Sexual health document series

Defining sexual health

Report of a technical consultation on sexual health 28–31 January 2002, Geneva

World Health Organization

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World Health Organization

Geneva, 2006

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Printed in

Photo credits: Anita Kolmodin

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Acknowledgements

A Technical Consultation on Sexual Health was convened in Geneva, Switzerland, from 28 to 31 January 2002, as a joint effort between the World Health Organization (WHO) and the World Association of Sexology (WAS). It was organized with the support and tireless efforts of Esther Corona and Eli Coleman (WAS) and Rafael Mazin (Pan American Health Organization). Financial support was received from the Ford Foundation. The success of the Consultation would not have been possible without the efforts of all those who participated in the regional round tables, in the preparation of the background papers, and in the Consultation itself.

Introduction

Sexual and reproductive health and well-being are essential if people are to have responsible, safe, and satisfying sexual lives. Sexual health requires a positive approach to human sexuality and an understanding of the complex factors that shape human sexual behaviour. These factors affect whether the expression of sexuality leads to sexual health and well-being or to sexual behaviours that put people at risk or make them vulnerable to sexual and reproductive ill-health. Health programme managers, policy-makers and care providers need to understand and promote the potentially positive role sexuality can play in people's lives and to build health services that can promote sexually healthy societies.

The past three decades have seen dramatic changes in understanding of human sexuality and sexual behaviour. The pandemic of human immunodeficiency virus (HIV) has played a major role in this, but it is not the only factor. The toll taken on people's health by other sexually transmitted infections (STIs), unwanted pregnancies, unsafe abortion, infertility, gender-based violence, sexual dysfunction, and discrimination on the basis of sexual orientation has been amply documented and highlighted in national and international studies. In line with the recognition of the extent of these problems, there have been huge advances in knowledge about sexual function and sexual behaviour, and their relationship to other aspects of health, such as mental health and general health, well-being and maturation. These advances, together with the development of new contraceptive technologies, medications for sexual dysfunction, and more holistic approaches to the provision of family planning and other reproductive health care services, have required health providers, managers and researchers to redefine their approaches to human sexuality.

Sexual health was defined as part of reproductive health in the Programme of Action of the International Conference on Population and Development (ICPD) in 1994. Statements about sexual health were drawn from a WHO Technical Report of 1975 (1), which included the concept of sexual health as something "enriching" and that "enhance[s] personality, communication and love". It went further by stating that "fundamental to this concept are the right to sexual information and the right to pleasure".

In response to the changing environment, WHO, in collaboration with the World Association for Sexology (WAS), began a collaborative process[1] to reflect on the state of sexual health globally and define the areas where WHO and its partners could provide guidance to national health managers, policy-makers and care providers on how better to address sexual health. As in 1975, the process began with a review of key terminology and of the evidence, and culminated in the convening of a large group of experts from around the world to discuss the state of sexual health globally.

[1] The current work on the promotion of sexual health globally was initiated in response to a call by the Pan American Health Organization (PAHO), the WHO Regional Office for Europe, and the World Association for Sexology to update the 1975 report. PAHO, in collaboration with WAS, had initiated the revision process by publishing a report entitled *Promoting sexual health* (2). To obtain a better understanding of how sexuality and sexual health are viewed in different parts of the world, WHO commissioned 14 national and regional background papers, held four regional meetings or round table discussions and one international preparatory meeting, and established an interdepartmental working group within WHO headquarters as part of a collaborative consensus-building process.

Purpose, objectives and overview of the consultation

On 28–31 January 2002, a Technical Consultation on Sexual Health was convened by the WHO Department of Reproductive Health and Research, in collaboration with the Department of Child and Adolescent Health and the prevention team of the Department of HIV/AIDS.

The Consultation was the first activity in an expanding area of work for WHO. Its purpose was to reaffirm sexual health as an important and integral aspect of human development and maturation throughout the life cycle and to contribute to the development of a long-term strategy and research agenda on sexual health for the Organization.

The specific objectives of the meeting were to:

- discuss key concepts including definitions of sexual health and related issues;
- examine the specific barriers to the promotion of sexual health for adolescents and adults; and
- propose appropriate, effective strategies for promoting sexual health.

The meeting brought together over 60 international and national experts on sexuality and sexual-health-related issues. Participants were from all regions of the world and included: representatives of governments and nongovernmental organizations (NGOs); social scientists; health providers, programme managers and policy-makers working on STI/HIV prevention, reproductive health and family planning; clinical psychologists, psychiatrists and sexologists; sexual health educators; representatives from WHO regional offices; and donors.

A paper giving an overview of sexual health as a public health issue was prepared by WAS, and two working papers dealing with, respectively, definitions and health sector strategies for addressing sexual health and development were prepared by WHO. These documents, together with a number of commissioned background papers, informed the discussion and served as a basis for this report.

The presentations and discussions were grouped in broad categories (see Annex 1). On the first day, the presentations stressed the importance of addressing sexuality and sexual health holistically, and laid out the consequences for individuals, families, communities and societies of not addressing sexual health. National and regional perspectives on barriers and opportunities for improving sexual health in different social, cultural and religious settings identified many of the particular challenges faced by those working on sexuality in specific contexts. The presentations indicated that, despite vast geographical and cultural differences, the obstacles that health professionals need to overcome are similar in all regions; they include the difficulty of talking about sexuality because of its private nature, and the gender aspects of sexual roles, responsibilities and relationships, including the power dynamics associated with them. A working group was formed to draft operational definitions of sex, sexuality, sexual health and sexual rights, and was asked to report back to the Consultation on the final day.

On the second day, the presentations and discussion focused on how the health sector has addressed vulnerability and risk related to sexuality and sexual health. The first presentation shared lessons learned from efforts to prevent HIV infection and acquired immunodeficiency syndrome (AIDS) over the past two decades. It was noted that HIV prevention and sexual health activities have extended, and must continue to extend, beyond the health sector to include individuals, families and communities, as well as environmental factors that contribute to vulnerability and risk.

The second presentation traced the history of integration of services noting that it took more than thirty years for family planning programmes to begin to address sexuality as part of reproductive health care services. The ICPD Programme of Action called for the integration of services as fundamental to achieving reproductive health. Participants noted the different approaches, emphases and

successes of HIV prevention programmes and reproductive health programmes, and the importance of gathering better evidence on the success of various methodologies aimed at changing behaviour.

Case studies of best practices from Sweden, South Africa and Thailand were presented. In Sweden, sexual health education has transformed the way people think about sex, sexuality, and reproductive and sexual health, but the road to achieving these successes has been long and sometimes difficult, and the political barriers posed along the way significant. In Thailand, where recent HIV prevention efforts have resulted in lower transmission rates, an early success was achieved by focusing the intervention strategy on commercial sex establishments and their clients. In South Africa, a current sexual rights advocacy campaign is focused on getting decision-makers and politicians to integrate a more comprehensive perspective of sexual health and rights into their work. This involves working with nongovernmental and community-based organizations to address HIV/AIDS, violence against women, and adolescent sexual health in an integrated manner based on a new vision of femininity and masculinity in which the sexual rights of all people are respected.

This report presents a summary of the presentations and discussions held over the course of the four-day meeting. It summarizes the critical issues raised, as well as the differences of opinion, approach and direction of actors in different regions in addressing common problems. While one stated objective of the meeting was to define appropriate sexual health strategies, the group concluded that such general recommendations would not be useful, given the very specific national and regional perspectives on how sexuality and thus sexual health can be addressed and promoted by the health sector. The group agreed, however, that despite the differences, all programmes and services aimed at addressing sexuality and promoting sexual health can and must be based on fundamental values and principles grounded in human rights. These guiding principles for work on sexuality and sexual health are described in chapter 6. The meeting concluded with a series of recommendations to WHO on how to take this important area of work forward in the coming years.

Working definitions

In 1975, a WHO expert group described sexual health 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" (1). The report incorporating this forward-looking description of sexual health laid the groundwork for a comprehensive understanding of human sexuality and its relationship to health outcomes. However, many terms, such as sex, sexuality and sexual rights, were left undefined, and there has been no subsequent international agreement on definitions for these terms (3). In English, the term "sex" is often used to mean "sexual activity" and can cover a range of behaviours. Other languages and cultures use different terms, with slightly different meanings.

The ICPD Programme of Action (4) included sexual health as part of reproductive health. Reproductive health was defined 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. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."

Reproductive health care was defined 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".

While sexual rights were not specifically defined either by ICPD or by the Fourth World Conference on Women in Beijing in 1995, or at their five-year follow-up conferences, ICPD did elaborate on reproductive rights. Reproductive rights were defined as embracing "certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. This includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents." Since human reproduction generally requires sexual activity, sexual rights are closely linked to reproductive rights.

Respect for bodily integrity was recognized as a fundamental element of human dignity and freedom as early as 1975 at the World Conference of the International Women's Year in Mexico City. It was further defined and elaborated in the Beijing Platform for Action (5): "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."

Building on these definitions, and bearing in mind the public health challenges of sexual health, the Consultation proposed the following definitions as a guide for health programme managers, policy-makers and others working in the field of human sexuality and sexual and

reproductive health. The definitions were informed by the background papers, regional discussions and round tables that preceded the Consultation, and were refined and amended following the Consultation by a small international working group.

Box 1: Working definitions[2]

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

- *Sexuality*
  Sexuality is a central aspect of being human throughout life and 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, ethical, legal, historical, religious and spiritual factors.

- ***Sexual health***
  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.

- ***Sexual rights***
  Sexual rights embrace 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;
  - sexuality education;
  - 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.

[2] These working definitions were developed through a consultative process with international experts beginning with he Technical Consultation on Sexual Health in January, 2002. They reflect an evolving understanding of the concepts and build on international consensus documents such as the ICPD Programme of Action and the Beijing Platform for Action. These working definitions are offered as a contribution to advancing understanding in the field of sexual health. They do not represent an official position of WHO.

Building sexually healthy societies: the public health challenge

The proposed definition of sexual health states that it "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." This definition calls attention to the inter-related nature of the physical, mental and social dimensions of sexuality, and importantly, the notion of sexual well-being. Sexuality is a fundamental part of being human. "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." Unfortunately, rather than enriching personal relationships and intimacy, sexuality is too often a cause of distress.

The two opening presentations focused on the public health imperative to build sexually healthy societies. The first discussed healthy sexual development, with a focus on adolescence. The second discussed the scope and prevalence of sexual-health-related problems and the public health imperative to address sexual health in all its dimensions. The presentations are summarized below.

4.1 Healthy sexual development – a gender issue (Smita Pamar)

What is healthy sexual development? This is a question that is answered within the context of the individual, family, community, society, and culture over time. What is considered "healthy" varies not only from generation to generation, from society to society, and between men and women, but also within any one individual: what may have been considered "healthy" at age 15 may not be at 45. The notion of health, just like sexuality, is not static and judgement-free. Sexual development occurs over a lifetime, but adult health status is closely linked to experiences during adolescence, the pivotal period of transition to adulthood. Adolescence sets the stage for sexual health in later life.

When considering adolescent sexual development, we must recognize the diversity of this population and the different ways sexual development will be experienced and interpreted. The diversity includes sex, marital status, class and socioeconomic status, place of residence, age, ethnicity, sexual orientation, level and manner of sexual experience (voluntary or involuntary), motivations for sexual activity (affection, status, and needs) and health status.

Discussing sexual health raises the question of what it means to be sexual. Who is, or has a right to be, sexual, under what conditions, circumstances and context, and for what purpose or motivation? What does being sexual mean in the context of power differentials, particularly for young women, and how do power differentials manifest themselves as we develop as sexual beings? Sexual identity and gender identity are intrinsically embedded in notions of power: who has power, for what purpose, and how they are allowed or entitled to use that power?

To be sexual is far more than a matter of physiology and sexual activity. Being sexual is very much about who we are, what we feel, what we value, what we think, and what we desire. It is to understand and experience what it means to be a man or woman, and what happens if one does not fit into the generally accepted idea [or social stereotype] of what those categories imply. Understanding what it means to be sexual involves how women and men, girls and boys interpret sexuality, what is considered sexual, and the meaning and value ascribed to it. Sexuality includes different dimensions of relationships, whether they are sexual or not, the degree of control and agency over sexuality, whether sexual activities involve violence and coercion, but also a sense of self-worth and self-esteem, pleasure and desire. Being sexual is also linked to the social, economic, and educational opportunities available to males and females, how

that availability influences decisions to be sexually active or not, and how information about sexuality and sexual health is interpreted.

Sexual development is often typified as something problematic to be contained and controlled, especially for girls. This characterization often has more to do with the anxieties, fears, and beliefs of adults than the reality experienced by adolescents. Adolescence is a time of rapid development, discovery, experimentation, and exploration about all aspects of life. It is a time of initiation and experimentation (voluntary and involuntary) in sexual activity. Yet socially it is often not acceptable for adolescents to be sexually active. As a result, young people, especially girls, have to hide their sexuality and sexual activity and submit to restrictions and control. Due to social, cultural and religious restrictions of young women, they may have less access to health care services, and information.

In considerations of healthy adolescent sexual development three issues emerge: (i) cognitive development and the context of decision-making; (ii) gender identity; and (iii) the socioeconomic context of physical development.

(i) Cognitive development — acquisition of the ability to think and reason abstractly, weigh consequences and make decisions — occurs during adolescence and is influenced by the social (particularly gender-related), political, economic, and cultural contexts in which decisions are made. What does it mean to make a decision related to one's sexuality when public knowledge of sexual activity is a serious social liability with potential long-term social sanctions and stigma?

(ii) Gender identity development defines for most people what it means to become a man or a woman. It is a process of interpreting and accepting (or not accepting) what family, community, culture and society, say about the appropriate roles, responsibilities and behaviours of men and women. Although gender identity is constructed over time, in adolescence gender roles (and their disparities, stereotypes, and inequities) are often solidified and intensified through observation of adults and peers. This is reinforced in messages received by young people through school, community, media, religious institutions and health services.

Social assumptions about gender identity and sexuality often carry the assumption, either implicitly or explicitly (depending on culture), that women should not want sexual activity or find it pleasurable, or have sexual relations outside of marriage. Sexual activity should be for procreative purposes and motherhood is a marker of social status. On the other hand, men and boys are often socialized to feel entitled to have sexual relations and pleasure and that their self-worth is demonstrated through their sexual prowess and notions of authority and power. Gender roles often dictate who is supposed to be passive or aggressive in sexual relationships and what the proper motivations are for seeking sexual activity: girls often report a need for intimacy, love, and affection; boys often report curiosity, pleasure, and status among their peers.

(iii) Social, cultural, and economic factors also affect sexual decision-making by boys and girls, as individuals and within society. Young people are often unprepared for, and lack information about, the physical changes they undergo during puberty and throughout adolescence. Community values and fears about sexuality in young people tend to limit the availability of the basic information and education they need to understand and appreciate their changing bodies, leaving the transfer of knowledge about sex and sexuality to parents, families and professionals. Unfortunately, parents, health workers, and teachers themselves also often lack such information, or do not feel comfortable communicating about sexuality. As a result, young people tend to enter into sexual relations without the necessary knowledge or skills to negotiate for their own sexual health and welfare.

All cultures assign meaning to the onset of puberty. The social meaning of puberty is different for boys and girls. In many cultures, the onset of puberty for a boy may lead to greater freedom, mobility, and opportunities. For girls, in many places, it may mean an end to schooling, restricted social or physical mobility, and the beginning of married life and childbearing. Traditional practices,

rites, ceremonies and celebrations often accompany this transition from childhood to adulthood, some of which, such as female genital mutilation/cutting, may have lasting effects on sexual health and well-being.

Factors such as poverty and educational opportunity also have a direct impact on an individual's ability to develop sexually in a healthy way during adolescence. Economic necessity often leads young people to leave school to work. Girls are often married early to transfer their economic burden to the husband's family and to fulfil the family's duty to protect the daughter until marriage when she becomes the responsibility of her husband's family. Women and girls (and sometimes boys) may use sex to secure financial or other support for themselves and their children or extended family. The meanings and motivation of each sexual act are therefore affected by numerous potential influences.

Adolescent sexual development does not happen in a vacuum. It is intrinsically linked to economic and social justice, human rights, and gender equity. Understanding and promoting healthy sexual development require understanding and promotion of social justice, in which all people have a right to their sexuality and to live with dignity, respect, and self-determination.

4.1.1 Discussion

The inter-related themes of gender and masculinity dominated the discussion. Some participants expressed a growing concern about the way men and masculinity are overlooked in discussions on gender. In the reproductive health literature, women are often portrayed as victims, men as perpetrators. Some participants emphasized the need to reconceptualize gender to include men, particularly since reproduction and sexual violence also involve men, both positively and negatively. Gender issues are not the same across and within regions. There is a need to start bridging gaps between research and programmes, in order to better understand what motivates men and women in different countries and regions as well as the power differentials between them.

Participants working in HIV prevention expressed concern about the wide divide between gender research and family planning research, which still characterizes men as the core group of HIV-infected people. Reproductive health activists acknowledged the prevalence of this gender bias against men, but felt strongly that there continue to be unaddressed gender issues in HIV prevention programmes, and that, in most cases, women are victims, whether as a result of lack of power to avoid HIV infection in relationships or as targets of sexual violence.

4.2 The public health challenge (Eli Coleman)

Sexuality is an integral part of human life. From infancy, we are conditioned for what our sexual life will be. Touch, attachment and bonding, together with good guidance, love and caring early in life, prepare children for healthy sexual development and maturation. Natural sexual curiosity, experimentation and learning before and during adolescence are both normal and healthy, and occur in all cultures. Adolescence is a time for learning to love oneself and others and to be responsible in one's relationships. During this period, young people develop intimate bonds and learn to enjoy the pleasures of sexual activity. They also learn about the health risks associated with sexual practices and behaviours, and their vulnerability to these risks – often at first hand. This period sets the stage for mature adult sexual relationships.

During the reproductive years, norms of behaviour, sexual activity and practices are solidified. Adults transfer their knowledge, beliefs and assumptions about sexuality and sexual life to their children and with this, patterns of sexual health or ill-health are established. For older people, sexual activity can be pleasurable and fulfilling, but with age come also increased risks of ill-health and its adverse effects on sexuality.

Risk of sexual ill-health begins with the onset of unsafe sexual activity, usually in the adolescent years, and continues as long as the unsafe activity or harmful sexual practices are engaged in. In all countries, many individuals suffer from the consequences of some form of sexual ill-health. The HIV pandemic has shown us that communities, countries and regions are in a sexual health crisis of incredible proportion.

Sexuality-related illnesses range from sexual dysfunction to sexually transmitted infections. The global AIDS pandemic has now affected the lives of some 40 million people. WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) reported that, in 2001, 5 million people were newly infected with HIV, 800 000 of them children. This is equivalent to approximately 14 000 new HIV infections per day, more than 95% of which were in developing countries (6). Recent estimates of the number of curable sexually transmitted infections in adults total 340 million cases worldwide, with the most dramatic rates occurring in south and south-east Asia, sub-Saharan Africa, Latin America and eastern Europe. The prevalence of syphilis in the Russian Federation, for example, has increased from almost no reported cases in 1990 to 260 per 100 000 population in 1996 (7). In developing countries, STIs and their complications are among the top five diseases for which adults seek care. The widespread prevalence of STIs and reproductive tract infection (RTIs) generally is also a major cause of infertility.

The reproductive health consequences of unsafe sexual activity are not limited to STIs. Unintended pregnancy, early childbirth and unsafe abortion all contribute to morbidity and mortality. Each year, 15 million women under the age of 20 give birth, accounting for one out of every five births worldwide (8). Girls aged 15–19 years are twice as likely to die in childbirth as women in their twenties, and their babies are also at higher risk. In addition, young mothers are at increased risk of pregnancy-related complications linked to cephalopelvic disproportion (9, 10). In developing countries, maternal death continues to be one of the most tragic consequences of poor sexual and reproductive health and well-being (11). Unintended pregnancy often leads to unsafe abortion, which in turn may lead to other health consequences, such as RTIs, infertility, chronic pelvic pain, pelvic inflammatory disease and death. Of the nearly 20 million women who have an unsafe abortion each year, 5 million are adolescents. Many adolescents resort to abortion in unsafe or unhygienic conditions out of fear, shame or guilt about their socially unacceptable sexual activity (12).

Sexual health problems also include sexual dysfunction, gender identity disorders and a variety of other concerns and anxieties. Sexual dysfunctions [such as low sexual desire, erectile dysfunction, inability to achieve orgasm, premature ejaculation, pain during sexual activity (dyspareunia) and vaginismus] are relatively common but seldom diagnosed or treated. Few figures are available for developing countries. However, in the USA, individual disorders appear to affect between 8% and 33% of the adult population (13). Sexual dysfunctions are often associated with other physical and mental disorders, such as diabetes, cardiovascular problems, blood pressure abnormalities, depression and anxiety (14, 15).

Sexual violence is common and occurs throughout the world. Available data suggest that in some countries one in five women experiences sexual violence at the hands of an intimate partner and up to one-third of girls report forced sexual initiation (16). There are many forms of sexual violence: forced intercourse/rape, sexual coercion, trafficking, forced prostitution, and sexual harassment. It takes place in all settings, but particularly in the home. It has a profound impact on the physical and mental health of those who experience it, often lasting well beyond the assault. It is associated with an increased risk of sexual and reproductive health problems, including unwanted pregnancy, STI and HIV infection, and mental health problems such as depression, anxiety and post-traumatic stress disorder. Sexual abuse of children is associated with low self-esteem, high-risk sexual behaviours and drug abuse in later life (17).

The sexual health of individuals, families and communities is indeed in crisis. Collective action is needed to help individuals and couples to live happy and healthy sexual lives. In a recent address, the Surgeon-General of the USA noted that “while sexuality may be difficult to discuss for some, and there are certainly many different views and beliefs about it, we cannot afford the consequences of selective silence” (18). Countries must begin to adopt national strategies, raise awareness, and carry out interventions (prevention and care), evaluation and research to address the public health crisis related to sexual health. Some countries, such as Australia, the United Kingdom, and the USA, have already done so. Many more need to follow.

Vulnerability and risk: influencing factors

The sexuality of individuals and couples is largely determined by family and community values and social mores. It is also influenced by sex, marital status, religion, culture, education, and economic factors. People's ability to make decisions about their sexual life is influenced by all of these factors, often simultaneously. Less recognized, but equally significant to decision-making, are the meanings, motivations and desires that people associate with sexual activity, behaviours and practice.

During the Consultation a number of presentations focused on understanding and addressing social and cultural determinants of sexual behaviour and decision-making from various disciplines and regional perspectives.

5.1 Models for addressing vulnerability and risk (Peter Aggleton[3])

In reflecting on what has been learned from the field of HIV prevention and sexual health over the past two decades, three issues emerge: the underdeveloped appreciation of sexuality and "the sexual", reluctance to engage with the overtly political, and concern with risk rather than with vulnerability.

In the early days of the epidemic, the focus of control activities was on the identification of relevant knowledge, attitudes and reported practices, on partner relations and on the frequency of different forms of sexual intercourse, which was largely assumed to be penetrative penile-vaginal intercourse. There was little or no discussion at that time about other forms of sexual activity or the motivations or meanings of those activities except in the context of homosexual sexual activity. The focus was rather on enumerating a limited range of "sexual risk behaviours" in specific target populations, which allowed sexual behaviour to be classified as risky or safe. At the time, it was not well understood or appreciated that, for example, a woman who regularly exchanges sex for food for her children may see herself as simply "getting by" or as a "responsible mother". The researcher, on the other hand, may describe this woman as a commercial sex worker. Such issues lie at the core of our understanding of sexual activity and sexuality and have profound implications for programmes.

Early responses to sexuality within the context of HIV/AIDS were also limited by a reticence to address the political aspects. The focus was on sexual behaviour rather than the context in which behaviour occurred. This was evidenced by the focus on sex outside a "regular union", regardless of whether it was desired or even the norm within a particular culture or setting. Politicians and health practitioners alike were quick to collude with the pretence that, all over the world, populations divided neatly into the majority – those who were chaste before marriage and faithful within it – and the minority, who were deviant or promiscuous. This essentially political response led to slow reactions and questioning of contemporary assumptions about sexuality and sexual behaviour.

Another feature of the early response to HIV/AIDS was the concern with individual risk. There was an assumption that individuals were largely rational decision-makers when it came to sexual activity and health concerns and, with the necessary information, attitudes and skills, would make sensible decisions about their sexual behaviour.

This led to a programme focus on information, education and communication (IEC) campaigns, social marketing and life-skills education.

Individual choice, however, is not the only thing that determines risk. In a key study (19), Hart & Flowers found that individual risk was affected by interpersonal aspects of sexual behaviour, formal and informal social structures, and organizational aspects of the person's life. It was also affected by the social context. Programmes, therefore, must address these different levels of influence in a systematic manner.

[3] In the absence of Peter Aggleton, this presentation was read by Gary Dowsett.

Recently, greater attention has been paid to the distinctions between risk and vulnerability (20) and between risk reduction and vulnerability reduction. In the context of HIV/AIDS, risk is defined as the probability that a person will acquire HIV infection. Certain behaviours create, enhance and perpetuate such risk. Early responses to the epidemic focused on reduction of risk-taking behaviours by targeting individuals and groups with specific interventions. Individual risk however is also influenced by social and environmental factors. There is now a growing recognition of how social inequalities influence risk.

Vulnerability is influenced by at least three sets of interacting factors: (i) personal factors; (ii) factors related to the quality and coverage of services and programmes; and (iii) societal factors. In combination, these factors can increase or reduce an individual's vulnerability to sexual and reproductive ill-health. Personal factors include, for example, knowledge and the capacity to use that knowledge to protect oneself and others from infection. Programme factors include the cultural appropriateness of programmes, accessibility of services, and the capacity of the system to respond to growing needs. Societal factors, such as gender and power imbalances, economic status and social exclusion as a result of, for example, sexual identity, also directly affect an individual's vulnerability. Programmes that aim to reduce vulnerability are necessary but extremely complex because of the interaction between factors such as gender and poverty, and may be able to reduce only some aspects of vulnerability in some contexts, while enhancing vulnerability in others.

Programmes that recognize the need for both risk reduction and vulnerability reduction in a balanced way are neither new nor impossible to put into action. Countries such as Thailand, Uganda and Zambia have done so with some success. Recent shifts in programme focus from individual behaviour to the broader context and settings in which sexual practices become meaningful are important. Equally critical are the opportunities for health promotion that vulnerability reduction strategies provide, and the transformative potential they hold for communities and societies as a whole. Changes are taking place that would previously not have been thought possible. Programmes on making sex work safer in Cambodia, the Philippines and Thailand, syringe and needle exchange programmes in Latin America and Central and Eastern Europe, programmes working with diverse groups of men who have sex with men in countries such as Bangladesh, India and Morocco, programmes working to empower women educationally and economically in Côte d'Ivoire and Kenya – all of these might have been considered impossible or unnecessary only two decades ago. The challenge is to bring similar successes and scale to other activities of sexual health programmes.

5.1.1 Discussion

Asha Mohamud, commenting on this presentation, raised the notion of individual and environmental antecedents as protective or risk factors. She noted that factors such as education about protective behaviour, condom knowledge, support from peers, connection to a social network, and positive institutional support are protective. Risk factors include lack of information, skills and power, gender inequalities, poverty and unemployment, negative peer influences, substance abuse and lack of services. Religion can be either a protective or a risk factor, depending on the social and cultural context. Recent work in this area (21) has stressed that "when there are a multitude of antecedents each with a small impact on sexual behaviour as opposed to a few antecedents with a large impact, it is unlikely that a magic bullet will be found to substantially change adolescent behaviour". In the African context, there are many antecedents that make adolescents vulnerable. In order to address their vulnerability, programmes must work to create an enabling environment by reducing the effects of those antecedents. This should be done by scaling up sexuality education programmes and paying particular attention within those programmes to gender and human rights.

Participants discussed the need to clarify approaches and language. The model of Hart & Flowers was a response to other vulnerability and risk reduction approaches. This model addresses vulnerability and risk as relatively equal factors influencing behaviour, and thus to be tackled simultaneously. Concern was expressed that this approach took all factors on board without dis-

tinction or prioritization for intervention. Because of cost and time constraints, the approach, though ideal, was not being implemented as intended. The design and staging of adolescent sexual health education programmes, for example, often include plans for second and third steps but, because of limited funds or commitment, do not move beyond the stage of providing information.

Moving discussion of sexual activity from the personal sphere – where it has been for centuries – to the public sphere has to be done with caution. How connections are made between the individual and institutions is critical to the success of any programme. Sexuality needs to be demystified before it can be appropriately addressed at the institutional level. Discussions will therefore need to cover sexual activity not related to reproduction, and the problems of dealing with the reality of sexual behaviours in various national and local contexts. Developing appropriate interventions that address the complex web of factors influencing sexual behaviour brings with it challenges. The resources and political will needed may vary. What may begin as a general sexual health education programme in schools, requiring ministerial support, may later require assistance from nongovernmental partners, such as churches, mosques or other traditional associations that have the cultural authority to address issues of sexuality at the family and community levels. By adding this level of complexity we run the risk of losing quality. The group emphasized that teachers charged with delivering basic health information often require significant training. When many different actors are involved in the delivery of messages, the risk of contradictory or incorrect messages may increase, thus exacerbating the very inequities the programme is trying to reduce.

The identification of best practices, as has been done by UNAIDS for HIV interventions, was also discussed. Best practices, some noted, were often rather the best *known* practices. In order to create complex programmes that are culturally appropriate, there remains a great need to monitor and evaluate projects in developing countries for locally successful approaches.

5.2 Regional perspectives on sociocultural factors

How sexual health is and can be addressed within different countries and regions is largely culturally determined. Perspectives on sexual health issues, and on the barriers and opportunities for addressing them in different countries and regions, were solicited before and during the Consultation. The presentations demonstrated that, despite vast differences in context, tradition and approaches, addressing sexuality in almost all regions (except perhaps in parts of western Europe), is bound by gender constructs and religion and reinforced by politics. Programmes that seek to reducing vulnerability and risks in sexual behaviour will therefore have to work with people's beliefs, values and traditions to support sexual-health-seeking behaviour and a more holistic view of sexuality throughout the life course.

5.2.1 Latin America (Esther Corona)

Despite a predominantly common language and historical factors, Latin America is a heterogeneous region, economically and ethnically diverse both within and across countries. Throughout the region, however, common structural and social factors influence sexuality and sexual behaviour. Poverty, the Catholic Church and the media directly affect how sexual and reproductive health is addressed by individuals, families and communities, and at the local and national government levels. Current constructions of sexuality are affected by indigenous culture and traditions, Spanish and Portuguese colonialism, and African traditions brought with the slave trade. Intermarriage and time have inextricably linked these traditions, forming sociocultural barriers to sexual health promotion related to gender issues, individual perceptions of the body and sexuality, levels of interpersonal violence, and complex belief systems. These constraints are further exacerbated by poverty, illiteracy, rural residence and political strife. As a result, problems such as unintended pregnancy, sexually transmitted and reproductive tract infections in adolescents, sexual

violence and gender disparities persist in the region. Key to addressing these issues is comprehensive sexuality education in schools, as well as for adults and parents through the media.

5.2.2 Sub-Saharan Africa (Uwem Esiet)

Sexual health in sub-Saharan Africa continues to be dominated by the HIV/AIDS pandemic. The increasingly young population (one in four people in sub-Saharan Africa is between 10 and 19 years of age) is disproportionally affected, accounting for six out of every ten infected persons on the continent. Heterosexual transmission of HIV is aided by the relatively early average age at first intercourse of just 14 years. Factors increasing young people's vulnerability to infection include poverty, lack of power in sexual relationships, violence, traditional customs such as early marriage and harmful sexual practices, and gender disparities. One result is the transactional nature of sexual relationships, where women or girls exchange sex for money, food, school tuition, or housing. Despite these challenges, opportunities exist to promote sexual health. The high premium placed on children can serve to mobilize political and religious institutions to promote, support and maintain a sexually healthy lifestyle as an imperative for the future well-being of children. Promotion of positive community and family values, especially those that support adolescent health and development (such as participation in sports, music, and drama), can be a constructive way of fostering supportive family and religious values, including the promotion of love, compassion and understanding.

5.2.3 Eastern Mediterranean region (Faysal El-Kak)

In the Eastern Mediterranean region, demographic changes are resulting in increasingly young (over 50% in some countries), urban and poor populations. The region is predominantly Arab and Muslim. Politics are aligned with religion and, as a result, social and government institutions tend to reflect traditional religious values and laws. Despite the predominance of traditional religious authority in all aspects of private life, there remains a divide for some between ideals and practice. This is most evident in young people, who appear to be at a distance from the authorities on issues related to sexuality and sexual health. Rapid changes in the social environment, as a result of urbanization, migration, displacement and globalization, are affecting expectations and behaviour. Despite these changes, however, traditional discourse and understanding of sexuality, gender dynamics, and the family remain. In this context, social taboos and fear of stigmatization by family, school, community and/or government and religious authorities continue to limit individual sexual expression, particularly outside marriage. Within marriage, sexuality is considered normal and healthy by religious scriptures, and is promoted as a healthy part of married life. The tension appears when practices, as evidenced by health outcomes such as increased prevalence of sexually transmitted infections, infertility and unsafe abortion, point to "unacceptable" social and sexual behaviour. Individuals in the region have support systems that can serve as positive or negative forces for the promotion of sexual health. These include the family, the community, the legal and political system, and religion itself. How these factors influence the sexual behaviour of individuals and families in the future will depend on how leaders, and in particular those in the health sector, choose to address these critical issues.

Participants noted the difficulty in the region in recognizing premarital or extramarital sexual activity and other forms of sexual expression, including men who have sexual relations with men, the denial of which has impeded progress in combating sexually transmitted infections including HIV. In addition, some in the region are beginning to discuss the role and impact of traditional customs, such as segregation of sexes, on sexual practices and behaviour, though there is no significant evidence yet collected on these topics. The first step towards improving sexual health in the region could be a realistic assessment and discussion of sexual health problems and the factors that underlie them. Based on such an assessment, sexual health policies could be established that recognize the diversity of sexual practices and behaviours in the region and positively promote individual responsibility in sexual relationships for the sexual health of the community as a whole.

5.2.4 Asia (Terence Hull)

Sexuality in the Asian region is "defined by differences but dominated by similarities". Differences in gender roles, socioeconomic status and sexual orientation can be observed throughout the region. Despite these, however, in all countries sexual activity is dominated by heterosexual penetrative intercourse and performance anxiety among both men and women is significant. Problems related to sexuality in the region include widespread recourse to commercial sex workers, male dominance in marital sexual relations codified in some religious traditions, and violence motivated by sexual conflicts, including violence against both men and women as a result of their sexuality, sexual preferences, or decisions related to sexual behaviour. In addition, recent evidence has shown that harmful sexual practices, such as dry sex using herbs, astringents and diet management, penis inserts intended to increase pleasure or performance, and male and female genital mutilation/cutting, are more widespread than had previously been thought. These sexual behaviours, and the increasing use of anti-impotence drugs and vaginal tightening operations, reflect widespread performance anxiety among men and women. Not surprisingly, these practices have resulted in a high prevalence of sexually transmitted and reproductive tract infections.

Some regional efforts to combat STIs and HIV have proven successful. Organization and regulation of the sex industries in some Asian countries have slowed HIV transmission in certain populations. In addition, in certain circumstances, relatively open discussions about sexual activity and sexuality are possible, allowing researchers and programme managers to identify and target areas for intervention. The region also has the technical capacity in its universities and government research centres to design and monitor such activities. The question remaining is who will lead these efforts: as elsewhere, addressing sexual health requires government leadership, resources and political will.

5.2.5 Discussion

Participants felt that an understanding of sexuality is critical to improving sexual health. Finding out how ordinary people define and understand sexuality and sexual health, as well as the barriers they perceive to improving their sexual life, may offer an opportunity for providers to work on these issues. In all regions, the subordination of women and traditional gender roles limit women's and girls' ability to have safe, equitable and consensual sexual relations. Traditional practices, many of which reinforce gender and sexual inequities, are beginning to be used to promote change. For instance, sexual health education to promote health and rights is being offered in unconventional arenas such as during initiation rites in Africa, through sexual health education groups for parents in Asia, in churches and mosques in the Mediterranean region, or through soap operas and other television programmes in Europe and Latin America. The women's movement, youth networks and other social movements are also bringing the issues to the public attention. Allies exist in all regions. Participants emphasized that this highly politically and socially contested area nevertheless produces opportunities to raise and work on the issues. Some participants stressed that these opportunities can exist in schools, communities and the formal health system – and we must identify leaders in all of these arenas to assist in our efforts.

Meeting people's needs

In order to address sexual health in existing service delivery points – whether family planning clinics, STI clinics, antenatal care clinics or primary health care posts – staff need to have knowledge about sexuality, skills to deliver appropriately the information, treatment and care people need, and the willingness and ability to deal with ease with sexuality-related issues. This may seem self-evident, but in most contexts and settings, one or more of these dimensions are lacking. In addition, many efforts to address one aspect of sexual health, whether through programmes to prevent STIs/HIV, to provide family planning or to address intimate partner violence, have failed as a result of a lack of a clear strategy based on proper assessment, targeting, and adaptation of the intervention to the needs and interests of the relevant population group. Others have made small gains in a specific setting but, because of their narrow focus, could not be scaled up.

Several presentations focused on a number of key strategies found to be critical to the promotion of sexual health and delivery of sexual-health-related services. These included issues related to integration of services, education, information, and the enabling legal and political environment.

6.1 Integrating sexual health into existing services (Judith Helzner)

The field of family planning was for years dominated by two themes or approaches: the expansion of contraceptive use as a means of slowing population growth, but without addressing individual needs of clients; and the quest for "respectability" of birth control. More recently, family planning providers and managers have acknowledged the connections between these issues. This shift was marked by a focus on determinants of contraceptive use, a holistic approach to reproductive health rather than family planning, and a gender analysis of male–female relations. Changes in thinking after the International Conference on Population and Development in 1994 were reflected in a series of publications (22-24) on the role of sexuality in family planning and reproductive health.

These publications added to the chorus calling for greater attention to sexuality as the most important determinant in family planning and sexual and reproductive health. They attempted to demystify sexual activity and sexuality by highlighting them. Prior to this, underlying assumptions had included the following:

- sexuality is a personal matter that people do not want to discuss;
- sexual activity is a voluntary activity between individuals;
- clients prefer family planning methods that do not interfere with coitus;
- family planning providers are not prepared to respond to clients' questions and needs concerning sexuality; and addressing sexuality will overburden family planning programmes.

Calling into question how family planning services were provided, as well as some of the assumptions about providers' knowledge and ability to address the issues, opened up a new area of work on linking sexuality and sexual health to reproductive health services.

Researchers, managers and providers began to ask questions about how women negotiate their reproductive lives. Investigations into power differentials in sexual relationships gave rise to work on power distinctions, such as "power to" act versus "power over" someone else. The fundamental connection between gender and power in sexual relationships was also established . Finally, programme managers began to realize that power differentials between men and women can and should be addressed in service programmes (25).

Linkages between sexuality and reproductive health are many. The HIV epidemic has raised awareness about the need to address sexuality in a frank and direct manner. HIV prevention programmes can and must include discussion of sexual practices, partnerships, relationships, power, and condom use if they are to be successful. In family planning, recent discussions of the impact of contraceptive methods on sexual pleasure and relations recognize that this may

influence method choice, use and continuation. In addition, family planning services are often well placed to discover other needs related to sexual problems or violence (26). During pregnancy, issues related to sexuality need to be addressed, such as the safety and impact of certain sexual practices and the possibility of a higher incidence of gender-based violence during pregnancy.

The International Planned Parenthood Federation (IPPF) and its partners are working on integrating sexuality and sexual health into family planning and reproductive health care programmes. This work includes transforming national family planning associations (FPAs) into sexual health agencies in a number of Caribbean countries, screening for gender-based violence in clinics in three Latin American countries, integrating sexuality and HIV/STI prevention in family planning service delivery in three countries, producing "sexwise" radio programmes in 11 languages to reach over 60 million listeners, and pilot-testing projects for staff, new protocols, and changes in structures and partners to better integrate sexuality and sexual-health-related services into the work of FPAs. IPPF has created a trainers' guide to sexual health, in Spanish and English, with exercises to help improve factual knowledge, clarify values, and increase the comfort of providers in dealing with sexuality and sexual-health-related topics.

IPPF, as an independent nongovernmental organization, has taken the lead in some countries by challenging traditional assumptions about sexuality and sexual health programmes. It emphasizes that governments can take up such programmes once feasibility and acceptance have been demonstrated. Partnerships are crucial if sexuality is to be successfully integrated into reproductive health care services.

6.1.1 Discussion

Participants concurred that sexuality needs to be better integrated into family planning programmes, but emphasized that that was not enough. HIV prevention strategies have addressed these issues in a wide variety of settings and contexts, and many felt that greater effort was needed from reproductive health programme managers and providers to reach beyond the clinic walls to other associations and workers' groups, including prostitutes, homosexuals, folk and traditional medical practitioners, and religious groups. It was stressed that religious groups need to be brought on board if real progress is to be made. In addition, some argued that if a number of sectors and interests join forces, there is a greater likelihood of getting government support and funds.

Participants also agreed that providers of existing services and programmes should receive training in human sexuality, to help them better address the sexual health needs of their clients. The integration of sexuality into these services, however, should not require health workers to do more, but rather to do things differently. The group felt that it was essential to improve the quality of services by better addressing sexuality and sexual health for all age groups, including the elderly. As populations in some regions get older, there will be an increasing need to address the sexual health of the elderly, including issues related to sexual function for both men and women. Some participants raised questions about how the health system could better address both sexual dysfunction related to mental illness and violence.

6.2 Sexuality information: how can the health sector make a difference? (Pilar Ramos-Jimenez)

"Sexuality is a concept that is doubly difficult because most persons do not want to talk about their own sexuality or they most likely do not know the term…in the Philippine languages there is no term for sexuality," wrote a prominent sexuality researcher (27).

In the Philippines, reference to sexuality in health programmes is limited; there is no equivalent word in the local language. Basic definitions of gender, sex, sexual health and sexual responsibility exist, as do comprehensive STI case management modules – all of which focus on STI and HIV prevention rather than on the wider issues related to sexuality and sexual well-being. This lack of terminology reflects social reticence in addressing sexuality. As a result, few data are collected nationally on sexual health, or sexual practices or behaviour. In research,

abstract concepts must be operationalized, so that we can measure them or convert them into something understandable in the local context. Given the constraints in the language of sexual health and sexuality, and the associated absence of data, what can the health system do to better address this difficult and complex issue?

The national health sector must be willing to operationalize sexuality programmes that extend beyond STI/HIV prevention and move towards a more holistic and positive approach to sexual health and sexuality. This can be done by offering providers at all levels of the health system tools and approaches that will enable them to be more compassionate, gender- and culture-sensitive, and respectful of client information related to sexuality. This will require a new paradigm for interventions, involving partnerships between the health sector, NGOs, research institutions and communities. Interventions must be designed with the needs and interests of special groups in mind (e.g. refugees, sex workers, street children, seafarers, men who have sex with men, transgender, etc.). Effective collaboration and consultation are needed, as has been demonstrated by HIV control and prevention programmes. Finally, research methods must be qualitative as well as quantitative, and the health sector must be willing to use the research findings and make them accessible to decision-makers, planners and implementers. This will require data collection by health services to be reconsidered and, if necessary, new types of sexual heath conditions incorporated, such as incest, rape and domestic violence. Collection of sensitive data will also require training and supervision to ensure records are collected in confidence and stored securely.

6.2.1 Discussion

Jane Kwawu shared the concerns expressed about the lack of adequate, relevant and reliable information related to sexuality and sexual health. She noted that in many cases decision-makers do not have sufficient unbiased information. Issues related to preventive health care, such as sexual health status, are given low priority and programmes therefore continue to focus on disease rather than health. She warned that without reliable data and information, sexual health would not be taken seriously by health sector reformers. Preventive health models need to be adapted to sexual health messages, and clear policies and laws need to be established to support a holistic approach to strategies aimed at changing sexual behaviour.

The health system should be made more accessible through the creation of mechanisms allowing community voices to be heard. Emphasis needs to be placed on implementing gender policies and institutionalizing the collection of disaggregated data. This will help countries to integrate sexuality and sexual health, not as an "add-on" but as part of a comprehensive approach to sexual and reproductive health, in which programmes are equitably distributed and address the needs of the people they are intended to serve. To achieve these changes, it is critical to build the capacity of the different players to better understand and address sexuality and sexual health.

Other participants noted that there is a critical absence of evidence and accurate information, especially from developing countries, about vulnerability reduction programmes. In particular, local practices and customs related to sexuality and sexual health are not well researched. Participants felt that capacity-building is needed to improve the quality of sexuality research, since few institutions in developing countries have the multidisciplinary research skills to successfully undertake such studies.

What information does exist needs to be better disseminated. Information can be adapted, made culturally appropriate, and translated for other countries and regions. One way might be to start "implementers' forums", where information can be exchanged and tools and resources shared. This could be done through the Internet. Other suggestions included developing dissemination strategies for all related sectors and partners with follow-up mechanisms to determine results. The group raised the fact that information, knowledge and its utilization are different. The health sector needs to be clear about its role with respect to information. For instance, what will the health sector do in situations where information is tightly controlled? What messages will be sent

through guidance documents for countries that do not have a word to describe sexuality? The challenge for health researchers is to find a way to describe and portray these things adequately.

At the global level, it is important to look at exactly what we are recording and analysing. WHO, for example, has invested in the DALY (disability adjusted life years) framework to measure the relative cost of specific diseases to society. However, the published data on DALYs have little relevance or application for sexual health. In this exercise, sexual dysfunction or disability, in terms of disenfranchisement or disempowerment, are not covered. One participant stressed that including sexuality-related morbidities in the DALYs may motivate action within the health sector. A new estimation of DALYs, to include serious sexual health problems, could demonstrate the importance and potential impact of addressing sexual health at national level.

6.3 Country case studies on sexuality education

Case studies from Thailand (Verapol Chandeying), Sweden (Lillemor Rosenqvist) and South Africa (Khosi Xaba) demonstrated how effective government, private sector and NGO collaboration can be in addressing sexual health.

In Thailand, where STIs and HIV infection rates reached record highs in the late 1980s, programmes targeting sex establishments managed to create a 100% condom use standard by 2000. This was achieved through cooperation between government authorities and the owners of establishments, followed by increased surveillance, supervision, provision of STI services, and changes in laws and policies. In Sweden, which has among the lowest rates of unintended pregnancy and abortion in the world, sexual health education is now provided in all schools beginning in the elementary years. Although today sexual health education is the norm in Sweden, the road leading to its widespread acceptance has been long – more than 20 years – and sometimes difficult. In South Africa, where HIV/AIDS affects more than one-quarter of the population, promotion of sexual health education has taken a different form. The Sexual Rights Campaign, launched jointly by NGOs dealing with HIV/AIDS, violence against women, and adolescent sexual and reproductive health, is a multipronged advocacy campaign to get decision-makers and politicians to integrate sexual health and rights into their work. Underlying the campaign is the belief that sexuality and sexual health can and should be associated with safe, positive and pleasurable experiences. The NGOs are trying to achieve this by advocating for a new vision of masculinity and femininity, in which all women and men can claim their sexual rights and recognize their sexual responsibilities.

6.3.1 Discussion

Sexuality education – whether for adolescents, parents, teachers or health workers – generated much discussion and enthusiasm. All participants agreed that, while sexuality education is a key to transforming entrenched belief systems and views of sexuality, programmes often face a significant challenge. In the Russian Federation, for example, despite early interest, sexuality education in schools was later denounced by religious and political leaders as inflammatory despite the rising incidence of STIs and HIV infection.

Sexuality education must seek to promote health and well-being, as well as sexual rights. It needs to extend to all sectors, recognizing that not all children go to school. Different approaches are needed in different settings, and it was noted that a large proportion of health and education services are delivered through the religious sector. Others reminded the group that sex education is not a “magic bullet”. It can empower young people, enabling them to make decisions and act, but the broader context may restrict their ability to act. The situation and context have a strong influence on sex education, and very often become a barrier, especially in developing countries.

An additional problem mentioned by participants was lack of knowledge among providers. Medical doctors are often brought in to provide sexual health education despite their own limitations (lack of knowledge, skills or comfort level). There is an urgent need to ensure that

medical education curricula include training on sexuality, gender and human rights. This training should also be extended to teachers, allied health workers, police and other members of the justice system, and policy-makers.

Information and education related to sexuality for adolescents is critical to building a sexually healthy future generation. Programmes must therefore move beyond simply providing information to building skills, so that young people can use the information they receive. Another group in need of information is the newly married. While some information and materials are available, they are often not packaged appropriately. Some suggested that the Internet could be used as a method of dissemination and that the media should be included as partners in promoting sexual health information.

6.4 Government response: creating an enabling legal and policy environment

An enabling legal and policy environment is critical to the promotion of sexual health. Two case studies were presented, both led by nongovernmental organizations advocating for change in laws, policies and practices related to sexual health. Amal Abdel Hadi of the New Woman Research Centre in Egypt described the history of regulation of female genital mutilation in Egypt, while Maria Isabel Plata of Profamilia, a family planning association, discussed how the organization established a legal clinic to protect the sexual and reproductive rights of clients in Colombia.

- **Egypt** – Female genital mutilation is a widespread practice in Egypt, and 97% of ever-married women aged 15-49 years have undergone the procedure. It is practised by both Muslims and Christians, and the reasons most often given are cultural tradition, religion, and the preservation of virginity. In Egypt, there is no penal law against female genital mutilation. Nevertheless, the practice has been hotly debated and contested by women's rights activists for years. In 1959, a ministerial decree was issued prohibiting the practice by non-medical personnel, such as traditional birth attendants and barbers. From that time until 1996, when the Ministry of Health issued a decree prohibiting the participation of health professionals in the practice, female genital mutilation was widely condoned by the medical profession. The tide began to turn in 1994, in part because of sustained local activism against the practice, and in part because of international opinion against it. With the support of international organizations, such as WHO and the International Federation of Gynaecology and Obstetrics (FIGO), and in line with the shift towards comprehensive reproductive health care and rights, local activists built a public and religious consensus around the condemnation of the practice. The change in policy in Egypt is an example of the coming together of different forces and factors to create the conditions for policy change to occur – a crucial element in producing change in practice at the national level.
- **Colombia** – In Colombia, Profamilia established a legal service for women, in an effort to help them secure their reproductive and sexual rights. The service addresses issues related to sexual orientation and discrimination, abortion, prevention of sexually transmitted infections, informed consent, emergency contraception and gender-based violence. In establishing the legal service, Profamilia is using human rights and law as instruments for social change, by promoting partnerships with interested groups in other sectors, such as the women's movement, human rights organizations and community-based groups. As a result of their efforts, the Ministry of Health in Colombia has elaborated guidelines for sexual and reproductive health services.

6.4.1 Discussion

Participants concurred that a legally enabling environment is fundamental to advancing sexual rights, although some noted that there are advantages to working in the nongovernmental sector, where political opposition can be seen as a challenge rather than a barrier. Others noted that if an NGO takes over critical services, the government may then not fulfil its role as provider of those services. The example of Profamlia demonstrates

that an NGO can be a catalyst for government action, and that such fear of government inaction is not necessarily justified.

Group discussions were held on specific national strategies deemed to be successful, based on established criteria. These strategies included a range of interventions that involved individuals, families, the community, and a variety of government and non-governmental services.

Successful interventions came from NGOs, religious groups, the private sector, the government sector, professional associations, sports and youth clubs, and numerous other agencies. Common features of successful programmes were discussed using a list of guiding principles provided (30), and a revised list was developed (see Box 2).

Box 2: Guiding principles for successful programme interventions in sexual health

- *Affirmative approach to sexuality* – Using a positive, affirming approach to sexuality, rather than one based on fear, addresses both the pleasure and safety aspects of sexuality and sexual health and recognizes that every human being is sexual throughout the life cycle.
- *Autonomy and self-determination* – Women and men must have the right and ability to make their own free and informed choices about all aspects of their lives, including their sexual lives.
- *Responsiveness to changing needs* – Sexual health information and services must respond to the changing needs of women and men throughout their life cycle.
- *Comprehensive understanding of sexuality* – Issues of sexuality are complex. Interventions must address and integrate emotional, psychological and cultural factors in planning and service delivery.
- *Confidentiality and privacy* – Sexuality touches upon intimate aspects of people's lives. Individuals have the right not to be identified or compelled to share information and the right not to have information about them divulged to someone else.
- *Advocacy* for the promotion of sexual health and well-being is essential for change.
- *Cultural diversity* – Programmes must consider which cultural practices, traditions, beliefs and values are beneficial and promote sexual health. Factors such as sexual orientation, illness, culture, age or disability must be taken into account in the design of programme interventions and services.
- *Equity* – Programmes and services must cater to needs that are specific to each sex, but must not perpetuate stereotypes or double standards about gender and sexuality. Since women have traditionally been less able to access information, services and education, programmes should actively redress gender imbalances through interventions that empower women to protect themselves from sexual ill-health and disease.
- *Address violence, sexual violence and abuse* – These are often the conditions under which people, especially women, experience their sexuality or initiation into sexual activity.
- *Non-judgemental services and programmes* – Providers and educators must respect the values that others hold, and refrain from judging and imposing their own views upon others.
- *Accessible programmes and services* – Programmes and services must be accessible, affordable, confidential, of high quality, and age- and culture-appropriate.
- *Accountability and responsibility* – The health system should ensure that sexual health programmes are implemented and services are provided according to the above principles.

Conclusion

The Consultation concluded with a series of proposals for future action by WHO:

- Develop an expanded research agenda on sexuality and convene a meeting to set research priorities.
- Develop normative guidance documents on sexuality and healthy sexual development and maturation for developing countries.
- Develop curricula and training tools on human sexuality for physicians and health workers.
- Evaluate models of service delivery and programmes to establish best practices related to sexual health.
- Advocate for the collection of data related to sexuality and sexual health in all countries.
- Evaluate research methods for studying sexuality and sexual behaviour and develop a guidance document on research methods.
- Build research capacity in sexual behaviour and sexuality in developing countries.
- Develop a comprehensive guidance document on sexual health to assist countries to develop national strategies and policies on sexual health.

Since the Consultation, the Department of Reproductive Health and Research, in cooperation with the Departments of Child and Adolescent Health and the HIV/AIDS Department, has developed a medium-term workplan on sexual health, which takes up several of these recommendations.

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Meeting agenda

World Health Organization
Department of Reproductive Health and Research in collaboration with the Department of Child and Adolescent Health and Development and the Department of HIV/AIDS

Challenges in Sexual and Reproductive Health:
Technical Consultation on Sexual Health
28-31 January 2002, Geneva, Switzerland

Agenda

Monday, 28 January Defining Sexual Health		Chair: Dr Purnima Mane Vice-Chair: Dr Rosemary Coates
9:00 – 10:30	Opening of the Meeting Introduction, purpose of the meeting *Plenary presentations* Sexual Health: The Public Health Challenge Healthy Sexual Development Discussion	Dr Tomris Türmen Ms Adriane Martin Hilber Dr Adepeju Olukoya Dr Eli Coleman Ms Smita Pamar
11:00 – 12:30	*Panel Discussion* Regional Perspectives on Sociocultural Factors related to Sexual Health Discussion Introduction to the group work on definitions	Africa (Dr Uwem Esiet); Asia (Dr Terence Hull); Eastern Mediterranean (Dr Faizal el Kak); Eastern Europe (Dr Ondrej Trojan); Latin America (Dr Esther Corona) Ms Jane Cottingham
14:00 – 15:30	*Working groups (Session A)* Three working groups will discuss draft operational definitions of sex, sexuality (including sexual maturation and development), sexual health and reproductive and sexual rights	(Facilitators: Ms Marge Berer, Dr Assia Brandrup-Lukanow, Dr Pat Nayar)
16:00 – 17:30	*Plenary session* Report back from working groups	
18:00 – 19:00	Reception	

Tuesday, 29 January Strategies for Addressing Sexual Health		Chair: Dr Purnima Mane Vice-Chair: Dr Rosemary Coates
9:00 – 10:30	*Plenary session* Sexuality and Sexual Development: Vulnerability and Risk	Dr Peter Aggleton Discussant: Dr Asha Mohamud
	Discussion	
11:00 – 12:30	*Panel discussion* Integrating Sexual Health into Existing Health Services Country Case Studies: Sweden South Africa Thailand	Ms Judith Helzner Ms Lillemor Rosenqvist Ms Khosi Xaba Dr Verapol Chandeying
	Discussion	
	Introduction to group work on health sector strategies	Ms Adriane Martin Hilber
14:00 – 15:30	*Working groups (Session B)* Four working groups will discuss health sector strategies for addressing family and community issues and information needs Working Group 1 Adolescents Working Group 2 Men Working Group 3 Women Working Group 4 High-risk Groups	 (Facilitator: Ms Radhika Chandramani) (Facilitator: Dr Rafael Mazin) (Facilitator: Ms Khosi Xaba) (Facilitator: Dr Gary Dowsett)
16:30 – 17:30	*Plenary session* Report back from working groups	

Wednesday, 30 January Strategies for Addressing Sexual Health (cont.)		Chair: Dr Purnima Mane Vice-Chair: Dr Rosemary Coates
9:00 -10:30	*Plenary session* Sexual Health Information – How can the Health Sector Make a Difference?	Dr Pilar Ramos-Jimenez Discussant: Dr Jane Kwawu
11:00 – 12:30	*Panel discussion* Enabling Environment for Addressing Sexual Health Colombia Egypt Discussion	 Ms Isabel Plata Dr Amel Abdel Hadi
14:00 – 15:30	*Working Groups (Session C)* Four working groups will discuss strategies for integrating sexual health into existing health services Working Group 1 Adolescents Working Group 2 Men Working Group 3 Women Working Group 4 High-risk Groups	 (Facilitator: Ms Radhika Chandramani) (Facilitator: Dr Rafael Mazin) (Facilitator: Ms Khosi Xaba) (Facilitator: Dr Gary Dowsett)
16:30 – 17:30	*Plenary session* Report back from working groups	
Thursday, 31 January Recommendations		Chair: Dr Purnima Mane Vice-Chair: Dr Rosemary Coates
9:00 – 10:30	*Plenary session* Revisiting definitions	
11:00 – 12:45	*Plenary session* Conclusions and recommendations	
12:45 – 13:00	Closing Remarks	Dr Paul Van Look

Participants' list

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Department of Reproductive Health and Research in collaboration with the Department of Child and Adolescent Health and Development and the Department of HIV/AIDS

Challenges in Sexual and Reproductive Health:Technical Consultation on Sexual Health
28–31 January 2002, Geneva, Switzerland

Participants' list

Dr Peter Aggleton
Institute of Education, Thomas Coram Research Unit
University of London
27-28 Woburn Square
London WC1H0AA, United Kingdom
Tel: + 44 (207) 612 6957 Fax: + 44 (20) 7612 6927
E-mail: p.aggleton@ioe.ac.uk

Dr Ayse Akin
Hacettepe University, Medical School
Department of Public Health
06-100 Sihhiye
Ankara, Turkey
Tel: + 90 -(312) 324 39 75 Fax: + 90- (312) 483 3364
E-mail: aysea@tr.net

Dr Regina Barbosa
Rua Piracuama, 386/35
Sumare, 05017-040 Sao Paulo S.P., Brazil
Tel: + 55 (11) 36723215 Fax: + 55 (11) 36723215
E-mail: rmbarbos@usp.br

Ms Marge Berer
Reproductive Health Matters
444 Highgate Studios, 53-79 Highgate Road
London NW5 1TL, United Kingdom
Tel: +44-20-7267-6567 Fax: +44-20-7267-2551
E-mail: RHMjournal@compuserve.com

Dr Dorothy Blake
Gremlin Hill, San San
Drapers P.A.
Portland, Jamaica
Tel: +1 876 993 7208
E-mail: blaked@cwjamaica.com

Dr Meiwitta Budiharsana
Reproductive Health, Gender and Women's Rights
Ford Foundation
P.O. Box 2030
Jakarta 10020, Indonesia
Tel: +62 (21) 252 4073 Fax: +62 (21) 252 4078
E-mail: m.budiharsana@fordfound.org

Dr Mariela Castro Espin
Centro National de Educacion Sexual
La Habana, Cuba
Tel: (537) 55 2528 Fax: (537) 30 2295
E-mail: cenesex@infomed.sld.cu

Dr Verapol Chandeying
Dept. of OB-GYN, Faculty of Medicine
Prince of Songkla University
Hat Yai 90110, Thailand
Tel: +66 (74) 429 617 Fax: +66 (74) 446 361
E-mail: cverapol@ratree. psu.ac.th

Dr Radhika Chandiramani
TARSHI (Talking About Reproductive and Sexual Health Issues)
49 Golf Links, 2nd Floor
New Delhi 110 003, India
Tel: +91 (11) 4610711 , 465 Fax: +91 (11) 4610711 , 465
E-mail: tarshi@vsnl.com

Dr Rosemary Coates
Curtin University of Technology
Division of Health Sciences
Sexual Health Research and Education Unit
Selby Street
Shenton Park, Western Australia 6008
Tel: +61 (8) 9266 3644 Fax: +61 (8) 9266 3699
E-mail: R.Coates@curtin.edu.au

Dr Eli Coleman
Dept. of Family Practice & Community Health
Program in Human Sexuality
University of Minnesota Medical School
1300 South Second Street, Suite 180
Minneapolis, MN 55454, U.S.A.
Tel: +1 (612) 625-1500 Fax: +1 (612) 626 8311
E-mail: colem001@tc.umn.edu

Ms Esther Corona-Vargas
Latin American Federation of Sexology & Sex Education Societies (FLASSES)
Asociación Mexicana de Educación Sexual (AMES)
Av. De las Torres 27-B-301, Col Valle Escondido
Tepepan, D.F., Mexico
Tel: + 52 525 653 66 42 Fax: + 52 (55) 15 61 03
E-mail: ecoronav@aol.com
esthercoronav@hotmail.com

Ms Sarah Costa
Ford Foundation
320 East 43rd Street
New York, NY 10017, U.S.A.
Tel: +1 (212) 573-5000 Fax: +1 (212) 351-3677
E-mail: s.costa@fordfound.org

Dr Adbessamad Dialmy
Faculty of Arts and Human Sicences, Dept. of Sociology
B.P. 50
Fes, Morocco
Tel: + 212 (55) 60-05-63 Fax: +212 (55) 60-05-63
E-mail: dialmy@iam.net.ma

Dr Gary Dowsett
Australian Research Centre in Sex, Health & Society
Faculty of Health Sciences, La Trobe University
1st floor, 215 Franklin Street
Melbourne VIC 3000, Australia
Tel: +61 (3) 9285 5382 Fax: +61 (3) 9285 5229
E-mail: g.dowsett@latrobe.edu.au

Dr Amal Abd El Hadi
New Woman Research Center (NWRC)
90D Ahmed Orabi Street Mohendseen,
Giza, Egypt
Tel: +20 202 304 8085 Fax: +20 202 304 8085
E-mail: nwrc@intouch.com

Dr Faysal El-Kak
American University of Beirut, Faculty of Health Sciences
POBOX:110236
Beirut, Lebanon
Tel: + 961 (3) 867 498 Fax: + 961 (3) 744 470
E-mail: docfaysal@yahoo.com

Dr Uwem Esiet
Action Health Incorporated
P.O. Box 803
Yaba
Lagos, Nigeria
Tel: +234 (01) -7743745 Fax: +234 (01) 863 198
E-mail: ahi@linkserve.com.ng

Ms Kathryn Faulkner
International Planned Parenthood Federation (IPPF)
Regent's College, Inner Circle, Regent's Park
London NW1 4NS, United Kingdom
Tel: +44 (0)20 7487 7900 Fax: +44 (0)20 7487 7950
E-mail: kfaulkner@ippf.org

Dr Jean-Yves Frappier
Hôpital Ste-Justine
3175 Chemin Ste-Catherine
Montréal, Canada H3T 1C5
Tel: +1 (514) 345 4722 Fax: +1 (514) 345 4778
E-mail: jyfrappier@videotron.ca

Dr Marc Ganem
World Association of Sexology
32, Avenue Carnot
75017 Paris, France
Tel: +33 1 45 74 52 15 Fax: +33 09 71 69
E-mail: marc.ganem@wanadoo.fr

Ms Françoise Girard
International Women's Health Coalition, (IWHC)
24 East 21 Street
New York, N.Y. 10010, U.S.A.
Tel: +1 (212) 979-8500 Fax: +1 (212) 979-9009
E-mail: fgirard@iwhc.org

Ms Judith Helzner
International Planned Parenthood Federation (IPPF)
New York, NY 10005-3902, U.S.A.
Tel: (212) 214 0233 Fax: (212) 248 4221
E-mail: jhelzner@ippfwhr.org

Dr Terence Hull
Demography Program, RSSS
The Australian National University
Canberra, ACT 0200, Australia
Tel: +61 (2) 6125 0527 Fax: +61 (2) 6125 3031
E-mail: terry.hull@anu.edu.au

Dr Hind Khattab
The Egyptian Society For Population
Studies and Reproductive Health, (ESPSRH)
3 Orabi street
Maadi
Cairo, Egypt
Tel: + 20 202 358 68 53 Fax: + 20 202 380 79 47
E-mail: espsrh@starnet.com.eg

Dr Prakash Kothari
ndian ASECT
203A Sukhsagar
N.S. Patkar Marg
Mumbai 400 007, India
Tel: +91 (22) 361 2027 Fax: +91 (22) 204 8488
E-mail: drpkothari@hotmail.com

Dr Igor Kon
Institute of Ethnology and Anthropology, Russian Academy of Sciences
Vavilova Str., 48-372
117333 Moscow, Russian Federation
Tel: +7 (095) 137-5576
E-mail: igor.kon@iname.com

Dr Jane Kwawu
International Planned Parenthood Federation (IPPF)
Africa Region
P.O. Box 30234
Nairobi, Kenya
Tel: + 254 (2) 720280 /1/2 Fax: + 254 (2) 726596
E-mail: jkwawu@ippfaro.org

Dr Ana Luisa Liguori
John D. and Catherine T. MacArthur Foundation
The Program on Global Security and Sustainability
Vito Alessio Robles 39-103
Ex-hacienda de Guadalupe
Chimalistac, Mexico, DF 01050
Tel: +52 525 661 29 11 Fax: +52 525 661 72 92
E-mail: aliguori@macfdn.org

Dr Purnima Mane
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017, U.S.A.
Tel: + 1 (339) 0686 Fax: + 1 (755) 6052
E-mail: pmane@popcouncil.org

Dr Eleanor Maticka-Tyndale
University of Windsor, Dept. of Sociology and Anthropology
Windsor, Ontario N9B 3PE, Canada
Tel: +1 (519) 253-3000 ext 2200 Fax: +1 (519) 971-3621
E-mail: maticka@uwindsor.ca

Dr Asha Mohamud
PATH-AYA-Uganda
Plot 62 Kiira Road (Opp. The Uganda Museum)
P.O. Box 10370
Kampala, Uganda
Tel: + 256 202 822-0033 Fax: + 256 202 457-1466
E-mail: amohamud@path-dc.org

Dr Emil Ng
Department of Psychiatry
University of Hong Kong
Queen Mary Hospital
Pokulam Road
Hong Kong SAR
Tel: + 852 (852) -28554488 Fax: +852 (852) -28551345
E-mail: HRMCNML@hkucc.hku.hk

Ms Smita Pamar
SIECUS
130 West 42nd Street, Suite 350
New York, NY 10036, USA
Tel: (212) 819 9770 Ext. 308 Fax: (212) 819 9776
E-mail: spamar@siecus.org

Ms Maria-Isabel Plata
PROFAMILIA
Calle 34 No 15-52
Bogota, DC, Colombia
Tel: +57 (1) 338-3160 Fax: +57 (1) 287-5530
Email: profamil@colomsat.net.co

Dr Pilar Ramos-Jimenez
De La Salle University
3 Saint Marcelino Street
San Jose Subdivision
Alabang
Muntinlupa
Metro Manila, Philippines
Tel: +63 (2) 524-5349 Fax: +63 (2) 524 5351
E-mail: clapri@mail.disu.edu.ph

Dr Hanne Risor
Foreningen Sex & Samfund
Danish Family Planning Association
Skindergade 28, 1. og 2. sal
1159 Copenhagen K, Denmark
Tel: +45 (33) 93 10 10 Fax: +45 (33) 93 10 09
E-mail: hannerisor@post.tele.dk

Ms Lillemor Rosenqvist
Swedish Association for Sexology
Box 65, 297 01 Degeberga, Sweden
Tel: +46 (44) 35 10 85 Fax: +46 (44) 35 10 85
E-mail: lillemorresenqvist@swipnet.se

Dr Simon Rosser
University of Minnesota, Program in Human Sexuality
Dept. of Family Practice and Community Health Medical School
1300 South Second Street, Suite 180
Minneapolis MN 55454, USA
Tel: +1 (612) 625-1500 Fax: +1 (612) 626-8311
E-mail: srosser@famprac.umn.edu

Dr Eusebio Rubio-Aurioles
World Association of Sexology
Tezoquipa 26
Colonia La Joya
Tlalpan D.F.
Mexico 14000,Mexico
Tel: + 52 (5) 604-2652 60 Fax: + 52 (5) 513 1065
E-mail: eusebio@mail.internet.com.mx

Dr Rashidah Shuib
School of Medical Sciences
University of Sains Malaysia
16150 Kubang Kerian
Kelantan, Malaysia
Tel: +609-765-1700 est. 2713 Fax: +609-765-3370
Email: rashidah@kb.usm.my

Dr Ondrej Trojen
Sexological Institute
(Affiliated with 3rd Medical School Charles University)
Lannova 2
115 60 Prague 1, Czech Republic
Tel: +420 608 452453 Fax: +420 2 41432344
E-mail: trojan@avinet.cz

Dr Beverly Whipple
Rutgers University
31 NW Lakeside Drive
Medford, NJ 08055, U.S.A.
Tel: +1 (609) 953 1937
E-mail: bwhipple@recom.com

Ms Khosi Xaba
Ipas-South Africa
P.O. Box 1079
Auckland Park 2006
Johannesburg, South Africa
Tel: 27-11-482 2569 Fax: 27 11 482 4718
E-mail: makhosazanax@ipas.org.za

UN Agencies

Dr Ibrahima Diallo
UNICEF
Charge de programme adolescent/adolescent officer
UNICEF WCARO (BRAOC)
04 B.P. 443
Abidjan, Ivory Coast
Tel: +225 (20) 21 31 31 Fax: +225 (20) 22 76 07
E-mail: idiallo@unicef.org

Dr Malika Ladjali
Education for Sustainable Development
UNESCO
7 Place de Fontenoy
75700 Paris 07 SP, France
Tel: +(33 1) 4568 0124 Fax: +(33 1) 4568 5635
E-mail: M.Ladjali@unesco.org

Dr Laura Laski
UNFPA
Reproductive health Branch, Technical Support Division
The News Building
220 East 42nd Street
New York, NY 10017,U.S.A.
Tel: +1 (212) 297-5224 Fax: +1 (212) 297-5145
E-mail: laski@unfpa.org

Secretariat

WHO Regional Offices

Dr Antoine Serufilira, AFRO
E-mail: serufiliraa@whoafr.org

Dr Patricia Hoes, AMRO/PAHO
E-mail: hoespatr@paho.org

Dr Rafael Mazin, AMRO/PAHO
E-mail: mazinraf@paho.org

Dr Ghada Hafez, EMRO
E-mail: HafezG@who.sci.eg

Dr Assia Brandrup-Lukanow, EURO
E-mail: ABR@WHO.DK

Dr P. Nayar, SEARO
E-mail: NAYARPD@WHOSEA.ORG

WHO Headquarters

Dr Tomris Türmen, EXD/FCH
Dr Paul Van Look, Director, RHR
Dr Hans Troedsson, Director, CAH

Dr Andrew Ball, FCH/HIV
Tel: +41 22 791 4792
E-mail: balla@who.int

Ms Magdelena Cerda, VIP/PVL
Tel: +41 22 791 2867/ 3480
E-mail: cedam@who.int

Ms Manuela Colombini, FCH/RHR
Tel: +41 22 791 4281
E-mail: colombinim@who.int

Ms Jane Cottingham, FCH/RHR
Tel: +41 22 791 4213
E-mail: cottinghamj@who.int

Ms Amel Fahmy, FCH/RHR
Tel: +41 22 791 3328
E-mail: fahmya@who.int

Ms Jane Ferguson, FCH/CAH
Tel: +41 22 791 3369
E-mail: fergusonb@who.int

Dr Shireen Jejeebhoy, FCH/RHR
Tel: +41 22 791 3348
E-mail: jejeebhoys@who.int

Ms Adriane Martin Hilber, FCH/RHR
Tel: +41 22 791 3607
E-mail: martinhilbera@who.int

Ms Annette Mwansa, MSD/MDP
Tel: +41 22 791 4314
E-mail: nkowanea@who.int

Dr Adepeju Olukoya, FCH/CAH
Tel: +41 22 791 3306
E-mail: olukoyaa@who.int

Dr Gundo Weiler, FCH/HIV
Tel: +41 22 791 1226
E-mail weilerg@who.int

Ms Nena Musngi (Secretary) FCH/CAH
Tel: +41 22 791 4789
E-mail: Musngim@who.int

Ms Jenny Perrin (Secretary), FCH/RHR
Tel: +41 22 791 33 38
E-mail: perrinj@who.ch