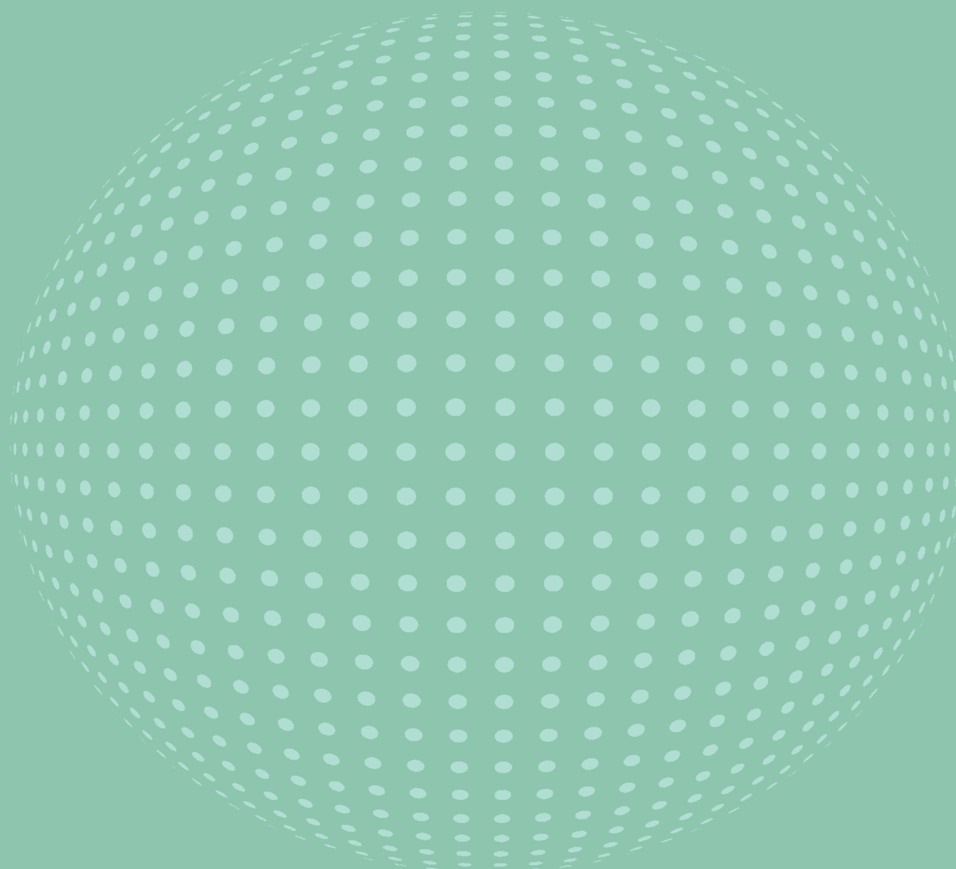
WHO/RHR/10.12

Measuring sexual health: **Conceptual and practical considerations and related indicators**

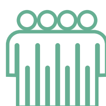


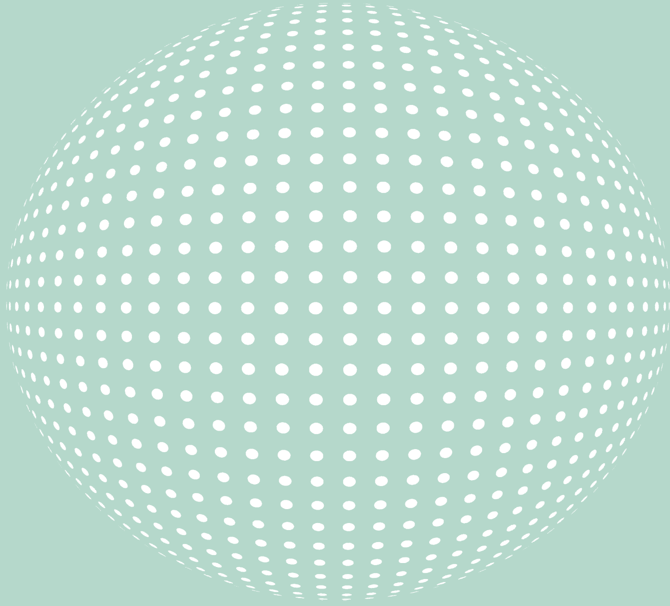
World Health Organization

UNFPA

WHO/RHR/10.12

Measuring sexual health:
Conceptual and practical considerations and related indicators





Measuring sexual health: conceptual and practical considerations and related indicators

© World Health Organization 2010

All rights reserved. Publications of the World Health Organization can be obtained from Marketing and Dissemination, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 2476; fax: +41 22 791 4857; email: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to Publications, at the above address (fax: +41 22 791 4806; email: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

This publication contains the collective views of an international group of experts and does not necessarily represent the decisions or the stated policy of the World Health Organization.

Printed by the WHO Document Production Services, Geneva, Switzerland.

Contents

Acknowledgements iv

BACKGROUND TO THE MEETING 1

AIM AND OBJECTIVES 2

KEY CONCEPTS 3

SPECIFIC CONSIDERATIONS 4

Healthy sexuality 4

Sexual dysfunction and sexual vulnerability 5

Female genital mutilation 6

Sexual violence 7

CONCLUSIONS 8

REFERENCES 9

ANNEX 1. WORKING DEFINITIONS 10

ANNEX 2. PARTICIPANTS 11

ANNEX 3. PROPOSED INDICATORS OF SEXUAL HEALTH 13

Acknowledgements

All the members of the working group, whose names appear at the end of the document, are thanked for their invaluable work and reflections on the topics at hand. Thanks go also to Sonali Johnson, who prepared the first draft, and Jane Cottingham and Lale Say who finalized it.

Background to the meeting

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality and not merely the absence of disease, dysfunction or infirmity (WHO, 2006). Human sexuality is constructed through interactions between the individual and wider society, and its development depends on the expression of basic human needs, including intimacy, emotional expression and love (World Association for Sexual Health, 1999). Sexual health is influenced by a complex web of biological and social factors. It requires a positive, responsible approach to sexuality and sexual relationships as well as pleasurable, safe sexual experiences that are free from coercion, discrimination or violence.

In 1974, an international expert meeting was organized by the World Health Organization (WHO) so that participants could share knowledge and experience in teaching, research and clinical practice in human sexuality and make recommendations for the training of health professionals. Sexual health was defined as "the integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love" (WHO, 1975). Since then, there have been important developments in how human sexuality and sexual behaviour are understood, particularly in relation to sexually transmitted infections (including HIV), unsafe abortion, gender-based violence and other health and social factors that affect sexual and reproductive health and well-being and how sexual health is defined and promoted.

The Programme of Action of the International Conference on Population and Development in 1994 subsumed sexual health into reproductive health. The Programme defined reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (United Nations, 1994). The Programme defined reproductive health care as including care for sexual health, "the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases". (Paragraph 7.2)

In the past few decades, there has been more research and programme and policy attention to factors that influence sexual health, such as sexuality, sexual violence, female genital mutilation and human rights related to sexuality and sexual health. Various technical meetings and consultations have sought to draw attention to sexual health at global and country level. For example, in 2000, a regional consultation was convened in Guatemala by the Pan American Health Organization (PAHO), in collaboration with the World Association for Sexology. The consultation drew up a conceptual framework for sexual health and identified actions and strategies for promoting sexual health in the Americas (PAHO, 2000).

Building on the outcomes of that meeting, WHO convened a technical consultation in Geneva, Switzerland, in 2002, in collaboration with PAHO and the World Association for Sexology. Its objectives were to discuss the concepts of sexual health, to examine barriers to the promotion of sexual health for adolescents and adults and to propose appropriate, effective strategies for promoting sexual health. The working definitions derived from that meeting are listed in Annex 1.

After the International Conference on Population and Development, a number of international agencies agreed on a list of 17 indicators for global monitoring of reproductive health goals and targets. Some of the indicators are measures of health status (outcome or impact indi-

cators), while others are intended to capture 'processes'. After the adoption in 2004 by the World Health Assembly of the Global Reproductive Health Strategy (WHO, 2004) and subsequent adoption of the goal of the International Conference on Population and Development of "achieving universal access to reproductive health by 2015" as a target to monitor Millennium Development Goal 5, further attention was paid to assessing and defining a full range of indicators to measure "universal access to reproductive health".

A joint WHO/UNFPA technical consultation was held in March 2007 to recommend indicators for monitoring progress towards the goal of universal access to sexual and reproductive health at country level (WHO, 2008). These indicators were intended to complement the previous 17 reproductive health indicators by including the concept of access. The indicators proposed were grouped under the five core elements of reproductive health listed in the Global Reproductive Health Strategy: improving antenatal, delivery, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health. The indicators were also classified into the following categories:

- policy and social indicators;
- access to services: availability, information and demand, quality;
- use of services; and
- indicators of output and impact.

The consultation categorized indicators as core, additional or extended according to their importance, the feasibility of data collection and contextual relevance. They recommended that the area of sexual health be discussed further. In particular, indicators were found to be deficient for the following issues: sexual health and healthy sexuality, sexual violence and female genital mutilation. Therefore, a working group on sexual health indicators was organized in September 2007 to elaborate these indicators, in order to ensure that all components of sexual health were covered.

This document summarizes the discussions of the working group and includes a list of the indicators proposed. This document should be considered an annex to the document National-level monitoring of the achievement of universal access to reproductive health. Conceptual and practical considerations and related indicators (WHO, 2008).

Aim and objectives

The aim of the meeting was to elaborate and refine the indicators for sexual health proposed by the joint WHO/UNFPA technical consultation on national-level monitoring of the achievement of universal access to reproductive health, held in March 2007.

The specific objectives were to

- review the definition of sexual health;
- elaborate indicators related to sexual health; and
- make recommendations for further work in the area.

The opening of the meeting was followed by a plenary discussion on measuring sexual and reproductive health and related conceptual and technical issues. Working groups were organized on:

- healthy sexuality;
- sexual dysfunction and vulnerability;
- sexual violence; and
- female genital mutilation.

The tasks of the working groups were to define indicators in each area, define potential sources and means of data collection and identify further research questions in areas for which indicators could not easily be identified. After each working group session, the group members discussed the proposed indicators and other related issues with all the participants.

At the last session of the meeting, the indicators identified by each working group were discussed in plenary. Key indicators were then selected by review and discussion. The final matrix is shown in Annex 3.

Key concepts

The overview presented by Dr Rosemary Coates included the definitions of 'sex', 'sexuality', 'sexual health' and 'sexual rights' drawn up by the WHO/ World Association for Sexology consultation in 2002 (see Annex 1). The definitions of sexuality and sexual health emphasize the positive aspects: "Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of pleasurable and safe sexual experiences, free of coercion, discrimination and violence". Typically, a medical response to sexual (ill-) health tends to identify 'sexual dysfunction'. This term is problematic as it suggests individual problems, whereas the definition of sexual health suggests that problems of sexual ill-health might be better labelled 'social dysfunction'. Sexual health is directly affected by a range of physical, psychological, cognitive, socio-cultural, religious, legal, political and economic factors, over some of which the individual has little or no control. Standards of sexual health depend on a complex interaction of many of these factors, which must therefore be taken into account in the measurement and promotion of sexual health. Indicators for sexual health are important for measuring how healthy the globe is, to serve as a basis for investment and to shape the content of education.

The group noted that, while 'sexual health' is often subsumed within reproductive health, it is in fact a wider term, as sex does not always involve reproduction. Most policies and programmes on reproductive health are aimed at women of reproductive age. Yet older people, for example, require information that responds to their sexual health needs rather than to reproductive health. Adolescents also explore their sexuality and engage in sex without necessarily wishing to reproduce. People in same-sex relationships may have specific sexual health needs that have nothing to do with reproduction. The more recent use of the two terms together, as 'sexual and reproductive health', could contribute to resolving this problem. The alternative 'sexual health including reproductive health' explicitly states that sexual health is the broader term and reproductive health the narrower one.

The group emphasized the fact that, as suggested in the working definitions, sexual health is closely linked to 'sexual rights'. For instance, if sexual relationships are entered into under coercion or violence, the result is likely to be sexual ill-health.

The group asked whether issues such as family planning and access to safe abortion services should be included in the discussion. They were informed that the meeting in March 2007 had dealt in depth with indicators related to four of the core components of sexual and reproductive health—family planning, pregnancy and childbirth care, preventing unsafe abortion and sexually transmitted infections—and that the focus of the present meeting was those aspects of sexual health that had not been adequately covered in the previous meeting. A comment was made that current measures and indicators of sexual health tend to focus on the prevalence and incidence of sexually transmitted infections, implying that the absence of such infections can be taken to imply 'sexual health'. The spirit of the definition of sexual health, however, clearly indicates that it goes well beyond the absence of disease.

The group noted that 'sexual health' and 'healthy sexuality' are sometimes used interchangeably. The term 'healthy sexuality' was considered to be problematic, as it suggests that there is 'unhealthy sexuality', which might be used to designate expressions of sexuality that are not considered acceptable in some societies, such as same-sex relationships. This can readily result in discrimination at many levels, including access to health information and services. The group therefore suggested that use of this term be avoided. It was emphasized that laws and policies related to sexual behaviour, such as sex work and homosexuality, have a significant influence on people's sexual health, which must be captured in indicators.

There was considerable discussion about adolescent sexual health. As sexual activity often begins during adolescence, sexual health must be considered critically important to this population group. It was noted that aspects of adolescents' sexual and reproductive

health were included in the March 2007 consultation and report and that the WHO Department of Child and Adolescent Health and Development has drawn up a series of indicators for adolescent health, which include some related to sexual health. Nonetheless, the group considered that it was important to consider adolescents in the current discussion, as they are often thought of as a 'separate' group from adults. The factors that influence whether they receive the necessary services may be different, particularly because of their age and legal status. Social mores for 'appropriate behaviour' by adolescents often result in lack of information about sexual and reproductive health. Information about sex and sexual health often comes from friends and magazines, which are frequently sources of misinformation. Special consideration for adolescents therefore seemed warranted. Although adolescents may have particular needs, this population group should be reflected in all indicators by routine disaggregation by age as well as by sex.

Specific considerations

The meeting participants separated into working groups to discuss 'healthy sexuality', 'sexual dysfunction', 'sexual violence' and 'female genital mutilation'. The key points of the discussions and the indicators identified are shown below.

Healthy sexuality

The definition of sexuality is complex: it includes gender roles and sexual orientation and is influenced by the interaction of biological, psychological, cognitive, social, political, cultural, ethical, legal, historical, religious and spiritual factors (WHO, 2006). Although individuals are labelled as 'homosexual', 'heterosexual', 'bisexual' and so on, these are not comprehensive definitions of sexuality, as they may not necessarily be expressed or experienced in a consistent way throughout an individual's lifetime. It is also unclear whether these terms refer only to sexual acts or to thoughts and desires as well.

Major concerns were raised about the term 'healthy sexuality'. Firstly, as discussed in plenary, 'healthy sexuality' was considered to be a value-laden concept, which can be misused to discriminate against sexual behaviour considered to be 'unacceptable' by some segments of society. A suggested replacement for 'healthy sexuality' was 'sexual health', which is more suitable for a public health approach. It was pointed out, however, that the two terms are interrelated, in that one can be seen as a 'prerequisite' for the other, i.e. if sexuality is healthy, sexual health is more readily attainable.

The term 'sexual well-being' was discussed as another possibility. The problem again is the definition and understanding of 'well-being', which is likely to be culture- and context-specific. A sense of well-being might be linked to aspects such as sexual identity, sexual preference and sexual behaviour. The term would also include expressions of sexuality by people living with physical and intellectual disabilities or illness. 'Sexual well-being' could probably be measured only as 'self-perceived sexual health', which could include being comfortable or satisfied with one's sexual identity and the motivation and ability to protect and enhance one's sexual health. Such considerations could capture both positive elements of sexual health and negative ones, such as coercion and discrimination. Rather than a 'Yes' or 'No' response, a composite scale of well-being could be designed. The participants considered, however, that more research was needed to explore the various dimensions of 'sexual well-being' in order to draw up an appropriate set of indicators.

As the participants did not agree on a term, they decided to focus on identifying indicators for positive aspects of sexual health and sexuality. They agreed that understanding what people find pleasurable is important for understanding sexual behaviour and noted that achieving pleasure does not always mean healthy or responsible sexual behaviour. For example, the pleasure derived by one individual from sexual behaviour can violate the rights of another (e.g. in the case of child sexual abuse). Informed choice does

not necessarily result in sexual health; for example, HIV-negative people might choose to have sex with HIV-positive partners without a condom. This and other examples illustrate the need for good-quality information and counselling on sexual health, and this was included as an indicator.

Proposed indicators

Three possible areas for indicators were identified:

- the ability of men and women to make informed choices;
- action in relation to sexuality on the basis of intention, substantial understanding and the absence of coercion, discrimination or violence; and
- satisfaction with one's sexuality and sexual identity, on a composite scale of satisfaction.

The group concluded that, as relatively little research has been conducted in these areas, primary research is required to identify appropriate indicators. Although qualitative research methods might be more appropriate for collecting the necessary information, it would be difficult to standardize and thus compare findings from different settings. Therefore, qualitative research would be the first step in identifying indicators that could be included in survey instruments.

Proposed indicators of access to and use of services

The group identified two indicators of access:

- the availability of service delivery standards and protocols for promoting sexual health (modified from March meeting); and
- the proportion of the population that has ever received counselling on sexual health or sexuality (new).

Proposed indicator related to outcome:

- proportion of people who discuss sexual choices with their partners and act on the basis of intention and substantial understanding and without coercion.

Sexual dysfunction and sexual vulnerability

The participants debated the definition of 'sexual dysfunction' and the indicators that could be included under this term. In developed countries, 'sexual dysfunction' is often used to refer to erectile dysfunction; however, sexual dysfunction is broader than physiological processes, as it can be influenced by both psychological factors and factors that go beyond the individual. Sexual function may also depend on social and medical attitudes to sexuality, such as what is considered 'acceptable' or 'normal' and what is not. Generally speaking, the group agreed that 'sexual function' and 'sexual dysfunction' were problematic terms.

It agreed, however, that people undoubtedly suffer from problems with their sexuality, such as 'anorgasmia' (lack of orgasm), that sexologists might categorize as 'sexual dysfunction'. As dissatisfaction or difficulties related to sexuality are individual experiences, it would be more important to find an indicator that captures this personal aspect rather than some textbook category. The group agreed that the act of consulting a health service in relation to problems with sexuality would represent the 'sexual dysfunction' dimension, without having to define the content of the problem, which would depend on the individual and his or her context. The group agreed that access to appropriate sexual health counselling services is important and that this would be useful for obtaining information about men's sexual health in particular, as it has been shown that, although men consult for problems with sexual performance, they do not necessarily do so for other sexual and reproductive health problems. The group noted some evidence of an association between women's experience of violence with an intimate partner and reported sexual problems of their husbands. The group agreed that this important topic requires further research.

The discussion of sexual dysfunction led to a discussion of the opposite—sexual well-being—and how it might be measured. The group spoke about 'sexual inclusion' or a sense of belonging in society and feel-

ing comfortable with one's sexuality. As it would be difficult to arrive at an overall objective measure of sexual well-being or pleasure, the group suggested that one measure could be society's perceptions of whether women and men enjoy sex or are allowed to enjoy sex. In some societies, for instance, women are not expected to enjoy sex.

The group agreed that sexual well-being involves not only feeling comfortable but also, for instance, the ability to resist unwanted sex. Experience with a composite indicator in a survey of young people's sexuality in the United Kingdom was described. This indicator, called 'sexual competence', was designed to capture the extent to which people's first experience of sexual intercourse was: protected (i.e. from unwanted pregnancy and sexually transmitted infections); undertaken without regret; the result of an autonomous decision; and consensual (i.e. with the agreement of both partners). The group questioned use of the word 'autonomy', in that it relates mainly to an individual's behaviour and does not take into account social and other pressures. For example, a woman may make an autonomous decision to engage in transactional sex, but she may make the decision under the pressure of having to feed herself or her family. An individual may be autonomous but not necessarily healthy. The group considered, however, that the dimension of autonomy could be included in a composite indicator with other dimensions.

The discussion of autonomy raised the question of the sexuality and sexual health of people with physical or mental disabilities. The group acknowledged the importance of the issue but considered that, given the limited time available, they could not do justice to a discussion on indicators in this area.

The group concluded that, in order for sexual health to become a reality, people (particularly young people) need access to information about sexuality and sexual health. Thus, they proposed as an indicator the existence of mandatory, comprehensive education on sexuality, the content of which would depend on the age group. Training in sexual health and sexuality counselling for health providers was likewise considered important.

Proposed indicators of determinants: policy and social factors:

- whether sexuality education is mandatory (modified from March meeting);
- perceptions of and social attitudes to sexual enjoyment or expression (both aimed at populations and at specific groups) (new);
- level of sexual autonomy (new), i.e. ability to resist unwanted sex and ability to make healthy decisions about sexuality; and
- level of sexual competence (protection, no regret, autonomy of decision-making and consensuality) (new).

Proposed indicators of access to and use of services:

- per capita provision of psychosexual services (new); and
- awareness (and access to and use of) appropriate sexual health services (modified from March meeting): for sexual dysfunction (new), for family planning and for sexually transmitted infections.

Female genital mutilation

At the March meeting, three indicators on female genital mutilation were included: existence of a law prohibiting it, a strategy for eliminating the practice and service delivery points for medical, psychological and other services for women with genital mutilation. In addition, the group discussed the indicators developed by MEASURE Evaluation[1] and used them as the basis of their discussion, with new indicators added as appropriate.

The group agreed that the existence of a law prohibiting female genital mutilation remains an important indicator in this area, even though there is a danger that a law criminalizing the practice might drive it underground. They emphasized that policies and strategies should be put in place to ensure that the existence of the law is known and understood by practising communities. They stressed that a community-based approach, through advocacy and

[1] The MEASURE Evaluation partnership provides technical leadership through collaboration at local, national, and global levels to build the sustainable capacity of individuals and organizations to identify data needs, collect and analyse technically sound data, and use that data for health decision-making.

awareness of the harmful effects of female genital mutilation, was the only way to sustain change, and they agreed that a related indicator should be included. Changes in attitudes towards the practice could be monitored through questions in survey instruments on whether women and their daughters have been cut. The group considered it important to document men's attitudes towards sexual partners who have not undergone gential mutilation.

The group expressed concern about the increased medicalization of female genital mutilation (performed by health-care providers). It recommended use of an indicator on ethical guidelines for health professionals, which would reflect the commitment of professional organizations to advocate abandonment of the practice. Another indicator to measure progress in the abandonment of the practice would be inclusion of training in the prevention and management of female genital mutilation in pre-service and in-service curricula of health professionals. Inclusion of an indicator on the number of medical institutions nationally that include training on the prevention and management of female genital mutilation was also suggested.

Proposed indicators of determinants: policy and social factors:

- a law prohibiting female genital mutilation (identified at March meeting);
- a strategy or plan for eliminating female genital mutilation (according to local needs, on the basis of local research on cultural practices) (identified at March meeting); and
- the existence of medical professional association guidelines against the practice of female genital mutilation, against practising reinfibulation and encouraging appropriate care for women who have undergone genital mutilation (new).

Proposed indicators of services – access and availability:

- service delivery points for the provision of medical, psychological and other services and referral for women with genital mutilation (identified at March meeting); and
- number of medical institutions that provide compulsory training on prevention and treatment of female genital mutilation (new).

Proposed indicators of outcome and impact:

- proportion of women who report they have undergone genital mutilation (by age cohort) and/or whose daughters have been cut, with identification of who performed the procedure (modified from March meeting and MEASURE indicator);
- proportion of men and women who are aware of the harmful consequences of female genital mutilation, particularly poor neonatal outcomes, maternal morbidity including fistulae, sexual morbidity, infertility, physical and emotional harm from the practice (new); and
- perception of social acceptance of women who have not undergone genital mutilation (e.g. asking men whether they prefer as a partner a woman who is cut) (new).

Sexual violence

Sexual violence is defined as 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work' (WHO, 2002). The group noted that it is difficult to establish the prevalence of sexual violence, as the definition covers a wide range of acts, including rape within marriage or another intimate relationship, rape by strangers, rape during armed conflict, sexual abuse, forced marriage, forced pregnancy, forced abortion, forced prostitution and trafficking for the purpose of sexual exploitation (WHO, 2002). They also noted that violence, including sexual violence, is a major problem for men as well as women of any age, but also for transgender people.

The group noted a number of initiatives to find indicators of violence against women, including sexual violence. These initiatives include the compendium of indicators designed by the MEASURE Evaluation, work by the Special Rapporteur on Violence against Women within a human rights framework, identification of national indicators for reporting, the purposes of and work done by the Division of the Advancement of Women and the Economic Commission for Europe on indicators that can be integrated into the collection

of national statistics. The group also highlighted the role of the Demographic and Health Surveys in collecting data on the prevalence of sexual violence.

The group based their discussion on the indicators used in the MEASURE project and those from the March consultation. The indicators discussed address the three areas considered to be key to measuring progress in eliminating sexual violence: attitudinal shifts, service delivery and process. With regard to attitudinal shifts, the group discussed whether interventions can reduce the normalization of sexual violence and how attitudes towards violence can be measured. In the area of service delivery, the discussion focused on whether and how health services can contribute to preventing and dealing with sexual violence. The process indicators included those relating to laws and policies for eliminating violence.

Proposed indicators of outcome – attitudinal shifts:

- proportion of people surveyed who say that wife-beating is acceptable (modified MEASURE indicator);
- proportion of people who say that a woman has a right to refuse sex (MEASURE indicator); and
- proportion of boys and girls who feel able to say no to sex or sexual activity (modified MEASURE indicator).

Proposed indicators of services: access and availability:

- service delivery providers giving appropriate medical, psychological and legal support to women and men who have been raped or have experienced incest (identified at March meeting);
- health providers trained to detect signs of sexual abuse, violence, anxiety, shame, anger or depression related to sexual relations (modified from March meeting); and
- police trained in issues of sexual health and rights, including responding appropriately to sexual violence (modified from March meeting).

Proposed indicators of process:

- existence of laws to promote and protect sexual health, e.g. those prohibiting sexual violence, those related to sexual exploitation and those related to sex work, homophobia and sexual harassment in the work place (new);
- existence of a line in the national budget to implement programmes on eliminating sexual violence (modified MEASURE indicator); and
- existence of a national plan of action to eliminate sexual violence (MEASURE indicator and indicator modified from March meeting).

Conclusions

The group pooled all the proposals from the working groups, and the proposed indicators were discussed within the matrix used at the March 2007 consultation. Some overlapping indicators were eliminated; other indicators from the March 2007 meeting were modified. The indicators were organized according to the structure used at the March meeting. The final matrix is given in Annex 3.

Areas for research

The areas in which the group considered further research was needed were:

- the meaning of sexual well-being in different contexts;
- the association between men's sexual dysfunction and violence against women;
- the frequency of intercourse between husbands and their genitally mutilated wives;
- men's attitudes and perceptions of sexual pleasure with women who have undergone genital mutilation; and
- the attitudes of medical personnel towards female genital mutilation.

References

PAHO (2000). *Promotion of sexual health: recommendations for action*. Washington, DC, Pan American Health Organization.

United Nations (1994). *Report of the International Conference on Population and Development.* New York (A/CONF.171/13/Rev.1).

World Association for Sexual Health (1999). *Declaration of sexual rights.* Mexico.

WHO (1975). *Education and treatment in human sexuality: the training of health professionals.* Geneva: World Health Organization (WHO Technical Report Series No. 572).

WHO (2002). *World report on violence and health.* Geneva, World Health Organization.

WHO (2004). *Reproductive health strategy*. Geneva, World Health Organization.

WHO (2006). *Defining sexual health: report of a technical consultation on sexual health, 28–31 January 2002.* Geneva, World Health Organization (http://www.who.int/reproductive-health/publications/sexualhealth/index.html. Accessed 30 November 2007).

WHO (2008). *National-level monitoring of the achievement of universal access to reproductive health: conceptual and practical considerations and related indicators.* Report of a WHO/UNFPA Technical Consultation, 13–15 March 2007, Geneva. Geneva, World Health Organization.

Annex 1. Working definitions

Sex: the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as some individuals possess both, they tend to differentiate humans. In general, in many languages, the term 'sex' is used to mean 'sexual activity', but the above definition is preferred for technical purposes in the context of discussions of sexuality and sexual health.

Sexuality: a central aspect of being human throughout life, which encompasses sex, gender identity and role, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviour, practices, roles and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

Sexual health: 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, respectful approach to sexuality and sexual relationships and 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.

Sexual rights: human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health-care services;
- seek, receive and impart information related to sexuality;
- education on sexuality;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

Annex 2. Participants

Carlos F. Caceres
Professor and Vice-Dean
School of Public Health
Cayetano Heredia University
Director, Institute of Studies in Health, Sexuality and Human Development
Avenida Armendariz 445, Lima
Peru
www.upch.edu.pe

Dr Harriet Birungi
Medical Anthropologist
Frontiers Program
Population Council
Ralph Bunche Road
General Accident House
Nairobi
Kenya

Professor Aysen Bulut
Head
Department of Family Health
Institute of Child Health, Head, Medical Education
Istanbul Medical School
Istanbul University
Istanbul
Turkey

Ms Radhika Chandiramani
Executive Director
Talking About Reproductive and Sexual Health Issues (TARSHI), 49 Golf Links
New Delhi
India
http://www.tarshi.net

Dr Rosemary Coates
Curtin University of Technology
Division of Health Sciences
Sexual Health Research and Education Unit
Selby Street, Shenton Park
Western Australia
Australia

Dr Maryanne Doherty
Associate Dean of Education
University of Alberta
Edmonton
Canada

Dr Sarah Hawkes
Clinical Senior Lecturer
Sexual Health and Sexually Transmitted Infections
London School of Hygiene and Tropical Medicine
Keppel Street
London
United Kingdom
http://www.lshtm.ac.uk

Dr Guyo Jaldesa
Consultant Obstetrician-Gynaecologist
Kenyatta National Hospital
Honorary Senior Lecturer, Department of Obstetrics and Gynaecology
Kenyatta National University and University of Nairobi
PO Box 50976
Nairobi
Kenya

Ms Barbara Jones
Manager
Sexual Health and STI Section, Public Health Agency, 200 Eglantine Driveway, Jeanne Mance Building
Tunney's Pasture
Ottawa
Canada

Professor Kaye Wellings
Professor of Sexual and Reproductive Health Research
Department of Public Health and Policy
London School of Hygiene and Tropical Medicine
Keppel Street
London
United Kingdom
http://www.lshtm.ac.uk

Dr Nono Simelela
Director
Technical Knowledge and Support
International Planned Parenthood Federation (IPPF)
4 Newhams Row
London
United Kingdom
http://www.ippf.org

Dr Khuat Thu Hong
Co-Director
Institute for Social Development Studies
Suite 19.1, VIMECO Building, Pham Hung Road
Hanoi
Viet Nam
www.isds.org.vn

WHO Secretariat

Dr Avni Amin
Technical Officer
Department of Reproductive Health and Research
www.who.int/reproductivehealth

Dr Krishna Bose
Scientist
Department of Child and Adolescent Health and Development
www.who.int/child_adolescent_health

Dr Michael Mbizvo
Coordinator and Senior Scientist
Department of Reproductive Health and Research
www.who.int/reproductivehealth

Dr Francis Ndowa
Team Coordinator
Department of Reproductive Health and Research
www.who.int/reproductivehealth

Ms Jane Cottingham
Team Coordinator
Department of Reproductive Health and Research
www.who.int/reproductivehealth

Dr Claudia García Moreno
Medical Officer
Department of Reproductive Health and Research
www.who.int/reproductivehealth

Dr Elise Johansen
Technical Officer
Department of Reproductive Health and Research
www.who.int/reproductivehealth

Dr Lale Say
Medical Officer
Department of Reproductive Health and Research
www.who.int/reproductivehealth

Ms Sonali Johnson
Consultant
London School of Hygiene and Tropical Medicine
Keppel Street
London
United Kingdom
http://www.lshtm.ac.uk.

Annex 3. Proposed indicators of sexual health

Indicators expanded on those defined within the WHO/UNFPA report: *National-level monitoring of the achievement of universal access to reproductive health – conceptual and practical considerations and related indicators* (WHO, 2008).

DETERMINANTS: POLICY AND SOCIAL FACTORS				
Sexual health area	Indicator	Type of measure	Type of indicator (core, additional,[a] extended)	Source of data
Sexual health/ sexuality	Law prohibits discrimination on the basis of: - age - gender identity - sexual orientation - physical and intellectual disability	Yes/No	Core	Law/policy review
	Law prohibits marriage for both men and women prior to age 18	Yes/No	Extended	Law/policy review
	Law requires full and free consent of the parties to a marriage	Yes/No	Core	Law/policy review
	Law does not prohibit: - sex between men - sex between women - prostitution	Yes/No	Core	Law/policy review
Sexual violence	Law prohibits sexual violence	Yes/No	Core	Law/policy review
	Law prohibits marital rape	Yes/No	Core	Law/policy review
	Strategy/plan to prevent and respond to sexual violence, including marital rape	Yes/No	Core	Law/policy review
Harmful practices	Law prohibits all forms of FGM	Yes/No /NA	Extended	Law/policy review
	Existence of medical regulations against the practice of FGM	Yes/No /NA	Extended	Policy review
	Strategy/plan for abandonment of FGM (according to local need, informed by local research on cultural practices)	Yes/No /NA	Extended	Policy review
Adolescent health	School-based comprehensive sexuality education is mandatory	Yes/No	Core	Policy review

[a] Indicators requiring special data collection efforts (e.g. surveys) and/or relatively developed health information systems are classified as ‘additional’ instead of ‘core’ except for key measures.

ACCESS: AVAILABILITY				
Sexual health-providers	Health providers trained in sexuality counselling	Percentage	Additional	Survey (facility)
	Health providers trained in youth-friendly service provision	Percentage	Additional	Survey (facility)
	Health providers trained to detect signs of sexual abuse or violence	Percentage	Additional	Survey (facility)
	Police and judiciary trained in sexual health and sexual violence	Percentage	Additional	Survey (facility)
Sexual violence-services	Service delivery points providing appropriate medical, psychological and legal support for women and men who have been raped or experienced incest	Percentage	Core	Survey (facility)
Harmful practices-services	Service delivery points providing medical, psychological, and other needed services and referral for women with FGM	Percentage	Extended	Survey (facility)
	Medical training institutions that provide training on prevention and management of complications of FGM	Percentage	Extended	Survey (special)
Adolescent health-services	Service delivery points providing youth-friendly services	Percentage	Additional	HIS
	Availability of alternative service delivery mechanisms for sexual health of adolescents (e.g. peer education, social marketing of condoms, outreach interventions such as mobile clinics)	Yes/No	Additional	Expert assessment
ACCESS: INFORMATION				
	Young men and women (15–24 years) OR "at risk" groups who correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	Percentage	Core	Survey (population)
	Awareness of sexual health services for: - sexual dysfunction - sexual violence - infertility	Percentage	Additional	Survey (population)
ACCESS: QUALITY				
	Service delivery standards and protocols that promote sexual health are promoted and used	Yes/No	Additional	Survey (facility)

USE OF SERVICES				
Sexual violence	Number of incidents of sexual violence, including marital rape, reported to law enforcement and/or health professionals in the past five years	Number	Additional	Administrative records (police)
	Reported cases of above incidents resulting in prosecution	Number	Additional	Administrative records (police)
Adolescent health	Adolescents who have received comprehensive sexual and reproductive health education in schools	Percentage	Additional	Survey (population)
OUTCOME/IMPACT				
Sexual health	Sexual competence (composite indicator including whether sex is consensual, with no regret, protected (STI and unplanned pregnancy), and decision made autonomously)	Percentage	Additional	Survey (population)
	Women's and men's perceptions of social attitudes towards sexual enjoyment/expression (broad mass and/or specific groups)	Percentage	Additional	Survey (population)
Sexual violence	Approval/disapproval of intimate partner violence (public opinion on sexual violence)	Percentage	Additional	Survey (population)
Harmful practices	Women and men who are aware of the harmful consequences of FGM[b]	Percentage	Extended	Survey (population)
	Women and men who consider FGM to be acceptable	Percentage	Extended	Survey (population)
	Proportion of women reporting they have undergone FGM (by age cohort) and/or whose daughters have been cut[c]	Percentage	Extended	Survey (population)
Adolescent sexual health	Adolescent birth rate[d]	Rate	Core	Vital registration/ Survey (population)
	Adolescents who have ever had sex[e]	Percentage	Additional	Survey (population)
	Sexually initiated adolescents who used contraception at first/last sex	Percentage	Additional	Survey (population)
	Sexually active, unmarried adolescents who consistently use condomss	Percentage	Additional	Survey (population)
	Men and women (aged 15–24 years) who have had more than one partner in the past 12 months	Percentage	Additional	Survey (population)
	Men and women (aged 15–24 years) who have had sex before age 15 years	Percentage	Additional	Survey (population)

[b] Particularly poor neonatal outcomes, maternal morbidity including fistulae, sexual morbidity, infertility, physical and emotional harm of undergoing FGM.

[c] Disaggregated by the person who performed the cut.

[d] Cross-referenced with family-planning indicators.

[e] Sex-disaggregated.