From miniscule biomedical models to sexuality's depths

Stella Nyanzi

analyses and make recommendations based on evidence of what works best for children. Finally, JLICA does not seek to perpetuate itself or carve a permanent niche in the HIV/AIDS research landscape. It aims to get a specific job done by a defined target date. This time-bound approach should enhance JLICA's focus and effect.

The initiative consists of four themed learning groups, whose membership will be balanced by sex and geography, with disciplinary diversity and strong representation from high-burden countries (panel). Beyond reports and analyses, JLICA will: produce methods for programme planning, implementation, and evaluation; establish an interactive website and communications platform for practitioners; and sponsor national and regional workshops, at which policymakers and practitioners can share experiences, learn from one another, and build foundations for sustained collaboration. The initiative will identify successful models of local practice that might have been under the radar of international organisations, national governments, and donors. Learning groups might participate in operations research with specific projects at national and subnational levels to document, evaluate, and improve promising strategies in real time.

For too long, children have been at the margins of the response to HIV/AIDS. But political momentum is shifting, and today an opportunity exists to place policies and programmes for children's well being at the forefront of our struggle against the disease. In a world scarred by HIV/AIDS, JLICA is ready to make common cause with all people committed to children's flourishing.

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From minuscule biomedical models to sexuality's depths

Nearly three decades of prevention interventions against HIV/AIDS have yielded little effect, with the few success stories heralded universally as potential blueprints in best-practice dossiers. Unprotected sex is still the most common mode of HIV transmission. Unintended or teenage pregnancies, sexually transmitted infections including HIV/AIDS, and sexual abuse, violence, and discrimination remain major public-health challenges, despite targeted strategies of redress. What is missing in available sexual-health programmes, policies, and activism? Why are they not as effective as they promise? What is wrong with these interventions? One possibility is foundational: interventions are premised on limited working definitions of sexuality as a concept.[1]

The production of knowledge on sexuality in the AIDS era is a field rich with a complex array of social actors from diverse institutions, disciplines, political motivations, and funding agencies. However, biomedicine maintains the hegemony over what knowledge is valued and thereby implemented as policy and practice.[2] Before the advent of HIV/AIDS, human sexuality research was mainly a terrain for biomedicine—physiology, psychology, psychiatry, and epidemiology.[3] Sexuality was perceived in terms of deviance, disease, and abnormality, needing correction, control, punishment, and cures. Early sexuality scholars reproduced the theoretical and methodological commitments of biomedical research. Statistics and quantitative methods dominated their inquiry. The onslaught of knowledge, attitude, behaviour, and practice surveys to understand the dynamics of sexual behaviour responsible for transmitting HIV portrays the persistence of this trend in knowledge generation.

This positivistic approach is good for measurements (eg, how much, how often, how many) but not for exploring meanings (ie, how and why things occur). Despite advantages of such an approach (eg, quantification, representativeness, generalisability), there are problems such as over-simplification of complex, nuanced, and

Still Pictures

ambivalent concepts like sexuality. Straightforward questions—eg, "are you gay?"[4] or "are you married?"[5]—with simple answers in western society were unanswerable in other contexts. Conflicting systems for classification, fluid contextual connotations, ambivalent expressions, differences between self-definition and labelling by others, and shifting meanings are salient issues within sexuality that challenge generalisations and bounded concepts with restricted definitions that focus on sexual behaviour, identities, practices, and so on. In response to the crisis within sexuality, how does one measure shifting contexts? Where does sexuality start and end?

Limitations of the positivistic approach to sexuality emphasise the urgency for alternatives, which yields a complementary role for social constructionists, including anthropologists and sociologists.[6] In qualitative models, they can explore the wider meanings embedded within sexuality to generate more context-specific conceptualisations that violate rigid blueprint definitions.

Preventive interventions against HIV/AIDS reignited the overt medicalisation of sexuality, such that the sexual self became restricted by intricate ties to the body, to bodily functions of coitus and reproduction, and to illness and health. Responding to the crisis in sexuality, sexual health programmes focused on disease, pregnancy, and death.[7] Sexual health is subsumed under the rubric of reproductive health, although much of sexuality has no bearing on reproduction.[8]

Since human sexuality is rife with contestation, politics, and enactments of control and power,[9] and because biomedicine acted as a principal instrument of that control, is it safe for meaningful interventions to maintain this ancient premise? If they do, what is the opportunity cost for relevance, effectiveness, and appropriateness?

Rather than conceptualising sexuality as merely situated in the body and bodily functions, consideration of the range of meanings that individuals and groups attach to it is critical.[10] Such a nuanced definition should embrace: desire, the erotic, emotions, sensuality, fantasy, intimacy, commitment, power, relationship, negotiation, exploration, exploitation, expression, trust, personhood, belonging, identity, pleasure, entertainment, consumption, obligation, transaction, dependence, work, income, resistance, abuse, masculine entitlement, feminine propriety, respectability, spirituality, custom, ritual, and more. These factors touch on gender, race, class, citizenship, community, and religion.

The hallmark of sexuality is its complexity—its multiple meanings, sensations, and connections.[11] Therefore HIV prevention interventions that target sexuality must of necessity embrace its inherent ambivalence and depth of scope to be effective. Interventions driven, designed, and implemented by participation of targeted communities have warranted some success because of local input into conceptualisations, process, and outcome.

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