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World Health Organization

Action framework

Action framework

Developing sexual health programmes

A framework for action

Contents

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Acronyms and abbreviations

ABC	abstinence, be faithful, use a condom
ADF	African Development Foundation
AIDS	acquired immunodeficiency syndrome
FGM	female genital mutilation
FP	family planning
GBV	gender-based violence
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IEC	information, education and communication
IPPF	International Planned Parenthood Federation
LGBT	lesbian, gay, bisexual, and transgender
MCH	maternal and child health
NGO	nongovernmental organization
PAHO	Pan American Health Organization
PMTCT	prevention of mother-to-child transmission (of HIV)
RHR	reproductive health and research
RTI	reproductive tract infection
SHAPE	Strategizing HIV Prevention Efforts
SIECUS	Sexuality Information and Education Council of the United States
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNIFEM	United Nations Development Fund for Women
VCT	voluntary counselling and testing (for HIV)
WAR	Women Against Rape
WAS	World Association for Sexual Health
WHO	World Health Organization

Executive summary

Background

Sexual health is fundamental to the physical and emotional health and well-being of individuals, couples and families, and to the social and economic development of communities and countries. When viewed affirmatively, sexual health encompasses the rights of all persons to have the knowledge and opportunity to pursue a safe and pleasurable sexual life. However, the ability of men and women to achieve sexual health and well-being depends on their access to comprehensive information about sexuality, knowledge about the risks they face, their vulnerability to the adverse consequences of sexual activity, their access to good-quality sexual health care, and an environment that affirms and promotes sexual health.

In 2002, WHO convened a meeting entitled "Challenges in sexual and reproductive health: Technical consultation on sexual health". This meeting was one of a series of international gatherings with several defined objectives, namely: to review and update definitions of sexual health and related concepts such as sexuality; to identify challenges and opportunities in addressing sexual health; and to define strategies that countries and regions might adopt in order to promote sexual health according to their specific contexts. Building on the outcomes of the meeting, this document outlines a framework for developing sexual health programmes. It contextualizes an internationally agreed set of ideas concerning what constitutes sexual health and what factors influence sexual health, and discusses how the concept of sexual health can best be promoted in health programmes. This framework for programming is intended to assist anyone working to improve sexual health outcomes and so create the conditions for a sexually healthy society. In order to ensure that everyone attains the highest possible level of sexual health, the framework emphasizes the need for governments to promote healthy sexuality throughout the individual's lifespan and to offer sexual health services that are appropriate, affordable, accessible and of good quality, to all persons and without stigma or discrimination on the basis of sex, race, ethnicity, age, lifestyle, income, sexual orientation or gender expression.

Defining sexual health

Efforts to define sexual health have been substantially influenced by the definition of health adopted by the World Health Organization in 1948. This views health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. In the field of sexual and reproductive health, an International Conference on Population and Development (ICPD) was held in Cairo in 1994. This reached consensus on an expanded concept of reproductive health that included sexual health and emphasized the importance of the access of everyone to reproductive and sexual health services.

In recent years, the ICPD definition of sexual health as a component of reproductive health has been questioned. It has been widely recognized that sexual health encompasses more than reproductive health alone, and should in fact be considered in its own right. Chapter 1 of the report explains that, rather than being a component of reproductive health, sexual health underpins (and is a necessary condition for) the achievement of reproductive health.

Sexuality and sexual relations are central to both reproductive and sexual health, but most sexual activity is not directly associated with reproduction and is of relevance throughout a person's lifespan, so sexual health may be considered to be a broader concept. For example, sexual health recognizes the desire of individuals and couples of all sexual orientations and any background to have fulfilling and pleasurable sexual relationships, and its concerns go beyond fertility and reproduction to encompass issues such as sexual dysfunction and disability, and violence related to sexuality. These issues do not necessarily fit well within a framework that is devoted exclusively to reproductive health.

Discussions are ongoing with respect to human rights and sexual health, and international human rights instruments are being used increasingly to support and advance individual and community claims for national governments to guarantee the respect, protection and fulfilment of their sexual and reproductive

health rights. The framework for programming presented in this report is therefore grounded in internationally recognized human rights and offers a rights-based approach to programming in sexual health.

A multisectoral framework

Actions to improve sexual health can take place within a range of settings, including reproductive health programmes, through primary health care or other sectors, such as education, social welfare and youth programmes. A multisectoral approach is required in all cases. Programmes that have brought about improvements in sexual health outcomes, to reduce HIV infection or unwanted pregnancies for example, often owe their success to a variety of actions that have been implemented simultaneously.

There has been great debate about the best types of intervention, whether they should be offered in an integrated manner across sectors, or as vertical programmes implemented alongside one another, and whether they achieve similar results. This aspect of the framework for programming is discussed in Chapter 2. It does not attempt to resolve the issue, but acknowledges the need for complementary actions across a number of key domains. The five domains are:

- laws, policies and human rights;
- education;
- society and culture;
- economics;
- health systems.

Laws, policies and human rights

Affirmative legal or policy interventions are critical for supporting existing sexual health interventions or for introducing new ones. Countries may use laws, policies and other regulatory mechanisms that are enshrined in international treaties to guarantee the promotion, protection and provision of sexual health information and services, and to uphold the human rights of every person within their borders. They may use monitoring and enforcement mechanisms such as legal aid services and telephone advice lines, as well as imposing sanctions against providers who are unwilling to perform specific health interventions as required by the law. Laws and policies can also provide legal protection against any discrimination and stigma related to sexuality and sexual health status. Such legislation is fundamental to the creation and maintenance of a sexually healthy society. While laws and policy can be supportive of sexual health and well-being, they may also be obstructive, or heavily influenced by restrictive cultural norms. Furthermore, it is important to recognize that the existence of a law or policy does not mean it will be implemented. The framework offered here uses a rights-based approach that seeks to integrate the norms, standards and principles of international human rights agreements into national policies and plans in order to promote sexual health and development. This framework builds on the principles of equality and participation and rights of individuals – the right to education and access to information on sexual health issues, to privacy, to non-discrimination and freedom from violence, to self-determination within sexual relationships, and to health care.

Education

The correlation between education level and sexual health outcomes has been well documented. One of the most effective ways to improve sexual health in the long-term is a commitment to ensuring that adolescents and young people are sufficiently educated to make healthy decisions about their sexual lives. Accurate, evidence-based, appropriate sexual health information and counselling should be available to all young people, and should be free of discrimination, gender bias and stigma. Such education can be provided via schools, workplaces, health providers and community and religious leaders.

Society and culture

Social and cultural factors can be significant in determining access of people to sexual and reproductive health services and information. The influence of traditional values, beliefs and norms must not be underestimated. They affect the family, the community and society, and play an important part in shaping people's sexual lives. While the sociocultural determinants of sexual health outcomes vary in time and place, it seems that the groups in society that have relatively little power have poorer sexual health, often because they have poor access to information and services or legal redress. Gender-influenced power relations, for example, have a significant effect on the sexual health of many women and girls. The interventions that seem to be most likely to succeed at improving sexual health are those in which the community itself reflects upon – and agrees to change – its traditions.

Economics

Poverty and economic inequality are intrinsically linked to poor sexual and reproductive health outcomes. These links are bidirectional, in as much as poor communities experience worse sexual and reproductive health than richer communities, and poor health leads to poverty. Financial necessity is often the driving force behind some forms of high-risk sexual behaviours. Health interventions can therefore only be effective if the relationships between a person's economic need, vulnerability and health outcome are fully understood, in both the short and the long term.

Health systems

Accessible, acceptable, affordable and good-quality sexual health services are fundamental to achieving a sexually healthy society. Interventions to maintain and ensure sexual health have been shown to work best when they are offered to people of all ages, throughout their lifespan, regardless of their marital status. It is also important to make efforts to target young people in particular because of their social and biological vulnerability. Services for people of any age should be easily accessible, confidential and non-discriminating. Providers should be trained to screen and detect sexual health problems and provide appropriate educational information about prevention, counselling, treatment, care and referral. Efforts to prevent and treat sexual ill-health continue to show the importance of improving understanding about the sexual behaviours, desires and aspirations of both communities and individuals. They also highlight the role that sexual pleasure, satisfaction and well-being play in people's health status.

In addition to working across these five domains, the creation of a sexual health programme requires the expansion of existing reproductive health services and the acknowledgement of broader determinants of sexuality and well-being as they relate to health. The framework described in this report therefore offers a holistic, multisectoral and interdisciplinary approach to planning, programming and service delivery for sexual health. It addresses both the individual factors (such as sexuality and health-related behaviours) and the societal factors (such as education, economic opportunity, and cultural or religious determinants) that affect sexual health outcomes, and discusses specific areas of intervention, providing practical examples of the framework as applied to a variety of real sexual health issues.

The report also reviews the key influences on sexual health within the five domains outlined above. Chapter 3 explores how interventions across these domains have evolved over recent years, and examines the complex interplay between "downstream" (individual) and "upstream" (societal) determinants that can affect sexual health, with a particular focus on the latter as key areas for programme-based interventions. It also considers changes in prevailing understandings of sexual behaviour, as well as the concepts of risk and vulnerability, and the importance of a rights-based and lifespan approach. It is crucial to recognize that efforts to change the behaviour of an individual or group are unlikely to succeed on their own. The framework offered here argues that underlying problems of social exclusion and inequality must also be tackled, and this should be done using simultaneous, multilayered interventions that address risk and vulnerability within the context of sexual behaviour.

Developing a programme-based response

The sexual health framework in this report can be used to develop a sexual health programme. Chapter 4 highlights a number of key entry points for promoting sexual health within and across the five domains. Some of these focus on eliminating the barriers to sexual health goals. Others concentrate on strategies to promote sexual health. The suggested strategies and actions may be undertaken by several different actors, both governmental and nongovernmental, depending on the context. A range of practical examples from around the world are presented to demonstrate how to eliminate barriers and promote the development of sexual health among particular groups and in specific settings.

With respect to laws and policies, rights-based approaches that are potentially beneficial include developing and implementing national legislation to support rights relating to sexual health, and repealing laws that violate such rights. The framework specifically advocates laws that protect vulnerable people from exploitation and implement actions that fulfil peoples' rights to comprehensive information relating to their sexual health and sexuality. It also supports any policy that recognizes the rights to bodily integrity, that protect the basic rights of women and individuals in homosexual and transgender relationships, as well as those living with HIV, and that promote equity.

A number of entry points for promoting sexual health and healthy sexuality are identified within the domain of education. These include: providing comprehensive education on sex and relationships to young people in school; training in sexuality and sexual health for health workers, teachers, social workers, youth workers and other professionals; and targeted community-based strategies, such as outreach work and peer- and media-based education, to meet the needs of young people who are not in school or who may be especially vulnerable.

Promoting sexual health in diverse social and cultural domains requires sensitivity to social norms and an indepth understanding of the diverse sexual and reproductive health needs of the population as a whole. Working within social, cultural and religious norms can be challenging, but this is necessary if public health goals related to sexual and reproductive health are to be achieved. Initiatives that attempt to improve health outcomes include interventions that influence social norms and promote gender equity, and the mobilization of community and religious leaders to develop and implement culturally appropriate strategies.

Entry points for intervention in the economic domain include activities or interventions to generate income, and programmes that recognize (and respond affirmatively to) the complex relationship between economic dependence, power and sexual health. Among the successful economic approaches are initiatives that strengthen women's property rights. The lack of ownership of key assets can leave a woman destitute on the death of her male partner, forcing her into a situation that may compromise her sexual health.

With respect to the health systems domain, the framework advocates sexual health programmes that provide comprehensive sexual health-care services for women and men throughout their lifespan, without discrimination based on sex, race, ethnicity, age, lifestyle, income, marital status, sexual orientation or gender expression. The provision of good-quality, integrated sexual and reproductive health services is identified as a key entry point for interventions. Priorities for intervention include reaching men, reaching vulnerable and stigmatized groups (such as migrants and displaced populations), providing targeted services for young people, and identifying and managing the repercussions of sexual violence and female genital mutilation.

The framework for programming on sexual health also provides programme managers with a holistic lens through which to conceptualize their work and direct resources, and plan and implement programmes to promote sexual health. It also emphasizes the need to coordinate inputs across all sectors that can influence sexual health outcomes, in order to achieve shared goals. With these factors in mind, Chapter 5 provides a series of questions relating to each of the five domains. Programme managers might

consider these while they developing programme-based initiatives for the promotion of sexual health. The questions are based on a number of key principles for working to promote sexual health, from maintaining awareness of the influence of gender and gender power in sexual health and the need to address both risk and vulnerability, to recognizing and respecting sexual diversity, promoting respect for (and the rights of) individuals, ensuring participation of all people and working positively within social norms.

Conclusions

This framework points to the importance of programming for sexual health across the five domains of laws, policies and human rights; education; society and culture; economics; and health. Using a multisectoral rights-based approach, it outlines elements of a programme-based response, together with key entry points for the promotion of sexual health by providing information and support for both broad-based and targeted community education initiatives.

Introduction

Sexual health is fundamental to the physical and emotional health and well-being of individuals, couples and families, and to the social and economic development of communities and countries. Sexual health, when viewed affirmatively, encompasses the rights of all persons to have the knowledge and opportunity to pursue a safe and threat-free sexual life.

However, the ability of men and women to achieve sexual health and well-being depends on their access to:

- comprehensive good-quality information about sex and sexuality;
- knowledge about the risks they face and their vulnerability to the adverse consequences of sexual activity;
- their access to sexual health care;
- an environment that affirms and promotes sexual health.

Sexual health concerns are wide-ranging, encompassing sexual and gender identity, sexual expression, relationships, and pleasure. They also include negative consequences or conditions such as:

- infections with human immunodeficiency virus (HIV), sexually transmitted infections (STIs) and reproductive tract infections (RTIs) and their adverse outcomes (such as cancer and infertility);
- unintended pregnancy and abortion;
- sexual dysfunction;
- sexual violence; and
- harmful practices (such as female genital mutilation, FGM).

Sexual health is closely linked to reproductive health. With the emergence of HIV and AIDS and the increasing incidence of STIs, as well as growing public health concerns about gender-based violence and sexual dysfunction, issues relating to sexuality and the implications for health and well-being have become more important, so influencing a broad range of health and development agendas.

In 2002, WHO convened a meeting entitled "Challenges in sexual and reproductive health: Technical consultation on sexual health" (WHO, 2006a). This meeting was one of a series of international consultations, the first of which had been held in 1974. The goals of the 2006 meeting were:

- to review and update definitions of sexual health and related concepts such as sexuality;
- to identify the challenges and opportunities encountered when addressing sexual health; and
- to define strategies that countries and regions might adopt in order to promote sexual health in their own context.

This document builds on the outcomes of that meeting, to outline a framework for developing sexual health programmes. It contextualizes an internationally agreed set of ideas concerning what constitutes sexual health, and considers what influences sexual health. It also discusses how best the concept of sexual health can be promoted through local programmes and actions.

The document is divided into five chapters.

Chapter 1 gives working definitions of sexual health, sexuality and sexual rights, briefly summarizing the history of conceptual work on sexual health, and examining the relationship of sexual health to reproductive health.

Chapter 2 outlines a framework for sexual health programmes. It emphasizes the importance of taking action across five domains (laws, policies and human rights; education; society and culture; economics; and the health system) and it provides examples of how the framework can be applied to specific areas, such as HIV, AIDS, unintended pregnancy and sexual dysfunction.

Chapter 3 reviews the key influences on sexual health within each of the five domains outlined in Chapter 2. It describes the changes in our understanding of sexual behaviour, including concepts of risk and vulnerability and the importance of taking an approach that is both rights-based and lifespan-based. It also examines the evolution of interventions across the five domains in recent years.

Chapter 4 describes how the framework can be used to create a sexual health programme, including key entry points for the promotion of sexual health and healthy sexuality within the five domains. It identifies ways of eliminating barriers and promoting the development of sexual health among particular groups and in specific settings.

Chapter 5 contains a number of questions that programme managers need to answer when developing programme-based responses for the promotion of sexual health.

Creating sexual health programmes requires the expansion of any existing reproductive health services, and attention must be given to broader determinants of sexuality and well-being related to health. The framework for sexual health programmes, as described here, offers programme managers a holistic standpoint through which to conceptualize their work, to direct resources, and to plan and implement programme-based responses for promoting sexual health, and emphasizes the importance of coordinating input from all sectors (such as education, labour and the legal sector) in order to influence sexual health outcomes and achieve a common goal.

1. Sexual health: concept and scope

Efforts to define *sexual health* have been substantially influenced by the definition of the term *health* adopted by the World Health Organization in 1948. This views health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This positive, holistic and comprehensive view of health and well-being has been reaffirmed subsequently in numerous international agreements and declarations. In the field of sexual and reproductive health, the International Conference on Population and Development (ICPD) held in Cairo in 1994 reached consensus on an expanded concept of *reproductive health,* which includes sexual health, and emphasizes the importance of individuals having access to reproductive and sexual health services. As commentators have made clear

> "Human rights provide an international legal framework within which the sexual and reproductive health needs and aspirations of all people can be considered." *(Gruskin, 2005)*

In recent years, international human rights instruments have been increasingly used to support and advance legal claims by individuals and whole communities so that national governments will guarantee the respect, protection and fulfilment of their sexual and reproductive health rights (Cook et al., 2003). The working definitions and framework for programming presented here are grounded in internationally recognized human rights and offer a rights-based approach to programming in sexual health. The key conceptual elements of sexual health are listed in Box 1.

Box 1. Key conceptual elements of sexual health

When viewed holistically and positively:

- Sexual health is about well-being, not merely the absence of disease.
- Sexual health involves respect, safety and freedom from discrimination and violence.
- Sexual health depends on the fulfilment of certain human rights.
- Sexual health is relevant throughout the individual's lifespan, not only to those in the reproductive years, but also to both the young and the elderly.
- Sexual health is expressed through diverse sexualities and forms of sexual expression.
- Sexual health is critically influenced by gender norms, roles, expectations and power dynamics.

Sexual health needs to be understood within specific social, economic and political contexts.

Definitions

WHO has been working in the area of sexual health since at least 1974, when the deliberations of an expert committee resulted in the publication of a technical report entitled "Education and treatment in human sexuality" (WHO, 1975). In 2000, the Pan American Health Organization (PAHO) and WHO convened a number of expert consultations to review terminology and identify programme options. In the course of these meetings, the working definitions of key terms used here were developed. In a subsequent meeting, organized by PAHO and the World Association for Sexual Health (WAS), a number of sexual health concerns were addressed with respect to body integrity, sexual safety, eroticism, gender, sexual orientation, emotional attachment and reproduction (see Annex 1 for further explanations of these terms).

According to the current working definition, *sexual health* is:

> "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." *(WHO, 2006a*)

Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health. The working definition of *sexuality* is:

> "…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors." *(WHO, 2006a*)

There is a growing consensus that sexual health cannot be achieved and maintained without respect for, and protection of, certain human rights. The working definition of *sexual rights* given below is a contribution to the continuing dialogue on human rights related to sexual health.[1]

> "The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws.
>
> Rights critical to the realization of sexual health include:
>
> - the rights to life, liberty, autonomy and security of the person
> - the rights to equality and non-discrimination
> - the right to be free from torture or to cruel, inhumane or degrading treatment or punishment
> - the right to privacy
> - the rights to the highest attainable standard of health (including sexual health) and social security
> - the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
> - the right to decide the number and spacing of one's children
> - the rights to information, as well as education
> - the rights to freedom of opinion and expression, and
> - the right to an effective remedy for violations of fundamental rights.
>
> The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination." *(WHO, 2006a, updated 2010)*

Sexual health and reproductive health: defining the relationship

The past decade has witnessed considerable progress in the definition and consolidation of the field of sexual and reproductive health. Expansion of policies and programmes at global, national and local levels has been supported by international agencies, governments and nongovernmental organizations (NGOs). In particular, programmes dealing with family planning, maternal and child health, prevention of HIV transmission, and care of people living with HIV have received substantial resources. A major impetus for the consolidation of work on sexual and reproductive health was the 1994 ICPD conference

[1] It should be noted that this definition does not represent an official WHO position and should not be used or quoted as such. It is offered instead as a contribution to ongoing discussion about sexual health.

in Cairo, which called for public health investment in this field as an essential contribution to sustainable development and reduction of poverty.

In the ICPD Programme of Action (UNFPA, 1994) 179 countries agreed on a broad-based definition of reproductive health, clearly incorporating sexual health in the phrase "…reproductive health, including family planning and sexual health".

The Programme of Action advanced a positive view of sexual health, stating that its purpose is "…the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases". Reproductive health also implied that "people are able to have a safe and satisfying sex life" and "…have the capability to reproduce and the freedom to decide if, when and how often to do so".

The Programme of Action went on to describe two primary objectives that have relevance to sexual health. The first relates to the quality of a sexual relationship, emphasizing the need to promote "adequate development of responsible sexuality, permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals". The second objective concerns an individual's access to reproductive and sexual health services, including family planning, and the protection and exercise of the individual's rights. In particular it affirms the need to ensure that "women and men have access to information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities". (ICPD 1994).

Developments since 1994

Conceptually, sexual health and reproductive health are interlinked both directly and indirectly. Since the ICPD meeting, the term "sexual and reproductive health" has become standard in most parts of the world, although in some regions there are cultural and political sensitivities that limit use of the term *sexual health*, where the term *reproductive health* is interpreted and made operational as one that implicitly includes sexual health-related issues.

In recent years, the ICPD definition of sexual health as a *component* of reproductive health has been questioned, since it has been widely recognized that sexual health encompasses *more than* reproductive health. This underlines the importance of considering sexual health in its own right. Rather than being a component of reproductive health, sexual health underlies, and is a necessary condition for, the achievement of reproductive health.

Sexuality and sexual relations are central to *both* reproductive and sexual health, but since most sexual activity is not directly associated with reproduction and is of relevance throughout the lifespan, sexual health may be considered as a broader concept. For example, sexual health recognizes the desire of individuals and couples of all sexual orientations to have fulfilling and pleasurable sexual relationships. Sexual health concerns, therefore, go beyond fertility and reproduction to encompass issues such as sexual dysfunction and disability, as well as violence related to sexuality. All these issues do not necessarily fit well into a framework devoted exclusively to reproductive health.

To attain reproductive health, people need to be able to exercise control over their sexual health and life, and to achieve healthy sexuality. Sexuality and the dynamics of sexual relationships have a fundamental influence on the uptake and use of contraceptives, the risk of sexually transmitted infections (including HIV), and pregnancy and abortion. Important sexuality-related issues include the nature and frequency of sexual acts, the conditions of choice or coercion that motivate the acts, the meanings associated with them, the perception and experience of sexual drive and pleasure, the choice and number of sexual partners, and the formation and complexity of a person's sexual identity (Dixon-Mueller, 1993). Everywhere in the world, these conditions and their complexity are mediated and defined by gender relations and norms (see Chapter 2).

Key elements of sexual health

Public health systems cannot necessarily address every sexual health concern, but the key elements they should cover include the following:

- STIs and RTIs (including HIV);
- unintended pregnancy and safe abortion;
- sexual dysfunction and infertility;
- violence related to gender and sexuality (including FGM);
- young people's sexual health and sexual health education;
- sexual orientation and gender identity;
- mental health issues related to sexual health;
- the impact of physical disabilities and chronic illnesses on sexual well-being; and
- the promotion of safe and satisfying sexual experiences.

These issues, together with the relevant programme-based responses, are reviewed in Chapter 3.

2. A framework for sexual health programmes

Actions to improve sexual health can take place within reproductive health programmes, within the context of work on HIV and AIDS, through primary health care or other sectors such as education and social welfare, or in youth programmes. In all cases, however, a multisectoral approach is needed.

Programmes that have improved sexual health outcomes include those of Senegal, Thailand and Uganda (for reducing HIV infection) and Bangladesh, Romania and Viet Nam (for reducing unwanted pregnancies). They often owe their success to a variety of actions that were implemented simultaneously (Celentano et al., 1998; Family Health International, 2006a; UNAIDS, 2001). Early debates focused on whether these "interventions" should be offered in an integrated manner, or whether vertical programmes (implemented alongside one another) can achieve equivalent results. The broad consensus now is that a comprehensive approach is needed (Askew & Berer, 2003; Lush et al., 1999).

The framework for programming offered in this document stresses the need for complementary action across all five domains, namely laws, policies and human rights, education, society and culture, economics, and the health service. This framework is intended to assist those who are working to improve sexual health outcomes in order to create the conditions for a sexually healthy society. To ensure that people attain the highest possible level of sexual health, governments need to promote healthy sexuality throughout the lifespan, and offer sexual health services that are appropriate, affordable, accessible and of sufficiently good quality to everyone – without stigma or discrimination on the basis of race, ethnicity, age, lifestyle, income, marital status, sexual orientation or gender expression.

Such programmes and interventions are most successful when provided alongside actions in other sectors. For example, a youth programme that provides community-based peer education on family-life skills, including counselling on the use of condoms and negotiation about using contraceptives, is likely to be more effective if it is reinforced by similar messages from local religious or community leaders, school teachers or the media. This will demonstrate local cultural and social acceptance of the key message. A political and legal climate that supports the provision of sexual and reproductive health information to young people is essential for the programme to operate successfully. If the programme is also linked (and can make referrals) to a local health clinic where young people can obtain sexual and reproductive health services and condoms, for example, the chances of success increase even further. While it is difficult to measure the success of behaviour change programmes, there is evidence that integrated multisectoral approaches are effective (Advocates for Youth, 2006a; UNFPA, 2003a, 2004a).

The five domains

Sexual health interventions may be offered in one or more areas of a programme. As stated above, when they are offered simultaneously or in tandem with interventions from other sectors, the chances for success increase.

1. Laws, policies and human rights

Legal and policy interventions are often critical for supporting existing sexual health interventions or for introducing new ones. Countries may use laws, policies and other regulatory mechanisms to guarantee the promotion, protection and provision of sexual health information and services. As signatories to the different international and regional human rights treaties, countries should strive to fulfil their human rights obligations. They might do this by providing health care to everyone or by ensuring the right of people living with STIs or HIV to access information and services without discrimination (Cook et al., 2003). Appropriate monitoring and enforcement mechanisms range from providing legal aid services and telephone hotlines to reporting acts of discrimination and violence (UNAIDS, 2003).

Other broader legal and policy interventions can also have an impact on the health of women. For example, by raising the age of marriage, the age of first sexual intercourse can be delayed, and so the adverse consequences of early pregnancy reduced (University of Toronto Women's Human Rights Resources, 2006). Sanctions can be enforced against health-care providers who are unwilling to perform specific health interventions required by law, such as abortion (Brookman-Amissah & Moyo, 2004; WHO, 2003a). Legal protection against discrimination and stigma related to sexuality and sexual health status is fundamental to the creation and maintenance of a sexually healthy society. To this end, enactment of

laws and policies can be a powerful and rapid means of mitigating the worst effects of prejudice, stigma and discrimination.

2. Education

Knowledge and information, provided through sexual health education, are essential if people are to be sexually healthy. The best way to ensure that young people learn and adopt safe and healthy sexual behaviour, and limit their risk and vulnerability to sexual ill-health (such as unwanted pregnancy, unsafe abortion, STIs and HIV), is by providing appropriate education about sex and personal relationships. This can be delivered through schools or workplaces, or in the community. Such action can, and should, be reinforced by messages from community and religious leaders, to create awareness about the importance of safe sexual behaviour. Health providers have an important role, too, if they create a safe, judgement-free, confidential environment in which people feel free to share any concerns and problems related to their sexuality.

Anyone involved in providing sex and relationships education – from teachers and community and religious leaders to health-care providers – should receive training and continuing education to ensure that the information and counselling they give are accurate, evidence-based, appropriate, and free from discrimination, gender bias and stigma. The curricula of teachers and health-care providers should be regularly reviewed and updated, and new training materials may be required. Making a commitment to ensure that young people have the information they need to make healthy decisions about their sexual lives is one of the most effective ways of improving sexual health in the long term (Advocates for Youth, 2006b; Sexuality Information and Education Council of the United States, 2006; UNESCO, 2005).

3. Society and culture

Social and cultural factors are very significant in determining people's access to sexual and reproductive health services and information. The role that family, community and society play in shaping a person's sexual life should not be underestimated. Any intervention to improve the sexual health of a population must therefore be understood and accepted by the community. However, older members of the family and community are often confused and sometimes distressed about the pace of change in sexual behaviours, lifestyles and norms. They can have difficulty in understanding or accepting change, which can lead to them imposing restrictions, particularly for young people, and reaffirming traditional values, beliefs, rites and rituals. Experience has shown that programmes and interventions that contradict traditional teachings and do not attempt to achieve some level of acceptance or consensus among power-holders in the community are likely to fail (Katumba, 1990). Success is most likely when the community agrees and chooses to change its traditions itself (UNFPA, 2004a).

4. Economics

Financial necessity is often the cause of some types of high-risk sexual behaviour. Health interventions can only be effective if the relationship between economic need and health outcome is understood. The relationship between individual sexual behaviour, power dynamics and financial dependence is often underestimated (Luke & Kurz, 2002). There is an assumption that, with the necessary information and tools, everyone will make decisions that improve or preserve their health, but this has been shown to be unjustified, for example in relation to the HIV pandemic (Kamali et al., 2003).

The context in which behaviour change is expected to take place is especially important (Entwhistle et al., 1986). A woman or girl who is poor may know about the dangers of HIV and other STIs, but engaging in transactional or commercial sex may be the only way for her to earn money. How can her risk and vulnerability best be reduced? In the short term, strategies that encourage her clients to use condoms may be the best approach. In the longer term, however, her risk and vulnerability will be reduced only when her economic power and position are improved (Weiss & Rao Gupta, 1998).

5. Health systems

Interventions to maintain and ensure sexual health must be offered to women and men of all ages, regardless of their marital status. Health-care providers should be trained to detect any problems and to provide referral when needed. Services should be made as accessible as possible to young people

and adults, and should be confidential, private, and non-discriminating. The sexual health services can be provided as part of primary health care, including reproductive health services, or as a stand-alone service, and should address the most significant sexual health problems and concerns.

The health system of a country should provide at least the following:

- Sexual health education and prevention information for young people, single adults, and couples, where confidentiality and privacy are assured.
- Sexuality counselling for the client's sexual health concerns or needs, and desired sexuality, reproductive or contraceptive preferences.
- Identification and referral for victims of sexual and other forms of violence.
- Voluntary counselling, testing, treatment and follow-up for STIs, including HIV.
- Diagnosis, screening, treatment and follow-up for RTIs, reproductive cancers, and associated infertility.
- Diagnosis and referral for sexual dysfunction.
- Safe abortion to the full extent of the law.
- Post-abortion care, including provision of contraceptive information, counselling and methods.

Accessible, acceptable, affordable and high-quality sexual health services are fundamental for achieving a sexually healthy society.

Applying the framework

The framework for sexual health programmes is a holistic, multisectoral and interdisciplinary approach to planning, programming and service delivery for sexual health. It addresses factors that affect sexual health outcomes, both at an individual level, such as sexuality and health-related behaviours, and at a societal level, such as education, economic opportunity, and cultural and religious determinants. Comprehensive intervention strategies can also contribute to improving primary healthcare, reproductive healthcare, and HIV prevention, treatment and care.

The importance of the framework outlined in this document can be appreciated best from considering some practical examples. Not all sexual health topics can be covered here, but the descriptions below demonstrate how the framework may be applied to a number of key sexual health issues.

Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs), including HIV

Among the RTIs are STIs, iatrogenic infections associated with unsafe medical procedures in the reproductive tract (e.g. unsafe abortion) and endogenous infections such as bacterial vaginosis and candidiasis that arise as a result of disruption to the normal vaginal microflora.

STIs are a major public health concern, contributing significantly to the global burden of adult disease both because of the acute illness and because of long-term outcomes such as chronic pain, infertility, adverse outcomes of pregnancy (including stillbirth and low birth weight) and cancers of the reproductive tract (including cervical cancer). Rates of STIs are very high worldwide. It is estimated that there are over 340 million new cases each year of the four most common and curable STIs (WHO, 2006b; WHO, 2007). These are Chlamydia, syphilis, gonorrhoea and trichomoniasis.

The impact of HIV and AIDS on individuals, families, communities and national institutions, including the health and education sectors, is enormous in many parts of the world. Between 31 and 36 million people are known to be infected.[1] Most cases of HIV infection are sexually acquired, but there is a general

[1] Of the 31–36 million people living with HIV and AIDS, between 1.2 and 2.9 million are aged under 15 years (UNAIDS/WHO, 2009). In 2008, between 2.4 and 3.0 million people were newly infected. Sub-Saharan Africa is most severely affected. In 2008, over two-thirds of people infected with HIV (that is, between 20.8 and 24.1 million individuals) were living in sub-Saharan Africa. Nearly 10% of child mortality is associated with HIV, cancelling out the progress made in childhood survival rates over the past decades. Between 11.5 and 17.1 million African children currently under the age of 15 have lost one or both of their parents to HIV or AIDS (UNAIDS/WHO, 2009). Although the latest data suggest that the epidemic has stabilized in many places, infection rates have continued to increase in Eastern Europe and Central Asia (UNAIDS/WHO, 2009).

reluctance to address sensitive issues related to sexuality which has contributed to a slow response in many parts of the world.

Untreated STIs and RTIs are associated with an increased risk of HIV transmission. Effective management of STIs is therefore crucial for controlling the transmission of HIV in some populations (Grosskurth et al., 2000). Control of STIs in particular requires commitment to sexual health in the broadest sense of the term. A narrow focus on infectious disease control is unlikely to be successful if it takes no account of the many factors that increase risk and vulnerability of specific individuals and groups. A framework for action that places control of STIs within a wider context is more likely to have long-term success, because it will recognize both the cofactors of transmission and the societal factors that increase an individual's vulnerability.

Applying the framework for sexual health involves recognizing that some sections of the population are particularly vulnerable to STIs. These include young people, people who engage in transactional sex or commercial sex, and people who are sexually abused or at risk of violence within their sexual relationships. The sexual health needs of these people go well beyond providing appropriate clinical care, to include counselling about sexuality, making referrals to deal with violence, its consequences, or the risk of violence, and assistance in negotiating about use of contraceptives.

Unintended pregnancy and abortion

Unsafe abortion is "a procedure for terminating an unintended pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both" (WHO, 1992). It is estimated that nearly 20 million women each year have an unsafe abortion, of whom 19.2 million are in developing countries. Of these, 5.5 million are in Africa, 9.8 million are in Asia (excluding Australia, Japan and New Zealand) and 3.9 million are in Latin America and the Caribbean. The majority (59%) of unsafe abortions in Africa are performed on young women aged 15–24 years (WHO, 2004). Unsafe abortions account for 13% of all maternal deaths worldwide. It is estimated that 66,500 women died from the complications of unsafe abortion in 2003 alone (WHO, 2007). It thus represents a considerable barrier to achieving the Millennium Development global target that aims to reduce the maternal mortality ratio by 75% between 1990 and 2015 (Berer, 2004).

A sexual health framework applied to unintended pregnancies and unsafe abortions would seek to explain why these issues continue even though effective and safe methods of contraception and induced abortion have been available for many years. Across the five domains of sexual health, a number of factors influence the incidence of unintended pregnancies and unsafe abortions in any setting. These include:

- access of young women and young men to information on contraception;
- the legality of supplying contraceptives to unmarried young people;
- the legality of abortion;
- sociocultural norms and practices with regard to sex outside marriage;
- unintended pregnancies and the provision of safe abortion;
- the influence of gender-power relations on the ability of girls and women to use contraceptive methods, or to reject sexual relations with men;
- the readiness of the health service to provide safe abortions to the full extent of the law.

A sexual health framework applied to abortion in general would seek to act across a range of domains, with the intention not only of ensuring that abortion is made safe, but also to reduce the need for abortion in the first place. A number of countries such as Nepal, Romania, South Africa, Tunisia, and United States of America, have successfully reduced the incidence of unsafe abortion by legalizing it (Cook et al., 2003; Grimes, 2006). Mongolia and Viet Nam reduced the incidence by making their existing legal services safer (Ganatra et al., 2004; Tsogt et al., 2008). Other countries like South Africa and Ghana have taken steps to reduce the stigma associated with abortion (Ngwena, 2004; Ipas, 2008). Some countries have also made progress in reducing the number of unintended pregnancies (Berer, 2004).

Sexual dysfunction

Concerns related to sexual functioning are universal, but they have culturally specific forms. Generally it is estimated that between 8% and 33% of the adult population in developed countries experience some kind of sexual dysfunction in their lifetime, although some studies suggest that the true figure may be higher (Laumann et al., 1999). Sexual problems include low sexual desire, male erectile dysfunction, an inability to achieve orgasm, premature ejaculation, pain during intercourse, and vaginismus. These concerns are relatively common, but they are seldom diagnosed or treated in public sector services. It is only recently that the etiological and epidemiological factors have been explored in any depth, with most research focusing on erectile dysfunction in men. Erectile dysfunction is surprisingly common in all societies in which studies have been conducted (Prins et al., 2002). In a number of countries (Egypt, Islamic Republic of Iran, Morocco, Nigeria, and Pakistan), the likelihood of men reporting erectile dysfunction has been found to be associated with various characteristics, most common of which is increasing age (Berrada et al., 2003; Safarinejad, 2003; Seyam et al., 2003; Shaeer et al., 2003).

Most men and women with sexual dysfunction who seek care, tend to look for it within the private sector. This is because public sector services addressing sexual function and dysfunction are relatively uncommon. However, within a sexual health framework, the importance of addressing male and female sexual dysfunction is clear. Studies around the world, including research in Egypt, Nigeria and Pakistan, have found that sexual dysfunction is associated with common mental illnesses, including depression, and with low quality-of-life (QoL) scores. Sexual function is also closely associated with the dominant expectations of society at that particular time (about what it means to be a man or a woman, for example), as well as local cultural mores and beliefs.

If not addressed, sexual dysfunction can cause great suffering, by damaging a person's ability to form or to sustain an intimate relationship. In a broader sense, discomfort with sexuality may reduce a person's ability to set appropriate behavioural boundaries for himself or herself, whether alone or within a relationship (Robinson et al., 2002). The sexual health framework recognizes the critical role that sexual function plays in maintaining positive sexual relationships.

Violence related to gender and sexuality

Violence related to gender and sexuality is both a violation of human rights and a public health concern. Sexual and other forms of gender-based violence include rape, coerced sex, child sexual abuse, sexualized forms of domestic violence, intimate partner violence, FGM, "honour" crimes, and forced prostitution. Sexual violence can be directed at women or men, girls or boys, and any group in a position of vulnerability. While it takes multiple forms, the most common is violence towards women by men who are known to them, particularly their partners and husbands, but also other family members.[2] "Intimate partner violence" includes acts of physical aggression, psychological abuse, sexual coercion (including rape), and a range of controlling behaviours (WHO, 2005). These acts are often interlinked, with various types of abuse taking place in the same relationship and repeated over time.

There are both direct and indirect links between violence and sexual health. Violence can be an important factor in unwanted pregnancy, in the acquisition of STIs including HIV, and in sexual dysfunction.[3] Forced sex, both vaginal and anal, can potentially increase the risk of HIV transmission because of the resulting abrasions and injuries. Studies show that sexual abuse early in life can lead to increased ill-health in adulthood. This is partly because of increased sexual risk-taking, such as having early first sex, multiple partners, and participating in sex work of various kinds (Klein & Chao, 1995; WHO, 2002; Ziegler et al.,1991).

[2] In 48 population-based surveys around the world, between 10% and 69% of women reported being physically assaulted by a male partner at some point in their lives (WHO, 2002), while a study in 10 countries found between 6% and 59% of women 15-49 years had experienced sexual violence by an intimate partner and between 1% and 12% non-partner sexual violence since the age of 15 (WHO, 2005). Surveys conducted with men have also produced high figures of self-reported violence against women (Blanc, 1996; Jewkes 2009). In some countries, nearly one in four women experience sexual violence by an intimate partner (WHO, 2002).

[3] Violence is linked with reproductive as well as sexual ill-health. Experiencing assault during pregnancy is associated with a range of negative reproductive outcomes, including spontaneous abortion, premature labour, antepartum haemorrhage and low-birth-weight babies. More broadly, violence against women can have fatal outcomes. Fatalities occur with so-called "honour killings" of women who have been raped, in order to "cleanse" the family honour – as well with as HIV infection, suicide and maternal mortality (WHO, 2002).

Experiencing violence can be an obstacle to achieving sexual health in more indirect ways. In particular, when a woman has reduced autonomy in an inequitable and coercive relationship, it restricts her ability to make sexual choices and negotiate the conditions of sexual intercourse, including the use of condoms and other contraceptives (Jejeebhoy & Bott, 2003).

In promoting sexual health, it is important to tackle both the underlying determinants of sexual violence, through high-quality education about sex and relationships for young people and mental health support for children who have been sexually abused to reduce the risk of perpetratation of violence, as well as the direct psychological, economic and acute healthcare needs of the victims of violence. Using a sexual health framework involves educating the broader community about the impact of sexual violence and engaging community and religious leaders in addition to the media to bring the issue into public discourse and reduce its stigma. It might also focus on removing the legal and policy barriers for bringing criminal charges against perpetrators of violence or protecting the dignity and confidentiality of victims who press charges against the perpetrator(s) of violence. It may therefore require training of judges, police and social welfare workers so that they can better understand and support victims of violence.

A comprehensive review of sexual health must also consider violence that is committed against people because of their real or imagined sexual characteristics, even though it might be delivered through non-sexual means (i.e. non-sexual assault or injury). These real or imagined sexual characteristics or attributes might relate to sexual behaviour or practices, a same-gender sexual partner, lack of virginity, extramarital sex, sexual contact with social "inferiors" or members of "enemy" groups, a "bad reputation", "dishonour" to a kin group, and sexual "disobedience". Although the delivery of violence may not involve rape or sexual injury, the physical and psychological effects are similar – injury, a reduced ability to access healthcare for the injuries, and an increased burden of disease.

In addition to representing an assault on a person's fundamental right to life and bodily integrity, violence may be both a sign *and* a consequence of gender discrimination. Sexual violence against women and girls reduces their freedom of movement, association and speech. It also limits access to education, work and life outside the home. Sexual violence reinforces (and stems from) other forms of inequality as well, serving to reinforce hierarchies of power based on class, race, ethnicity or caste, or other important social divisions. Sexual violence thus serves as an "extra-legal" form of punishment and control (that is, punishment and control that is outside the legal system), which is often intended to induce shame and diminish the reputation of the victim.

Impact of physical disabilities and chronic illnesses on sexual health

A variety of physical disabilities can affect sexual functioning and have a negative impact on sexual well-being, through the profound effect they have on interpersonal relationships, self-esteem and body image (Drench, 1992; Sipski & Alexander, 1997). These physical disabilities include neurological disabilities such as spinal cord injury, stroke, multiple sclerosis, traumatic brain injury and cerebral palsy. The sexual needs and expressions of people with these disorders are often ignored, because there is a perception that they are not – or should not be – sexually active.

Some chronic illnesses also have a negative impact on sexual health. Certain cancers, particularly those associated with the reproductive system, combined with the effects of the often radical treatment involved, can profoundly affect a person's sense of their sexuality and sexual functioning (Kaplan, 1992). Other chronic illnesses, including arthritis, cardiovascular disease, diabetes and depression, as well as certain medications (such as those used for treating high blood pressure) are also implicated in sexual health problems (DeBusk et al., 2000; Krousel-Wood et al., 2004). A sexual health framework might include the creation of policies to increase the social acceptability of sexual expression by people with a disability or chronic illness. It might also address the provision of information and education regarding certain side-effects of medicines used by people with chronic disease.

3. What affects sexual health?

The key elements of sexual ill-health, as defined in Chapter 1, arise from a complex interplay of both "downstream" (individual) and "upstream" (societal) determinants. The susceptibility of an individual to infection, physical disability or violence is determined not only by factors particular to that person, like his or her immune status, the presence or absence of a congenital disability, and his or her self-efficacy, but also by levels of risk and vulnerability and the ability to protect oneself. These factors are influenced by the family and community, as well as social, legal and political circumstances. For example, rates of violence related to sexuality are determined not only by individual factors, such as a family history of violence and learnt behaviours, but also by cultural norms and the legal and political position, such as the existence of laws that protect women as well as men from sexual violence, or that recognize rape within marriage as an offence.

Risk and vulnerability in relation to sexual ill-health

One of the most significant developments of the past decade has been acknowledgement of the social, economic, and political forces that influence people's vulnerability to sexual ill-health, especially in the field of STIs, including HIV. Much of the early research on HIV and AIDS was focused on sexual behaviour, with the intention of mapping out individual risk factors and the characteristics of people at high risk. Since then, improved understanding of the social and epidemiological patterns of the disease has led to the development of more sophisticated analyses of the social drivers of the epidemic. Sexual health experiences and outcomes are influenced by many factors, including the globalization of media like films and television shows, and changes in family structures, sociocultural norms, religious beliefs and practices, sexual and other forms of gender-based violence and level of education. Efforts to change behaviour at an individual or group level are crucial, but they are unlikely to succeed on their own. Underlying patterns of social exclusion and inequality, in particular poverty, gender inequality and unequal access to education and healthcare, must also be addressed through simultaneous, multilayered interventions that address both risk and vulnerability within the context of sexual behaviour.

Box 2. Defining risk and vulnerability in relation to STIs and HIV

Risk is the probability that a person will acquire an infection and/or disease. Certain individual behaviours (such as unsafe sex) increase this risk. Risk is also influenced by multiple factors among which are aspects of the person's physical and psychological development, and their sexual history, exposure to abuse, ability to negotiate in relationships, awareness of sexuality-related issues, access to support, and membership of social networks.

Vulnerability forms a backdrop to risk-taking, and arises from the broader social, political and environmental factors that provide the context in which people act, so influencing the kinds of risks they take. These contextual factors include the political economy of the setting (and its inequalities and exclusions relating to gender, ethnicity and sexuality) and its legislative context, as well as the existence or absence of health and education programmes, and their accessibility, quality, content and delivery.

Sources: Mann & Tarantola, (1992); Shaw & Aggleton, (2002); UNAIDS, (1998b)

While recognizing the importance of individual-level determinants of sexual health status, the framework for programme development would examine in more detail the role of "upstream" determinants, in order to identify areas for intervention. Individual-level determinants clearly interact with the more fundamental determinants across a number of areas – most obviously in the areas of gender and poverty, but also in other fields. This framework focuses on underlying factors and the possibility for intervention at a contextual level. However, where individual-level characteristics are important, then this is recognized and articulated in each of the five domains.

The five domains influencing sexual health

1. Laws, policies and human rights

As outlined in Chapter 1, international codes and consensus documents such as the ICPD Programme of Action can play a key role in mobilizing governments to pursue goals and targets set by the international

community. The rapid growth of programmes in the field of sexual and reproductive health since 1994 shows how much influence the ICPD mandate has had. The same is true of the Fourth World Conference on Women held in Beijing in 1995 and the United Nations General Assembly Special Session on AIDS (UNGASS) held in 2001, and their follow-up meetings.

A rights-based approach to health seeks to integrate the norms, standards and principles of international human rights agreements into national laws, policies and plans to promote health and development (WHO, 2006a). Commitment to using human rights in this way cuts across all the domains within this framework. Rights that are enshrined in laws and policies at international and national levels include:

- the rights to life, liberty, autonomy and security of the person;
- the right to education and access to information (including on sexual and reproductive health issues);
- the right to privacy;
- the right to non-discrimination;
- the right to be free from torture or cruel, inhumane or degrading treatment or punishment;
- the right to self-determination within sexual relationships;
- the right to the highest attainable standard of health, including sexual health.

Underlying all these areas are the principles of non-discrimination (equality), inclusion and equal participation in society.

To have the maximum effect, international human rights and development goals need to be translated and adapted to a national level. More challenging still, these policies and principles have to be translated into *action* that has an *impact* . At the national level, reproductive and sexual health laws can be used to promote particular policies (Cook et al., 2003). They may be supportive of sexual health and well-being (as in laws that outlaw discrimination on the basis of sexuality) or overtly obstructive (as in laws that set a different age of consent based on either sex or sexuality).

It has to be recognized, however, that just because a law or policy exists, it does not mean it will be implemented. For example, many countries in Africa have laws prohibiting FGM, but it still occurs (WHO, 2008). Most countries in sub-Saharan Africa have health policies that promote antenatal screening for syphilis, but a review of 22 of the countries revealed policies that were patchily implemented so that most pregnant women did not undergo screening (Gloyd et al., 2001).

In some cases, the absence of a law can be harmful. One example is the failure to recognize the concept of rape within marriage.

In sexual health, more than in almost every other area of health and well-being, the political–legal area is heavily influenced by cultural norms and moral standards, and in many societies these norms and standards are deeply rooted in religious beliefs. The dual influences of international agreements (such as the ICPD Programme of Action) and local pressures from religious authorities cause difficulties in many countries. The 179 countries that endorsed the ICPD Cairo Programme of Action have a responsibility to implement the principles the programme enshrines, while respecting their own local laws governing various aspects of sexual and reproductive health (Cook et al., 2003; UNFPA, 2004b).

In recent years there has been an increasing focus on the protection and promotion of rights relating to sexual and reproductive health. Unfortunately, stigma, discrimination and other human rights violations[1] are still commonplace and have a significant impact on sexual health. In relation to sexuality and sexual health, stigma and discrimination are often directed towards people who are sexually active outside of a marital relationship, or to those who are pregnant and unmarried, or those who are homosexual, bisexual or transgender, as well as people with STIs or who have HIV (or are merely perceived to have it). Different

[1] Stigma and discrimination are inter-related, reinforcing and legitimizing each other. Freedom from discrimination is a human right, enshrined in the Universal Declaration of Human Rights and all other human rights instruments, and is based on the recognition of the equality of all people. Discrimination itself may violate other basic human rights, such as the rights to health, dignity, privacy, equality before the law, and freedom from inhumane and degrading treatment or punishment (Aggleton & Parker, 2002). Laws that violate any of these human rights must be repealed.

kinds of sexual stigma are compounded by existing inequalities, in particular those related to gender, ethnicity, culture and socioeconomic status (Wood & Aggleton, 2004).

2. Education

Universal primary education is a Millennium Development Goal and a goal of the ICPD Programme of Action (United Nations, 2006). The General Comment Number 3 (paragraph 16) of the Convention on the Rights of the Child provides clear direction for governments:

> "To refrain [from] censoring, withholding or intentionally misrepresenting health-related information including sexual education and information … State parties must insure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality." *(United Nations, 2003)*

The correlation between a person's level of education and sexual health outcomes has been well documented (Glynn et al., 2004) and reviews of research evidence have found that the probability of using a condom with a non-regular partner is strongly associated with education level (Adair, 2008; Filmer, 1998). A survey carried out in Uttar Pradesh in India found that men with higher levels of education, or with higher economic status, or who live in urban areas have a better knowledge of reproductive health matters, sought treatment more frequently, and were more likely to protect themselves against sexually transmitted infections (Singh et al., 1998). Reviews of HIV epidemiology and documentation of risk factors in four cities in Africa found lower rates of infection from herpes simplex virus type 2 and HIV among people with higher levels of education, leading the authors to conclude that "the most educated may be responding more readily to health education programmes" (Glynn et al., 2004).

In addition to general education, good-quality comprehensive sexuality education (particularly through school-based programmes) has been shown to improve sexual health outcomes, including reducing unintended pregnancies, delaying sexual debut, and reducing high-risk sexual behaviours (Kirby, 2002).

3. Society and culture

The social and cultural domain encompasses – but is not limited to – characteristics of the individual, family, community and social system (Diderichsen et al., 2001). Determinants of sexual health include gender-power relations and cultural norms (such as those relating to acceptability of transactional sex or FGM). Sociocultural determinants of sexual health outcomes vary with time and place and cannot be generalized. However, one unifying theme across the social domain is that *power* is a key determining variable. Groups in society that have relatively little power – because of their sex, their race or their economic status, for instance – tend to have poorer sexual health, often as a result of their poor access to information, services and legal redress.

Gender relations, power in sexual relationships and gender-based violence

Since WHO began working on sexual health in 1974, there have been important advances in understanding the significance of gender (both norms and gender inequality) as it relates to sexual health (Baylies & Bujra, 2000; Parker et al., 2000; Sobo, 1995). Notions of gender are socially constructed and are associated with different roles, responsibilities and expectations among women and men, often resulting in the creation of unequal access to resources and power. Gender-influenced power relations within communities, families and sexual relationships have a significant impact on sexual health. Girls and women are often considered to have lower status and value, placing them at a disadvantage in terms of access to resources, goods, decision-making, choices and opportunities in all aspects of their lives (UNFPA, 2003a). Broad gender inequalities are likely to be reflected in sexual relationships. Research has been carried out on sexual decision-making, on factors affecting the use of protection against pregnancy and STIs, and on the dynamics of intimate partner violence. All three have increased in importance because of the HIV epidemic, which indicates that female sexual safety is frequently compromised by any prevailing unequal gender norms and sexual expectations (Maitra & Schensul, 2002; Wolff et al., 2000; Worth, 1989).

In the early research and programming, "gender" tended to be associated with the differential power relationships and their impact on women/girls. More recent research has examined how masculinity

is constructed, practised and experienced in different contexts around the world (Connell, 1995; Cornwall & Lindisfarne, 1994; Mane & Aggleton, 2001). There is a growing recognition that the gender roles assigned to men also significantly influence their sexual health, and impact on women's sexual health (and vice versa). Recent accounts of men's sexual lives, however, have challenged the view that men are only a "major part of the problem". Increasingly, international agencies such as WHO, UNAIDS and UNFPA who are involved in promoting sexual health, see men's participation as critical. It is clear that in a couple relationship, one partner's intentions to engage in sexual health-promoting practices are unlikely to succeed without the other's agreement and support (Moore & Helzner, 1996; Zeidenstein & Moore, 1995).

Over the past decade, violence related to gender inequality and sexuality has been recognized as a serious public health issue, and there is growing evidence of its contribution to suffering and ill-health worldwide. Such violence takes numerous forms – sexual and physical abuse of women by partners; violence against sexual minorities such as homosexual and transgender people; sexual abuse and exploitation of children and young people; trafficking of females of all ages into forced sex work; and the neglect of girls (WHO, 2002). Violence is closely linked to wider norms and expectations relating to gender and sexuality, and to the exercise of power. Women and girls are disproportionately affected by violence because of prevailing gender inequalities that reduce their autonomy and decision-making capacity (WHO, 2009a).[2] The most common form of violence against women is physical or sexual violence, or both, from a close partner. This is also referred to as "intimate partner violence" (WHO, 2005). However, men and boys also suffer from violence that affects their sexuality; this may involve sexual abuse during childhood or physical abuse as a consequence of non-heteronormative (e.g. homosexual or transgender) sexual activity.

Evidence is accumulating that physical and sexual violence increase a woman's risk of adverse health outcomes (Campbell, 2002). In addition to the direct physical sequelae and mental health problems, physical and sexual violence increases a woman's vulnerability to STIs, including HIV, and to negative reproductive health outcomes, including unwanted pregnancy and miscarriage (Dunkle et al., 2004; Garcia-Moreno & Watts, 2000; Maman et al., 2000; Morland et al., 2008). More indirectly, the threat of violence, or actual violence, within a sexual partnership constrains a woman's ability to develop equitable partnerships with men, and can complicate their struggle to achieve a healthy sexual life (Wood et al., 1998). Sexual abuse during childhood can lead to sexual risk-taking in adulthood (Klein & Chao, 1995; Ziegler et al., 1991). For women who are HIV-positive, disclosing their HIV status to a partner may lead to violence (Garcia-Moreno & Watts, 2000).

4. Economics

Poverty and economic inequality are intrinsically linked to poor sexual and reproductive health outcomes. The links are bi-directional – not only do poor, marginalized and vulnerable communities experience worse sexual and reproductive health than more affluent communities, but poor sexual and reproductive health can itself contribute to poverty, for example by limiting earning potential or by making it necessary to spend money on health care. This association is particularly well documented in the case of HIV infection, as well as other sexual and reproductive health problems.

Within- and between-country comparisons show that poor people have larger families and poor women are less likely to be attended during childbirth by trained health workers compared to people with high incomes (Gwatkin, 2004). In many countries, poor people have little access to family planning services and safe abortions. As a result, poor women are at particular risk of the consequences of unsafe abortion (WHO, 2003a).

The connection between financial dependence, power imbalance and health is also receiving increasing attention. Transactional sex and sex work often take place in the context of a lack of money. Intergenerational relationships of girls (and sometimes boys) with older, wealthier men (so-called

[2] This explains the widespread use of the term "gender-based violence", which is generally interpreted as meaning abuse suffered by women. The United Nations defines violence against women as: "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life". Declaration on the elimination of violence against women. Resolution No. A/RES/48/104. New York, United Nations, 23 February 1993.

"sugar daddies") and the impact of these relationships on their sexual health and well-being have been documented (UNAIDS & AIDSMARK, 2002; Dunkle et al., 2004). From the point at which the link between sex work and the transmission of HIV became clear, health experts and programme managers have sought to understand and deal with the dual imperatives of financial need and health consequences. Sex workers and aspects of sex work have been regulated to make it safer in countries such as Brazil and Thailand, showing definite progress (AIDSNET, 2006; UNAIDS, 2006). But prevention and control programmes for STIs and HIV infection must acknowledge the pressures on poor men and women that make them continue to engage in unsafe sexual behaviours which yield economic or other material gains. These programmes must also find ways to provide services within the context of this reality. Without significant national investment to provide long-term economic opportunities, transactional sex and commercial sex, regardless of their associated health risks and threat to life, are likely to remain a major determinant of sexual health outcomes. Health providers and programme managers must accept this situation and work with individuals and couples to help them negotiate ways that will make their sexual activities less detrimental to their health.

5. Health systems

The health services, along with services in other sectors, play a significant role in responding to the consequences of sexual ill-health. They are frequently involved in promoting primary prevention, usually by providing information to individuals or communities and encouraging behaviour change. The focus of sexual health programmes, the content of the services, and the means of delivering them, have recently undergone profound changes. In principle, there has been a move away from vertical or narrowly focused programmes towards horizontal, integrated, comprehensive and sometimes multisectoral services. A rights-based approach has been introduced into many services for young and elderly people who were previously excluded, so now they too are considered in reproductive and sexual health care. The role of gender inequality in influencing and impacting on health care has been highlighted, and in some situations the need to work with couples and families is being addressed.

The shift from *treating* sexual ill-health to *promoting* sexual well-being is taking longer to materialize at a programme level. However, the importance of sexual preference is being increasingly recognized, as is its potential impact on health and health interventions (Braunstein & van de Wigert, 2003; Myer et al., 2005). Therefore it is likely that more attention will be given to understanding and appreciating sexuality, sexual pleasure, eroticism and people's perceptions of sexual well-being (for more on these terms, please see Annex 1).

Box 3 summarizes the major conceptual shifts in health services in recent years, outlining the reasons for the changes, and highlighting the effects on service delivery.

Integrated sexual and reproductive health services

The integration of services can be understood as the bringing together of different components of sexual and reproductive health care, and establishing strong connections with other healthcare and related social services. The aims of integration are to increase effectiveness and efficiency of the health system, and to meet people's needs for accessible, acceptable, convenient and client-centred comprehensive care (WHO, 2006c,d). Integration does not mean that all the core elements of sexual and reproductive health care or other services must be provided within one site, but it does require that healthcare providers have the knowledge and skills to provide an appropriate range of services and refer patients for other necessary services, either within same the facility or another site (WHO, 2006c). However, although there is consensus about the importance of integration, the situation remains fragmented, and vertical programmes are still the prevailing model of service provision for many countries (Askew & Berer, 2003).

A lifecourse perspective

Sexuality, sexual experience and the struggle for maintaining sexual health are now recognized to be lifelong processes, with important implications that extend beyond the reproductive years. For these reasons, a "lifecourse" perspective is being increasingly incorporated into programming. A person's sexuality is experienced in different ways at different stages of his or her life, as the sexual health needs and chosen form of sexual expression alter.

Box 3 Conceptual shifts in health service delivery

Conceptual shift	Historical reasons for shift	Programme outcome
From hospital to community-based care	Declaration of Alma-Ata and concept of comprehensive primary health care	Emphasis on maternal and child health
From vertical to horizontal programming	Influence of ICPD (1994) World Development Report (1993) Cost-effectiveness of integrated programmes compared with vertical programmes	Shift from family planning and maternal and child health to reproductive health Integrated sexual and reproductive health programmes
From promoting individual behaviour change to influencing networks and the broader social context	Lack of effectiveness of early behaviour change efforts (e.g. condom promotion and safe sex campaigns, peer education)	Programmes targeting communities rather than individuals Programmes addressing the social context to reduce risk and vulnerability (e.g. in the field of HIV and AIDS)
From considering discrete demographics of people of reproductive age to a total lifespan perspective	Demographic shifts across the world highlight the importance of health promotion among younger and older age groups	Some Demographic and Health Survey (DHS) and other population-based surveys include people from age groups beyond the traditional reproductive years (e.g. within the context of HIV testing in Swaziland)
From considering gender dynamics to an understanding of the role of power in sexual relationships	Attempts to improve the quality of care in family planning services highlighted the importance of choice and decision-making, which directed attention to the dynamics of couples, and the role of men in particular	Increased attention to gender-based violence Men as partners in programmes for women Importance of improving client–provider interactions and providing client-centred services Importance of skills-building in health promotion
From a needs-based approach to a rights-based approach	The ICPD encouraged a move beyond an individual's needs to consider their rights, and stressed how important it is for governments to make progress in ensuring sexual and reproductive rights for all	Increasing recognition of sexual and reproductive health as a human rights issue IPPF and partner organizations released a reproductive rights charter that was widely used around the world
From focusing on sexual ill-health to well-being and pleasure	A lack of progress in promoting safer sex led to a need for greater understanding of the motivations for sexual behaviour, including issues related to pleasure and sexual satisfaction	Programmes began asking more detailed questions about sexual lifestyle, opening the door for discussions about sexual dysfunction, infertility and other issues related to sexuality

Lifecourse begins before birth because in pregnancy, the sexual health status of a woman relates not only to her own health but also to that of the unborn child. In the childhood years, a child will experience his or her first sexual impulses and experiences – both desired and undesired. And as the child gets older, early sexual experiences, together with information coming from family, friends, the media, schools and the community, will shape his or her expectations and behaviours within sexual relationships. These influences will also have an impact on his or her risk and vulnerability to sexual ill-health. During adolescence and the reproductive years, the influence of family and community norms in relation to sexual behaviour, childbearing, marriage and gender relations will determine how, when and where he or she will have access to, and receive, sexual health information and services.

As the average lifespan of humans continues to increase, particularly in more affluent communities and regions, the sexuality of older people is gaining more attention. Their sexual health problems and

concerns may be life-threatening, such as reproductive cancers, and others, such as sexual dysfunction, may be particularly difficult to discuss. Hormonal changes can have a negative impact on sexual functioning, but changing social norms together with the development of medical technology has allowed many older people to continue enjoying sexual activity. In parallel to this there has been a rise in the rates of divorce and re-marriage, as well as increases in leisure time and mobility, all of which provide further opportunities for new sexual partnerships to form among older people.

Young people

The importance of focusing on young people in the promotion of sexual health is clear. Nearly half of the global population is under 25 years of age – the largest youth generation in history (UNFPA, 2003a). Adolescents and young people have been shown to be particularly vulnerable to sexual ill-health in all countries. Half of all new HIV infections, for example, occur in people aged 15–24 years. The vulnerability of young people is based on both social and biological factors. They are more likely to acquire an STI and are particularly vulnerable to HIV infection, they experience high levels of sexual coercion, have high numbers of unwanted pregnancy and unsafe abortions, and lack adequate access to health services and balanced information (Rivers & Aggleton, 1998; UNFPA, 2003b; WHO, 2009b; Wood et al., 1998). Young women are particularly vulnerable to HIV and other STIs because of biological factors, earlier sexual debut, prevailing gender inequalities, and relationships with older partners (UNFPA, 2008a).

HIV and STIs are not the only aspects of sexual health of interest to young people: the ages of menarche and puberty have been falling steadily over the past 100 years, possibly as a result of improved nutrition and better general health. There has also been an increase globally in premarital relationships among young people, as well as an increase in age at first marriage in many countries. The age of sexual debut is falling globally.

From sexual ill-health to well-being and pleasure

Despite the ICPD's call for services that promote positive sexual health choices and well-being, sexual health interventions in many parts of the world are limited to the prevention, treatment and care of primary sexual health problems and concerns, such as STIs, including HIV, and unwanted pregnancy. Other sexual health problems are now beginning to be addressed; these include sexual violence, infertility and sexual dysfunction. Efforts to prevent and treat sexual ill-health have highlighted the need for greater understanding of the sexual behaviour, desires and aspirations of both communities and individuals. They have also raised awareness of the link between sexual ill-health and sexual pleasure and satisfaction and well-being in health status.

The shifting of programmes from an exclusive focus on prevention, treatment and care of sexual ill-health to encompass the broader concepts of health and well-being remains a challenge, however some shifting has taken place. Recognizing the importance of behaviour change in the control of HIV infection and AIDS has led to greater efforts towards promoting various approaches aimed at creating or maintaining healthy sexual lifestyles. Programmes incorporate messages and interventions ranging from the promotion of sexual abstinence as part of an “ABC” approach (Abstain, be faithful, use a condom) to the promotion of alternatives to penetrative sex for young people (Rutgers University, 2006; Youth Incentives, 2004).

In many countries, counselling for people living with HIV promotes healthy sexuality through discussion on how to continue to have a satisfying and safe sexual life. The safer sex messages found on government and non-government websites target both heterosexual and homosexual individuals and couples (Board of Sexual Health and Family Planning, 2006; Coletivo Feminista de Sexualidade e Saúde, 2006; Queensland Government, 2006). Clearly, how such health programmes make the shift to broader concepts of sexual well-being will depend on the social and cultural norms of the specific country or community, but increased recognition, understanding and acceptance of the role of sexuality in people’s lives will create further opportunities for more comprehensive interventions. These interventions will improve health status and offer the possibility of improving satisfaction and pleasure in the sexual lives of both individuals and couples.

4. Towards a programme-based response

In previous chapters, the multidimensional nature of the key influences on sexual health outcomes were outlined. A sexual health programme that seeks to address determinants as well as consequences will, by its very nature, need to be multisectoral in its philosophy and approach. There are several key areas (including the health sector) in which policy and programme change can have an impact on sexual health in the population. This chapter offers guidance to programme managers with respect to the range of interventions that could improve sexual health. Several examples are presented that relate to a variety of disciplines and areas.

It is possible to identify a number of entry points for action in each of the five key domains (Box 4). Some of these entry points focus on eliminating barriers that prevent achievement of sexual health goals; others concentrate on strategies that promote sexual health. The strategies and actions suggested here may be undertaken by several different actors (both governmental and nongovernmental) depending on the particular context.

Some key principles cut across all these social and institutional domains. These include:

- awareness of the importance of gender and gender-linked power dynamics in influencing sexual health;
- recognition of, and respect for, sexual diversity;
- promotion of, and respect for, the human rights of individuals;
- ensuring participation of all, including women and vulnerable and marginalized populations;
- awareness of the need to address both risk and vulnerability;
- the importance of promoting positive social norms that foster equal and mutually responsible relationships.

The following sections describe some key strategies for the promotion of sexual health within each domain, with programme-based examples.

Laws, policies and human rights

The respect, protection and fulfilment of human rights include developing and implementing national legislation to support rights related to sexual health and repealing laws and practices that violate such rights. International human rights standards should be adhered to. More specifically, laws are needed to:

- protect those who are vulnerable from exploitation (e.g. in relation to child prostitution, trafficking and early and forced marriage);
- recognize and implement actions to fulfil the right of every person to comprehensive information relating to their sexual health and sexuality, without the need for consent from another person;
- recognize the right of everyone to autonomy, self-determination and privacy (e.g. eliminate authorization requirements from spouses to receive services) and to be free from torture or cruel, inhumane or degrading treatment (e.g. protection from any form of violence and FGM);
- protect the basic rights of all individuals without discrimination, including on the grounds of sex and sexual orientation (e.g. antidiscrimination legislation);
- promote equality (e.g. equal opportunity legislation) (PAHO/WHO, 2002).

Example: Challenging legislation and promoting sexual rights in India

The Naz Foundation, an NGO in India, successfully challenged the constitutional validity of Section 377 of the Indian Penal Code 1860 (IPC) at the High Court of Delhi, New Delhi, which criminally penalizes what is described as "unnatural offences" (sex other than heterosexual penile–vaginal). The court held that because Section 377 IPC covers sexual acts between consenting adults, in private, it infringes the fundamental rights guaranteed in the Constitution of India. The Court decided that Section 377 IPC should apply only to non-consensual penile non-vaginal sex and penile non-vaginal sex involving minors. The court declared that "in our view, Indian Constitutional law does not permit the statutory criminal law to be held captive by the popular misconceptions of who the LGBTs are. It cannot be forgotten that discrimination is the antithesis of equality and that it is the recognition of equality which will foster the dignity of every individual".

Source: High Court of Delhi (2009)

Box 4. Sexual health: strategic action for change

Domain	Eliminating barriers to sexual health	Promoting sexual health
Laws, policies and human rights	Work to change political structures that do not recognize sexual health concerns, or HIV- and sexuality-related stigma Work for the repeal of discriminatory laws and policies, and to establish mechanisms to redress violations of human rights Work to review laws and policies as they affect sexual and reproductive health Work to review the application of human rights standards to sexual and reproductive health	Work to create political support for sexual health issues and interventions Promote dialogue about sexual health at all political levels from grass roots to national leadership, including religious and community leaders Publicize the efforts of leaders who work to promote sexual health Develop a strong evidence base to identify best practices in relation to sexual health, and promote commitment to them Promote and implement supportive rights-based national legislation, policy frameworks and institutional policies Promote awareness of rights (e.g. through work with media) Use international human rights standards in advocacy (e.g. in challenging FGM)
Education	Recognize and remove barriers to general and sexuality education	Incorporate promotion of rights, diversity and gender equality into teacher-training curricula Increase access to comprehensive, choice-based sexuality education in schools Promote sexuality education for the most vulnerable, including young people who do not attend school Promote equality within sexual partnerships and challenge and condemn violence Promote community-based work on gender equality, building on positive social norms
Sociocultural	Recognize the role of gender-based power in sexual relationships as a determinant of sexual health outcomes Identify cultural practices that contribute to sexual ill-health	Promote equality and responsibility in relationships Challenge discrimination on the basis of sexual and gender diversity Recognize the positive role that men can play in improving women's health Promote cultural practices that improve sexual health (e.g. early discussions of sexuality and sexual health) Engage influential community leaders (e.g. religious leaders) in debate to promote awareness of public health imperatives of addressing sexual health issues Build partnerships to implement culturally sensitive programmes aimed at preventing violence against women, sexual violence, intimate partner violence, and FGM
Economic	Recognize and emphasize the links between economic marginalization and sexual ill-health	Promote economic empowerment and alternative livelihood strategies for vulnerable groups (e.g. women, sex workers, young people, migrants, and LGBT who leave home) Promote economic development that favours economic improvement and opportunity for women and girls Support research on the links between sexual health and poverty

Box 4 continued

Health	Eliminate barriers to service provision Ensure adequate resources for sexual health services	Increase access to sexual health services and resources, especially for the most vulnerable Improve quality of sexual health care by implementing non-stigmatizing, rights-based approaches to service provision Encourage religious leaders to challenge HIV- and AIDS-related stigma and social and gender issues that are harmful to health within communities Enhance communication between providers and clients (e.g. by promoting counselling within sexual health services) Promote greater integration of sexual health services Reach out to men in more positive ways

The development and implementation of rights-based policies in institutional settings – in particular in workplaces, health-care services, prisons, and schools – are needed to eliminate existing discriminatory policies, to counter discrimination through procedures of redress, and to promote human rights. Institutional discrimination is particularly visible in relation to HIV and AIDS. Examples include substandard care in health services, denial of access to care, HIV testing without consent, denial of employment because of HIV status, and expulsion of HIV-infected children from schools (UNAIDS, 2000).

Example: Improving the hospital environment for HIV-positive patients in India

In an initiative in India, people living with HIV and their carers reported receiving differential and discriminatory treatment from healthcare workers. This included isolation in wards, early discharge from hospital, delays in surgery, and serious breaches of confidentiality – all effectively limiting their access to care. There were few links to community-based care and support services. The study team also found that, within the healthcare setting, there were misconceptions about HIV transmission, negative and judgemental attitudes towards people living with HIV, inadequate training and supplies for infection control, and lack of institutional policies on confidentiality and HIV testing, which contributed to inequality in treatment.

On the basis of these findings, a "self-assessment checklist for a patient-friendly environment" was developed. In developing the checklist, a list of "gold standards" was compiled from national and international guidelines and policies on the human rights of people living with HIV, HIV testing and counselling, infection control, and on the care and management of AIDS patients. The checklist helps managers to identify how well their facility reaches, serves and treats HIV-positive people, to assess their institutional strengths and weaknesses, and to set goals for improving services. Hospital managers were also engaged in developing and reviewing policy guidelines, to help them assess their own institutional policies.

Managers at each hospital worked with the project team in a participatory process, to draft an action plan on how to improve services for people living with HIV and working conditions for staff. An interactive training module has been pilot-tested, aimed at making aware or "sensitizing" healthcare workers to various issues related to HIV, including client rights and the provision of humane and equitable care and treatment.

By developing solutions through action plans tailored to their particular setting, hospitals are actively cooperating and appear to feel a sense of ownership of the project. A follow-up study conducted since the pilot-testing of the interactive training module found greater understanding about HIV transmission and positive changes in attitudes and behaviour among all categories of healthcare workers. The checklist, policy guidelines, and other materials have been endorsed at national level, and distributed to NGOs and health-care organizations including the Employees State Insurance Corporation, which is one of the country's largest insurance based health delivery systems.

Sources: George et al., (2002); Mahendra et al., (2006)

As indicated earlier, policies and regulations can promote, or hinder, access to sexual health care. Examples of regulatory barriers include the prohibition of certain services such as emergency contraception or safe abortion, and the denial of services to particular groups, such as unmarried adolescents.

Example: Reducing the numbers of unsafe abortions in Colombia

Following a considerable amount of campaigning by women's groups, Colombia's Constitutional Court introduced less restrictive laws on abortion in 2006. In this campaign a Colombian lawyer successfully argued that a total ban on abortion violated the basic health and human rights guaranteed to women under a number of international treaties ratified by the Government, including the Convention on the Elimination of all Forms of Discrimination Against Women and the International Covenant on Political and Civil Rights, and that the criminalization of abortion in the Colombian Penal Code was thus inconsistent with international human rights obligations and should be declared unconstitutional.

Despite fierce opposition from the Catholic Church, this direct appeal to the highest court was combined with massive efforts by Colombian women's groups and international institutions working in the field of human rights. Together, they worked effectively to inform people about the case and to educate the public by addressing the abortion issue as one of public health, human rights, gender equality and social justice.

Source: Singh et al., (2009)

Legislation can be used to promote access to education, and that includes sexuality education. Some countries have introduced rights-based legislative changes in order to support school-based sexuality education programmes.

Example: National policy on HIV/AIDS for the education sector in Zambia

Through a policy entitled Educating Our Future, the Zambian Ministry of Education has put in place many of the components necessary for a comprehensive response to HIV and AIDS. The policy contains guidelines aimed at minimizing the social, economic and developmental consequences of HIV and AIDS on the education system, on students and on educators. It also promotes effective prevention, care and support within the context of schools and other educational institutions in keeping with international standards and in accordance with education law and constitutional guarantees, such as the right to a basic education and the right not to be unfairly treated or discriminated against.

Sources: Republic of Zambia (2009); UNESCO (2008a)

Access to community-based legal counselling and services is essential if rights-based approaches are to be effective. These services allow individuals to seek redress in cases where laws are not implemented. Some institutions are also providing the legal services required to facilitate access to specific services, such as emergency contraception or assistance in cases of violence.

Example: Legal support for survivors of sexual violence in the Democratic Republic of the Congo (DRC)

Many agencies, both of the UN and NGOS, have been aiding survivors of sexual violence throughout the DRC by providing medical care, economic and social rehabilitation, and legal assistance. In 2007, legal support was provided to 295 survivors of sexual violence and 7550 members of the armed forces and police force were trained on how to protect and care for survivors of sexual violence. In Kasai Oriental, North and South Kivu, police special protection units for women and children have been established, and over 15,000 sexual violence survivors have received medical care as a result.

UNFPA and others also played a key advocacy role in the adoption of the DRC law on sexual violence in July 2006. This law has broadened the definition of sexual violence to include acts such as sexual harassment, forced pregnancy, forced sterilization and other brutal practices.

Source: UNFPA (2008b)

Education

There are many entry points for the promotion of sexual health and healthy sexuality through education. These include:

- provision of comprehensive sexuality education for young people in school;
- training in sexuality and sexual health for health workers, teachers, social workers, youth workers and other key professionals; and
- a range of community-based strategies to meet the needs of young people who do not attend school and others who may be especially vulnerable.

Sexuality education for young people

Within schools, there is strong evidence for the importance of promoting sexual health through comprehensive education on sexuality, sex and relationships. Such work should begin before young people are sexually active and it must offer choices on issues such as abstinence and condom use. While the terminology used in sexuality education (and the way it is implemented) differ across countries and settings, a comprehensive approach is likely to include the following key elements:

- information about prevention of STIs and HIV, contraception, and the mechanics of fertility and reproduction;
- information about the role of pleasure, eroticism (see Annex 1) and satisfaction;
- discussion of gender differences and inequalities and human rights, and about the negative and positive effects of gender norms;
- information on the importance of responsibility and joint decision-making, and training in communication and negotiation skills;
- information on sexual and gender identity and sexual choice.

Recent reviews suggest that school-based programmes on sex and relationships are most successful when they are comprehensive, age-specific, and skills-based, use teaching methods that involve students, address social pressures, and when teachers are motivated and trained (UNFPA, 2003b). (Box 5)

For young people who do not attend school, urgent action is needed to provide education in innovative and flexible ways, for example by way of community and distance education, and radio or television broadcasts (UNESCO 2008b; Warwick & Aggleton, 2002).

Sexuality education, training and support for professionals

Training and support in sexuality-related issues, for health and education professionals (including teachers, nurses, medical practitioners, social workers and other community workers) remain important components of sexual health promotion (WHO, 2001a). Critical to the approach are challenging negative attitudes in a sensitive way, using participatory strategies, and promoting gender equality.

Counselling in health-service settings offers a particularly important potential entry point into broader discussions of sexual health with clients. However, it is a challenge to ensure quality in counselling. Good quality counselling requires that providers have the correct age- and sex-appropriate information to share with their clients and, importantly, can share this information in a non-judgemental and non-stigmatizing manner. Individuals have the right to receive balanced and comprehensive information about their health, their bodies and their options, so they can make informed decisions about preventing and treating sexuality-related ill-health.

There are many cases of violations of this basic right. One example is when voluntary counselling and testing for HIV is inadequate, and adolescent girls are coerced into using particular contraceptive methods and HIV-positive women are coerced into undergoing sterilization or an abortion (de Bruyn, 2003). By counteracting stigmatizing attitudes and discrimination by health workers towards sexually active young people, people living with HIV, and other groups, the likelihood of such groups accessing needed services will increase.

Box 5. Characteristics of successful health education programmes to prevent HIV

This list is based on reviews of school-based HIV prevention programmes in over 38 countries. Health education programmes provide basic, accurate information that is relevant to behaviour change, especially regarding the risks of unprotected intercourse and methods for avoiding unprotected intercourse.

Successful health education programmes have the following characteristics:

- They make use of social learning theories as the foundation for programme development.
- They are age-appropriate so they target students in different age groups and at different stages of development with suitable relevant messages and appropriate goals. For example, a programme for younger students who are not yet sexually active might have the goal of delaying initiation of intercourse; but a programme for older sexually active students might place emphasis on reducing the number of sexual partners and encouraging use of condoms.
- They are gender sensitive, and intended for both boys and girls.
- They use participatory activities such as games, role-playing and group discussions to personalize information, explore attitudes and values, and allow practice of skills.
- They include training for teachers and trainers, so that implementers master the basic information about HIV and AIDS, and opportunities for them to practise and become confident in life-skills training methods.
- They emphasize clear and appropriate values that strengthen individual values and group norms against unprotected sex.
- They offer modelling and practice in communication and negotiation skills, as well as other related life skills.
- They address social influences on sexual behaviour, including the important role of the media and peers.
- They support reproductive health and HIV/STI prevention programmes set up by school authorities, decision-makers and policy-makers, and the community at large.

Improving sexuality-related counselling depends on investment in training that clarifies and positively influences service providers' values, with intensive follow-up supervision and support (WHO, 2006c). As noted above, health sector capacity also needs to be built up around specialist issues such as FGM and sexual violence. Training on the elimination of FGM should be given to midwives and gynaecologists who work in communities where it is practised, or in settings in which health workers are likely to encounter immigrants who have undergone the procedure. It is also important to build up capacity among private-sector practitioners who are often consulted about STIs, as well as other key professionals such as pharmacists.

Teachers and youth and community workers have opportunities to discuss health-related issues with children and adolescents almost every day. Increasing their capacity to do so is an important means of widening young people's sources of information and counselling about sexual health.

Community-based education

Community-based education and advocacy, including both broad-based and targeted interventions, can raise awareness of (and reduce complacency about) particular sexual health-related issues, including HIV and AIDS. They can also promote sexual rights, challenge stigma and discrimination, reduce violence against women, question social gender-related norms that have negative consequences and promote positive norms. Community-based advocacy has an important role to play in addressing contextual factors that influence sexual health, such as gender-linked power inequalities.

Targeted interventions are often undertaken by community-based organizations and local and international NGOs. They can be effective when specific problems need to be addressed, or when the potential for sexual ill-health (including HIV transmission) is high. Targeted approaches are tailored to specific groups, defined by, for example, age, income, sexuality, educational status, geographical location or ethnicity. Such interventions can have a positive impact on sexual health, but they risk missing individuals who are not perceived – either by themselves or by the programme designers – as being part of a particular group. For example, women who engage in transactional sex for food may have the same sexual health needs as sex workers, but would not be reached by services targeted at the latter.

Example: A comprehensive HIV programme in Bangladesh

Family Health International published data on the overlapping occurrence of various risk behaviours in Bangladesh. These data show a close relationship between injecting-drug use, sex work and transportation work (i.e. truck drivers). It was found that many of the people involved in these activities are married. CARE Bangladesh has been using a multi-pronged approach to address sex work, drug use, transportation work, male-to-male sex, and living with HIV. Their successful programme is based on a strategic mix of preventive measures that address all the key factors that could potentially fuel a large HIV outbreak. Their strategy is underpinned by social and political development work, and their efforts to reduce individual risk behaviours are backed up by activities that address the context in which they occur.

In developing more strategic approaches to HIV prevention, CARE Bangladesh attempts to move beyond simplistic "risk group" approaches. This is because in the real world HIV risk behaviours do not occur in isolated pockets of society, but form part of the normal social fabric.

Source: Care International (2002)

Other examples of targeted and broad community-based interventions include outreach and peer education.

Outreach: This may be needed to reach especially vulnerable groups, including young people who do not attend school, drug users, female and male sex workers, street children, soldiers, prisoners, truck drivers, and men who have sex with men (Shaw & Aggleton, 2002). Outreach work can encompass various models of education and service provision and can take place in a range of settings.

Peer education: Examples of this approach include training certain individuals to educate communities about HIV and AIDS. Among the professions trained in this way are barbers in the Dominican Republic, taxi drivers in Guyana, gang members in El Salvador, and people living with HIV in several countries (Aggleton et al., 2000; Wood & Aggleton, 2004).

Media-based education: The media – especially television and radio – are an important source of information about sexuality, particularly for young people. Sexuality and sexual ill-health are often shrouded in secrecy and shame, which can restrict communication and fuel stigma and prevent individuals from seeking help or advice. The media can help to encourage discussion of these issues by treating them as everyday health problems that affect everyone at some stage in their lives. The media are also useful for promoting awareness of sensitive or hidden problems, such as trafficking or child sexual abuse. (See Box 6.)

Telephone hotlines: These have proved to be a successful way of providing sexual health-related information in a safe and confidential way.

Box 6. Key media actions for promoting sexual health

Mass media campaigns using social marketing and "edutainment" such as soap operas and music videos that are themed around sexual health.

Embedded messages in existing entertainment programmes.

Media advocacy whereby health activists generate stories for media coverage.

Media literacy whereby critical analysis skills are developed (especially among schoolchildren) to give an insight into how the media portray reality and assign meaning, to enable greater understanding of media stories and possibly facilitate personal change.

"Small" media to be distributed strategically in schools and communities, such as brochures, pamphlets, and documentaries.

Internet sites for delivering sexual health-related information.

Source: Keller & Brown, (2002)

Example: Peer education through Homies Unidos in El Salvador

Homies Unidos was created in 1996 in El Salvador by rival gang members who came together to create a better and safer life – that is, without violence. The organization is dedicated to providing educational and employment opportunities for young men and women aged between 8 and 35 years, to help them move out of their violent lifestyles.

The 12-year-long war in El Salvador caused millions of people to flee to the United States of America. There, many Salvadoran parents had two or more jobs, so they spent long hours outside the home and their children had to fend for themselves. These children often faced racism and alienation, and many of them – some as young as 8 or 9 years old– turned to the streets where they were recruited, sometimes forcibly, into gangs, which took on the role of friends and family. At the end of the war, many young Salvadorans were deported to their home country, taking with them the culture of the gangs. These violent gang members joined in with the less-organized local gang culture already in existence in El Salvador.

Gang members have an "accelerated" lifestyle. Many do not reach the age of 25, and they readily experiment with intravenous drugs, tattoos, unprotected sex, and violence, and aim to have a family and children before they are killed. They do not fear death. In fact, many accept it as an early interruption to their lives. STIs, including HIV, are not considered major factors in an already short life expectancy. They are at risk of HIV, as a result of their drug use, tattoos and unprotected sex, and often have no access to health services or education. Injured gang members are often turned away from hospitals and clinics because the staff fear them, associating them with HIV and violence.

The founders of Homies Unidos knew that they had to address both the physical violence and the STIs. They began the difficult task of convincing gang members that they needed to use a condom during sex, and provided an educational programme about STIs. The programme's Director developed workshops to reach out to teenagers. The first was held during a weekend retreat with 25 gang members. New skills were required to connect with the gang members and to translate medical terminology into street slang, so gang members who were familiar with the lifestyle, slang and codes of conduct of the gangs were selected to help reach their peers.

Counselling discussions enable many gang members to seek information on health issues related to their sexual activity. They are most concerned about STIs. Some ask for condoms. This new openness about STIs has led to increased educational efforts through a peer-education programme. Peer counsellors as well as youth trainers and educators are trained, and condoms are distributed.

There are many obstacles to peer education. Gang members and young people at high risk are reluctant to sit in workshops, so they are coaxed into participating by relating the programme with their self-interests and specific cases in their community that they know about. There is a reluctance to talk about personal matters, but conversations about sex are not taboo. One critically important aspect of the programme is that it provides a vision of a better life, and a longer life, so that these young people have a reason to care about their health.

Lessons learnt to date are:

- Young people identify more readily with their peers, so programmes that want to reach vulnerable young people need to find leaders among the target population to train. Homies Unidos selected young people to serve as peer educators, in addition to board members, fundraisers and programme staff.
- Programmes should provide information that is appropriate to the level of knowledge and skills of the target community, using relevant language including slang. Written information should also be handed out to reinforce verbal messages.
- Programmes need to target both young women and young men, as well as reach out to the wider community to raise awareness of the issues.

Source: Family Health International (2006b)
see also http://homiesunidos.org/

Society and culture

Example: Using the media to promote HIV awareness in Ukraine

Ukraine has one of the highest HIV prevalence rates in Eastern Europe. In an analysis of media activity, it was found that printed media in Ukraine addressed HIV issues in only 3% of articles. Since 2001, therefore, the International HIV/AIDS Alliance in Ukraine has been working with an international media development organisation, InterNews Ukraine, to provide training about HIV and AIDS for journalists, editors and NGOs.

Since 2005, the head of the Steps Rehabilitation Centre has made frequent appearances on a show for young people, aired live on the Odesa Oblast television channel and a radio channel in the town of Yuzhnoe. Guests on the show discuss "controversial" issues such as safer sex and the social causes and effects of drug dependency.

A telephone hotline operates during the programme and has proved to be an effective way to draw new clients into drug prevention programmes at the local Youth Development Centre. Since the show began, the number of clients attending the prevention programme for injecting drug users has increased by a third, and in so doing has further increased HIV awareness and support.

Source: International HIV/AIDS Alliance (2006)

Promoting sexual health in diverse social and cultural contexts can be challenging. Attitudes, behaviours, policies and laws – particularly those dealing with gender relations and reproductive health and rights – may inhibit or prohibit access to information or care related to sexuality and sexual health. Promotion of sexual health in such contexts requires sensitivity to social norms and clarity of the sexual and reproductive health needs of the whole population, including marginalized or discriminated groups. Working within these social, cultural, and even religious, norms is *essential* if we are to achieve public health goals related to sexual and reproductive health. Below are examples of initiatives that aim to change social norms and so improve health outcomes.

Countering violence against women

Example: Working with male perpetrators of violence in Jamaica

Brothers for Change is a programme of the Jamaica Family Planning Association (Famplan). This group-counselling initiative was launched in 1999, in order to help men who have been violent towards their female partners change their ideas and practices in relation to power and control. The programme resulted from Famplan's observations, as a health-care provider, of the negative effects of violence on the sexual and reproductive health of its female clientele, including STIs, unintended pregnancies and gynaecological disorders.

The programme depends on the support of local judges and probation officers. Men who are found guilty of domestic violence are referred to evening group-counselling sessions as part of their probation, and are supposed to attend one meeting a week for 40 weeks. During each session, they are challenged by both the counsellors and their peers to take responsibility for their abusive behaviour, and work towards developing more constructive ways of dealing with their anger and frustration. Topics include lessons on the male and female reproductive systems, coping with grief and loss, jealousy and fidelity, employment issues, family history, alcoholism, self-evaluation, and anger management techniques. Often, the men are shown video clips from popular films that highlight relevant issues.

The changes that Famplan is trying to bring about are not easily achieved. Dominant norms of masculinity teach men that they are supposed to be powerful, strong and aggressive, and that violence is a male instinct that cannot be controlled. In this context, violence against women can be construed as "natural" and a way for a man to "prove" his masculinity. This is why many of the men referred to the programme do not initially see anything wrong in what they have done, and it is often challenging to get them to attend the counselling sessions. Yet despite this, there have been many successes.

To supplement the counselling element, Famplan conducts education of the community to increase awareness of gender-based violence among men and adolescent boys in five areas. Famplan outreach workers visit schools, youth groups, churches, correctional facilities, police stations, squatter communities and juvenile detention centres to highlight violence against women as a problem.

Source: International Planned Parenthood Federation Western Hemisphere (IPPF/WHR) (2001)

Culturally appropriate strategies to address female genital mutilation (FGM)

The most successful interventions against FGM are community-based, organized by local women's groups or other organizations, and integrated into existing health, child protection and community development efforts (WHO, 1999). Because the issue is culturally sensitive, success is likely to require the mobilization of key community leaders, including local and national religious leaders, with strategies based on an in-depth cultural understanding of FGM and facilitating dialogue and alliances between traditional and medical practitioners (WHO, 2008).

Example: Challenging FGM among Sudanese refugees in Chad

The practice of female genital mutilation (or cutting) is widespread among Sudanese refugees in Chad, and is a deeply rooted tradition. National statistics report that 45% of women have undergone the procedure in Chad, while Sudan has a prevalence rate of about 70%. By involving key community leaders in a new training programme, communities are beginning to question their deeply entrenched attitudes towards FGM. Key leaders are encouraged to engage in informal discussions with householders in the refugee camps, about violence against women and upholding women's rights. This has already resulted in greater gender equality during community activities.

Source: UNFPA (2008c)

Engaging religious leaders for change concerning attitudes towards people with HIV

In many countries, religious leaders have been mobilized to help the population learn about, and better respond to, people living with HIV. This group can be extremely important in countries where religious norms influence a government's response to sexual health concerns and problems.

Example: Mobilizing religious leaders in Thailand

The Sangha Metta ("Compassionate Society") project was initiated in Thailand in 1998 with the aim of responding to community needs in relation to HIV prevention and care for AIDS patients. The rationale was to use existing community resources to respond to the HIV epidemic, and to extend the traditional role played by Buddhist monks and nuns in social welfare in the region. They are mobilized to participate in prevention and care activities, based on understanding, compassion and community solidarity.

The project provides training for monks and nuns in HIV-related concerns, giving them the management skills and tools required to work in their communities, both to prevent HIV transmission and to provide support for affected families. A crucial part of this training involves developing positive attitudes to people infected with HIV. There is close contact between participants and people with HIV who, for example, may prepare the food that they eat on the course. Buddhist doctrine is used to emphasize the importance of compassion and awareness in responding to people living with HIV. By putting compassion into practice and raising awareness, the monks and nuns help promote openness and acceptance of people living with HIV and dispel the myth that HIV is transmitted through casual contact. Because of the respect given to monks and nuns by the community, a gesture as simple as their acceptance and eating of alms from someone affected by HIV helps to reduce the fear and stigma the disease generates. For people living with HIV, and their families, the unconditional embrace by these highly respected community members seems to be more important than material support.

Seminars are also run with local monastic and lay community leaders to raise their awareness about the impact of HIV on their communities, to motivate them to accept HIV prevention and care of AIDS patients as part of their community development activities, and to help them devise appropriate strategies for this.

Using Buddhist ethics as their guide, project-trained monks and nuns teach villagers how to reduce high-risk behaviour, gain awareness of HIV, and prevent prejudice and discrimination. They conduct home visits, providing Buddhist-based counselling and advice on home-based care, and ensuring that people living with HIV can maintain a spiritual life by providing training in meditation and organizing daily or weekly meditation retreats. In addition, they help families with the costs of burial, so that people who die of an AIDS-related illness receive traditional funeral rites.

In regions where many people are infected because of injecting drugs, the monks and nuns use traditional Buddhist debating techniques to encourage street children and other young people to discuss the dangers of substance abuse. They also conduct awareness-raising events within their communities, advertising "HIV-friendly" temples to promote integration of people living with HIV within their community, in which people living with HIV give presentations and discussions are held with the local community. People living with HIV now take a more active part in community and temple festivals, and after this sort of public event some individuals will contact the organization to reveal that they, or a member of their family, is HIV-positive.

Source: Buddha Dharma Education Association (2006)

Economics

Actions and interventions in this domain may involve activities or interventions to generate income, or projects and programmes that recognize the relationship between economic dependence, power and sexual health.

The practice of fish-for-sex exchange is common among Ila and Tonga women traders and immigrant fishermen in the Zambian Kafue Flats. The practice is sanctioned both by notions of customary marriage (for short periods of time) and by the economic opportunities that the fish trade provides women in conditions of poverty and changing livelihoods. Promoting sexual health in such a setting requires engagement not just with cultural practices and traditions, but also with the local economy, by providing alternative means to make a living and by enabling women to provide for their families and children (Merten and Haller, 2007).

Enquiry into the life circumstances of female sex workers in Viet Nam has revealed something about the complex interactions between their social and economic lives, their working environments, their social relationships and their presentation of self in everyday social situations. Interviews were conducted and focus groups set up with street-based and venue-based sex workers in Da Nang and Hanoi (Ngo et al., 2007). Regardless of the context in which they worked, these women had limited abilities to protect their personal security or secure payment for services rendered. For street-based sex workers, economic hardship was found to be a major problem, contributing to their practice of unsafe sexual activities. Venue-based sex workers were found to have less economic hardship, but frequently incurred gambling debts. Many of them expressed a strong desire to leave sex work but found themselves trapped because of a lack of alternative employment options (Ngo et al., 2007).

In these kinds of situations, as well as those in which children or young people are orphaned, abandoned or left to fend for themselves, economic interventions are necessary to help avoid entry into high-risk sexual behaviour, including sexually exploitative practices such as sex for food, money or shelter.

Examples of successful economic approaches include initiatives to strengthen women's property rights in contexts where a woman's lack of ownership and control over economic assets such as housing and land can leave her destitute upon the death of her male partner. Under the auspices of the International Center for Research on Women (ICRW), a variety of initiatives have been supported that focus on reducing the vulnerability of women and girls to HIV by safeguarding their property and inheritance rights. Initiatives include community "watch-dog" groups to monitor enforcement of women's and girls' rights in Kenya, legal rights support work in Zimbabwe, and advocacy in Malawi that focuses on HIV-infection risk reduction. In each case, the goal has been to safeguard and promote sexual and reproductive health through economic and legal intervention (International Center for Research on Women, 2006).

In Limpopo Province in northern South Africa, the IMAGE project has been working to develop and evaluate an approach to the prevention of HIV infection that explicitly addresses structural factors driving the epidemic, such as poverty. IMAGE has set about integrating and mainstreaming a programme of gender awareness and HIV education into an existing microfinance initiative. In this way, it aims to operationalize a model for addressing the HIV epidemic that is relevant to settings in which poverty and gender inequalities pose a critical challenge to prevention efforts. The "Sisters in Life" curriculum developed as part of the project's work aims to raise critical awareness and promote solidarity among women already involved in a local microfinance initiative. Preliminary findings suggest there is potential to build natural leadership skills and community mobilization against HIV in a context where economic barriers were previously a hindrance to women's capacity to "take charge" and "fight back" (IMAGE Study Group, 2006). Similar initiatives are being developed elsewhere in the world.

Example: Giving women economic tools to fight HIV in northern Botswana

The Government of Botswana has earned international praise for taking decisive action against its national HIV epidemic. It is the only African country – and one of just a handful of countries across the globe – that is committed to providing free antiretroviral therapy to all its HIV-positive citizens. There has been considerable investment in public education campaigns designed to provide every age group with effective and appropriate information about what they can do to avoid high-risk behaviours that increase the likelihood of infection. There has also been heavy investment in providing education and economic opportunities to lower-income citizens. Nevertheless, many young women in poor outlying communities are still highly vulnerable to HIV infection because they lack access to independent income-generating activities, and risk abuse and exploitation in their relationships with male partners.

Few women and adolescent girls have direct access to a cash income, so they often find it difficult to resist the sexual demands of male partners. The African Development Foundation (ADF) has provided funding to one NGO called Women Against Rape (WAR), which trains poor women in income-generating skills, identifies potential market niches for new businesses, and helps participants gain access to credit for the development of sustainable micro-enterprises. "The object of our programme is to break the dependency syndrome that results from women not having their own income and their own resources," says coordinator, Chibuya Dabutha. "We will be conducting research on viable small businesses for women in Ngamiland – from cooking, to sewing, to basketry for the local tourist industry – and working with women from across northern Botswana to train them in starting and managing their own small businesses."

WAR will work with the staff of the ADF's Botswana partner organization, Action for Economic Empowerment Trust (AEET), to assess market opportunities for women, design business-skills workshops, and conduct participatory monitoring and evaluation of the project.

Source: African Development Foundation (2006)

Health systems

Sexual health programmes should aim to provide comprehensive sexual healthcare services for individuals throughout their lifecourse, on the grounds of race, ethnicity, age, lifestyle, income, or sexual or gender identity. The recommendations below are drawn from individual country experiences and reviews (de Koning et al., 2006).

Providing good-quality, integrated sexual health services

The integration of sexual health services into reproductive health services for women has mainly focused on the prevention and management of RTIs and STIs, including HIV. Both family planning and maternal and child health services have documented experience in integrating infection prevention and management for their (female) clientele, including in some instances promotion of dual protection (to reduce the risk of both pregnancy and infection), counselling on sexuality, and voluntary counselling and testing for HIV.

Far less attention, if any, has been paid to integration of other sexual health services for women, such as care for women with sexual dysfunction. Much of the evidence on the integration of STI and HIV interventions relates to issues of clinical management, rather than, for example, what promotes and sustains behaviour change or how partner management should be handled.

Example: Integrating HIV services with local family planning in Zimbabwe

The Zimbabwe National Family Planning Council and Ministry of Health created a community-based distribution (CBD) programme in 1967 to bring family planning (FP) services to the doorsteps of hard-to-reach rural populations. However, data showed that fewer people were accessing contraception through the programme over time. There was a simultaneous growth in HIV prevalence rates, which presented a critical public health challenge in the country. A national assessment conducted in 2002 revealed that family planning clients were approaching community-based distributors for information about HIV-prevention, treatment and care services. The existing community-based programme was at that point inadequately equipped to provide both family planning and HIV services.

As a result, the community-based programme was developed to provide these integrated services. This involved training community-based distributors and a new cadre of community-based health workers (called "depot holders") to integrate HIV prevention strategies and voluntary counselling and testing (VCT) into the existing family planning programme. Using a "satellite approach", depot holders served as stationary resupply agents with commodities in their homes, and as mobile agents who distributed door-to-door in communities. They also supported home-based care activities, for example by visiting the homes of people living with HIV to keep them supplied with contraceptives, by providing counselling on healthy behaviours, and by referring sick clients to health and VCT centres. Family planning services were also provided at community sites (e.g. churches and markets), which was often preferred by men and young people.

A series of meetings between community-based health workers and clinical providers identified ways to maintain a continuum of care between clinic and home. It also encouraged a range of service providers to sustain communications with one another. This community dialogue also created opportunities for information sharing, and to normalize the use of services as women, men, and young people grew accustomed to hearing about family planning and HIV services and taking action to receive care.

As a result of this project:

- Integrated HIV, AIDS and family planning services were successfully introduced in 16 health districts in rural and urban areas.
- 174 CBD agents and 708 depot holders were trained in STI, HIV and AIDS prevention and counselling. Their additional knowledge and skills have resulted in increased referral to both HIV and family planning services.
- Large increases were seen in the distribution of male and female contraceptives.
- There was a significant rise in people's awareness of HIV risk factors and in uptake of HIV testing.
- There were many new family planning clients, including men, young people, and people living with HIV.

Source: USAID (2007)

With respect to the prevention and management of STIs and RTIs in women, health services have generally concentrated on strategies for detection (testing and screening) plus treatment.

Effective and feasible screening programmes include:

- screening of pregnant women for syphilis and HIV;
- screening of women attending reproductive health services for HIV; and
- screening of (older) women for cervical cancer.

Screening for HIV should be provided within a framework of voluntary counselling and testing (VCT) and supplemented by provider-initiated HIV testing (WHO/UNAIDS, 2007). Family planning clinics offer one of just a few opportunities to screen for cervical cancer, although the target age group needs to be carefully considered. Counselling on sexuality, although provided infrequently, should be a component of all counselling related to sexual and reproductive health, as it represents a welcome shift towards a dialogue with clients to assess their needs, including dual protection.

Example: Improving cervical cancer screening and treatment in Peru

Peru has one of the highest incidence rates of invasive cervical cancer in the world. It is the leading cause of cancer deaths among women. A National Plan for the Prevention of Gynecological Cancer has been in place since 1998. This includes cytology as the screening technique, as well as visual inspection with acetic acid and cryotherapy as a treatment method for pre-cancerous lesions. Despite such measures, many women considered to be at most risk were not being systematically screened. Laboratory and human resources were limited, and follow-up and care after abnormal test results were poor.

In response to these challenges, the Ministry of Health collaborated with the Pan American Health Organization and Program for Appropriate Technology in Health (PATH) to investigate methods that could improve the effectiveness of the screening programme. To this end, a cervical cancer demonstration project was developed, named TATI (Tamizaje y Tratamiento Inmediato). From 2000 to 2004, this programme was implemented in the region of San Martin, an area with limited access to health services but high levels of community participation.

It aimed to screen 80% of women aged 25–49 within 3 years. It consisted of three linked components: community information and education, screening services, and diagnostic and treatment services. Seventy-nine community promotion teams (comprising representatives from health services and from the community itself) were trained to raise community awareness and deliver health education sessions. Awareness-raising activities informed women about early detection and treatment of pre-cancerous lesions and where they could go for such services. Once awareness was raised, the promotion teams held four interactive educational sessions with groups of women themed on knowing the female body, vaginal infections, prevention of cervical cancer, and self-esteem. Home visits were also made to encourage attendance for screening and to follow-up and support women with positive test results.

Twelve teams were assembled to provide screening and immediate treatment, and 30 primary health centres were equipped to provide support services. All health workers received up-to-date training in screening techniques, and midwives and physicians were re-trained in aspects of female anatomy, prevention of cervical cancer, diagnosis and management of sexually transmitted infections, infection control, and communication and counselling skills.

As a result of this programme:

- The community awareness teams provided cervical cancer prevention information to almost 35 000 women aged 25–49 years. They also helped to organize and support the activities of over 60 community advisory groups (including community leaders) to provide consistent educational messages and to motivate women to undergo screening.
- Around 19% of women participating in the programme were screened for the first time in their lives, Nearly half of the screened women (45%) were aged 35–49, which is considered to be the most difficult age group to reach with screening services.
- A mobile multidisciplinary team was able to travel to serve women requiring specialized treatment who did not have access to secondary-level health care.
- Some 542 women were diagnosed with pre-cancer and received treatment to prevent cervical cancer from developing.
- Treatment and emotional support was provided for 126 women who were diagnosed with cervical cancer.

Sources: Winkler et al., (2008); Luciani and Winkler(2006)

The barriers to integrated services need to be defined. In many cases, interventions that are known to be effective may not be implemented or sustained (e.g. antenatal syphilis screening). A broad-based sexual health service that incorporates elements of counselling, screening, and client and partner management will require additional staff training and supervision. Referral services will need to be strengthened, for instance in the case of women who are found to have cervical abnormalities on screening. Laboratory services also need additional resources to enable them to support integrated screening and management programmes for cervical cancer and STIs.

There is, as yet, little experience with scaling-up of services, and more thought needs to be given to the mechanisms and requirements for achieving this. Sexual health should be integrated into other primary care services only if there is sufficient capacity to manage the process. Increasing the capacity of health service providers through training and sustained follow-up is critical. Strengthening collaboration between services and referral systems is also crucial (WHO, 2003b).

Example: Providing sexual health services and counselling and training in Brazil

The Coletivo Feminista Sexualidade e Saúde in São Paulo, Brazil, was founded in 1981 to promote and provide integrated health- and sexuality-related services for women. Working from a rights perspective, the Coletivo is one of the leading women's health activist organizations in Brazil. It provides ambulatory sexual and reproductive health services and specific mental health services (counselling for individuals and couples). It holds workshops for diverse groups, such as male and female sex workers, homosexual men and women, young people, older women and rural workers, and training and capacity-building for other organizations that want to work on sexuality in their own service setting.

To help disseminate their achievements, they have developed training materials and other tools. The Coletivo provides training and education for individuals and for couples, as well as São Paulo's public health system, the Catholic Church's pastoral support services, police and judiciary training organizations and associations (related to violence), and other organizations dealing with a variety of groups and sexual health issues.

Source: Coletivo Feminista Sexualidade e Saude (2006)

Strengthening counselling in maternal and child health and family planning services can provide an important entry point into promoting sexual health through these services (Abdel-Tawab et al., 1999). However, this kind of counselling is still relatively rare. Research is needed to evaluate the feasibility and effectiveness of integrating counselling on sexual health matters into broader sexual and reproductive health programmes. There is some evidence that programmes that have taken up the challenge of addressing sexuality through counselling can improve client satisfaction and staff motivation. However, the intensive training of providers, the provision of revised guidelines and aids (e.g. flipcharts) and sustained follow-up are critical (Askew & Berer, 2003).

Example: TASO – The AIDS Support Organization in Uganda

TASO provides sexuality counselling and promotes discussion on sexual pleasure, masturbation, family planning, and other sexual health issues with HIV-positive individuals, and in couples in which one person is infected. TASO's services are linked to the National Public Health services, but are not fully integrated. By its nature, TASO plays a pivotal and strategic role in the region, by building capacity and scaling up HIV- and AIDS-related interventions. Between 2005 and 2008, 687 HIV/AIDS practitioners from across sub-Saharan Africa were trained in best practices in service provision.

Source: TASO (2008)

Integrating sexuality counselling into broader sexual and reproductive health services involves more than just giving information, and can represent a serious challenge for the health sector and health workers. Time constraints, a lack of privacy in many public health services and – perhaps most significantly – the need for intensive training of health care staff on sexuality, remain key challenges. Other means of providing counselling, e.g. telephone hotlines, should also be considered.

Example: Sexuality counselling in India

TARSHI (Talking About Reproductive and Sexual Health Issues) is an NGO in New Delhi, India. Since 1996, it has run a telephone helpline that offers a free, anonymous, confidential, safe and non-judgemental means for people to obtain counselling, accurate information, and appropriate referrals on sexual and reproductive health, and sexuality-related issues. Information is provided in both Hindi and English by a team of trained counsellors, and a qualified clinical psychologist directs the helpline's operations.

By the end of 2008, the helpline had responded to over 60 000 calls from people of all ages, sexes, sexual preferences, and backgrounds. The helpline addresses wide-ranging concerns related to sexual health, behaviour and relationships. Analysis of data from the helpline has deepened TARSHI's understanding of sexuality issues within the Indian sociocultural environment and has enabled them to offer supportive advice to other organizations running sexual health helplines.

Source: TARSHI (2008)

Programmes aimed at improving provider–client interactions, particularly via the discussion of sexuality-related issues, are more likely to be successful if health workers are involved in their design. In many settings, the personal and professional characteristics of health providers critically affect whether clients feel that discussion about sexual health is legitimate and the information provided is credible. Many married women, for example, are more comfortable discussing sexuality with women providers who are also married and have children. Service providers need to adopt an open and non-judgemental approach, respect confidentiality and be aware of recent developments (Box 7).

Reaching men and vulnerable groups

In most parts of the world, maternal and child health and family planning services reach mainly adult married women, while HIV services reach individuals who have, or are deemed to have, high-risk practices. Other groups may not be reached by sexual health services; these groups can include men in general, as well as vulnerable and stigmatized groups such as migrant communities, refugees, and displaced populations (Niang et al., 2002).

Example: Health services for men who have sex with men in Lebanon

The International HIV/AIDS Alliance and the National AIDS Programme of Lebanon have been collaborating with local NGOs to address the medical and psychological needs of men who have sex with men in Lebanon. Findings from participatory community assessments carried out in 2005 and 2006 revealed that these men often had low levels of awareness regarding sexual health and were engaged in high levels of risky behaviour. Fewer than 55% of the men who were surveyed, for example, reported using condoms. Only 34% had discussed their sexuality during visits to health professionals, despite 37% reporting that they needed urgent medical attention for STIs. This problem was felt to be exacerbated by discriminatory attitudes among health workers towards men who have sex with men.

These results demonstrated the urgent need for the implementation of a referral system appropriate for these men that would link to prevention and treatment services for HIV and other sexually transmitted infections, as well as psychological and legal support services.

In response, the Alliance and the National AIDS Programme of Lebanon have been working with two organizations, known as Soins Infirmiers et Développement Communautaire (SIDC) and Helem, to initiate a referral system among 15 NGOs and medical and social services in Beirut. This system comprises legal, healthcare and social services, psychological support and free HIV counselling and testing.

To ensure the services were promoted, the project had to strengthen partnerships through meetings with officials, NGOs, medical and social facilities, and pharmacies, and work to sensitize political and religious authorities and the public about the importance of implementing services for men who have sex with men. This led to the creation of a partnership with owners of bars and movie theatres and the establishment of a group of peer educators (via street work, an advice service and a hotline) to promote the services.

They developed promotional materials including a referral protocol, guide and card. The project team also developed and distributed "health boxes" containing preventive materials, cards to promote the referral system, a brochure about men who have sex with men, and a brochure for the families of these men.

Source: International HIV/AIDS Alliance (2007)

The past decade has witnessed a move away from women-focused population programmes, first to programmes that involved men in family planning and other reproductive health services through a sense of solidarity and responsibility, then to programmes that aimed to meet men's own sexual and reproductive health needs. More recently, programmes have emerged that attempt to address women's and men's sexual and reproductive health needs in a gender-equitable way.

Example: Engaging men in the prevention of gender-based violence in El Salvador

Gender-based violence (GBV) in El Salvador is high. Seven out of every ten women reported experiencing some form of violence between 1999 and 2004. However, GBV is not considered to be a serious problem by many people, reflecting an understanding of accepted masculine behaviour in El Salvador which emphasizes control, physical force and the treatment of women as possessions who lack rights of their own.

Against this backdrop, seven organizations joined together in 2005 to create the Campaign for the Prevention of Gender Violence in El Salvador. The Campaign "Entre vos y yo, una vida diferente" (Between you and me, a different life) addresses the topic of GBV with positive messaging for creating change. An important key aspect of this programme is working with men and helping them to explore their experiences and understandings of gender roles and relations and culturally constructed concepts of masculinity.

The campaign has involved several elements, as described below:

- The development of a certificate course on GBV for NGO representatives and public officials. The course covers issues of gender and human rights; prevention of GBV from the perspective of public policy; and gender-based violence and the construction of masculine identity.
- The Masculinities Programme, run by the NGO Centro Bartolomé de las Casas, seeks to work with men of all ages and backgrounds to reflect critically on gender and to analyse the causes and impacts of GBV. Using participatory techniques through games and art, it encourages individual and group reflection on the construction of masculine identity within relationships. This in turn, helps men to identify ways in which they can positively transform their lives and their family's lives.

The campaign has brought about positive shifts in attitudes among male participants, with the majority saying that they have changed the way in which they view themselves and interact within their personal relationships. They also reported an improvement in their ability to express their feelings and emotions, and had a better appreciation of the role and value of their wives, children and other family members. Many participants also expressed an eagerness to train other men.

Sources: Bird et al., (2007); Madrigal and Tejeda (2009)

Many programmes are managing to involve successfully men in family planning, encouraging them to accompany their pregnant partners to antenatal care appointments and, in some cases, improving their parenting skills. Such interventions aim to improve men's understanding of women's reproductive health (e.g. to recognize danger signs in pregnancy) or to change men's behaviour (e.g. to increase male participation in contraception). In some settings, emphasis is placed on the counselling of couples.

Box 7. Key elements of sexual and reproductive health counselling

- Discuss matters related to contraceptive choice, including effectiveness of each method, their side-effects and complications, proper use of each method, what to do in the event of unwanted pregnancy, emergency contraception, and dual protection.
- Promote condoms as a contraceptive method, and as a means of preventing STIs.
- Discuss the effects of different contraceptive methods as a possible entry point into discussion of sexuality.
- Discuss matters related to the prevention of mother-to-child transmission (PMTCT) of HIV.
- Discuss measures of protection against STIs and HIV, safer sex and other preventive behaviours, as well as communication and negotiation in sexual relationships.
- Make available voluntary and confidential counselling and testing for HIV, where it is appropriate and feasible.
- Create space to discuss broader concerns relating to sexual health.

Source: Adapted from de Koning et al., (2006)

Other programmes provide sexual health services and interventions for men themselves. They tend to focus on management or prevention of STIs and HIV. In many countries, this has primarily involved the private sector, where STI treatment is usually provided. In other countries, men have been reached successfully through workplaces, sports settings, and via the military.

Example: Sexual and reproductive health services in the army in Nicaragua

The Military Medical Corps of the National Army of Nicaragua provides healthcare services to army members and their dependents. A UNFPA-supported project was initiated not only to strengthen the quality of healthcare in the army, but also to provide primary healthcare, information, education and communication (IEC) and reproductive healthcare to communities surrounding military units with little access to public health services.

The project had two components: (i) training and education for military personnel in reproductive health and family planning, and (ii) service delivery. It promoted the concept of sexual and reproductive health as a human right. Doctors, nurses, and nurse auxiliaries were trained to integrate reproductive health and family planning services into the primary and secondary healthcare offered by military health units. Some 1000 soldiers and officers were trained to carry out information and sensitization (awareness- raising) activities on reproductive health and sexual rights. Educational materials produced by the Nicaraguan Community Movement organization were adapted for use in reproductive health and IEC activities. The Military Medical Corps developed a working relationship with several government and nongovernment reproductive health projects. For instance, the Centro de Información y Servicios de Asesoría en Salud (Centre of Information, Services and Counselling on Health) and the Nicaraguan Community Movement worked with the Medical Corps to train health leaders in reproductive health and family planning.

As a result of the project:

- Army commanders, officers, and soldiers became far more aware about issues related to sexuality, particularly prevention of STIs and gender-based violence.
- Military personnel, men, and women, were sensitized about reproductive health, family planning, and gender equality.

After the country was struck by Hurricane Mitch, military health teams working in disaster zones provided reproductive health and family planning information, and distributed oral contraceptives and condoms.

Two lessons were learnt from this:

- First, the Military Medical Corps and army are effective mechanisms for reaching large numbers of men, including male adolescents.
- Second, the army can become a provider of quality services to rural populations.

Source: Reproductive Health Outlook (2006a)

There are still relatively few programmes that aim to improve sexual and reproductive health for both men and women in a gender-equitable way, and even fewer have been assessed or evaluated. There is a need to implement and evaluate more of these types of intervention.

Example: Encouraging male adolescents to think critically about gender norms in Nigeria

The Nigerian Conscientizing Male Adolescents (CMA) programme was established in 1995, with funding from the International Women's Health Coalition. The programme aims to teach and encourage Nigerian male adolescents, aged 14–20 years, to develop a critical awareness of their prejudices and practices in an effort to help them abandon them. Taking cultural norms into consideration, the programme focuses on topics such as Nigerian society, women's roles and family structures, sexuality, reproductive health and rights, and violence against women.

The programme started with 25 participants who met weekly for 9 months to discuss, debate, question, and analyse issues such as reproductive health, violence, gender equality, and human rights. The dialogue was led by adult facilitators, who encouraged the participating adolescents to explore their attitudes, beliefs, and values. As a result, the participants became better equipped to think independently and analytically. After evaluating the one-year programme, a second year was added, in which monthly meetings were held to reinforce what had been learnt. In 1999, the two-year programme had 100 participants. Since then, it has been expanded even further, with a peer-education component, an outreach element, and development of a training manual.

Several other initiatives are planned. One aims to establish discussion groups in several post-primary and secondary schools in the state and in a neighbouring state. The CMA also plans to disseminate a newsletter more broadly, so that it reaches more schools. Ultimately, the CMA hopes to replicate its programme in other locations, to have a greater effect on Nigerian society.

Sources: International Women's Health Coalition (2000); Population Council (2003)

Services for adolescents and young people

The increasing emphasis on adolescent and young people's sexual and reproductive health is based on a growing recognition of the challenges they face – particularly girls. It is estimated that at least one-third of STIs and half of all new HIV infections are in people aged 15–24 years. Of nearly 20 million unsafe abortions carried out each year, 19.2 million take place in developing countries, and almost 14% of these are performed on girls aged under the age of 20 (WHO, 2007).

Service providers throughout the world are evaluating different ways of improving adolescent and young people's access to sexual and reproductive health services and information. Models of service provision include creating youth centres, making health facilities "youth-friendly", making primary healthcare services more responsive to young people's needs, and providing counselling and services in schools through peer educators and community-based distributors.

Example: Providing youth-friendly sexual health services in Lesotho

In 2003, the Lesotho Planned Parenthood Federation set up a youth resource centre with a clinic and sexual and reproductive health information integrated with recreational services, a library and an internet café. Young people were encouraged to take ownership of the project, and saw the centre as a safe space for discussing topics such as sexuality, contraception and STIs. As well as working with schools, the centre staff provided outreach work to target vulnerable groups such as young people with disabilities, teenage parents, young people in correctional institutions, and herd boys (a tradition in which young boys aged as young as 5 years are sent to tend livestock alone in the remote highlands for months at a time). The project also made use of radio, television, music, drama and puppetry to address sexual and reproductive health issues.

Between 2003 and 2007:

- 16 289 girls and 10 595 boys received sexual and reproductive health information.
- 3550 visits were made to the youth centre.
- 103 peer-educators were trained to provide sexual and reproductive health information and support.

Sources: UNFPA (2009)

Specific strategies are needed to expand services to hard-to-reach groups, such as adolescents and young people who do not attend school, or who are unemployed, refugees, young sex workers, street children, sexually abused children, lesbian, bisexual and gay young people, and drug users. An important aspect to consider when identifying people who are hard to reach is the complex nature of vulnerability. Services should be available and accessible without parental consent, taking into account the young people's evolving capacity and best interests. See General Comment 4 of the Convention on the Rights of the Child (CRC) (United Nations, 2003). The most effective programmes are holistic ones that operate on multiple levels.

Example: A community-based programme for sexual minorities in Indonesia

Consider the following scenario. Around midnight, Dede pulls his motorcycle up beside a large, dark field at the end of the main street of his town. Before he gets his helmet off, two young men holding each other's hands approach him and ask him for condoms. Dede is a street outreach worker working in the "gay community" on behalf of Lentera, a programme of the Indonesia Planned Parenthood Association.

Lentera was founded in 1993 by a group of young people concerned about sexual health. One of its first initiatives was a programme for young homosexual men, who at that time were becoming increasingly concerned about what they heard about AIDS from other countries. Lentera's strategy is to provide them with the information, support, and services that help them choose to lead healthy lives. The programme first reaches young men in the "cruising" areas, where they congregate at night and meet sexual partners. Street outreach workers are in the area several nights a week to talk, provide condoms, and refer people for relevant services. The programme has developed a series of pamphlets using "gay" slang to discuss issues such as the correct way to use condoms, relationships, and STIs. Outreach workers also help organize events in the community, such as monthly meetings of support groups and weekend retreats for the youths, and the Planned Parenthood Association clinic provides them with STI services one evening a week.

The following lessons were learnt from the programme:

Example A continued

- Involving young homosexual men in the programme built trust between Lentera and the gay community. The programme has had at least one homosexual member of staff since it was founded, and encourages others to get involved as volunteers – both for the gay community and for the other programmes Lentera provides. Support-group meetings and weekend retreats are fully planned and organized by homosexual youths.
- Careful selection, training, and supervision of outreach workers are key to the programme's success. Outreach workers receive three days of training, and accompany a senior outreach worker for a month before being assigned to their own field location. They must commit to carry out outreach work at least two nights a week for at least six months, and are required to write a short report each time. A strong code of ethics, developed and reviewed periodically by the street outreach team, guides their work in the field. They are supervised by a part-time staff member who meets with the gay community monthly to get feedback about the team's performance.

After the first year of outreach, Lentera had built up enough trust within the gay community to conduct almost 200 interviews with young homosexual men about their relationships and sexual behaviour. The programme was then able to identify key risks and target them more effectively. For instance, it was found that these men often used condoms the first few times they had sex with a particular partner, but abandoned them once they felt that the relationship was stable. Information, education, and communication messages were adjusted accordingly. Lentera also found that the most common reason for not using a condom was not having one; this prompted them to develop an innovative condom distribution scheme through the small food stands frequented by gay youths at night.

While supporting safe sexual behaviour, the programme also pays attention to the broader spectrum of young people's needs, namely issues relating to sexual identity, telling friends and family about being gay, depression, the religious implications of being homosexual, problems with relationships, drinking and drug use, and coping with life after marriage. These are dealt with in various ways through the programme.

Reaching young homosexual men through a programme that works with young people in general has several benefits. First, many of them are not open about their sexual orientation and so feel more comfortable with an organization that is not identified as having an exclusive focus on homosexuality. Second, the work has resulted in a broader understanding and acceptance of the gay community by non-homosexual young people.

Source: Reproductive Health Outlook (2006a)

One of the greatest challenges is to develop guidelines for assisting policy-makers and programme managers in planning, implementing and evaluating sexual and reproductive health services that are appropriate to the context. They must take into account specific needs and barriers related to age, gender and sexuality, as well as the social and cultural situation. They should also respect and protect the best interests of the adolescent or young person with respect to their evolving capacity.

There is a need for more research in several areas: on the effectiveness of various programmes; on what are aspects of youth centres and clinics that most influence attitudes and behaviour; on the cost-effectiveness of different approaches; on strategies for scaling-up programmes, paying attention to reaching different groups with a range of choices for counselling, preventive care and treatment; and on the differences between the perceived needs of young men and women (Box 8).

Box 8. Strategies for reaching young people

- Strengthen primary care by increasing the capacity of providers to provide appropriate services to adolescents and young people.
- Establish youth centres where sexual health clinics are integrated with sporting and other opportunities.
- Where possible, provide comprehensive sexuality health education in schools.
- Provide condoms and other services through outreach workers.
- Use trained and supported peer and community educators.

Example: Providing advice and support on sexual health issues for young people in Kenya

The Kenya Adolescent Reproductive Health Project (KARHP) was implemented by the Program for Appropriate Technology in Health (PATH) and the Population Council/FRONTIERS (Frontiers in Reproductive Health project) from 1999 to 2003 in two rural districts in Western Kenya. Focusing on sexual health issues for in-school and out-of-school youths aged 10–19 years, the project included peer education, guidance and counselling in schools, and the introduction of youth-friendly services in participating health facilities.

A group of peer educators was trained to provide information to young people and to make referrals to health centres for more information and services. The peer educators reached young people through group discussions, drama presentations, outreach meetings, demonstrations of condom use, condom distribution, one-to-one counselling, video shows, and distribution of other information, education, and communication materials. Eighty religious leaders were also trained as counsellors to young people in their congregations and allowed the peer educators to use their facilities for outreach activities. Health service providers were trained to deliver youth-friendly reproductive and sexual health services in special "youth friendly" rooms within the health centres.

The success of the programme is such that it has been expanded to cover six additional districts in western Kenya, and to two further provinces since 2003.

Sources: Humphres et al., (2008)

There are widespread double standards regarding the premarital sexual behaviour of young men and women that must be addressed through community development strategies. There must also be clarification about the ways in which gender inequality affects access to services.

Quality of care

Quality of care is a major issue for adolescents and young people, who often feel badly treated or discriminated against by health providers for being sexually active. Bottom-up approaches, in which healthcare staff are involved in evaluation and decision-making, have had some success in making health workers aware of adolescent and young people's circumstances and needs.

Integrating rights in training

Integrating concern for human rights and the rights of young people into the training of health workers is a key strategy for promoting sexual health. Evidence suggests that enabling adolescents and young people to participate in decision-making related to development of a programme (including its design, implementation and evaluation) can increase its effectiveness; however, it is rare that this is done in an integrated and genuinely participatory manner (Box 9).

Box 9. Key elements of a youth-friendly health services

Service providers should:

- be specially trained;
- show respect for adolescents and young people;
- consider the best interests of the young person and take into account their evolving capacity;
- ensure privacy and confidentiality;
- allow adequate time for client–provider interaction.

Health facilities should:

- have separate, adequate space or special times set aside for consultations with adolescents and young people;
- be in an easy-to-reach location and be open at convenient times.

The programme should be designed:

- with involvement of adolescents and young people through design, service outreach, service delivery and feedback;
- so that drop-in clients are welcome and appointments are arranged rapidly;
- to welcome both boys and young men and girls and young women;
- to provide a wide range of services and referrals, including peer counselling.

Source: UNFPA, (2003b)

Carrying out sensitization work with adults in relevant positions – including community leaders, parents and teachers– is a strategic way to promote young people's rights. It is crucial for increasing their understanding about young people's needs and the realities of their sexuality and sexual lives.

Example: Sensitizing parents in Ghana

Discussion with children about matters related to sexual and reproductive health is regarded by many parents in Ghana as taboo. However, there is a high incidence of abortion, teenage pregnancy, STIs and HIV infection among young people, which has highlighted the need to improve the role of parents in communicating about sexual and reproductive health.

World Education Ghana, through the Strategizing HIV Prevention Efforts (SHAPE Project) is collaborating with civil society organizations to sensitize parents through parent–teacher association meetings.

During one of these meetings, a group of parents were presented with data from a baseline study on students' sexual behaviour. They were asked whether their own children were aware of STIs, HIV and reproductive health issues. While some parents responded in the affirmative, others considered that these issues were not important. Two students who had been trained at a newly-established sexual and reproductive health club were invited to facilitate one of the sessions. The parents listened with keen interest and asked the students several questions, expressing surprise at the students' wealth of information and the assertiveness skills they had acquired. They asked for training in communication skills (for themselves), to enable them to talk to their children about sexual matters.

Sources: Wood & Aggleton (2004)

Managing sexual violence in health services

In the past decade, the role of health services in managing partner violence (physical and/or sexual) and non partner sexual violence has been widely discussed. The arguments for increasing the capacity of health workers in this respect are compelling, especially since healthcare facilities are the first point of contact for many women who have been abused. The use of health services may itself put women at risk of violence from their partners – for example, if a woman uses contraceptives covertly, or if a woman's partner needs to be notified about an STI, or if a woman tests positive for HIV (WHO, 2006b).

It has been proposed that screening for the early detection of violence against women should be carried out, but evidence for its effectiveness is insufficient. When health workers include routine questions about violence as part of an assessment process, there is an increase in the identification of violent incidences. However, this research involves little systematic evaluation of the effects of such screening, and whether it can improve safety of an individual woman or increase the likelihood that she will seek care (WHO, 2002). However, this does not preclude raising awareness of, and providing information to, health providers on VAW so that they know how to respond if someone discloses, or when they suspect abuse is underlying health problems (Box 10).

Box 10. Key elements of an integrated health service response to sexual violence

The key elements of integrated care and treatment (either on-site or by referral to specialized services) for clients who have suffered sexual violence include:

- medical care for, and accurate recording of any injuries and health problems;
- evaluation for STIs and preventive care;
- evaluation of risk of pregnancy, provision of emergency contraception, where necessary, and access to abortion as permitted by law;
- evaluation of risk of HIV infection and provision of post-exposure prophylaxis (PEP);
- psychological support;
- follow-up services for all of the above;
- collection of forensic evidence.

Source: Adapted from WHO, (2003c)

There are a number of operational obstacles to the integration of the detection and management of physical and sexual violence into primary care settings. Among these obstacles are: difficulty in identifying the occurrence of violence early, the absence of effective referral systems or appropriate health and legal services, and time and capacity constraints. The attitudes of service providers have also been found to reflect social norms that tolerate violence against women, or that consider that violence should be dealt with within the family. Note also that many health workers have experienced physical and sexual violence themselves, or have been implicated in abusing clients (WHO, 2002). A number of trials are being conducted on alternative models of service provision, including identification and intervention protocols.

Example: A multidisciplinary approach to dealing with violence against women in Brazil

A multidisciplinary approach is needed when dealing with violence against women, because the consequences of such violence have many implications – medical, psychological, social and legal. One very comprehensive response is illustrated by a case in Brazil. In 1988, the hospitals in Rio de Janeiro and São Paulo were authorized to terminate pregnancies that resulted from an incident of rape.

From 1996 onwards, services were set up in a number of additional hospitals to address the consequences of sexual violence. These services included providing emergency contraception, prophylactic antibiotics to prevent syphilis, gonorrhoea and chlamydial infection, immunization against hepatitis B, and antiretroviral drugs for HIV, as well as termination of pregnancy and psychological counselling. Women were also advised to report assaults to the police.

In 1998, on the basis of these measures, the Ministry of Health published standards for the prevention and treatment of the consequences of rape in women and girls. Only three hospitals offered such services in 1997, but the number had increased to 71 by the end of 2001.

Source: Faundes & Andalaft (2002)

Managing female genital mutilation (FGM) in health services

The health sector has an important role to play in monitoring the prevalence of FGM and its sequelae, and in treating its complications, including psychological distress. Maternal and child health services are particularly likely to encounter FGM-related issues and problems. Antenatal visits, the delivery itself and postpartum care provide opportunities for managing health problems associated with FGM. They also present opportunities to prevent the decision to go through with FGM, because they allow education and counselling of the parents of newborn girls. Advice can be given to a woman after giving birth on reasons to avoid re-stitching (or infibulation) following defibulation (reconstructive surgery of an infibulated scar).

In some countries mechanisms are already in place to refer women to specialized services. Further work is needed to understand what a comprehensive programme of response might entail, including implementation of WHO manuals on preventing and managing the health complications of FGM (WHO 2001b, 2001c, 2001d). These documents cover both pre-service training guidelines (for students and teachers) and specific guidelines on the management of pregnancy, childbirth and the postpartum period.

5. Key questions for programme managers

It is clear that in developing a comprehensive programme-based response to promote sexual health, a variety of factors must be taken into account. Answers to a number of questions will help programme managers decide whether the actions and interventions they are planning are on target. Key questions relating to each of the five domains are given below.

Laws, policies and human rights

Legal and regulatory mechanisms

- Are there any discriminatory laws and policies that *hinder* the promotion and achievement of sexual health (e.g. regulations that block access of unmarried adolescents and young people to contraception without parental consent or prohibit emergency contraception, or laws that criminalize same-sex sexual activity or sex outside of marriage)?
- How might deficiencies in legislation be addressed? What kind of legislation would *promote* sexual health (e.g. laws that promote access to sexual health-related information in schools, that recognize marital rape as a criminal offence, or that criminalize sexual harassment)?
- Do mechanisms exist to redress violations of rights in particular institutional settings (e.g. legal redress for women who have experienced sexual violence)?
- Does the implementation of existing legislation need to be strengthened (e.g. the extent of training for police, judiciary and teachers in gender and rights issues in relation to sexual health)?
- To what extent do communities have access to legal counselling and advice (e.g. through community-based legal aid organizations)?
- Do government policies display a commitment to international human rights standards?
- Is there legal redress for women who have experienced physical or sexual violence? Is legal reform needed in this area? Does the existing legislation need to be implemented more strongly? How well trained in gender and rights issues are police and other relevant officials including those within the judicial system?

Promotion in the community

- Do the media promote general awareness of rights related to sexual health? How can they be encouraged to do so?
- How can political will to promote sexual health be more effectively mobilized?
- Are there any public figures who have spoken out on issues like HIV and AIDS who could be mobilized?
- How can public health-related evidence about sexual health be disseminated? How can dialogue be encouraged within political and other leadership (e.g. religious) structures?
- Are religious leaders and faith-based organizations working to challenge issues that negatively affect sexual health such as HIV-related stigma and FGM in local communities? How could these efforts be strengthened?

Education

Provision in schools and teacher-training

- To what extent is good-quality education about sex, sexuality and relationships being provided in schools?
- To what extent are existing school-based programmes comprehensive in their approach? How well do they provide information and access to services, including condoms? To what extent are they age-specific? Do they use participatory methods? Are they skills-based? Do they seek to address social norms?

- How can the capacity of teachers to deliver such programmes be increased?
- Do existing teacher-training curricula adequately prepare teachers to provide education on sex, sexuality and relationships? To what extent do existing curricula incorporate perspectives that promote rights, diversity and gender equality?
- Do schools have policies and procedures in place to ensure that children living with, or affected by, HIV/AIDS are not stigmatized or discriminated against (excluded from school or denied confidentiality)?

Methods of delivery

- In what other ways are information and services available to different groups? Can different media or telephone hotlines be employed? How can the media be used more effectively to promote awareness of sexual health issues?
- Is education about sex and relationships provided to young people through youth centres, outreach activities or via peer-education schemes? To what extent are health providers trained to be youth-friendly or are youth-friendly services available?
- Which types of provision are best suited to different local contexts (e.g. rural, urban, informal settlements) and different groups (e.g. young people who do not attend school)?
- Which groups are reached by existing efforts, and which are left out? Which groups have no access to education about sex and relationships?
- Are programmes in place to work with parents to sensitize them to young people's needs and rights?
- To what extent are focused interventions used to reach especially vulnerable groups within communities such as sex workers, drug users, men who have sex with men, truck drivers and prisoners? Which methods are proving most successful (e.g. peer education or outreach work)? To what extent are these initiatives community-led?
- To what extent are broad-based interventions being used to meet information needs (e.g. telephone hotlines)? How could these be expanded?

Society and culture

- Is the influence of sociocultural factors on sexual health outcomes understood in your particular environment?
- Have opportunities for engaging with community and religious leaders been fully explored?
- Are there any local or regional examples of the promotion of sexual health by community and religious leaders?
- What is known about gender power relations in your particular setting?
- Are stakeholders from a broad range of community organizations represented and participating in sexual health programmes?

Economics

- Are strategies to promote economic empowerment and alternative livelihoods being implemented for vulnerable groups such as women, sex workers, young people who do not attend school or migrants? How could these efforts be expanded?
- Are there opportunities to develop an evidence base regarding the benefits of combining sexual health and economic interventions in communities?

Health systems

Addressing vulnerability and risk

- Which groups are especially vulnerable to lack of access to sexual health services? What are the underlying reasons? What are the current sexual health-seeking practices of different vulnerable groups?
- Are policies and procedures (including disciplinary procedures) in place to promote and protect the rights of people who are particularly likely to experience stigma and discrimination in healthcare settings, such as people living with HIV, unmarried adolescents, sex workers, and men who have sex with men?
- Are there culturally appropriate, community-based programmes to challenge the practice of FGM? Are these based on partnerships between local political and religious leaders, traditional and biomedical practitioners, and local community groups?
- Are there programmes that challenge norms which condone violence? Are there programmes that promote early attendance to services after rape or sexual assault? Are there policies in place for the prevention of violence, rape and assault?

Engaging with diversity

- Is there any evidence that sexual health services and programmes are suitable for and available to a wide variety of different groups (e.g. women, young people, people with disabilities, men who have sex with men, transgender people, migrants)?
- What kinds of barriers restrict access by particular groups to sexual health services (e.g. location of centre, time of opening, staff attitudes, languages in which services are available)?
- To what extent are young people able to participate in the development of sexual health programmes and provision of services? Are they consulted in relation to needs assessment or the programme design?

Promoting quality

- How are sexual health services structured? How could sexual health services be better integrated into primary health care or reproductive health care services? How could their management be strengthened in order to achieve this?
- Do sexual health services perpetuate and contribute to stigma and discrimination? If so, in what ways? For which groups in particular?
- To what extent are privacy and confidentiality maintained in sexual health services? How can they be improved?
- How can health-provider and client interactions be enhanced, for instance through the expansion of counselling? Are sufficient numbers of health professionals trained in counselling about sexual health? What proportion of trained professionals use their skills? What is the local capacity for training of new counsellors?
- What is the capacity of the health sector to deal with physical and sexual violence against women and with the practice of FGM? Do guidelines for identification exist? Do clinical care protocols exist? Are there appropriate referral mechanisms? How well do existing mechanisms, if any, deal with violence occurring within healthcare settings? Is there a sexual harassment policy?
- How can men be reached by sexual health-promotion efforts and sexual health services? Do men have access to counselling on sex and sexuality?
- Are there outreach services for vulnerable groups? If so, how might their quality and coverage be improved?

Providing training and support

- Do training programmes on gender equality and rights exist for health professionals? How might these be expanded to ensure that health professionals maintain a non-judgemental approach to clients and respect their rights?
- Are specialist rights-based training programmes for health professionals (e.g. in relation to sexual violence and FGM) being implemented?
- Are there monitoring and evaluation mechanisms for sexual health services?

Conclusions

Sexual health is a broad area that encompasses many inter-related challenges and problems. Key among the issues and concerns are human rights related to sexual health, sexual pleasure, eroticism (see Annex 1), and sexual satisfaction, diseases (HIV/AIDS, STIs, RTIs), violence, female genital mutilation, sexual dysfunction, and mental health related to sexual health.

This document offers a framework for programming for sexual health. It describes the historical processes underlying our evolving understanding of sexual health, and discusses why sexual health is becoming an issue of sexuality and why the promotion of sexual health is of critical importance in the reproductive health field. Key factors that influence sexual health include laws, policies and human rights, economic and health systems, and education, societal and cultural issues.

Significant progress has been made since HIV began to transform the field of sexual health over 20 years ago. Major breakthroughs in that time were recognizing the importance of sexual rights in the struggle for sexual health, focusing on social vulnerability as well as risk-taking by individuals, and the understanding that sexual and reproductive health programmes must engage seriously with issues relating to sexuality.

The important elements of a sexual health programme-based response are also outlined in this document. It provides key entry points for the promotion of sexual health in communities, as well as information and support regarding issues of sexuality, with respect to the health and education sectors and in legislative contexts.

A move away from vertical programmes is central to this approach, towards broader-based programmes that involve the integration of sexual health services with reproductive health services and broader systems of provision. In an effort to promote sexual health effectively, reaching men and vulnerable people (individuals and groups) and implementing both broad-based and targeted community education initiatives are likely to be significant.

Key principles for working to promote sexual health include:

- maintaining awareness of the importance of gender and gender-related power dynamics in influencing sexual health;
- recognizing and respecting sexual diversity;
- promoting respect for, and the human rights of, every person;
- ensuring the participation of all, including the most vulnerable and marginalized;
- maintaining awareness of the need to address both risk and vulnerability; and
- working positively with social norms.

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Annex 1. List of sexual health concerns and problems

During a meeting held in Antigua, Guatemala in May 2000, an expert group convened by the Pan American Health Organization and WHO in collaboration with the World Association for Sexology (WAS) compiled an overview of sexual concerns and problems that should be addressed in order to advance sexual health (PAHO/WHO 2000). Sexual health concerns are life situations that can be addressed through education about sexuality and society-wide actions in order to promote the sexual health of individuals. The health sector has a role to play in assessment, and in providing counselling and care.

Sexual health concerns

1. Sexual health concerns related to body integrity and to sexual safety

- Need for health-promoting behaviours for early identification of sexual problems (e.g. regular check-ups and health screening, breast and testicular self-scans).
- Need for freedom from all forms of sexual coercion and sexual violence (including rape, sexual abuse and harassment).
- Need for freedom from body mutilations (e.g. female genital mutilation).
- Need for freedom from contracting or transmitting STIs (including HIV).
- Need for reduction of sexual consequences of physical or mental disabilities.
- Need for reduction of impact on sexual life of medical and surgical conditions or treatments.

2. Sexual health concerns related to eroticism

- Need for knowledge about the body, as related to sexual response and pleasure.
- Need for recognition of the value of sexual pleasure enjoyed throughout life in safe and responsible manners within a values framework that is respectful of the rights of others.
- Need for promotion of sexual relationships practised in safe and responsible manners.
- Need to foster the practice and enjoyment of consensual, non-exploitative, honest, mutually pleasurable relationships.

3. Sexual health concerns related to gender

- Need for gender equality.
- Need for freedom from all forms of discrimination based on gender.
- Need for respect and acceptance of gender differences.

4. Sexual health concerns related to sexual orientation

- Need for freedom from discrimination based on sexual orientation.
- Need for freedom to express sexual orientation in safe and responsible manners within a values framework that is respectful of the rights of others.

5. Sexual health concerns related to emotional attachment

- Need for freedom from exploitative, coercive, violent or manipulative relationships.
- Need for information regarding choices or family options and lifestyles.
- Need for skills, such as decision-making, communication, assertiveness and negotiation, that enhance personal relationships.
- Need for respectful and responsible expression of love and divorce.

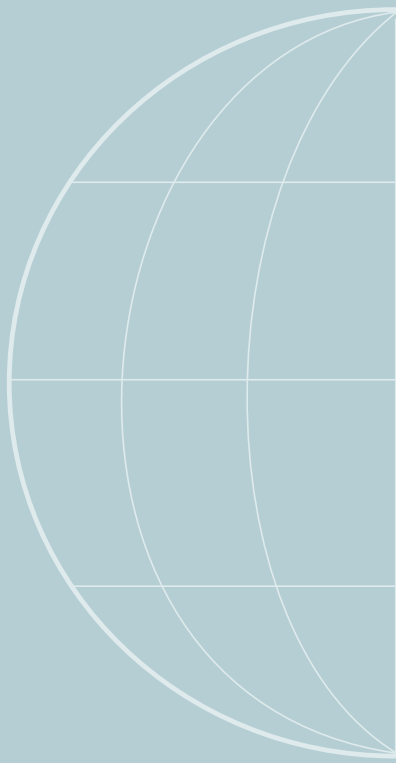
6. Sexual health concerns related to reproduction

- Need to make informed and responsible choices about reproduction.
- Need to make responsible decisions and practices regarding reproductive behaviour regardless of age, sex and marital status.
- Access to reproductive health care.
- Access to safe motherhood.
- Prevention of and care for infertility.

Sexual health problems

- Sexual health problems are the result of conditions, either in an individual, a relationship or a society, that require specific action for their identification, prevention and treatment.
- The expert working group of PAHO/WHO proposed a syndromic approach to classification that makes problems easier to identify by both health workers and the general public, and easier to report for epidemiological considerations.
- All of these sexual health problems can be identified by primary health workers. Some can be addressed by trained health workers at a primary level, but for others referral to a specialist is necessary.
- Clinical syndromes that impair sexual functioning (sexual dysfunction) such as sexual aversion, dysfunctional sexual arousal and vaginismus in females, and erectile dysfunction and premature ejaculation in males.
- Clinical syndromes related to impairment of emotional attachment or love (paraphilias) such as exhibitionism, paedophilia, sadism and voyeurism.
- Clinical syndromes related to compulsive sexual behaviour such as compulsive sexual behaviour in a relationship.
- Clinical syndromes involving gender identity conflict such as adolescent gender dysphoria.
- Clinical syndromes related to violence and victimization such as clinical syndromes after being sexually abused as a child (including post-traumatic stress disorder); clinical syndromes after being sexually harassed; clinical syndromes after being violated or raped; clinical phobia focused on sexuality; patterns of unsafe sexual behaviour placing self and/or others at risk for HIV infection or/and other STIs.
- Clinical syndromes related to reproduction such as sterility, infertility, unwanted pregnancy, abortion complications.
- Clinical syndromes related to sexually transmitted infections such as genital ulcers, urethral, vaginal or rectal discharge, lower abdominal pain in women, asymptomatic STIs.
- Clinical syndromes related to other conditions such as clinical syndromes secondary to disability or infirmity, secondary to mental or physical illness, secondary to medication.

WHO/RHR/HRP/10.22



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