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Chapter 14

Sexual Health is Public Health

Learning Outcomes

By the end of this chapter, you will be able to:

- appreciate the importance of sexual health and well-being, as an integral dimension of public health
- explore holistic definitions of sexual health, to improve your professional practice
- examine the need for proactively promoting the public's sexual health and wellbeing, challenging erotophobic prejudice and discrimination in service provision
- critique the impact of influences on legislative and policy guidance
- identify ways in which you can make a positive difference to public health sexual health and well-being.

Public health and the importance of sexual health and well-being

Sexual health *is* public health! A simple statement, but none the less true. Belfield *et al.* (2006: 17) state that sexual health is "vital to overall health and wellbeing", an important point which health professionals aim to integrate into holistic client care (NMC, 2018). Any definition of holistic health, however, which does not include a full integration of sexual health and promotion of sexual well-being - equally, to all people, across the life course - is no more than lip-service to a philosophy, a tick-box exercise for *Activities of Daily Living*. This lip-service approach is contrary to genuine holism and equates to reductionism. Reductionistic healthcare treats physiological systems, not the person. Bold or controversial claims to make, or a call to public health action? This call to action will be explored in greater depth throughout this chapter.

This chapter supports practitioners in promoting a positive and respectful approach to sexuality, health and relationships. Equally, it raises awareness of definitions which can promote gender health, sexual health and well-being, supported by international human rights declarations, which are acknowledged as strategic imperatives within the wider, formal, Public Health agenda (Naidoo and Wills, 2016) .

A call-to-action is important for identifying ways in which a broader understanding of holistic health and well-being is fundamental, not just to each and every member of the public (i.e. humanity) but to the Public Health strategies, policies, laws and practices of their society, too. This call-to-action is for intentionally promoting the public's sexual health, gender

health and well-being, including all aspects of reproductive and psychosexual health (Brough and Denman, 2019).

Putting sexual health on the public health agenda

From the perspective of international public health policy, a notable shift across sexual (ill-) health occurred in response to World War I. In the UK of 1914, and successive decades since, public health dimensions of sexual ill-health - and what was perceived as a breakdown of hitherto social, class and moral orders - led to Parliament passing DORA, the Defence of the Realm Act (1914). This Act made sexual *mores* (morality); sexual problems e.g. conception outside of marriage, abortions, and, of course, illnesses (sexual infections) formal Public Health concerns as never before. At that time, male homosexuality was a criminal offence in the UK and throughout the reach of the British Empire.

In that first quarter of the 20th century, sexual infections were referred to as "venereal diseases", such as with the VD ACT 1917, (Steward and Wingfield, 2016). Public Health messages tended to be moralistic and judgemental. The practice of Contact Tracing and Partner Notification, common parlance in the era of Covid-19, had their origins in response to the growing incidence of 'VD' at the time of World War I.

The cultural, legal, psychopathologising and moralist agendas were strict and punitive on a wide range of sexual deeds and relations, some with resonance across parts of the world and their Public Health policies to this very day. For example, there were various forms of 'corrective' treatments, such as psychopathological 'therapies'; custodial incarcerations and common-place traditional and 'back-street' quack remedies. These various 'treatments' were used in relation to poor sexual health outcomes and / or personal lifeways. Such 'corrective' treatments ranged from punitive action against people who had sex outside of marriage, especially sex that resulted in 'illegitimate' pregnancies, i.e. pregnancies conceived 'out of wedlock'. There were punitive actions against commercial sex workers ('prostitutes'), too; against same-sex relations (particularly male homosexuality); abortion and various non-reproductive sex acts. Non-reproductive sex acts included those purposefully avoiding conception (i.e. using contraception), and 'sex-for-one', such as solitary masturbation, frequently labelled *Onanism* (Bockting and Coleman, 2002). In relation to sexual 'ill-health', elements of statutory public health legislation have shrouded sexual health promotion initiatives, as well as treatments and care provision, in stigma, invisibility, shame and guilt right into the third decade of the 21st century (Heath and White, 2002).

Public health facts today

- Male masturbation can lead to a reduction of prostate cancer later in life (AboulEnein, Bernstein and Ross, 2016).
- Live births outside of marriage and civil partnership in England and Wales reached 58.7% in 2017 (ONS, 2019)
- Male sterilisation (vasectomy) is more than 99% effective, yet a poorly promoted, method of contraception (NHS, 2018; Everett, 2020).

Key concepts relating to sexual health for public health

In relation to promoting and protecting sexual rights, the World Health Organisation (WHO) produced a definition of sexual health in 1975 which is still cited, popularly, today

> "Sexual health is the integration of the somatic, emotional, intellectual and social aspects of **sexual** being in ways that are positively enriching and that enhance personality, communication and love" [**emphasis added**].

Since then, WHO has produced numerous definitions, as no one definition will be fit for purpose across all times, all places and for each and every society or individual within it (WHO, 2002). Subsequent WHO definitions have adapted to draw attention to local and regional concerns, as well as wider, transnational, phenomena (WHO, 2020). These public health policy definitions draw attention to people who are victims of abuse and sexual violence; those discriminated against and mistreated for minority sexual orientations and gender identities (SOGI); or those who suffer persecution simply because of their gender, orientation or practices. Later definitions highlight those living with stigmatised and / or chronic (sexual) health conditions, including infertility, HIV infection and disease (especially AIDS), FGC / FGM i.e. Female Genital Cutting / Mutilation) and those with attendant guilt associated with many such conditions and lifeways (Brough and Denman, 2019). This list is just the tip of the iceberg. WHO (2002) therefore encourages national and local communities to customise their own definitions, taking into consideration the profile of specific (local) needs and the demographics of their own diverse cultures and populations.

Action point!

- If your organisation needed to draw up a definition of sexual health and well-being, as part of its public health policy manifesto, what key words you would consider essential or even desirable to go into it? Who would be included in this definition? Equally significant: who might be excluded or left out?

! You could have this conversation with your colleagues, sharing ideas to see how this exercise snowballs into a workable definition for your current practice setting, at this time and place. Remember, however, WHO (2002) encourages definitions to be revised and updated, as often as necessary, not just written once and for all time.

Sexual pleasure – good for health

Several declarations of the World Association for Sexual Health have been agreed-upon over the past few decades. They include the Declaration of Sexual Health, Declaration of Sexual Rights (WAS, 2014), and now further declarations specifically promoting the relational aspects of sexuality and young people's sexual health and educational rights, too. The international Declaration on Sexual Pleasure (WAS, 2019) promotes sexual pleasure as an innate and inalienable right, for each and every individual.

These declarations, aspects of human rights, are a far cry from the moralising discourses against 'VD' just over 100 years ago. It is crucial to remember than no matter how important these international public health declarations of rights may be, in reality, on the ground, in individual people's lives, far too often so many suffer because their rights are hidden or

invisibilised and down-trodden by elements in the wider society in which they live (Collumbien *et al.*, 2012).

Sex-negative or 'erotophobic' (Evans, 2004) elements of cultures or societies often emanate from over-powerful, hegemonic, bullying dimensions of patriarchy, toxic masculinity and hetero-supremacy. Women, girls, and all those who are held as different – who *queer* the cultural perception of masculinist supremacy - pay the price, be this through violence against them or lack of equality granted to their social, educational, legal and, especially, their healthcare needs, ultimately denying them individual respect and their human rights. Equally problematic are the intersecting cultural, institutional, inter-personal and intrapersonal dimensions of erotophobia which come from other social forces, such as specific traditional cultures, age ranges, religions, locations or the impact of poverty, lack of learning capabilities and various personal or individual attributes.

Public Health (PH) Professionals have a duty and crucial role to play in challenging all forms of erotophobia, including homophobia, biphobia and transphobia, as well as the sexism and heterosexism which invisibilises a range of sexual matters across the public health arena. For example, PH Professionals are involved in commissioning and implementing policies; sourcing and conducting population research and advising people on ways which maximise their health and prevent ill-health. This ill-health may include sexually acquired infections (SAIs / STIs), particular conditions (e.g. infertility; erectile dysfunction) or life-changing situations (e.g. genital cancers).

If professionals themselves – students and registered practitioners - are erotophobic (or sexist, homo- bi- or transphobic) to start with, then they may impose their own prejudices on the public health service they provide, through invisibilising people and specific sexual health needs. Invisibilisation of people and needs can happen in various PH initiatives or campaigns. For example, if a practitioner is heterosexist / homophobic, and in a position of responsibility for commissioning public sexual health prevention campaigns, they may focus only on the issues or people which *their* morals or belief systems permit them to do, neglecting a genuine, proactive, health response for all others, especially LGBandT+ people (lesbian, gay, bisexual, transpeople + others) and matters detrimental to minority health (GEO, 2019). This lack of cultural competence around sexualities (Fish and Evans, 2016) may be evidenced in a reproduction-only focus for campaigns, which lacks attention on the implications of sex for pleasure, and on the potential impact of condomless sex as a safer sex / infection control resource. A lack of cultural competence, for all but heterosexual / reproductive people also invisibilises the root cause of poorer mental health for LGBandT+ people. Poorer mental health *sequelae* so often originate in societies that lack equal acceptance of LGBandT+ people, their sexual health matters and their cultural and relationship life-ways. Similarly, if a PH practitioner has specific beliefs about abortion, or transpeople, or people with learning / physical disabilities and sex, or commercial sex workers, or child sexual exploitation (CSE), or Pre-Exposure Prophylaxis (PrEP) against HIV – this list is endless – then, without accurate personal and professional reflection, by the individual PH practitioner, to challenge their own world-view assumptions and knowledgedeficit, then the work they do may actually be sub-optimum from that which is

genuinely required, all because of an imposition of *their* beliefs*, their* customs or traditions, on the work they are paid to do for the general public.

> **!** Consider the restraining and facilitating forces which hinder / enable a sexpositive public health policy. This process is called a 'force field analysis', where the goal of the public health initiative can be written in the centre of a page, starting with the imperative "to ……." do something, for example, "To intentionally promote awareness of sexual pleasure and health needs of people, routinely hidden or discriminated against in traditional public health messages and campaigns".

The goal of a force field analysis is to explore and over-come various 'restraining forces', i.e. those which hinder public health efforts trying to maximise the Aim. Equally important is to ensure that there are enough positive or 'facilitating forces', which will enable and ultimately enact the Aim. This exploratory technique could be used with excellent benefit by teams of Public Health Professionals, exploring how they might conduct campaigns for advertising physical, mental and relational health benefits of pleasure in sex / sex for pleasure. Similarly, it might be a force field analysis on exploring how to route-out erotophobia and prejudice in Public Health services as well as specific campaigns. As a Queer Theory motif (*anon*) suggests, it is important not just to 'think outside the box, but think as though the box doesn't even exist!'

Two other key concepts to explore with regards to sexual health for public health, include wider understandings of **sexuality**, and an holistic approach to **three key dimensions of sexual health** for promoting personal health and well-being.

'Sexuality is …'

According to Foucault (1978), sexuality is a relatively modern concept. It is more than some solitary dimension of a person's identity; more than something to be labelled simply as either one thing or another. It is important to consider multiple dimensions of this oftentimes binary labelled term 'sexuality', to avoid reducing people to being either 'straight' (heterosexual), on the one hand, or any of the many other identity labels for all people deemed 'not-straight' on the other. It should be noted that whilst many sexual identities – such as heterosexual, gay, lesbian, bisexual - rely on notions of orientation *immutability* (Wintemute, 1995), i.e. something given and unchangeable, as with a person's ethnicity or skin colour, the term queer (often with a capital Q, when used in Queer Theory) is a critical theoretical rebellion against the need for putting people into any such labelled categories. Queer Theory originated as an active doing, a verb, e.g. 'to queer all heterosexualised spaces' (Evans, 2011), rather than a noun, an identity or label: '*a* queer', although it is often used interchangeably.

Of course, with abbreviations such as LGBTI (or LGBandTI), the 'T' stands for transperson / transgender, and, as such is a gender identity not a sexual orientation; similarly so 'I,' for intersex people. A '+' sign might indicate 'and all others' (Vincent, 2016).

Evans (2017) suggests that the concept of 'sexuality', still a somewhat contested term across times and places, is beneficially considered from four inter-relating dimensions (Figure 1):

orientation, **identity** / expression, **attractions** and **behaviours** (sexual practices). This 4-fold consideration of sexuality encompasses dimensions that not only agree with each other, but, more significantly, may *not* agree with each other. For example, a married couple in a country which criminalises male and female homosexuality, are, without any need for consideration, perceived as straight i.e. heterosexual. And yet this union might be a 'marriage of convenience', or a marriage for local law and custom's sake. No one needs to label the orientation of this couple as straight / heterosexual; it is a given. One or both parties, however, might actually have a different orientation to their perceived identity. Their orientation might be gay / lesbian, bisexual, heteroflexible, queer, questioning or a whole host of other non-heterosexual terms. **Figure 1**

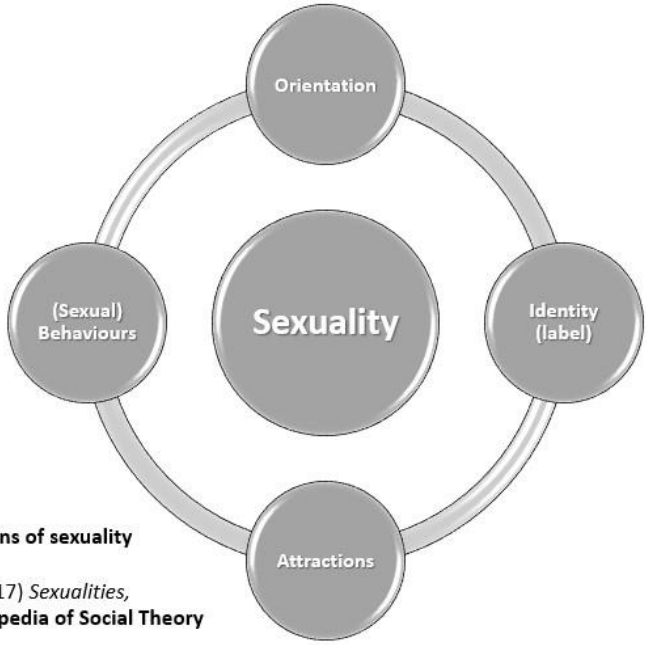

Figure 1: Four dimensions of sexuality

Based on Evans, D.T. (2017) *Sexualities,* **Wiley Blackwell Encyclopedia of Social Theory**

A person's sexuality is not reducible to an identity label; Public Health perspectives need to be cognisant of sexual behaviours (such as various sexual practices and relations) and associated risk factors. Hence the reason why "MSM" refers to sexual acts or behaviours, e.g. males who have sex with other males, whereas 'gay' and 'bisexual' are sexual identities. Self- acknowledged identities may be far more indicative of an orientation, and, possibly a life-style, than a mere indication as to whether the person is sexually active or not, e.g. celibate or asexual. For example, a person may define themselves as gay, straight, lesbian or bisexual, but that says nothing about whether they are actually having sex, or what sort of sex they are having; whether sex is safer sex; protected; enjoyable; consenting and so on.

With sexuality an integral part of wider sexual health, a formal strategic approach for PH Professionals can be directed via three domains, as explained next.

A sexual health triptych – three key dimensions for public health

A 'triptych' usually refers to three panels of an integrated art production. Visually considering sexual health in three such panels, in the *sexual health triptych* (Figure 2), Evans (2011) highlights, firstly, the central, **holistic dimensions** of sexual health and well-being. The

holistic dimensions apply to all individuals and incorporate the person's **physical** (somatic), **psychological** (mental), **existential** (e.g. life-beliefs / spiritualty / religion / ethical standards and moral behaviours) aspects of being as well as their **love and relationships** with self and others.

Figure 2

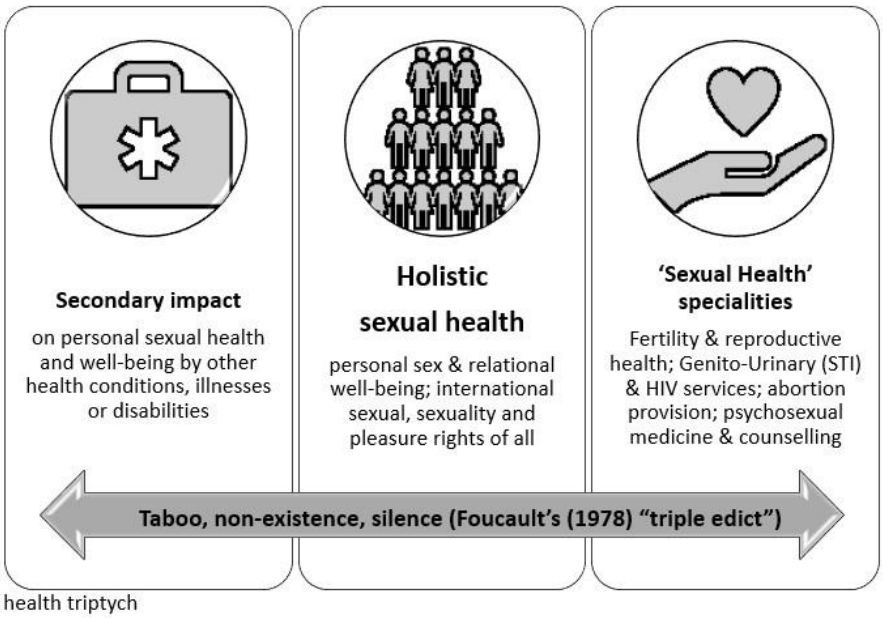

Figure 2: A Sexual health triptych

Evans, D.T. (2011) **Sexual Health Matters! Learning for Life** (EdD thesis)

A second panel identifies ways in which so many other healthcare conditions, especially physical or mental illnesses or particular disabilities, can have a profound **secondary** impact on a person's sexual health and well-being. These secondary-impact conditions may be detrimental to personal and sexual relationships; diminish an individual's sexual performance; inhibit positive esteem and well-being, or frustrate the outcome of various sexual preferences or choices.

> *Consider how medications for certain conditions interfere with the successful functioning of methods of hormonal contraception; or when 1 in every 2 men with type 1 diabetes experiences erectile dysfunction (ED); or when people with low selfesteem care so little about themselves – or crave love and affection and are fearful or rejection – that they take sexual risks detrimental to their health and well-being.*

The third element of the triptych model is focused on aspects of health traditionally catalogued under the umbrella term "**sexual health**", or "**sexual and reproductive health**" (SRH) (RCN, 2019). "Sexual health" more-often refers to associated problems of health, such as infections and conditions which are core to genito-urinary healthcare practice; contraception and reproductive health; abortion care, and to psychosexual medicine and therapeutic counselling (Brough and Denman, 2019).

As a somewhat neglected, hidden or taboo area of Public Health, sexual health is genuinely the com/passionate heart at the centre of the public's health. But notice how relatively few textbooks or journals have identifiable chapters or articles proactively raising the profile of

sexual health within the Public Health discipline. Too few texts address matters of sexual health, or enable practitioners to promote individual and societal equality, respect and wellbeing, including gender equality and sexual well-being, devoid of any form of discrimination (Mitchell *et al.* 2021).

From an epidemiological perspective, too, missing out sexual health from Public Health clearly counteracts the often-times preventable outcomes of condomless and unprotected sex. It is the intention, here, to demonstrate how sexual health is truly woven into the very fabric of Public Health, the political mission at the core of the PH speciality. Public Health practice that adequately addresses sexual health and well-being can help maximise best outcomes 1) across primary prevention, i.e. of the things that could go wrong; 2) across the promotion of holistic rights and well-being, and ultimately, 3) help reduce the need for subsequent treatments and / or episodes of care.

Economic reality of good sexual Public Health reveals how it is far less expensive to prevent the unintended, as well as kinder on individuals. For example, the cost *per capita* for effective methods of contraception is a significant saving on any of the unwanted outcomes of unplanned conceptions (Hadley *et al.* 2018). Likewise, HPV (Human Papilloma Virus) vaccination is reducing costs and impact on lives from genital warts as well as HPV-related cancers (cervical, oro-pharyngeal, penile and rectal). Free condoms and freely accessible Pre-Exposure Prophylaxis (PrEP) against HIV are significantly less expensive and more desirable than a life-time on antiretroviral medication for – currently, 37.9 million - people living with HIV (UNAIDS, 2020).

PH Professionals are in an unparalleled position to positively influence sexual, reproductive and gender health: i) holistically; ii) in areas of life impacted as secondary to other health conditions, as well as iii) specifically, across the range of sexual and reproductive health (RSH) specialities, too.

Empowering public health practitioners in the identification and facilitation of fundamental sexual health promoting behaviours

Public health professionals are accustomed to using scientific data resources and associated terminology for the study of population health (Oliffe and Greaves, 2012; Green *et al.*, 2019). These resources and terminology include the science of epidemiology; of counting personal level demographics, and applying these data to study the spread of disease, such as with epidemics and pandemics, across broad population densities (McClean *et al.*, 2020). Public Health Professionals are equally accustomed to investigating and reporting on the wider determinants of health and the impact on general population ill-health phenomena, through primary and secondary prevention initiatives, in regard to communicable infections or risk-associated life-styles and their *sequalae*. So many research-orientated resources are traditionally applied to particular cases across gendered health and sexual health (Oliffe and Greaves, 2012). Typical examples to think of include the focus on unplanned teenage conceptions; HPV vaccination debates; intimate partner, gender or sexuality-based violence; sex (gender)-related cancers and conditions; abortion; sexual infections and HIV. This list is not exhaustive, but significant to mention that many of these conditions are frequently hidden and marginalised, even in national public health strategies until they become too

large to hide and result in being 'problematic'. Even when conditions become significant or 'problematic', national / international political will, public (and media) 'morals' or moralising, and lack of adequate funding often mean that a project ends up task-oriented e.g. "reduce numbers of XYZ" rather than being genuinely preventative, proactive, personcentred (holistic) and people-focused (Fowler, 2014).

Considerations for the facilitation of fundamental (safer) sexual health-promoting experiences include four messages often *out-of-kilter* with wider public discourse and / or approval. Firstly, **the ability to talk freely about all matters sexual**, especially to healthcare professionals, openly, without discrimination, shame or embarrassment. A prime example is the social or media furore or stigma about breastfeeding in public spaces, particularly in certain countries including the UK. Then there is the matter of the **global unsustainability of humanity,** caused by over-population. This problem emanates from the so-called procreative imperative - "be fruitful, multiply, fill the earth and subdue it" - underpinning many religions, their approach to contraception, and the supremacy afforded to promoting reproductive heterosexual relations. The third consideration is the **hesitancy many healthcare professionals would have in *proactively* and intentionally promoting gender and sexual health**, including sexual pleasure (WAS, 2019) and well-being (Mitchell *et al.* 2021), and elements often left out of public discourses of 'sexual health' *per se*. By neglecting this key element of Public Health beneficence, professionals fail to promote this important aspect of life for a happier and healthier population. Finally, **so many nonheteronormative sexual practices and / or life-ways are considered by certain societies, religions and cultures, to be abject** i.e. dirty / filthy / shameful. The abjectification of matters sexual oftentimes renders the topic unspeakable, stigmatised, discredited and marked out as 'wrong'. To the extent that Public Health policies / policy makers are unable to challenge and overturn such negativities, then a fuller wealth of human sexual potential fails to be achieved or personally actualised.

Underpinning legislative and policy guidance: global and national perspectives

Over and above the influence and impact various professional bodies and political unions can have, individual nurses and other healthcare professionals are oftentimes members of national or regional legislative authorities and governments. This, potentially, can have a positive bearing, especially for insuring inter-professional learning and expertise are utilised, positively influencing sexual and gender health onto the public health agenda of a nation's health.

To add to the benefit of having Public Health Professionals in strategic positions of governance, the influence of their specialist organisations collaborating together put them in a stronger position of influence for public health partnerships, knowledge and resources. Other key influencers include third sector / voluntary (charities) and direct-action organisations. These latter embrace advocating for people living with HIV or AIDS; ending Female Genital Mutilation; ending Gender and Sexuality-Based Violence; promoting safe abortion services; advocating contraception and reproductive rights; sex workers and transgender people's rights and sexuality rights organisations(ILGA, 2020). There are many

other institutions, too, such as UNAIDS, International Planned Parenthood Federation, MSI (formerly Marie Stopes International), the International AIDS Society and more.

Four essential difficulties against improving inter / national sexual and gendered Public Health, however, can originate from:

i) individual practitioners
ii) practitioners' wider societies or cultures iii) multidimensional impacts of poverty iv) a lack of funding adequate to need.

Poverty is especially maleficent to health when linked across other intersectional disadvantages, including disproportionate effects on age groups (the very young to the old), ethnicities, geography and in those countries where a noticeable de-prioritisation of matters of sexual, reproductive or gender health and equality exist. In such circumstances, promoting a positive awareness of all aspects of sex is compromised from within a Public Health perspective.

International research highlights how many health care professionals still maintain that they do not have the professional or personal knowledge, skills or attributes to address sexual or gender health with their client populations. Neither do they have the knowledge, skills or attributes to strategically address sexual health, in their capacity as Public Health leaders, when in positions of influence (Wellings, 2012). These problems may stem from wider dimensions of sexual and gender health routinely missing from pre-registration curricula (Cesnik and Zerbini, 2017; Brown *et al.* 2021; Natzler and Evans, 2021). Couple this personal and professional disadvantage with the shrouding of wider aspects of sexuality and sexual health, in the individual professional's national or social *psyche*, and it is no wonder that areas of sexual health and well-being are noticeably absent from key Public Health strategies.

A lack of consistent funding, coupled with absence of public awareness of sexual health matters, results in a socially deafening silence (Serrant-Green, 2011). This silence may be in regard to routine resources, such as freely available condoms, safer sex promotion campaigns, contraception and reproductive health provision, but also a silence which goes much deeper. The silence can impact negatively on abortion legislation, provision and care; sexual abuse and rape; support services and refuge for those stigmatised and shut out from their communities, and services for all those discriminated against on the grounds of invisibilised or marginalised status. For every one of these people, being silenced and missed out of Public Health initiatives - especially when they are not proactively targeted by Public Health Professionals - simply compounds their problems and further incentivises their oppression and neglect.

Chapter summary

This chapter has highlighted opportunities where a formal Public Health recognition, across a range of matters sexual, may be invisibilised or wholly missing. The impact is deleterious to health and well-being. The role of Public Health services and professionals, is, of course, never solely reactionary, such as in exploring epidemiology to count what has gone wrong.

Public Health's promotion responsibilities are clearly grounded in being proactive, to champion the case for better health for all peoples, including their sexual health. That promotion responsibility could start by ensuring students of Public Health have sexual health and sexuality matters specifically programmed into their curriculum and practice opportunities (Brown *et al.* 2021).

The paucity of entries in major Public Health textbooks and journals, intentionally promoting sexual health and well-being - including safer and pleasurable sexual experiences - requires a sufficient level of knowledge and training both in understanding and uncovering the issues, as well as being willing and able (confident and competent) to address them and challenge the professional's own assumptions or prejudices.

Collaboratively building on strategic declarations of the WHO, the World Association for Sexual Health (WAS), national programmes and individual healthcare professionals' own respect for sexual health in Public Health is a position that has been developed throughout this chapter. This position highlights the importance of the tripartite or triptych approach (Evans, 2011) to sexual health in Public Health, encompassing wider holistic dimensions of sexual health and well-being (Mitchell *et al.* 2021); elements of health secondary to, and impactful upon, sexual health and well-being, as well as the core specifics, under the umbrella term for sexual, reproductive and gender health. The challenge is for each Public Health Professional to be able to work towards ensuring these matters are clearly addressed and incorporated into the curriculum of students, as well as the policy and practice of their own organisation and in their wider national community.

Joining up the dots - how can you make a difference?

What further difference can you make? There are many ways in which Public Health Professionals can raise the profile of sexual health, directly – and indirectly. One indirect impact, out of many, is to join up the dots between various health and well-being campaigns; remember to factor-in the sexual health dimensions. For example, if a PH campaign is exploring how bullying of children often continues as discrimination into adulthood, it might examine how these phenomena can lead to isolation, low self-esteem, and a detrimental impact on poor mental health, increasing the risks of smoking, having condomless sex, increased alcohol consumption and substance abuse. Now, consider and highlight the impact of this scenario on an individual's sexual, reproductive or psychosexual well-being. This scenario is particularly relevant to all those stigmatised over their sexual orientation or identity, or those deemed not to fit in to a country's specific heteronormative model.

Remember: many consequences of poor sexual and gendered health are preventable, especially with strong, proactive, Public Health services and effective campaigns. All this takes adequate resourcing and the will to actively promote the positive benefits of sex and feeling good to talk about it in public health *fora*.

Critical questions

1. From the perspective of your own professional stand-point / field of practice / service area: what difference can *you* make to raise the profile of sexual health and well-being, as a public health matter?
2. What could prevent you from raising the profile or taking action on it, such as barriers or hindrances, or difficult gate keepers that you need to manage?
3. What sources of enablement, strengths and opportunities can you maximise on, to achieve your aim of raising the profile of sexual health, as a public health matter, within your service?

Key terms

Erotophobia (irrational fear of sex, including talking about sex / sexual health); **Onanism** (old fashioned term for masturbation); **Sexual Health**; **Sexual Well-being**; **Sexual Pleasure**; **Sexual Rights.**

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