-ordination among providers of health, education and social services have greatly aided these efforts. Other factors that have promoted sexual health have been the lack of official restrictions on both sex education and the distribution of contraceptives and the support of the state church with respect to many sexual policy issues.

The Parliament of Finland has ratified the following four international documents upon which the previously listed sexual and reproductive rights were based: the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the UN Convention on the Rights of the Child; and the UN Convention on the Elimination of all Forms of Discrimination Against Women. Finns have been part of the Nordic delegations to international meetings where they have worked to promote an understanding of policies that have been shown to effectively reduce sexual health problems. Even before the focus on reproductive and sexual health

in the mid 1990s as a result of the Cairo and Beijing conferences, Finns recognised the link between sexuality and health. In 1989, the Finnish National Board of Health published a report entitled "Eroticism and Health". The message of this report was clear: Sexual expression can improve the health and general quality of life of individuals and their families. The primary author of this publication, Osmo Kontula, wrote, "Positively experienced sexual activity is an efficient antidote against the ill-effects of stress...sexual intercourse produces thorough relaxation and alleviates the problems caused by hurrying and various kinds of discomfort. Romantic and sexual relationships have been found to effectively prevent loneliness and the resulting anxiety and depression" (p. 123). One of the recommendations of this report was that health care providers give guidance on sexual matters to parents, adolescents, the ill, disabled, and the elderly. In more recent work, Kontula (1998) has argued that a satisfying and safe sex life is the most important determinant of sexual health.

A representative sample of Finns has also acknowledged the connection between health and sexuality in a recent national survey: 88% of men and 79% of women agreed that sexual activity was beneficial for health and well being (Kontula and Haavio-Mannila, 1995). In this same survey sexually satisfied people reported better states of health and well being and less loneliness than did sexually unsatisfied people. Kontula and Haavio-Mannila (1997, p. 14) in an article on quality of life as a function of sexual satisfaction conclude " it would be beneficial to both individuals and society on the whole to adopt such social policies that would help people overcome their fears, worries, and problems concerning sexuality as well as provide favourable conditions for sex life, for example by teaching rewarding sexual practices."

The aforementioned examples illustrate views about sexual health in Finland. In the concluding chapter of this book, the state of sexual health in Finland will be evaluated with respect to recent criteria outlined by international groups of health, family planning, and sexuality professionals and also with respect to macro and micro determinants of sexual health. Such determinants are the focus of the next two chapters and will facilitate an understanding of sexual health in all countries, not just in Finland. To conclude this chapter, however, I discuss briefly the meaning and implications of the newly adopted rights approach to sexual health for such a discussion will help the reader understand the linkages among the issues and concepts presented in chapters 1 and 2.

Meaning and Implications of Rights

The use of the word 'rights' has important implications. Dixon-Mueller (1993b, p. 6) states that the notion of rights involves the "concept of individual liberty in which the primary role of the state is to ensure freedom of the citizenry from abuses of power." She also states that another "concept of human rights is one of social entitlement, that is, the responsibility of society and the state to guarantee not only freedom of opportunity

to all its citizens but also achievement of results.“ An additional concept that is associated with rights or individual liberty is one of responsibility and obligations – on the part of individuals, parents, and families as well as of governments and institutions. Correa and Petchesky (1994) stress that the concepts of POWER and RESOURCES are essential components of rights. For example, they emphasize that rights are meaningless unless people have the POWER to make informed decisions about reproductive and sexual matters and the RESOURCES to carry out their decisions safely and effectively. Thus, people must have enough resources in terms of knowledge and economic and political power in order to exercise their sexual rights.

In a recent publication by the United Nations Population Fund (UNFPA) (1997) several reasons were given to support the importance of human rights. One use of the descriptions and lists of human rights agreed upon at international meetings is to promote change that will benefit large numbers of people. Several global trends create a need for an international consensus to set a standard of ethics by which nations can act to reduce the negative impact of the abuse of power that these trends typically encourage. The global commonalities cited by UNFPA (1997) include increasing urbanisation which often results in people of varying attitudes and cultures interacting with each other; increased international and internal travel and migration which also bring diverse groups in contact with each other. Other commonalities listed were increasing complexity and decentralisation of government, the collapse of civil administration, and the rising power of transnational entities and multinational corporations. All of these trends make the protection of less advantaged groups more difficult and promote the need for safeguarding basic rights of groups and individuals. Thus, rights agreed upon by representatives of a large number of countries at international conferences can serve as universal guidelines to express the “international conscience on matters of human rights“ (UNFPA, p. 7, 1997). They can be one mechanism to protect against the strong tendency – documented so thoroughly by social scientists – for the more powerful to abuse the less powerful and marginalised of society.

The view of the meaning of rights endorsed here, and sexual rights in particular, is that rights always involve responsibility. Several ‘responsible’ actions are implied by the lists of sexual rights. For example, heterosexual couples must use contraception to avoid an unwanted pregnancy. Responsibility for birth control ideally should involve both participants in sexual activity. To have sex without unnecessary risks of getting a sexually transmitted disease, of course, means that safer sex techniques have to be known, discussed and enacted. Participants in sexual activities need to consider the wishes of their partner as well as their own in deciding how to interact sexually. These are just a few of the obvious responsibilities that are implied in the lists of sexual rights.

International discussions about rights have involved a good deal of debate and controversy. For example, rights have been associated with Western notions of individualism, and those who value a more collectivist worldview have been critical of the emphasis on

individuals and their rights. Several questions have been raised. For example, how are rights of individuals reconciled with the good and benefit of the larger community and society? What responsibilities should accompany the exercise of someone's rights? How should conflicts of rights between individuals be resolved? Thus, the 'rights' concept does not always imply simple or obvious actions.

During the same time that family planning, women's health, human rights, and sexuality education and counseling organisations initiated their focus on sexual health and sexual rights, members of academic disciplines in the humanities and social sciences also began to focus upon these same topics. In the academic world, rights are commonly discussed in the context of inequality and the meaning of citizenship. A citizen is a member of a community/country and the rights and status of citizens vary considerably, both within and between communities/countries. It has been common to identify three types of citizenship. *Civil* citizenship relates to personal freedoms and property rights. *Political* citizenship concerns the right to organise, vote, and hold public office. *Social* citizenship includes the right to education and economic well being. In the last decade, a new dimension of citizenship has been discussed, *sexual* citizenship. Jeffrey Weeks (1998) writes about the *sexual* citizen who can claim a new form of belonging. In his view, *sexual* citizenship is about protecting the choices for one's private life in a more inclusive society. This notion of citizenship expands previous views of citizenship to include the sexual realm. A new international journal was launched in 1997 to deal with this as well as the more traditional aspects of citizenship – *Citizenship Studies*. In addition, in 1999 the UK sponsored an international conference entitled "Sexual Diversity and Human Rights". Most conference themes involved linking aspects of rights, sexuality, and citizenship. In the next chapter, relationships among rights, empowerment mechanisms and sexual health are discussed more thoroughly.

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