Traditionally, family planning programmes have placed little emphasis on the context in which sexual relations take place or on the ill-treatment of women at home and in society. They have shown little solidarity with women’s efforts to improve their social position. Only recently, within the concepts of the comprehensiveness and quality of care, have such issues as the hierarchical relationships between the sexes, domestic and sexual violence, and non-consenting sex begun to be discussed. Considering the seriousness of these problems, they are still discussed very timidly.

Public opinion surveys show that the idea is still prevalent that HIV infection/AIDS occurs only in “risk groups”, identified as people whose sex life does not follow conventional patterns, such as male homosexuals, prostitutes and the promiscuous. The facts are very different: recent worldwide data show that women now represent a considerable proportion of all infected persons. If men and women are to be free from such infection, they need to practise safer sex, above all by using the condom. For women this presents an additional problem, since it is the men who need to use it, very often in contexts where the women have little or no control over their sexual availability, and where the refusal of sex or the suggestion of using a sheath could bring the risk of rows, violence or abandonment by the partner.

Another serious problem with family planning programmes has been the emphasis on high-technology methods that are extremely effective but over which, again, the woman has little or no control; they involve a high degree of dependence on family planning services, and provide no protection against sexually-transmitted diseases. In the countries of the South, barrier methods are used much less than in the countries of the North. Priorities in the South are based on reducing population growth and on the belief that women could not cope with a method that they had to apply themselves, whether through lack of education or because they carry too little weight in their relationship with their partners. In Brazil, as in other countries, the cost of motherhood for women (material and emotional cost, extra work, etc.) leads 85% of female contraceptive users to opt for pills or surgical sterilization.

A further problem is that, in some countries, while women are required to be monogamous, the man is allowed to have other relationships.

The AIDS epidemic makes it extremely urgent for society as a whole, and for family planning programmes in particular, to reformulate their role on the basis of an understanding of who decides how, when and why to have sexual relations, and to honour a commitment to promote greater awareness and negotiating power for women. Very often, such programmes still offer the only possibility of access to any kind of social service, especially in the context of overall poverty in the countries of the South.
The worldwide movement of women has stepped up its struggle for access to safe contraception and abortion, and for wider recognition of their reproductive rights. The fight for these rights introduces a new logic into the efforts to build up women’s citizenship, by regarding motherhood as useful work, and thus as something that they should freely choose with the support of society. Thus women become active participants in reproductive and sexual choices. In the countries of the South in particular, this implies radical changes in the relations between the sexes. As rates of HIV infection/AIDS among heterosexuals increase, the relationship between socioeconomic status and risk behaviour becomes clearer – and once again women are the poorest among the poor. In São Paulo, Brazil, where AIDS is already the leading cause of death among women aged between 20 and 35, these women have substantially lower incomes and less education than men with the disease.

There is an urgent need to increase the available financial resources and to change family planning policies:

- By incorporating the awareness that the sexual relationship is one that empowers people at different levels. Everything suggests that the most effective solution is to increase the negotiating power of women.

By re-evaluating family planning methods on a basis of the risks of HIV infection, either because the methods do not prevent it or because they increase the risks. For example, the IUD presents a risk by facilitating pelvic infection. In Brazil, the high rate of tubal ligations makes women more vulnerable, since they find it harder to insist on a barrier method when there is no longer any need for contraception.

It is vitally urgent to give priority to methods that combine contraception with prevention of sexually transmitted diseases. Barrier methods, which help to prevent an unwanted pregnancy as well as these diseases and cervical cancer, must be given priority if we are committed to the sexual and reproductive health of women - indeed of the whole human race.

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**AIDS: no immediate demographic repercussions**

Is there a danger that AIDS might depopulate the planet? The question is constantly asked, and it reflects a real but unjustified anxiety. Despite the vast scale of the epidemic in every continent and the dramatic inroads that it is making, the world population is not threatened with self-destruction as things stand at present. The five countries hardest hit by the epidemic are grouped in sub-Saharan Africa. Between 7% and 9% of the population of Malawi, Rwanda, Uganda, Zambia and Zimbabwe are infected with HIV, but rates in the big cities and more seriously affected zones are approaching 25%.

While the impact of AIDS in terms of individual suffering and of social and economic cost remains intolerable, in demographic terms it is barely noticeable. The fact is that the rate of demographic growth of these countries exceeds 3%, and this largely compensates for the negative effect of deaths from AIDS. Paradoxically, the poor performance of organized family planning programmes (an average of only 13% using contraceptives) protects these countries from recording a drop in population. The effect would be quite different if contraceptive use were as popular in these countries as in other continents. In the present situation, only if as many as 50% of the population were infected with HIV would there be immediate demographic repercussions.