Volume 3 Number 1 (2026) E-ISSN: 3032-7873
Jan-Jun 2026
Page: 25-38 DOI: 10.63199/progresif.v3i1.93

PROGRESIF

Psychological Well-Being as a Mediator Between Physical and Sexual Health Among Rural Women in Wayanad, Kerala, India

Jasna V.R [1*] Dr. J.O. Jeryda Gnanajane Eljo [2]
[12]Department of Social Work, Bharathidasan University, Kajamalai Campus, Tiruchirappalli-620023,Tamil Nadu, India
* k33614983@gmail.com

Article history Submitted: 2026/05/14 Revised: 2026/06/08 Accepted: 2026/06/20

Abstract

Sexual health is an important component of women's overall well-being. However, in India, research on women's health continues to focus mainly on contraception, pregnancy, and infection control, while sexual well-being receives limited attention. Although physical and psychological factors are known to influence sexual health, few studies have examined these relationships together in rural Indian settings. To the best of our knowledge, this is among the first studies from rural Kerala to examine the mediating role of psychological well-being in the relationship between physical health and sexual health among women. Methods A cross-sectional community survey was conducted among 680 rural women in Wayanad district, Kerala. Data were collected using structured questionnaires measuring physical health, psychological well-being, and sexual health. Mediation analysis was performed using regression and bootstrapping techniques. Physical health significantly predicted both psychological well-being and sexual health. Psychological well-being also significantly predicted sexual health after controlling for physical health. Mediation analysis showed that psychological well-being partially mediated the relationship between physical health and sexual health (indirect effect = 0.039, 95% CI [0.019, 0.061]). The findings support the biopsychosocial perspective of women's sexual well-being. While better physical health contributes to improved sexual health, psychological well-being also plays an important mediating role. The results suggest that integrating psychological support into women's health services may help improve sexual well-being, particularly among rural women.

Keywords Psychological Well-Being; Sexual Health; Physical Health; Mediation; Rural Women; Kerala.

1. INTRODUCTION

Sexual health is an important component of overall health and well-being. The World Health Organization (WHO, 2006) defines sexual health as a state of physical, emotional, mental, and social well-being related to sexuality. It is not limited to the absence of disease or dysfunction. Sexual health includes comfort, safety, satisfaction, communication, consent, and freedom from coercion. Despite its importance, discussions on women's health in India continue to focus mainly on pregnancy, contraception, fertility, and sexually transmitted infections. As a result, aspects such as sexual comfort, satisfaction, and emotional well-being often receive less attention (Narasimhan et al., 2023).

Many women experience sexual concerns such as pain, low desire, discomfort, or emotional distress. However, discussions about sexual health are often limited because sexuality remains a sensitive topic in many social and cultural settings (World Health Organization, 2006). In India, sexual health is still closely linked to reproductive health, and women's sexual experiences are rarely explored beyond reproduction. National surveys provide detailed information on fertility and family planning but offer limited information on sexual well-being (IIPS & MoHFW, 2021).

The situation may be more challenging for rural women. Many women balance household responsibilities with physically demanding work. Domestic responsibilities, agricultural work, limited privacy, and social expectations may affect their physical and emotional well-being. These factors may also influence their sexual well-being. Access to specialised sexual health services is also limited in many rural areas.

Kerala is known for its achievements in female literacy and healthcare. Despite these advances, discussions related to sexual health often remain limited because sexuality continues to be a sensitive topic in many social and cultural settings (World Health Organization, 2006). Women may hesitate to seek help because of embarrassment, stigma, or concerns about privacy. Wayanad district provides an important setting for this study because of its predominantly rural population and distinct socio-cultural context (International Institute for Population Sciences & Ministry of Health and Family Welfare, 2021).

The biopsychosocial model provides a useful framework for understanding women's sexual health. According to this perspective, sexual well-being is influenced not only by physical health but also by psychological and social factors (Thomas & Thurston, 2016). Physical health conditions such as fatigue, chronic pain, hormonal changes, and reproductive health problems may affect sexual experiences. At the same time, psychological well-being plays an important role in how women perceive and respond to these experiences.

Previous studies have reported associations between physical health, psychological well-being, and sexual health. However, most studies have examined these factors separately. Research focusing on the pathways linking these variables remains limited, particularly in the Indian context. Furthermore, studies examining the mediating role of psychological well-being between physical health and sexual health among rural women are scarce. Therefore, the present study addresses this gap by examining whether psychological well-being mediates the relationship between physical health and sexual health among rural women in Wayanad, Kerala.

The objectives of the study were: (1) to examine the relationship between physical health, psychological well-being, and sexual health; (2) to test the mediating role of psychological well-being in the relationship between physical health and sexual health; and (3) to contribute to the biopsychosocial understanding of women's sexual health in rural India. By focusing on rural women and applying a mediation framework, the study provides evidence that may support more integrated approaches to women's health and well-being.

2. LITERATURE REVIEW

2.1. Defining sexual health as a multidimensional construct

It had been common for the last several decades to consider the sexual health issues primarily from a strict biomedical point of view. Issues like unintended pregnancy, the spread of sexually transmitted infections (STIs), and the use of contraception for fertility control became the major topics. Nevertheless, the WHO's (World Health Organization) expert discussion on sexual health made it clear that sexual health should be considered a "state of physical, emotional, mental, and social well-being in relation to sexuality" (WHO, 2006). This definition explicitly rejects a disease-based lens and emphasises autonomy, agency, desire, pleasure, and safety. In women's health, this was a conceptual shift: sexual well-being is not merely freedom from infection, but also a capacity to enjoy intimacy, communicate personal needs, and engage in consensual pleasure without discomfort or fear.

Sexual well-being includes multiple domains: desire, arousal, lubrication, orgasm, comfort, relational closeness, and subjective satisfaction (Laumann et al., 2005).

2.2. International research on physical health and sexual well-being

Globally, there is extensive evidence linking physical health to sexual experiences. Menopause, diabetes, cardiovascular illness, chronic pain disorders, pelvic inflammatory disease, and postpartum recovery are consistently associated with sexual pain, discomfort, reduced lubrication, and low desire (Kingsberg et al., 2019). Chronic illness can alter hormonal systems, neurological response, and physical responsiveness. For many women, chronic fatigue syndromes reduce their ability to participate in intimacy. Pelvic floor injuries, childbirth trauma, and gynaecological surgeries can lead to long-term dyspareunia.

However, across international studies, researchers have repeatedly found that physical health alone does not fully determine women's sexual well-being. A consistent finding in Europe, North America, and Latin America is that psychological and relational factors moderate or mediate these effects (Bancroft & Graham, 2011). In menopausal samples, women with high self-esteem and intense partner support report satisfaction even when experiencing physical symptoms. In contrast, women with minimal biomedical symptoms often report distress when experiencing depression, anxiety, or low confidence.

These findings support the theoretical argument that physiological capacity is only one factor among many. The subjective meaning of intimacy, emotional closeness, and identity as a sexual person play substantial roles in determining women's sexual well-being. In this sense, isolating the study of physical health from a psychological negative impact misrepresents the reality of female experiences.

2.3. The psychological dimension: mood, stress, and intimacy

Psychological well-being plays an important role in women's sexual health. Emotional factors such as stress, anxiety, depression, and low self-esteem can influence sexual desire, arousal, and satisfaction. Women who experience psychological distress may find it difficult to enjoy intimate relationships and may report lower levels of sexual well-being.Psychological well-being also affects communication, relationship quality, and emotional intimacy. Research suggests that psychological and interpersonal factors are closely linked to sexual functioning and sexual difficulties among women. Women with better emotional well-being are more likely to experience positive sexual relationships and greater sexual satisfaction (Brotto et al., 2016).

2.4. Sociocultural Influences on Women's Sexual Health

Sociocultural factors play an important role in shaping women's sexual health experiences. Cultural beliefs, social norms, and gender expectations can influence how women perceive sexuality, communicate intimate concerns, and seek healthcare services. In many settings, discussions related to sexual health remain limited because sexuality is often considered a sensitive topic (World Health Organization, 2006).

Women may face barriers in expressing sexual concerns due to embarrassment, stigma, lack of privacy, and fear of negative social judgment. These barriers can affect access to information, support, and healthcare services, resulting in unmet sexual health needs and reduced well-being (World Health Organization, 2006). Psychological and interpersonal factors are also closely linked to women's sexual health. Research has shown that emotional well-being, relationship quality, and interpersonal communication influence sexual functioning and sexual satisfaction. Women with better psychological well-being are more likely to report positive sexual experiences and healthier intimate relationships (Brotto et al., 2016). These findings suggest that sociocultural conditions and psychological well-being together play an important role in shaping women's sexual health experiences.

2.5. Empirical evidence linking psychological well-being and sexual health

International research consistently shows that psychological well-being predicts sexual satisfaction even when physical health is controlled. For example, women with high self-esteem and low anxiety report greater pleasure (Laumann et al., 2005); women with supportive partners tend to experience higher lubrication and orgasm rates (Davis et al., 2021); and women with chronic illness often report better sexual satisfaction when psychological coping is strong (Bancroft & Graham, 2011). Regardless of growing evidence on the importance of psychological well-being, emotional factors remain underrepresented in many studies of women's sexual health. Women's sexual well-being is particularly sensitive to stress. When emotional burden increases—financial strain, care overload, conflict, bereavement—sexual avoidance becomes common. Conversely, positive psychological well-being increases body comfort, emotional connection, and openness to intimacy.

Although previous studies consistently report associations between physical health, psychological well-being, and sexual health, most have examined these variables independently. International studies have increasingly explored psychological pathways influencing sexual well-being, whereas Indian studies have largely focused on reproductive health outcomes and barriers to care. As a result, evidence explaining how psychological well-being links physical health and sexual health remains limited, particularly among rural women.

2.6. Physical health as a predictor of psychological well-being

Physical health improves mental health because it alleviates chronic pain, fatigue, and other somatic discomfort. Previous studies have reported that improvements in physical health are associated with better psychological well-being, increased confidence, and improved quality of life (Kingsberg et al., 2019)). But when women feel physically strong, confidence returns, energy rises, social life picks up - It's all connected.

In rural India, where domestic labour is physically demanding, poor physical health often means continuous discomfort. Repeated strain can reduce energy for emotional labour, interpersonal connection, or intimacy. Therefore, improvements in physical health may improve psychological well-being, and psychological well-being may then improve sexual well-being. This is the theoretical basis for testing mediation. Empirical studies have also reported similar patterns. Kingsberg et al. (2019) found that chronic physical health conditions were associated with poorer sexual well-being among women.

2.7. Physical Health, Psychological Well-being and Mediation

Previous studies suggest that physical health, psychological well-being, and sexual health are closely interconnected. Women experiencing chronic illness, pain, fatigue, or reproductive health problems often report poorer sexual well-being (Kingsberg et al., 2019). Although these relationships have been reported in previous research, most studies have examined physical health, psychological well-being, and sexual health separately. Limited attention has been given to understanding the pathways through which these variables are connected. Examining psychological well-being as a mediator may provide a better understanding of how physical health influences women's sexual health. However, empirical evidence on this relationship remains limited, particularly among rural women in India.

2.8. Synthesis of Previous Studies

Previous studies have shown that physical health, psychological well-being, and sexual health are closely related. Research indicates that physical health conditions can influence women's sexual functioning and overall sexual well-being. Similarly, psychological factors such as emotional well-being, stress, self-esteem, and interpersonal relationships play an important role in shaping sexual experiences and satisfaction (Brotto et al., 2016). The literature also suggests that sexual health is influenced by a combination of biological, psychological, and social factors rather than by physical health alone. Cultural beliefs, social expectations, and barriers to communication may further affect women's ability to discuss sexual concerns and seek appropriate support (World Health Organization, 2006). Overall, previous research highlights the need to examine women's sexual health from a broader perspective that considers both physical and psychological dimensions.

2.9. Summary of Literature Gaps

The review of literature suggests that physical health, psychological well-being, and sexual health are closely interconnected. Previous studies have reported that physical health problems may negatively affect women's sexual well-being, while psychological factors such as stress, self-esteem, and emotional well-being influence sexual experiences and satisfaction. However, most studies have examined these factors separately. Research from India has primarily focused on reproductive health outcomes, access to services, and sociocultural barriers, with limited attention to sexual well-being as a multidimensional concept. Furthermore, empirical studies examining the mediating role of psychological well-being in the relationship between physical health and sexual health are scarce, particularly among rural women. The present study was designed to address this gap among rural women in Wayanad, Kerala.

3. MATERIAL and METHODS

3.1. Study design and Setting

A community-based cross-sectional survey design was adopted to examine the relationships among physical health, psychological well-being, and sexual health among rural women in Wayanad district, Kerala.

3.2. Sampling strategy

Participants were recruited through community-based outreach with the support of Accredited Social Health Activists (ASHAs) and local women's groups. ASHA workers identified eligible participants from their community registers based on the study inclusion criteria. Data collection was conducted during community programmes such as health awareness sessions, parenting classes, and health screening activities, where eligible women were invited to participate in the study.

A purposive sampling approach was adopted to recruit married women who met the eligibility criteria and were willing to participate. A total of 700 women were approached, and after eligibility screening and data verification, 680 participants provided complete responses and were included in the final analysis (response rate = 97.1%).

3.4. Eligibility criteria

Inclusion:

- Women aged 18 years or older
- Married or in a stable heterosexual relationship
- Resident in Wayanad district for≥12 months

- Able to understand Malayalam

Exclusion:

- Severe cognitive impairment or mental illness
- Pregnancy complications or acute medical crises at the time of data collection
- Refusal to provide consent

3.5. Instrumentation

A structured Malayalam questionnaire was used for data collection. The instrument was developed based on an extensive review of literature and expert consultation. To ensure cultural appropriateness, the questionnaire was translated and back-translated and subsequently reviewed by a Malayalam-speaking psychologist and gynaecologist familiar with rural sexual health communication.

The survey consisted of four sections: socio-demographic information, physical health, psychological well-being, and sexual health. The final instrument comprised 36 items assessing physical health, psychological well-being, and sexual health. Responses were recorded on a five-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), with higher scores indicating better outcomes in the respective domains.

To ensure content validity, the questionnaire was reviewed by experts from the fields of social work, psychology, and reproductive health. Their suggestions were incorporated during the finalisation of the instrument. Internal consistency reliability was assessed using Cronbach's alpha, which indicated good reliability ($\alpha = 0.839$).

3.6. Ethical considerations

Ethical approval was obtained from the Institutional Ethics Committee. Written informed consent was collected from all participants, and verbal consent with a witness was used where literacy barriers existed. No identifying information such as names, phone numbers, or addresses was recorded. Participants were free to skip any question without giving a reason.

3.7. Data analysis

Data analysis was carried out using SPSS version 28.0. Descriptive statistics, Pearson correlation, regression analysis, and mediation analysis were performed to examine the relationships among the study variables. Mediation analysis was conducted using a regression-based approach with bootstrapping procedures following Hayes (2018).Normality was assessed using skewness, kurtosis, histograms, and Normal P-P plots. Assumptions related to regression analysis, including normality and multicollinearity, were examined before conducting the analysis.

4. RESULTS and DISCUSSION

4.1. Results

4.1.1 Socio-demographic characteristics

The sample included women from multiple age groups, education, caste, and religious backgrounds, reflecting Wayanad's demographic diversity.

Table 1. Socio-demographic Characteristics of Respondents (N = 680)

Variable	Category	n (%)
Age	20–24	88 (12.9)
	25–29	132 (19.4)
	30–34	176 (25.9)
	35–39	146 (21.5)
	40+	138 (20.3)
Religion	Hindu	402 (59.1)
	Muslim	182 (26.8)
	Christian	96 (14.1)
Education	No schooling	52 (7.6)
	Primary	158 (23.2)
	Secondary	266 (39.1)
	Higher Secondary	142 (20.9)
	College and above	62 (9.1)
Occupation	Homemaker	352 (51.8)
	Daily wage labourer	120 (17.6)
	Agriculture	70 (10.3)
	Self-employed	84 (12.4)
	Service sector	54 (7.9)
No.of Children	None	46 (6.8)
	One	188 (27.6)
	Two	314 (46.2)
	Three or more	132 (19.4)

The majority were within reproductive age, had secondary schooling or less, and were homemakers- typical demographic patterns in rural Kerala.

4.1.2. Descriptive statistics

Physical health, psychological well-being, and sexual health scores reflected moderate overall well-being.

Mean and SD:

- Physical Health: **M = 3.50, SD = 0.70**
- Psychological Well-Being: **M = 3.46, SD = 0.79**
- Sexual Health: **M = 3.46, SD = 0.68**

4.1.3. Pearson correlations

Table 2. Correlations among study variables

Variable	Mean	SD	1	2	3
1. Physical Health	3.50	0.70	—	.251***	.260***
2. Psychological Well-Being	3.46	0.79	.251***	—	.214***
3. Sexual Health	3.46	0.68	.260***	.214***	—

***p < .001

All constructs were significantly correlated in theoretically expected directions.

4.1.4. Regression and mediation

Regression models were conducted to test mediating role of psychological wellbeing in relation to physical health and sexual health.

Model 1 (Path a):

Physical health → Psychological well-being

- β = **.284**, p < .001

Model 2 (Path b and direct path c'):

Psychological well-being → Sexual health (controlling physical health)

- β = **.137**, p < .001

Direct effect (c'):

Physical → Sexual health (controlling psychological)

- β = **.215**, p < .001

Total effect (c):

Physical → Sexual health (without mediator)

- β = **.254**, p < .001

Bootstrapping (5,000 samples) produced a significant indirect effect:

- **Indirect effect (a × b) = 0.039**
- **95% CI = [0.019, 0.061]**

Since the CI does not cross zero, mediation is **statistically significant**.

Regression Table

Predictor	B	SE	β	t	p
Physical Health	0.215	0.037	0.220	5.814	< .001
Psychological Well-being	0.137	0.033	0.159	4.192	< .001

Model Summary

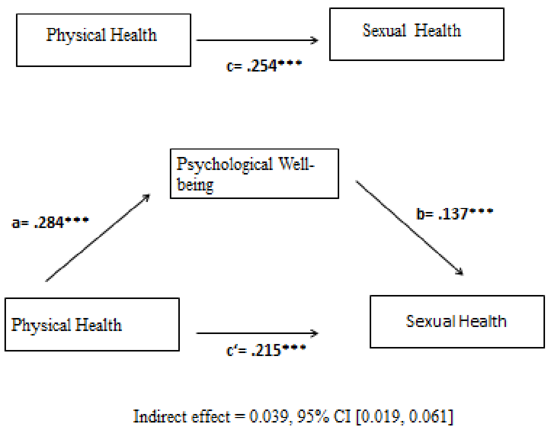
$R = 0.302$; $R^2 = 0.091$; Adjusted $R^2 = 0.088$; $F(2, 677) = 33.920$; $p < .001$.

Physical health ($\beta = .220$, $p < .001$) and psychological well-being ($\beta = .159$, $p < .001$) emerged as significant predictors of sexual health.

Although the effect size was modest, the findings indicate that physical health and psychological well-being together contribute meaningfully to women's sexual health outcomes.

Figure 1. Mediation of psychological well-being between physical and sexual health

Note. *a = effect of physical health on psychological well-being; b = effect of psychological well-being on sexual health; c = total effect of physical health on sexual health; c′ = direct effect of physical health on sexual health after controlling for psychological well-being. ***p < .001.*



4.1.5. Interpretation of findings

Better physical health was associated with higher psychological well-being and sexual health scores. Psychological well-being remained a significant predictor of sexual health after controlling for physical health, supporting its mediating role.

4.1.6. Clinical and cultural significance of quantitative findings

The mediation analysis indicated that psychological well-being partially explained the relationship between physical health and sexual health. Although the indirect effect was modest, it was statistically significant, suggesting that psychological well-being contributes to sexual health outcomes beyond the influence of physical health alone.

The findings highlight the importance of considering psychological factors alongside physical health in women's healthcare programmes. In the context of rural women's health, interventions that support both physical and psychological well-being may contribute to improved sexual health outcomes. These results support a biopsychosocial understanding of women's sexual well-being, where physical and psychological dimensions are closely interconnected

4.2. Discussion

4.2.1. Main Findings

The present study examined the relationships among physical health, psychological well-being, and sexual health among rural women in Wayanad district, Kerala. The findings showed that physical health was positively associated with both psychological well-being and sexual health. Psychological well-being also emerged as a significant predictor of sexual health and partially mediated the relationship between physical health and sexual health. These findings indicate that both physical and psychological factors contribute to women's sexual well-being.

4.2.2. Comparison with Previous Studies

The findings are consistent with previous studies that reported positive associations between physical health, psychological well-being, and sexual health (Kingsberg et al., 2019; Stephenson & Meston, 2015). Similar to earlier research, women with better physical health reported better psychological well-being and sexual health outcomes. However, many previous studies were conducted in clinical or urban settings, whereas the present study provides evidence from a rural population that has received relatively limited attention in sexual health research.

4.2.3. Interpretation of the Mediation Effect

The mediation analysis indicated that psychological well-being partially explained the relationship between physical health and sexual health. Although the indirect effect was statistically significant, its magnitude was relatively small (0.039). This suggests that psychological well-being represents only one pathway through which physical health influences sexual health. Other factors, such as relationship quality, partner support, communication patterns, and sociocultural influences, may also contribute to sexual health outcomes and should be examined in future research.

4.2.4.Theoretical Implications

The findings support the biopsychosocial perspective of women's sexual well-being by demonstrating that physical health and psychological well-being are interconnected. The results suggest that sexual health cannot be understood solely through biological factors and that psychological processes should also be considered when examining women's sexual well-being.

4.2.5. Limitations

Several limitations should be considered while interpreting the findings. The cross-sectional design does not permit causal inferences regarding the relationships among physical health, psychological well-being, and sexual health. The study also relied on self-reported data, which may be influenced by social desirability and response bias, particularly given the sensitive nature of sexual health. Also, the study was conducted among rural women in one district of Kerala, which may limit the generalizability of the findings to other populations and settings. Finally, the study focused on a theory-driven mediation model and did not examine alternative pathways or additional factors such as relationship quality, partner support, and communication patterns, which may also influence sexual health outcomes. Future studies using longitudinal and mixed-method approaches may provide a more comprehensive understanding of these relationships.

5. CONCLUSION

This study examined the relationship between physical health, psychological well-being, and sexual health among rural women in Wayanad, Kerala. The findings showed that psychological well-being partially mediated the relationship between physical health and sexual health. This suggests that women's sexual health is influenced by both physical and psychological factors. By focusing on rural women, the study adds to the limited research on women's sexual health in the Indian context. The findings highlight the importance of considering psychological well-being alongside physical health when addressing women's sexual well-being. Future studies may explore other factors such as relationship quality, partner support, and social influences using longitudinal and mixed-method research designs.

6. Declarations

Conflict of interest: Both the authors have no conflict of interests to declare **Ethical Approval:** The current study complies with the current laws of the country in which it was performed. **Declaration of generative AI and AI assisted technologies in writing process:** During the preparation of this work author(s) used ChatGpt to make language corrections and improve the language and reviewed carefully before finalizing.

References

Bancroft, J., & Graham, C. A. (2011). The varied nature of women's sexuality: Unresolved issues and a theoretical approach. Hormones and Behavior, 59(5), 717–729. https://doi.org/10.1016/j.yhbeh.2011.01.005

Basson, Rosemary. (2008). Biopsychosocial models of women's sexual response: applications to management of 'desire disorders'. Sexual and Relationship Therapy. 18. 107-115. 10.1080/1468199031000061308.

Berman, J., & Bassuk, J. (2002). Physiology and pathophysiology of female sexual function and dysfunction. World Journal of Urology, 20(2), 111–118. https://doi.org/10.1007/s00345-002-0281-4

Brotto, L. A., Atallah, S., Johnson-Agbakwu, C., Rosenbaum, T., Abdo, C., Byers, E. S., Graham, C. A., Nobre, P., & Wylie, K. (2016). *Psychological and interpersonal dimensions of sexual function and dysfunction*. *The Journal of Sexual Medicine, 13*(4), 538–571. https://doi.org/10.1016/j.jsxm.2016.01.019

Hayes, A. F. (2018). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach* (2nd ed.). Guilford Press.

International Institute for Population Sciences & Ministry of Health and Family Welfare. (2021). *National Family Health Survey (NFHS-5): Kerala state report*.

Kingsberg, S. A., Schaffir, J., Faught, B. M., Pinkerton, J. V., Parish, S. J., Iglesia, C. B., Gudeman, J., Krop, J., & Simon, J. A. (2019). Female Sexual Health: Barriers to Optimal Outcomes and a Roadmap for Improved Patient-Clinician Communications. Journal of women's health (2002), 28(4), 432–443. https://doi.org/10.1089/jwh.2018.7352

Laumann, E. O., Paik, A., & Rosen, R. C. (1999). Sexual dysfunction in the United States: prevalence and predictors. JAMA, 281(6), 537–544. https://doi.org/10.1001/jama.281.6.537

Narasimhan, M., Gilmore, K., Murillo, R., & Allotey, P. (2023). Sexual health and well-being across the life course. *Bulletin of the World Health Organization,* 101(12), 750–750A. https://doi.org/10.2471/BLT.23.291043

Thomas, H. N., & Thurston, R. C. (2016). A biopsychosocial approach to women's sexual function and dysfunction at midlife: A narrative review. Maturitas, 87, 49–60. https://doi.org/10.1016/j.maturitas.2016.02.009

World Health Organization. (2006). *Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002, Geneva*. WHO Press.