In this opening chapter, we introduce the perspectives that guide the book. We examine how sexual health might be defined and the criteria used to do so. We summarize the main theoretical approaches to sexuality, in particular the distinction between those that see it as relatively instinctual and fixed, and those that see it as socially learned and as capable of being modified. We make the case for adopting the second of these perspectives in the context of public health practice, and we emphasize the importance of taking account of the social and historical context in efforts to understand sexual health issues, thereby setting the scene for the whole book. Next, we introduce the concepts of diversity and normality and examine their application in the context of sexual behaviour. Finally, we consider some of the social and cultural constraints on sexual behaviour and how these impact on public health efforts to improve sexual health.

Learning outcomes

After reading this chapter, you will be able to:

- Critically appraise a definition of sexual health
- Identify different theoretical approaches to the study of sexual behaviour, and understand the arguments for applying a social learning model to public health practice
- Understand the importance of considering cultural and social factors shaping sexual behaviour and sexual health interventions

Key terms

**Sex:** In everyday speech, the term ‘sex’ is used to refer both to sexual activity (for example, ‘having sex’, ‘sex work’) and to the sum of biological characteristics that define people as female and male. In this book, we use the term in both these senses and rely on the context to make clear in which it is being used.

**Sexuality:** A core human dimension that includes sex, gender, sexual identity and orientation, eroticism, attachment and reproduction, and is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, practices, roles, and relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical, and religious/spiritual factors.
A public health approach

Throughout this book, we take a public health approach to sexual health, typified by the following characteristics:

- **The focus is on the health of populations, rather than on that of individuals.** The social patterning of, and trends in, sexual ill health are a key focus, as is a concern with reducing inequalities.
- **The emphasis is on prevention of ill health and promotion of wellbeing, rather than on cure and treatment.** Prevention may be primary, where the focus is on modifying behaviours that expose individuals to sexual ill health, for example, unprotected sexual intercourse; secondary, where incipient disease or risk behaviours are prevented from progressing, as in the case of screening for cervical cancer or provision of emergency contraception; or tertiary, where the impact of already established ill health is attenuated, as in the case of public education campaigns aimed at countering discrimination against people with HIV infection.
- **Those designing public health interventions typically ask what factors can be most effectively modified to improve health status and these are seen to include not only behavioural factors determining individual risk, but also social structural factors impacting on the vulnerability of social groups or populations,** (MacDougall, 2007) as discussed in Chapter 10.

Sexual health: an emerging concept

Despite its relatively recent origin (Sandfort and Erhardt, 2004), the term ‘sexual health’ is in increasingly common currency (Giami, 2002) (see Figure 1.1). This reflects a shift in public health thinking that has implications for both research and practice. Most

![Figure 1.1 References to sexual health in Medline and PsycINFO, 1974–2002](image-url)
notably, it marks a move away from the medicalization of the specialty. Formerly, labels attached to this area of public health practice carried connotations of disease and pathology. Settings in which sexual health care was practised, for example, tended to be named according to disease categories (for example, venereal disease clinic), or else were so euphemistically identified (as in ‘special clinic’) as to suggest something extraordinary or morally questionable. The trend away from medicalization is mirrored in research: empirical work is increasingly focused on behaviour rather than pathology; concerned with prevention as well as treatment; carried out by interdisciplinary teams of clinicians and social scientists, often combining laboratory and behavioural measures; and conducted in communities rather than clinics.

Defining sexual health

There is surprisingly little agreement on how the concept of sexual health should be defined. The most frequently cited definition was originally formulated at a conference held by the World Health Organization (WHO) in 1975, as a guide for health professionals working in the field. This definition went through several iterations. It was revised in a report in 2001 by a panel including the WHO, the Pan-American Health Organization (PAHO), and the World Association of Sexology (WAS) and further modified in 2002, when the WHO published a definition on the section of its website devoted to gender and reproductive rights.

Sexual health is a state of physical, emotional, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

(WHO, 2006)

The WHO definition of sexual health has much to commend it. A holistic approach safeguards against seeing sexual health exclusively in terms of the prevention of adverse sexual health outcomes, such as unplanned pregnancy, sexually transmitted infections (STIs), and sexual violence. It expressly incorporates more positive aspects of sexual health, broadening the remit to include the enhancement of life and personal relations. Yet this definition has never been officially accepted in WHO terms of reference (even now, it is difficult to find on the WHO website). This may be because the inclusion of sexual satisfaction alongside adverse health outcomes makes some people uncomfortable. It may also reflect the inherent challenges associated with all ‘positive’ definitions of health (not just sexual health), particularly the vagueness of ‘a state of physical, emotional and social well-being’, the difficulty in anyone ever attaining this, and the challenges of measuring it. The WHO definition has, nevertheless, been used to help frame this book. The subjects of our opening chapters, the four most common outcomes in terms of interventions to improve sexual health – that is, unplanned pregnancy, sexually transmitted infection, sexual violence, and sexual function – correspond roughly to those incorporated in the WHO definition.
Conceptual and theoretical aspects of sexual health

Theoretical perspectives

Broadly speaking, theories about sexuality fall into two main categories: the essentialist and the social constructionist (DeLamater and Hyde, 1998). Essentialist theories hold that forms of sexual expression are for the most part fixed, innate, and instinctual, that sex is determined chiefly by biological forces, even though situational and environmental factors may give rise to variation. Social constructionist theories, by contrast, regard sexual behaviour as plastic and malleable, amenable to modification, and shaped extensively by cultural norms and socialization, often mediated by language as a way of organizing experience and sharing concepts. While few hold the extreme view that either nature or nurture is totally responsible for determining human sexual behaviour, perspectives vary greatly in their relative emphasis. The task here is to examine each for its usefulness in a public health context.

Essentialist theories: sexuality as instinctual and innate

The belief that the determinants of sexual expression are to be found in instinct has a long history, dating from Plato and Aristotle, appearing in the Middle Ages in the concept of natural law (Weeks, 2003) and resurfacing in the writings of late nineteenth-century sexologists such as Krafft-Ebbing, Havelock Ellis, Magnus Hirschfeld, and Sigmund Freud. The fashionable view in this latter period was to see the study of sex as a science, observing natural laws. The aim was to uncover a single, timeless, incontrovertible truth about sexuality that could be discovered from, and had its origin in, biology and psychology. Chromosomes and hormones, and psychic energy or unconscious compulsions, were the building blocks of sexuality.

The concept of sex as a biological imperative was reflected in much of the language used by early sexologists. Freud, for example, describes sex as a ‘drive’ (Freud 1949) and Havelock Ellis as an ‘impulse’. Implicit in the use of these terms is the notion of an uncontrollable natural energy in men and women (but particularly men) urgently seeking release. For Freud, the sex instinct, being the natural drive for survival of the species, was the prime motivational force of human life. He held that we are born with infinite capacity for sexual expression, and he used the term ‘polymorphous-perverse’ to describe this potential.

Freud believed that the range of sexual possibilities open to us was far greater than that lived out in everyday practices. His view was that adult patterns of behaviour are based on a blueprint laid down in the earliest years of life. For Freudian theorists, the whole process of civilization consists largely in the ‘sublimation’ of infantile sexual instinct to other ends than those they seemed designed to serve, so that they are revealed only through the unconscious mind in dreams, fantasies, and jokes. Hence sexuality is always linked with anxiety, stemming from a fear that the banished impulses might break through the barrier of repression. Thus for Freudian analytic theory, repression of some sex drives is the cause of psychological disequilibrium and neurosis.

Paradoxically, Freud’s own attitude towards many of the forms of sexual behaviour that he claimed so fearlessly to confront, including masturbation, homosexuality, and many aspects of women’s sexuality, was one of distaste, leading to contradictions for which his work has been criticized. The constant reference in Freud’s work to sexual practices as ‘normal’ and ‘abnormal’ is common in the writing of sexologists at the time, and central to the task they set themselves, to comprehensively identify and categorize sexual pathology. Arcane sexual preferences — necrophilia, foot fetishism, nymphomania,
Sexual health: theoretical perspectives

for example – were catalogued and described, using terminology such as ‘perversions’, ‘aberrations’, and ‘deviations’.

Evolutionary psychological and socio-biological theories of sexuality also fall into the ‘essentialists’ camp. Drawing originally on Darwinian theories of evolution, they explain sexuality in terms of reproductive strategies that evolved to ensure survival of the human species (Buss and Schmitt, 1993). According to this perspective, women optimize their chances of passing on their genes by choosing a mate offering the best genetic inheritance for her offspring and living in monogamous union with him, while men optimize theirs by pursuing and impregnating as many women as possible. Most contemporary evolutionary theorists accept that reproduction is no longer the central theme around which modern men and women organize their sexual relations. The sex act is nowadays easily separated from its reproductive consequences by the use of effective contraception, and sexuality has evolved in humans to serve functions other than those solely related to procreation. Yet socio-biology is still used by some to provide an ideological justification for uncontrollable male lust.

Despite their differences, all the early sexologists held a common belief that sex is an overpowering natural force needing either to be contained, channelled, and controlled to allow the orderly working of society, or else released to free us from damaging repressive forces. The preoccupation with sex as driven by biological forces was to last well into the middle of the twentieth century, when Alfred Kinsey’s two ground-breaking surveys of the sexual practices of 20,000 men and women in the USA were published (Kinsey et al., 1948, 1953). Kinsey’s surveys probably exerted greater influence on ideas about sexuality than any work since that of Sigmund Freud. Yet although he was dismissive of hormones as definitive in explaining sexual response, his approach was still essentially naturalistic. An entomologist by training, Kinsey’s scientific interest for the first twenty years of his career was in cataloguing and classifying insects, wasps in particular. When he turned his attention to humans, his attempts to develop a taxonomy of sexual practices very much reflected his background in biology.

Where Kinsey did part company with earlier writers, however, was in moving away from the distinction between ‘normal’ and ‘pathological’. In describing sexual expression in terms of diversity rather than uniformity, Kinsey offered not only an empirical dimension to the study of sexuality, but also a service to the American people. A collective cry of relief is said to have gone up across the USA on publication of the Kinsey report, as thousands of Americans learnt for the first time that personal habits they had previously believed to be shameful, unnatural, and abnormal (such as masturbation), were in fact practised by large numbers of fellow countrymen. Although these ideas still hold sway today, particularly in lay constructions of sexuality, and in certain settings, Kinsey’s work did much to remove the categories of ‘abnormal’ and ‘unnatural’ from discussions of sexual behaviour.

Sexuality as socially constructed

The alternative way of understanding sexuality – seeing it not as an essentially ‘natural’ phenomenon, but rather as a product of social and historical forces – began to attract a following in the immediate post-Kinsey era. The sexual diversity hypothesized by Freud from his readings of the unconscious minds of his patients, and demonstrated empirically by Kinsey from his research in the American population, gained further support from the first ever cross-cultural survey of sexual behaviour, undertaken in 1951 (Ford and Beach, 1951). Anthropologists Clellan Ford and Frank Beach showed marked
differences in sexual customs from one society to another. In some, the sexual impulses of children were encouraged and allowed expression, in others they were forbidden and punished. Some homosexual activity was considered normal or acceptable in 49 of the 76 societies examined. Different societies held widely different views, rules, and attitudes about sexual exclusiveness; in some societies, non-monogamy was heavily censured, in others polygamy was a normal part of the social arrangements.

Emerging awareness of the marked differences in sexual practices within and between cultures persuaded people that variety, not uniformity, was the norm. Social constructionists pointed to variation between social groups to argue for the cultural relativity of sexual behaviour: If sexuality were solely biologically determined, it was reasoned, then forms of sexual expression would vary little cross-culturally, and the evidence is that they do.

According to this view, there are no universals. A social constructionist approach admits the possibility that the range of sexual possibilities – gender identity, bodily difference, reproductive capacities, needs, desires, and fantasies – may be combined in any number of ways. How we define sex, what counts as sexual, how we code and categorize modes of sexual identity and expression, and what meaning they have in a society, depend on where we live and which era we are born into. Social constructionist theories do not deny the limits imposed by biology or psychology, but their focus is on cultural and social influences as the decisive factors in explaining human sexuality. They contend that our sexual potential and capacities are given meaning only in social relations and through forms of social organization. How we behave sexually is not so much genetically inherited as socially learned, through a variety of discourses. These discourses are embedded in moral treaties, laws, religious strictures, economic policies, educational practices, literature and popular culture, and are acquired through family, peer group, school, the media, and other cultural influences.

Social constructionist theories

One of the first attempts to apply a social constructionist perspective to the study of sexuality was made by John Gagnon and William Simon, whose collaboration began in the late 1960s and led to the publication of their book *Sexual Conduct* (Gagnon and Simon, 1973). Gagnon worked at the Kinsey Institute, but had studied in the Chicago School of Sociology under the influence of George Herbert Mead, who was renowned for formulating the theory of *symbolic interactionism*. Mead held that what distinguishes us from other animals is our wide range of conventional meanings which we express through words and actions. We learn how to adopt and play social roles through the process of ‘symbolic interaction’, that is, symbolically mediated patterns of reciprocal expectations.

Where Kinsey stopped short of linking sexual variation to social forces and social organization, Gagnon and Simon introduced a systematic interpretation of the social construction of sexual behaviour; one that is embedded in social scripts that are specific to particular cultural and historical settings, vigorously rejecting the determining importance of biological drives or energies. According to *scripting theory*, we use our interactional skills to develop scripts, with cues and appropriate dialogue, as a means of organizing our sexual behaviour. We acquire patterns of sexual conduct that we see as being in keeping with those of our culture or group, but we may make minor individual adaptations to these to fit our own needs and preferences. So while taking account of social-structural factors determining sexual expression, the theory also stresses the significance of individual agency; the idea that an individual is capable of 'making' as well as 'taking' specific social roles and patterns of behaviour.
Other theories are often used in combination with social scripting theory (Laumann et al., 1994). *Choice theory*, for example, focuses on how individuals choose between different options in sexual activities or partnerships according to different goals: sexual pleasure, emotional satisfaction, having children, and enhancing personal reputations. According to this theory, choices made depend on the personal values attached to these goals, the degree of certainty in attaining them, and the factors limiting choice. *Network theory* underlines the dyadic, and therefore essentially social, nature of sexual partnerships and this has three implications (Sprecher and McKinney, 1993). Put simply, people tend to treat their sexual partners in broadly similar ways to others in their social circle; they take account of their partner's action in what they do sexually; and they tend to have sex with the type of individuals they would be likely to have other kinds of relationships with.

Gagnon's work, in turn, paved the way for that of the French critical theorist Michel Foucault. Foucault's *The History of Sexuality* has had a spectacular influence on modern theoretical perspectives, forcing us to rethink our ideas about sexuality and to question the inevitability of the sexual categories and assumptions we have inherited (Foucault, 1983). He focused not only on how sexual conduct changes over time, but on how even the notion of sexuality itself is historically situated. Questions central to Foucault's work include: How and why has sex assumed such importance in Western culture? What is the relationship between sex and power? And how does sexuality relate to economic, social, and political structures?

**A balance and a bias**

No one theory explains all our sexual behaviour. The kinds of sexual relationships we enter into, the sexual practices we engage in, and the attitudes we hold towards sexuality, all are shaped by a complex network of factors. A comprehensive exploration of sexuality requires an understanding of both biological potential and cultural limits as the preconditions for human sexuality. If innate biological factors were the sole determinants of sexuality, then its expression would vary little between one society and another; yet as we have seen, there are marked differences between sexual norms and customs between different societies. On the other hand, if social factors were all, then members of social subgroups could be expected to exhibit similar forms of sexual behaviour; yet the behaviour of individuals differs even within families. Both sides of the nature–nurture debate help us to understand sexuality and it is also important to recognize both individual agency and social structure when theorizing sexual practices and sexual health outcomes.

**Activity 1.1**

In pursuing public health goals in relation to sexual health, practitioners often use a social constructionist perspective. Jot down some possible reasons for this.

**Feedback**

You might have given the following reasons:

Earlier in this chapter we described one of the characterizing features of public health as a focus on the social patterning of behaviours in populations, and on
differences between social groups rather than between individuals. Biological and psychological causes may be central when comparing individuals, but this is not the case when comparing groups. Narrowly biological explanations will be inadequate when research questions concern social trends and variations between different populations and subgroups.

You might have noted that theories emphasizing nurture as an influence on behaviour lend themselves better to intervention than do those focusing on nature, since if we are genetically pre-programmed to behave in particular ways there would be little scope for intervening to improve sexual health. Seeing sexual behaviour as fluid rather than fixed offers greater potential for adaptation to changing circumstances and threats, for all the inherent challenges. The aims of public health are less well served by a perspective that is essentially deterministic.

**The regulation of sexual behaviour**

We have seen that although human sexual capacity is universal, its expression is defined, regulated, and given meaning by cultural norms. Forms of sexual expression vary culturally, but there are neither societies, nor any periods in history, in which there have been no constraints on sexual behaviour. In general, societies support and encourage the kinds of sexual behaviour that best underpin their social arrangements. The raising of stable, well-adjusted children, for example, is seen in most social settings as being best achieved within a monogamous union in a common homestead.

There are some universals. As far as we are aware, there is no society which disapproves of monogamous, heterosexual behaviour aimed at procreation. But societies vary in the extent to which they impose constraints on the polar opposites—notably non-procreative sex, non-exclusive sex, and homosexual behaviour. These are represented diagrammatically in Figure 1.2.

![Figure 1.2](image-url)
Many non-procreative sexual practices, for example, have long been the subject of social disapproval or even prohibitive legislation. These include oral and anal sex, same-sex practices, and also sexual activity before the age deemed suitable for childbearing to begin. One of the tenets of the Christian faith – that sex is for reproduction – led to the censorship of practices like oral sex, anal sex, and homosexual sex because they do not lead to pregnancy. The practice of masturbation invokes particularly strong disapproval in this context (Figure 1.3). In the Christian Biblical reference to the sin of Onan in 'spilling' his seed, his transgression was seen as wasting

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**Figure 1.3** Eighteenth century leaflet warning against masturbation
Conceptual and theoretical aspects of sexual health

Vigorous attacks on masturbation were made in the nineteenth century when supposed adverse health implications, including blindness, were used to underpin the moral message.

Activity 1.2

For each of the other two circumscribed areas of sexual expression in Figure 1.2 – that is, non-heterosexual and non-monogamous sex – think of an example of a behaviour that is regulated and describe the way in which constraints have been imposed.

Feedback

In the context of homosexual sex (also non-procreative), you might have mentioned the example of sex between men (sex between women has, for the most part, tended to be relatively free from social regulation). Both legal and medical mechanisms have been common forms of control. Until 1861, homosexual behaviour was a hanging offence in England. In America it was not removed from the list of psychiatric disorders until 1973, at which point, as the neuroscientist Simon Levay remarked, ‘20 million homosexuals gained immediate cure’. (In many countries, homosexuality continues to be regulated legislatively; see Chapter 7.) You might have chosen as your illustration of how non-monogamous sexual relations are regulated, one of the more high-profile instances of public punishments, such as the stoning of ‘adulterous’ women in some parts of the world. Less extreme examples, however, are far more widespread. In many countries, infidelity almost always constitutes grounds for divorce, and may affect custody of children and the division of property. In addition, many governments create fiscal benefits for men and women who marry.

As the examples in Activity 1.2 show, diverse mechanisms have been used in attempts to regulate sexual behaviour, sometimes in combination. In the past, religion and legislation were commonly invoked. To some extent they still are, though increasing secularization has weakened the hold of religious institutions in many societies and, since sex is largely conducted away from the public gaze, laws are seldom effective in controlling sexual behaviour. Yet the fact that behaviour is illegal may be a powerful assertion of social norms governing the act. A law dating back to 1533 made anal sex between a man and a woman a criminal offence in England and Wales until it was repealed in 2003. In France, where it has never been criminalized, research shows it to be reported twice as commonly as in Britain (Bajos et al., 1995).

In the twenty-first century, medicine and psychology are used to underpin social rules relating to sexuality. Adverse health consequences of sexual behaviour, whether real or not, are often used to deter socially disapproved sexual behaviours. Anti-abortion campaigners in Britain, for example, have claimed links between abortion and breast cancer (Guardian.co.uk; 23 March 2012). And as we shall see in Chapter 2, the threat of sexually transmitted infection is commonly used to deter sexual activity among the young.
Barriers to the improvement of sexual health

Sexual health presents particular challenges for public health. The behaviours involved are not only for the most part personal and private, but are often stigmatized and discriminated against. Morals, taboos, laws, and religious beliefs employed by societies the world over circumscribe and radically determine the sexual behaviour of their citizens. Cross-national comparisons show huge variation in sexual practices. In some countries, such as Brazil, condoms are available to young people in schools; in others, such as parts of Indonesia, possession is a criminal offence. Nowhere are social norms more strongly felt than in the area of homosexual activity. In some parts of the world, sex between men can be celebrated in public parades of pride; in others, it carries the death penalty. Such deterrengs may have been put in place to protect wellbeing and rights, yet they can also hinder attempts to protect sexual health. This has consequences for public health at a number of levels.

Activity 1.3

In what ways might the regulation of sexual behaviour impact on public health efforts to improve sexual health?

Feedback

- Those in need may not come forward for help. People may not be inclined to seek help for sexual health problems for fear of highlighting that they have been involved in practices that are socially disapproved. Under such circumstances, it would be hard for those involved to access services and interventions.
- Service providers may not be able to help those in need. Where behaviours are socially censured, they are often practised covertly and those who do so may be hard to reach in terms of public health efforts. Social attitudes towards harm limitation (such as abortion, provision of contraception to young people, and post-exposure prophylaxis in HIV prevention) also limit service provision.
- Practitioners may not want to help those in need. Politicians and even service providers may be unwilling to support provision of services for some populations or may have negative attitudes towards them.
- Men and women may not be able to help themselves. Regulation may limit the extent to which men and women can act to protect their health. Stigmatized behaviours may be practised covertly and furtively, making it difficult to talk about and/or practise safer sex.
- Public health practitioners may not be able to help in ways that they consider to be effective. Regulation strongly influences the selection of acceptable public health messages and they may be chosen on political rather than scientific grounds.

At this point, you could be thinking that in adopting a social perspective we are doing no more than replacing one form of determinism, deriving from our biological makeup, with another, deriving from the social context. Our genes might not govern our behaviour, but is it not equally strongly dictated by the society in which we live?
To some extent, the answer is possibly ‘yes’, but in a public health context, we can take a more optimistic view. Social explanations are not inherently deterministic, but instead recognize the duality of agency and structure.

As we have seen, medicine is one of the social forces shaping the expression of sexuality. As such, it can be a conservative or a progressive force. A major challenge for public health lies in confronting existing categories and constraints that act as barriers to the maintenance and improvement of public health. At times, bringing about change in the interests of public health may bring us into conflict with those who would maintain the status quo. Public health has been at the centre of sweeping shifts in recent decades. The lifting of the ban on condom advertising, for example, in France, Britain, and elsewhere in the mid to late 1980s was a direct consequence of the public health response to the advent of the HIV epidemic. Exposure by public health practitioners of the difficulties faced by women in many countries in initiating safer sex practices with partners has brought increasing awareness of gender inequalities and resulted in efforts to address them. At the same time, the public health agenda has been influential in resisting homophobic legislation in Malawi, in Uganda, and most recently in Kenya.

The public health endeavour contributes to the social construction of sexuality and we need to be constantly aware of the ways, often subtle, in which this occurs. We need to be aware, for example, that the language used in a public health context can create or confirm normative categories and serves to maintain distinctions between behaviours that are pathologized and those that are not. We need to be aware that whether we talk of ‘drug use’ or ‘drug misuse’, or whether we describe sexual onset in terms such as ‘early sex’ as opposed to sex before a specified age (see Chapter 6), we are using culturally normative categories and we need to consider the merits and dangers of doing so. We need to be aware that when we talk of categories of people — whether homosexual men or sex workers — we are labelling people rather than describing practices, with all the potential for stigmatization that that affords.

Summary

This book takes a public health approach to sexual behaviour. Guiding the book is a broad definition of sexual health, one that emphasizes not only biomedical goals of averting unplanned pregnancy and sexually transmitted infections, but also behavioural ones such as preventing sexual violence, and which encompasses not only negative but also positive aspects of sexual health, such as wellbeing and satisfaction. Hence, the opening chapters of the book focus on four key areas: unplanned pregnancy, sexually transmitted infections, sexual violence, and sexual function.

We also take a social constructionist approach to sexual health, and so we see sexual behaviour as essentially modifiable. This has two important consequences. First, the fluidity and plasticity of sexuality means that men and women cannot be rigidly pigeonholed in terms of sexual identity, and so for the most part it makes more sense to think in terms of sexual behaviours rather than those practising them. This approach also demands that we take account of social influences on, and regulation of, sexual behaviour and so recognize that to change behaviour requires efforts not only at an individual level, but also at the social structural level. In the search for a healthy lifestyle, a perspective on sexuality that sees opportunities for choice and diversity is more valuable than one that sees sexual behaviour as immutably fixed by biological or psychological forces. A key focus for this book is on the social determinants of sexual health and the social context in which efforts are made to improve it.
References


