

Safe and Consensual Sex: Are Women Empowered Enough to Negotiate?

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Abstract:

Pakistan is a society that has been struggling for women's rights and empowerment over decades now. Nevertheless, discourse on mainstreaming gender equality and women's socio-economic empowerment often neglects the 'sexual' aspect. Rahnuma - FPAP² as a vibrant protagonist to work for the sexual reproductive health and rights, initiated a small-scale research project with married women of Lahore city. The purpose of this pilot project was to analyze empowerment of women from the perspective of sexual safety and rights. Another important aim of the project was also to test the theoretical intersections between sexualities and AIDS at grassroots level, and understand how HIV phenomenon facilitated the debate on sexuality and rights.

The study used both qualitative and quantitative approaches for analysis. A group of 30 women were selected and a base-line information survey was conducted. The women were trained on sex negotiation, HIV, STIs, Sexual Reproductive health & rights through a series of workshops spread over 8 weeks. A mid-term and final term assessment was conducted, against the already set indicators related to HIV & AIDS and SRHR³. For qualitative understanding, in-depth interviews and FGDs⁴ were conducted.

The study highlighted empowerment of women vis-à-vis their sexual lives, in a society that suppresses the needs and desires in the name of culture and traditions. Qualitative data reflected on suggestions to catalyze women empowerment in terms of ensuring safe and consensual sex. Attitudinal changes embedded in culture and traditions may be addressed through BCC⁵ tools and material. Findings of the study can be useful in understanding negotiating skills of women on safe and consensual sex practices in the similar areas and consequently plan and develop interventions.

Background:

Sexuality, though explicitly encouraged and manifested in masculinity ideals, remains a taboo and non-issue for women in 'traditional' societies; women's sexuality is too often tied to procreation process where as the desire aspect is by and large overlooked, particularly in heteronormative cultures. This perceived and presumed 'non-sexualness of women give rise to the notions of women as objects or reproductive machines who, in addition, are responsible to manage household chores. In such cultural settings, as in Pakistani society, even education and economic status are not determining factors of women's empowerment. Educated women are equally submissive, following the normative ideals of being 'obedient'; their economics status also doesn't not guarantee their safety from domestic violence. In feudal, agri-based or even business families, for example, women own properties but don't have access to or control over the resources.

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⁴ Focus Group Discussions

⁵ Behaviour Change Communication

Middle class working women is probably the most vulnerable group. At one hand they struggle to meet the economic needs of the family, either as the sole responsibility or by sharing the burden, on the other hand they strive to be *good* housewives. In presence of immense physical, mental and social stress, the sexual disempowerment puts them in an even marginalized situation where they have to cope with extra anxiety, violence, risk of disease or social pressures.

Women's sexuality though suppressed by almost every culture, yet experienced its worst form in the societies led by a fixed ideology, value system or orthodox interpretation of religion. Notions such as gender inequalities, physical and sexual violence and even divorce come under the touchy domain of the 'private'. Be it in the name of religion, social class or honour, women serve as a property of the male counter part. In Pakistan, this suppression in general coupled with a new theo-judicial system that started to emerge during dictator Zia's time, brought forth many women's groups; when established, they primarily focused on showing solidarity against the theocratic laws⁶.

The women's movement considers the legal reforms as the main strategic focus (that may give an impression that the movement is still struggling for very crude and fundamental issues: talking about issues such as sexuality would probably a frivolous argument). This movement, however, also addressed the other visible forms of inequality such as economic dependence, violence against women and limited choices in reproductive matters, as a matter of practical approach. Although, even as a practical approach, the sexuality aspect of empowerment was too often ignored by the 'feminist' discourse due to, probably, strong hegemony of the principles of the almighty Second Wave of Feminism.

After the ICPD, there was increased focus on Sexual Reproductive Health and Rights (SRHR) and the theoretical debate on sexuality and rights started to re-shape globally, along with the emergence of Third Wave of Feminism (the echo of this wave, however, is yet to be felt in feminist circles of Pakistan). In the meantime, the HIV and AIDS phenomenon emerged during the late 90s in Pakistan. The shift in donor's attention with an increased focus on HIV and AIDS, substantially affected other programs of community development, family planning and gender equality. It became almost inevitable for, perhaps, every NGO to include HIV related programs in the agenda in order to 'survive'. Women's organizations and groups were no exception. However, the programmatic momentum, particularly in the domain of women's reproductive autonomy, which was set over the decades suffered due to lack of funding.

At the same time, the HIV and AIDS phenomenon contributed immensely towards unpacking SRHR agenda as well; particularly it resulted in debate on sex and sexuality through a strong HIV / AIDS prevention campaign, using various media. 'Safe sex' and 'condom' are more commonly used and not the taboo words any more. In this scenario, the debate on Feminization of HIV and AIDS considerably contributed

⁶ The notorious Hudood Laws (the laws pertaining to adultery and other crimes derived from Quran) were imposed back in early 80s. Under these laws, if a woman is raped, she has the liability to prove it otherwise she is put into jail for adultery and/or false-blame. To prove her innocence, she is responsible to produce four eye witnesses, who saw the act of penetration. Clearly the law facilitates the perpetrator. Almost the entire strategic focus of the 'feminist' groups was to repeal these laws. The laws were moderately modified under the Women's Protection Bill of 2005; they are not completely repealed, however.

towards realization of women need to be empowered and make informed choices about their bodies.

In the conservative social milieu of Pakistan, where, not to talk about enjoying sexual reproductive rights - a majority of women have fewer choices and least realization of their basic needs, which further worsens their situation and puts them at greater risk and vulnerability in the times of HIV and AIDS. Using sexual reproductive rights approach facilitates to deconstruct the power structures and perceived notion of masculinity. It often challenges many exiting notions by posing questions: for example, *do women have the right not to marry or the right to decide whether or when to have sex within a marital relation?* In this connection, it was felt timely to intervene in the area of an 'ordinary' Pakistani women's sexuality to understand more on potential emergence of the sexual reproductive rights discourse.

The Project:

The pilot project was initiated with an aim to understand the relationship between sexual behaviour, gender meanings and rights vis-à-vis the negotiation for safer sex among women. It also focused on empowering women in order to protect them from HIV/AIDS & other STIs. The women's status remains major challenges for Pakistan to firewall against this pandemic. HIV / AIDS Surveillance data demystified that the transmission is not only through commercial sex worker or transsexuals and revealed the other dimensions of spread of the virus, such as Injecting drug users, bi-sexual married men having sex with men etc. These factors put women, especially those who are married, at greater risk. Having little or no idea of safe sex, lack of consent in sexual intercourse and skills to negotiate condom use, further worsens their condition. The project primarily conceived to test tools and techniques of making women aware about their bodies and sexual reproductive rights and empowering them confidence to ensure consensual and safe sex.

Rahnuma - FPAP, as protagonist in the domain of SRH and Rights, piloted this small-scale project for analyzing women's empowerment in sexual and reproductive matters. The IPPF South Asia Region provided technical and financial support for this project. The main objectives of the project were:

- To study the relationship between sexual behavior and gender meanings in relation to the negotiation of safer sex practices among women
- To empower women in order to protect them in the HIV/AIDS pandemic & other STIs/RTIs

The project also aimed at critically addressing the following questions (Nath 2007):

- Can a woman really be sexually assertive?
- Can she ever think of differing from the concept of mutual fidelity when she has been socialised and brought up on the principle that her husband is 'God'?
- Can a woman ensure safe sex by suggesting that sexual partner wear a condom when the very suggestion of condom implies infidelity that could threaten her personal security and destroy the relationship?
- Further, if the woman did have sex using a condom, how would she be able to prove that she is fertile and can bear a son?

The project also used a theoretical model to analyze sex negotiation and its potential outcomes. Having proper information about sexual rights, body protection, STIs/ HIV etc. results in risk perceptions that consequently challenges the power relation that women are culturally conditioned to abide by. The negotiation of safe and consensual sex may bring about positive or negative outcomes. Most importantly, women's perception about the outcome is directly associated with empowerment: if they perceive negative results and give up, they can hardly be assertive in sexual matters. However, anticipation of positive results and continuously discussing with a variety of arguments leads to empowerment in their sexual relations (Nath 2007, see Annex 1).

Methodology:

The area selection, identification of trainers, questionnaire translation and how to use appropriate language in field related issues were discussed at length by program and planning experts who finalized the processes after several meetings. A team comprised of three trainers/ workshop facilitators, two interviewers/ researchers, a research coordinator and an overall project coordinator worked for about 8 weeks with a selected group of 30 women. The participants were selected from a community that is inhabited by low to middle income group. The women were selected from the community through visits, they were explained the purpose of program and were invited to the FPAP clinic premises, where workshops were conducted.

After selection of the participants, the baseline data (quantitative) was collected through a structured Interview Schedule (face to face interviews). The intervention (i.e. workshops) went on for 7 weeks. A mid term evaluation was conducted after 3 weeks and after completing the 14 sessions (held on twice a week basis), a final term assessment was carried out using the same research tool. The tool was based on the following:

Knowledge on: Sexuality, Pregnancy, Fertility, STI/ HIV, Abortion, Contraceptives/ technologies, Consequence of unsafe, unplanned and unwanted sex, Sexual and gender rights

Attitude towards: Pre-marital sex, Sex in marriage, Extra-marital sex, Extra marital sex of husband, Virginity, Shame and dishonour, Unsafe, unplanned and unwanted sex, Contraception, STI/ HIV, Abortion, Sexual abuse

Risk perception: Sex as duty, Pregnancy, STI/HIV infection, Fun/ pleasure/ pain/ experience

Power relationship: Knowing the partner prior to the event, Inter-personal communication, Responsibilities and obligations, Consent/dissent, Use of force

Power to negotiate: Context, Privacy, Personal realization and motivation, Self esteem & self worth, Communication- verbal/non verbal, Access to commodities and services- contraceptives, spermicides, treatment, etc, Non-penetrative sex, Skills to assert

Consequences (perceived/ actual) of sexual negotiation: Postponement Acceptance by partner, Rejection by partner, Sexual violence

Data Analysis:

Quantitative data gathered through interviews was entered to computer using MS Excel program. Necessary statistical operations and graphs/ tables were generated for analysis.

Workshops with Participants:

A series of workshop, spread over seven weeks, was conducted with selected group of 30 women in community setting (at the FPAP Family Health Clinic). The intervention was planned after collecting the baseline data. The idea behind such intervention was the fact that women have been socialised, through cultural training, to accept sexual sub-ordination and even sexual oppression, the process of consciousness-raising seldom comes from women themselves and need to be induced. For a deeper understanding of their feelings and perceptions, the interviewers and trainers gathered the qualitative expressions as well. For research and training at field level, only the female staff of Rahnuma - FPAP was involved in this project. The training was divided into three phases with the following contents:

Phase I

- Skill of active listening-Developing group work related to HIV/AIDS
- Skills of how to talk about Sex and Sexuality
- Skills to make your emotion explicit-Using stories to explore Gender, Sexuality and Sexual Health
- Skills to make your emotions explicit-You decide
- Building self esteem and learning to be assertive-Am I assertive?

Phase II

- Building self esteem and learning to be assertive-Responding to persuasion
- Clarifying perceptions-Questionnaire
- Clarifying perceptions-Using picture codes to assess everyday experience
- Acting out problems and solution

Phase III

- Helping sexual partners to put themselves in each others shoes - (s) he has HIV!
- Focusing on interests and inventing options for mutual gain
- Focusing on interests and inventing options for mutual gain - Negotiation role play
- Dealing with threats and violence

Different techniques such as role plays, picture-story, discussions, personal experiences etc. were used to make workshops more interesting and participatory.

Findings:

Profile of the Participants:

Subjects were selected from a peri-urban community in Lahore city. Most of the participants belonged to lower-middle Socio-Economic status; the personal income of the subjects ranged between 1000 and 7000 Rs. Per month (i.e. US \$ 15 to 100 per month). However, when asked about perceived socio-economic status, most of them (n⁷=26) identified themselves with 'middle class' status. Most of the participants (n=20) were housewives, though one third of them were running home-based/ micro enterprise. About half of the participants could not read or write, where as the rest of

⁷ n refers to number of cases having a particular opinion/ characteristic/ response etc. out of a total of 30 cases/ subjects.

them received formal education (ranging from 5th to 12th grade). All the participants were married (21 - 40 age range) and currently living with their husbands. Average No. of children per woman was 4 (ranged from 0 to 5).

Knowledge about Sexual Reproductive Matters:

Data showed that a majority of women, when asked without probing, had not sufficient knowledge about family planning methods, while conducting baseline (i.e. when there was no intervention). Although some of them they had heard about oral pills and injection on TV, however, due to vague messages about family planning on media, only 14 of them had proper knowledge of modern contraceptive methods. They also had little knowledge about the fact that a person could get STI/ HIV in a single episode of unsafe sex. In the same way, the information about STIs, HIV and AIDS was minimal. Participants had little or no idea of sexual reproductive rights; similarly having a vague concept of 'wanted' vs. 'unwanted sex'. However, after intervention it was observed that they started opening up and about half of them admitted that they had unwanted sex at least once, during the last three months. They were more comfortable and confident about discussing these issues.

Attitudes and Risk Perceptions:

Women were asked different question about perceived risk to infections etc., many of them (n=18) were of the opinion that in most of the matters related to sex or reproduction, their spouses are more powerful and make decisions mostly. It was also revealed, while asking for the baseline survey, that they hardly felt being at risk of acquiring an STI or HIV. None of them reported/ admitted that they ever had any extramarital relationship. Another interesting finding (while asking for baseline) was that the participants would not favour using condom, within marital relationship, if they are Sterilized (Contraceptive Surgery). However, risk perception was changed after intervention; they preferred to use condom even in case of Sterilization if they would feel they are vulnerable to some infection (n=28). Similarly, when asked about condom negotiation in case of having STI/HIV infection (either partner), a significant behavior change was also observed (from base line to final term).

Power Structure and Negotiating Sex:

When asked the participants (for baseline) the perception about sex within the marital relations, many women agreed to the statement that sex is an obligation and the wife is bound to 'satisfy' her husband. However, after intervention, significant change in attitude was observed and they were of the opinion that relationship should be based on mutual pleasure and respect; a woman has the right to say 'no' to sex when she doesn't feel like having sex. Interestingly, about half of the participants (n=14) admitted that they faced at least one forced/ unwanted sexual activity during the last three months. A majority of them disclosed that they rarely discuss issues related to pregnancy, family planning, risk of STIs/ HIV with their spouses. However, the positive attitudinal change led them to discuss these issues with their spouses and after intervention they reported that they start talking more comfortably (see table). When respondents were asked, for baseline, about their probable response in a situation where husband is not willing to use condom, about one third of them expressed that they would feel helpless such situation. Other spontaneous response was to convince him about the risk of unwanted pregnancy. However, responses pertaining to risk of infection, bodily rights, protection etc. or considering alternative options to

penetrative sex started coming up after intervention. While asking for final term, many of them were clear about their stance, be it is protection from infection, asserting bodily rights, prevention of unwanted pregnancy or negotiating alternative methods of pleasure seeking.

[Perceived] Consequences of Sexual Negotiation:

When asked about the perceived consequences of negotiation, very interesting responses came up. The participants were concerned that in the socio-cultural setup where they have to conform to norms and values, asking the husband to use a condom might induce anger and give them a reason to suspect she is having an extramarital affair or husband may think that he is being suspected to be unfaithful.

However, after training majority of the participants were confident enough to say that they attained the ability to negotiate in a friendly way with sufficient arguments.

When the participants were also asked about the perceived outcomes of saying 'no' to sex: many of them were afraid of verbal (n=15) or physical (n=14) abuse or the husband's denial to fulfilling the needs of the wife (n=19). Some of them also expressed that the husband might intimidate her into having sex. These apprehensions were covered through equipping them with enough arguments, which, actually they themselves suggested during brainstorming.

The participants were also asked about the context if they ever said 'no' to sex. The main reasons that came up were: when they fought with each other, when the woman is physically ill or she just avoided in the pretext of head ache or fatigue. The responses were almost same during baseline, midterm and final term, however, the realization of the risk that the husband might be having sex with multiple partners was increased after the intervention.

Qualitative Findings:

The participants were asked to discuss the barriers to talking about sex: the most important theme emerged was modesty coupled with lack of confidence. Not having enough to say further suppresses their urge to express, even if, sometimes they feel to do so. Many of them were also of the opinion that culturally women are conditioned not to be 'open' about sexual matters is and women are generally discouraged to talk about these issues. People, otherwise, may question the chastity of the woman. Consequently, women may start developing the attitude that talking about sexual matters is disgusting. However, for having a piece of advice or 'cathartic experience', their female friends are there. Culture tends to keep it as a 'women's own/private thing'.

Participants of workshops were encouraged to freely express their feelings and emotions. These quotes were noted as qualitative evidence. Some of the impressions received were:

“Although I belong to an educated family, I had never received information or had any idea about Sex negotiation, HIV and AIDS, Sexuality and self esteem. I think we (women) never given an opportunity to express or discuss our emotions” Shamim,
27

“I learned a lot about my body through these workshops. I am happy and confident enough to express my desires” Rukhsana 24

“I never discussed these issues with my husband, rather I never thought about it. Now I realize that discussion is the most important aspect of a relationship ...comfort level with bodies and mutual understanding of desires central part of it... I was such an ignorant!” Akhtar 31

Lesson Learnt:

The comparison of results (pre and post intervention) clearly indicates that there is considerable enhancement of knowledge regarding sexual and reproductive matters and there was a significant level of increase in confidence among the group under intervention. Women were more comfortable to talk about their sexuality and express their desire & consent with partners. This provides enough confidence to further intervene in the area of sexual empowerment of women.

Sex negotiation within marital relationships not only represents women's empowerment in terms of sexual and reproductive matters but also is an expression of their greater control over their bodies. It is imperative for realization of their need to be equal in decision making, self esteem and pleasure within the relationship.

Conclusions and Policy Implications:

Sexuality is an important aspect of health and detachment of pleasure, sensation, desire and esteem from it, is perhaps ignoring the psychological aspect that is equally important for wellbeing. There has been a lot of focus on women's empowerment in terms of social or economic matters, nevertheless, a little has been researched or intervened in the area of sexuality and rights. The main reason behind is purely cultural, where stigma, shame and guilt are attached to, especially women's sexuality, in Pakistani culture: an ideal woman is modest, demure or silent. We need to further the discourse on female sexuality by extensive research, inducing discussions at various tiers and reaching especially the un-reached.

In 'traditional' societies, women of all educational, cultural or economic backgrounds equally disadvantaged and marginalized in terms of their physical & emotional health; their sexuality remains a non-existent discourse in public or even private spheres. Civil society in general tend to neglect the genuine issues of middle and lower middle women; it typically serves either the minority upper- and upper-middle class quarters of urban centres or claims to nourish those who struggle for mere existence. The civil society working for development in general, though with focus on diverse range of issues, should mainstream sexuality with their existing programs related to gender, whereby a large cohort of middle and lower middle class women should be addressed.

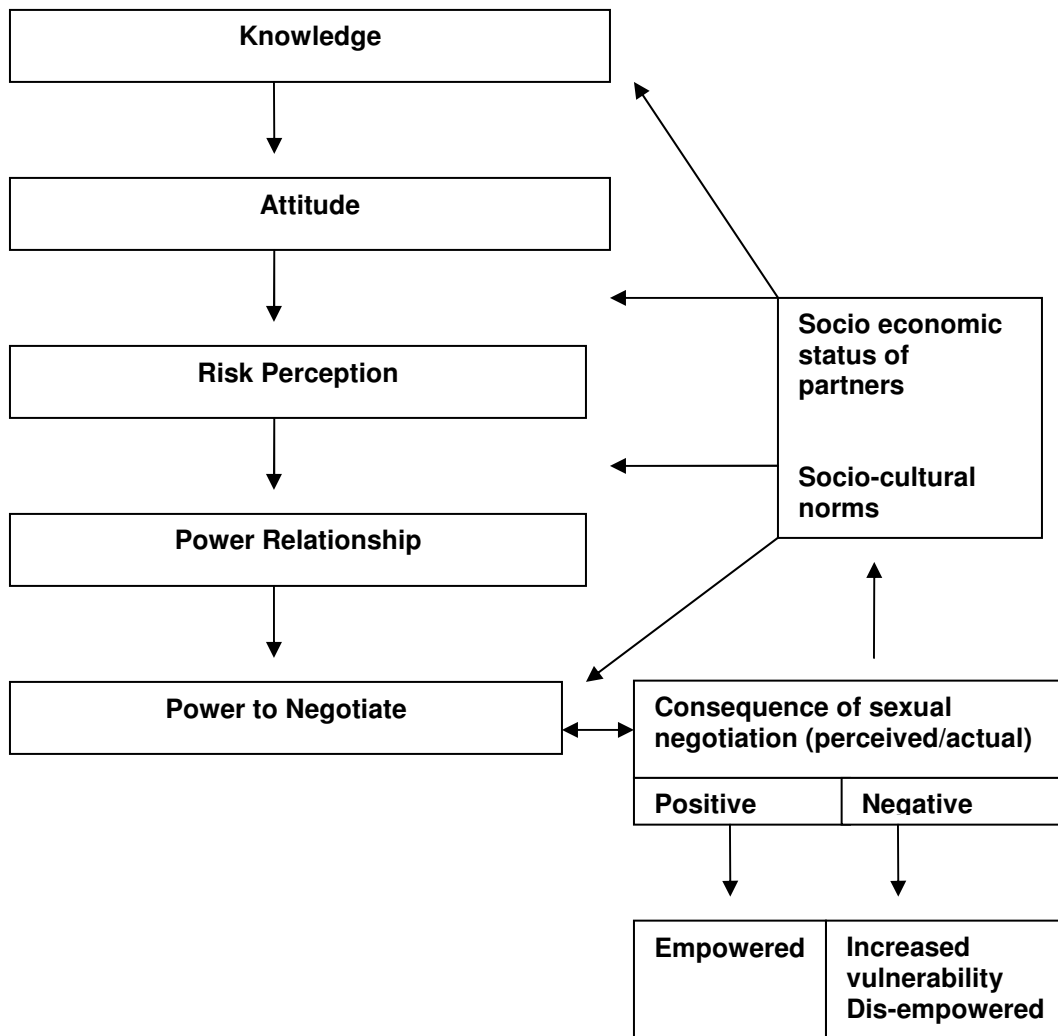
Theoretical discourse on sexual and reproductive empowerment, which lingers behind in public domain or political arena in Pakistan, has seriously been neglected so far. Typically, the gender sensitization or women empowerment programs are reluctant to touch upon the forbidden domain of sexuality. Even the HIV related programs rarely realize women's bodily rights, desire or sexuality. Such programs, by and large are 'donor-driven', tend to neglect the sexuality aspect because there is no

such requirement from the funding agency. Increased commitment of and continued support from the donor community in this area is the key to initiation of such efforts and their further extension.

Reference Document:

Nath, Madhu Bala. 2007. *How to Empower women to negotiate safe sex- A resource guide for NGOs*. UNIFEM/ Har-Anand Publications Pvt. Ltd, New Delhi - India

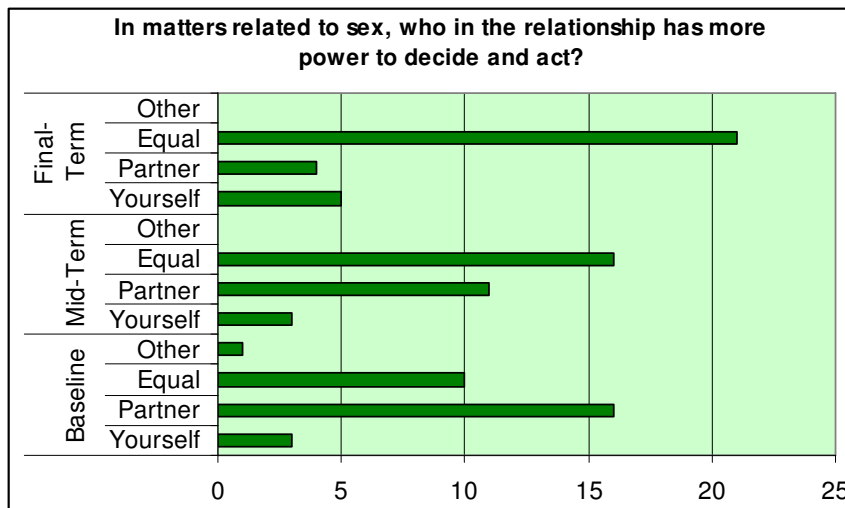
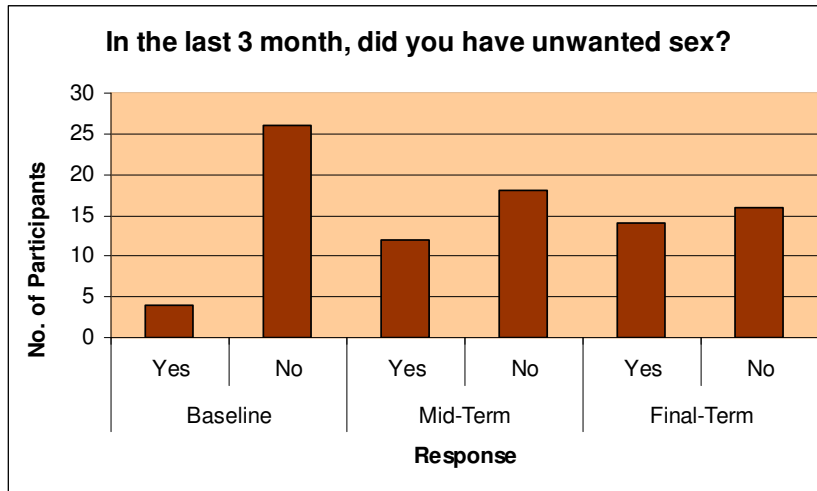
Annex 1: Theoretical Model:

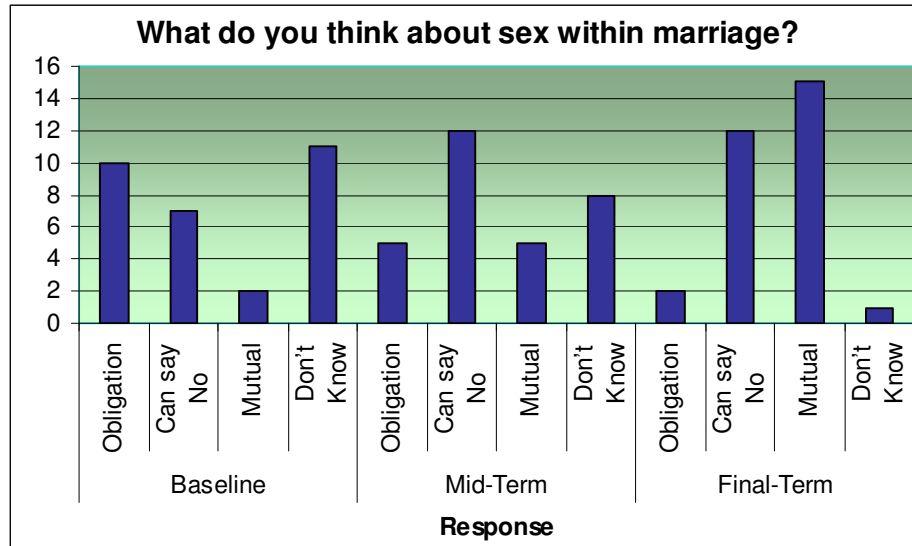


Adopted from: Madhu Bala Nath's *How to Empower women to negotiate safe sex- A resource guide for NGOs*, a UNIFEM publication

Annex 2: Tables/ Graphs:

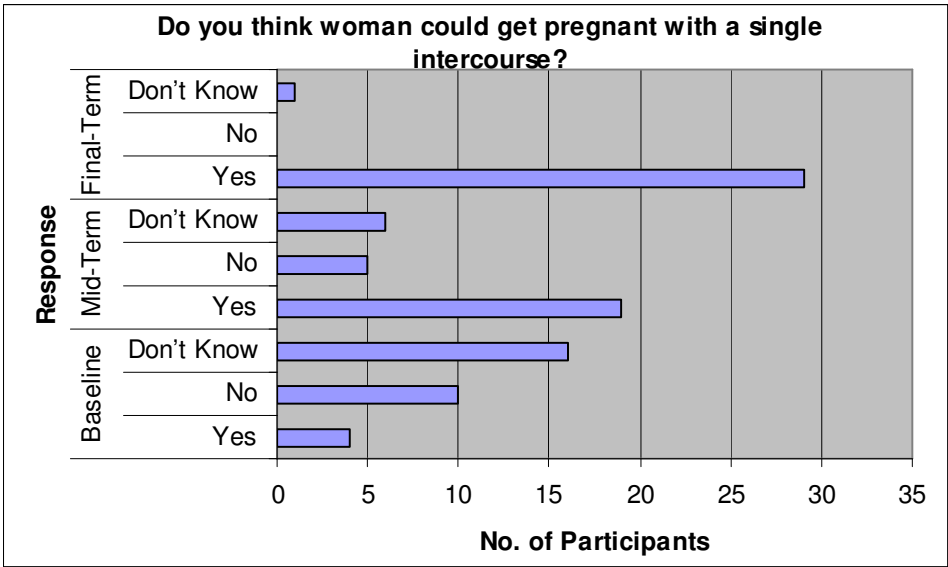
Basic Facts about Participants	
Age range	21 - 40 Years
Personal Income Range	1000 - 7000 Rs./ Month
Perceived SES	Middle Class (86%)
Education Range	5 th to 12 th Grade
Marital status	All married
Average No. of Children	4



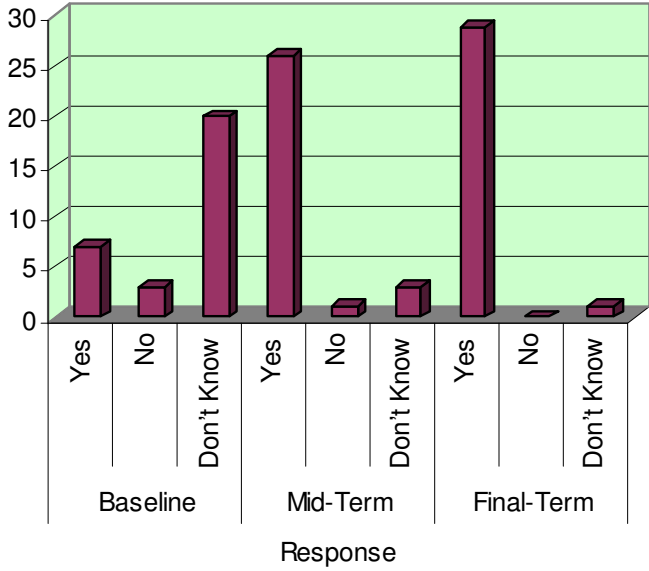


If you negotiate condom use with your partner, he will: (spontaneous)			
Perception while conducting:	Baseline	Mid Term	Final Term
Agree and use a condom	3	14	26
Get angry/ abuse you	9	5	2
Think you are having sex with others	7	4	1
Think that you suspect him of having sex with others	6	5	1
You cannot negotiate condom use	5	2	0

If you disagree to have sex without condoms then there will be: (probed)			
Perception while conducting:	Baseline	Mid Term	Final Term
Verbal abuse	15	8	2
More pain inflicted	6	5	2
Physical abuse	14	6	1
He will stop talking to me	6	4	3
Deny fulfilment of other needs	19	6	4
No problem	7	15	24



Do you think a person can get ST/HIV in a single episode of unsafe sex?



When you and your partner are together, do you both talk about:			
<i>Affirmative response while conducting:</i>	Baseline	Mid Term	Final Term
Sexual matters within your relationship	7	17	25
Issues about pregnancy, child bearing, and contraception	16	19	28
Sexual health including STI/HIV	5	15	22
All of the above	5	18	28
None of the above	14	12	2

Knowledge about Contraceptive Methods			
<i>Spontaneous knowledge while asking for:</i>	Baseline	Mid Term	Final Term
<i>Oral Pills</i>	12	21	28
<i>Injectables</i>	14	25	30
<i>Condoms</i>	15	24	29
<i>IUD/ Copper T</i>	15	23	28
<i>Sterilization</i>	16	24	27
<i>Withdrawal</i>	14	22	29
<i>Emergency Contraceptives</i>	2	20	27

If your partner is not willing to use condoms, will you: (spontaneous)			
Attitude while conducting:	Baseline	Mid Term	Final Term
<i>Refuse to have sex</i>	4	9	4
<i>Convincing about the risk of pregnancy</i>	10	7	3
<i>Talk about HIV/STI to convince</i>	5	8	12
<i>Go for non-penetrative sex</i>	0	2	5
<i>My health is my right and therefore I would take every step to protect it</i>	2	3	6
<i>I cannot do anything</i>	9	1	0

<i>If you have ever said 'no to sex', what was the context then?</i>			
<i>Attitude while conducting:</i>	<i>Baseline</i>	<i>Mid Term</i>	<i>Final Term</i>
<i>When your partner was under the influence of alcohol or drugs</i>	0	1	1
<i>When you 'fought' with each other</i>	12	14	14
<i>When you were physically ill or didn't feel like having sex</i>	13	12	12
<i>When you realized that your husband is having sex with multiple partners</i>	9	11	15
<i>Just avoided in the pretext of headache, stomach ache or fatigue</i>	12	13	13
<i>Not applicable</i>	1	0	1