EDITORIAL

Social determinants of sexual health

T. S. Sathyanarayana Rao, Rajesh Gopalakrishnan[1], Anju Kuruvilla[1], K. S. Jacob[1]
Department of Psychiatry, JSS Medical College, Mysore, Karnataka, [1]Christian Medical College, Vellore, Tamil Nadu, India

Sexual health can be defined as 'a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity.[1] Many complex issues including sexual behavior and attitudes, societal and cultural factors, biological risk and genetic predisposition, mental and physical illness influence sexual health.

The limited data from India are from nonsystematic surveys and opinion polls, which explore a limited and superficial range of issues.[2-9] Social, cultural, economic, psychological, and genetic factors, which affect desire, attitude, behavior and practice are rarely investigated. The silence of the Indian culture on issues related to sexuality compound many issues including help seeking related to neurotic and anxiety disorders (e.g., Dhat syndrome), the HIV epidemic, reproductive tract infections, sexual violence, contraception, abortion services and female genital mutilation.

Despite the "Kama sutra", Indian society is extremely conservative about sex and is ambivalent about sex education in high schools. The barriers to sexual well-being include issues related to individual empowerment and choice, access to educational and clinical services, social stigma, discrimination and sexual violence. Even professional medical education does not transfer skill and confidence related to sexual health and sexual medicine.[10-13] The resultant vacuum is often exploited by "healers" who also propagate sexual misconceptions and misinformation. The cultural ambivalence and manifest conservatism result in a lack of political will to improve sex education in schools and formulate and implement policies related to sexual health.

EXISTING POLICIES, PLANS AND PRACTICE

The National AIDS Control Program, with its focus on educating the general population about responsible sexual behavior, safer sex and condom use has had a significant impact. The reduction in the rate of HIV transmission in the country suggests success.[14] The extensive treatment provision for HIV and AIDS is also an achievement. On the other hand, the National Family Welfare and the Reproductive and Child Health Care programs have focused on antenatal care, hospital deliveries, immunization and contraception with an emphasis on postpartum sterilization. Sex education in schools has met with resistance and has had a restricted impact across the country. Although India has some policies on paper, the approach is fragmentary. In addition, the principal thrust based on health, makes it one-dimensional and much less effective.

ADDRESSING SOCIAL DETERMINANTS

Countries, which have accepted the need for a national policy, approach the task from a broad base employing multisectoral perspectives. The World Health Organization (WHO) has developed a framework, identified opportunities and challenges and recognized the need for contextualization and adaptation to cultural contexts in order to help promote appropriate, affordable, and accessible sexual health programs of high quality.[15,16] The WHO has argued for a broader context to sexual health going beyond fertility and reproduction and including sexual dysfunction, disability, sexual violence and sexuality. It has grounded the framework within international human rights and affirmed a rights-based approach to sexual health.

The framework has argued for social determinants and includes: (i) law, policies and human rights, (ii) education, (iii) society and culture, (iv) economics, and (v) health systems.[15-17] Legal mechanisms are crucial in introducing health intervention, protecting human rights and guaranteeing promotion, protection and provision of sexual health information and services. Laws can also help prevent discrimination related to sexuality and lifestyle. Legal

Address for correspondence: Dr. T. S. Sathyanarayana Rao, Department of Psychiatry, JSS University, JSS Medical College Hospital, M. G. Road, Mysore – 570004, Karnataka, India.
E-mail: tssrao19@yahoo.com

How to cite this article: Sathyanarayana Rao TS, Gopalakrishnan R, Kuruvilla A, Jacob KS. Social determinants of sexual health. Indian J Psychiatry 2012;54:105-7.

Access this article online

Website: www.indianjpsychiatry.org

DOI: 10.4103/0019-5545.99527

Quick Response Code

statutes are necessary to combat archaic social positions on sexuality and for protection against bigotry and violence. While the Delhi High Court has read down Section 377 of the Indian Penal Code,[18] the government continues to be ambivalent and reluctant to pass new laws to protect people with lesbian, gay, bisexual and transgender (LGBT) lifestyles.[19]

The correlation between sexual health outcomes and levels of education is well known.[15-17] Education policies, which provide accurate, evidence-based and appropriate sexual health information and counseling will go a long way in reducing stigma and discrimination. Such education should be provided through schools, work places, health facilities and in the community. India needs to develop progressive educational policies and diligently implement such plans in practice.

Society, culture and tradition have a significant impact on sexuality and sexual health. However, such impact is differential affecting those with least power including women and those with LGBT lifestyles.[15-17] Social exclusion of subgroups has a major impact on sexual health. Empowering these groups will go a long way in improving sexual health. India with its patriarchy and its value on heterosexual lifestyle places a huge burden on women, girls and those with LGBT lifestyles. Cultural and societal acceptance of sexual violence also affects sexual health. While community acceptance of sexual equity is crucial to implementing sexual health intervention, traditional and conservative societies will require legal and educational nudging to accept the humanity of all peoples.

The bidirectionality of the relationship between economic status and sexual and reproductive health is widely acknowledged. Poverty results in high-risk lifestyles and behavior and poorer sexual health and vice versa.[15-17] The differential uptake of contraceptive and family planning services has widened the already wide rich-poor gap in service utilization and consequent advantages of reduced fertility. Poverty is correlated with poor reproductive health indicators including maternal survival, early child bearing, unintended pregnancy, unsafe abortion, shorter birth interval and child mortality. An understanding of economic issues and poverty is crucial to developing effective interventions to improve sexual health.

There is evidence to suggest that health care provider attitudes and practices affect health care utilization.[15-17] Accessible, affordable, acceptable and good quality sexual health services for all is crucial. These should be offered to the community and to individuals throughout their lifespan. Confidential and nondiscriminatory health services with preventive, curative, counseling and referral services should be available to all. Political and financial pressures, which inordinately affect sexual and reproductive health services, need to be managed. Such services should be community-driven and community based for success.

The broad approach essentially argues for the social determinants of sexual health and the need to improve these rather than a narrow focus on health inputs *per se*.[15-17] While the immediate impact of health interventions is obvious, it is the more hazy and ubiquitous social determinants, which determine outcomes in sexual health, need to be addressed for success. India need to go beyond the current reproductive and fertility dominated sexual health interventions. A focus on people's lifestyle and behavior alone is not adequate in alleviating long-term sexual and reproductive health problems if such interventions fail to redress the social conditions that drive poor health outcomes.[17] Among the disadvantaged communities, lifestyle and behavior change interventions are unlikely to show tangible health improvements. Holistic, multidisciplinary and intersectoral approach to policies, plans, programs and service delivery is essential.[15-17]

Education and training for health professionals, teachers, educationists, economists, legal fraternity, judiciary, police, religious and community leaders will be necessary. While sexual medicine as a separate specialty is useful,[20] the training of primary and secondary care physicians and nurses is crucial for clinical service provision. The provision of services irrespective of age, sex, marital status, income, education, ethnicity, religion, lifestyle, gender expression and sexuality is mandatory. Vulnerable groups (e.g., women, migrants, displaced people, minorities, and LGBT people) need special inputs. The migration within the country with people moving from rural to urban areas and across state boundaries demands specific attention. This requires a legal policy and regulatory environment, which upholds the sexual rights of all people and understands sexuality, gender roles and power in designing and providing services. There should be a real and meaningful commitment to promote and reinforce the rights of people to have mutually respectful, happy, healthy and fulfilled sexual relationships free from abuse, violence or coercion. The policy should be able to influence cultural and social factors that have an impact on sexual health. It should support everyone to acquire and maintain the knowledge, skills and values necessary for sexual wellbeing. It should improve the quality, range, consistency, accessibility and integration of sexual health services.

Mass media should be used for community and societal education. The media should convey key messages of equality and humanity of sexual orientation and lifestyle choices. It should challenge gender and sexual stereotypes, break taboos, reduce stigma and discrimination. It should work proactively to promote sexual health and responsibility.

THE WAY FORWARD

India requires an approach that encourages a cultural shift toward a more open and positive view of sexual relationships and sexual health that is accepting of diversity. It should promote an ethos that encourages relationships based on equity and respect, challenges gender stereotypes and reinforces the responsibility of all people for protecting sexual health.

The sexual health needs of the country are largely unknown. Planning for meeting the challenges requires answers to many questions: What are the sexual health needs of the population? What kinds of services are needed? What should be the mechanism for making these services accessible? What organizations/networks need to be set up to facilitate, deliver and monitor such services? How can we make these services user friendly? How can intersectoral cooperation be ensured? What should be the legal and regulatory framework? What legislations need to be promulgated to improve sexual health? How can we increase the fiscal outlays for sexual health? How can sexual health be prioritized?

Sexual health is an area that is neglected in twenty-first century India. This has been at the cost of significant mortality, morbidity and disability. Viewing sexuality as a moral failing, an individual choice, a private family matter, a religious issue, a social concern or a political problem is not an option for a modern, civilized, democratic, and secular country. Public health, developmental and human rights perspectives are required for enlightened approaches to sexual health.

REFERENCES

1. World Health Organization. Defining sexual health: Report of a technical consultation on sexual health. Geneva: WHO; 2006.
2. Andrade C. Sexual dysfunction in India. Indian J Psychiatry 2005;47:181.
3. Sivaram S, Johnson S, Bentley ME, Go VF, Latkin C, Srikrishnan AK, *et al*. Sexual health promotion in Chennai, India: Key role of communication among social networks. Health Promot Int 2005;20:327-33.
4. Brahme RG, Sahay S, Malhotra-Kohli R, Divekar AD, Gangakhedkar RR, Parkhe AP, *et al*. High-risk behavior in young men attending sexually transmitted disease clinics in Pune, India. AIDS Care 2005;17:377-85.
5. Gupta N, Mathur AK, Singh MP, Saxena NC. Reproductive health awareness of school-going, unmarried, rural adolescents. Indian J Pediatr 2004;71:797-801.
6. Andrew G, Patel V, Ramakrishna J. Sex, studies or strife? What to integrate in adolescent health services. Reprod Health Matters 2003;11:120-9.
7. Schensul SL, Mekki-Berrada A, Nastasi B, Saggurti N, Verma RK. Healing traditions and men's sexual health in Mumbai, India: The realities of practiced medicine in urban poor communities. Soc Sci Med 2006;62:2774-85.
8. Dawn A, Biswas R. Reproductive tract infection: An experience in rural West Bengal. Indian J Public Health 2005;49:102-3.
9. Garg S, Sharma N, Bhalla P, Sahay R, Saha R, Raina U, *et al*. Reproductive morbidity in an Indian urban slum: Need for health action. Sex Transm Infect 2002;78:68-9.
10. Saksena S, Saldanha S. Impact of a course on human sexuality and adolescence. Indian J Pediatr 2003;70:203-6
11. Nayak J, Bose R. Making sense, talking sexuality: India reaches out to its youth. SIECUS Rep 1997;25:19-21.
12. Santhya KG. Early marriage and sexual and reproductive health vulnerabilities of young women: A synthesis of recent evidence from developing countries. Curr Opinion Obstet Gynecol 2011;23:334-9.
13. Rao TS. Some thoughts on sexualities and research in India. Indian J Psychiatry. 2004; 46: 3-4
14. National AIDS Control Organization. Annual Report 2010-11. NACO, Department of AIDS Control, Ministry of health and Family Welfare, New Delhi. Available from: http://www.nacoonline.org/upload/REPORTS/NACO%20Annual%20Report%202010-11.pdf [Last accessed on 2012 April 26].
15. World Health Organization. Developing sexual health programmes: A framework for action. Geneva: WHO. 2010. Available from: http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.22_eng.pdf [Last accessed on on 2012 April 26].
16. World Health Organization. Social determinants of sexual and reproductive health: Informing future research and programme implementation. Geneva: WHO. 2010. Available from: http://whqlibdoc.who.int/publications/2010/9789241599528_eng.pdf [Last accessed on 2012 April 27].
17. Women's Health West. Social determinants of sexual and reproductive health. Melbourne: Western region Sexual and Reproductive Health Working Group. 2011. Available from: http://www.whwest.org.au/docs/SocDetSRH2011web.pdf [Last accessed on 2012 April 27].
18. Kumar N. Delhi High Court strikes down Section 377 of IPC. Available form: available from: http://www.hindu.com/2009/07/03/stories/2009070358010100.htm [Last accessed on 2012 April 26].
19. Rao TS, Jacob KS. Homosexuality and India. Indian J Psychiatry 2012;54:1-3.
20. Rao TS, Avasthi A. Road map for sexual medicine: Agenda for Indian Psychiatric Society. Indian J Psychiatry 2008;50:153-4.

Source of Support: Nil, **Conflict of Interest:** None declared