Sexual Health for the Millennium

A Declaration and Technical Document

WORLD ASSOCIATION FOR SEXUAL HEALTH

Sexual Health for the Millennium

Introduction

The World Association for Sexual Health (WAS) (formerly the World Association for Sexology) was founded in 1978 by a multidisciplinary, world-wide group of non-governmental organizations (NGOs) with the aim of promoting sexual health and sexual rights throughout the world (See Appendix I). For nearly 30 years, the WAS has accomplished its aims through the advancement and exchange of scientifically based, multidisciplinary sexuality research, sexuality education, and clinical sexology. More recently, the WAS constituency has become much more involved in advocating for changes in public policy to recognize sexual health as a key ingredient in overall health and well-being. *Sexual Health for the Millennium* represents the collective voice of WAS in calling for the comprehensive integration of effective, evidence based sexual health promotion programming as an indispensable component of achieving the Millennium Development Goals (MDGs), derived from the United Nations Millennium Declaration (United Nations, 2000).

By the year 2000, we were facing a unique juncture in history and had a rare opportunity to develop global, national, and community strategies to promote sexual health for the new century (Coleman, 2002). In large part, this opportunity arose from the plethora of sexual health problems facing our world (most notably the HIV pandemic), the recognition of sexual rights as human rights, and the recognition that sexual health as a core component of overall health, as well as recent advances in the science of sexual health promotion. Together, these developments created the necessary conditions for the field of sexual health promotion to make an important contribution to the health and well-being of individuals, families, communities, and nations.

Previous globally focused initiatives have centered on the enunciation of sexual rights, typically grounded in a broader concept of human rights. The 1999 WAS *Declaration of Sexual Rights* (WAS, 1999) and the 2002 WHO *Working Definitions of Sexual Rights* (WHO, 2004a; WHO, 2006) are key examples of the enunciation of sexual rights for the global community (See Appendix II and III). The articulation and understanding of the reality that the achievement of basic human rights is inevitably tied to the achievement of a core set of sexual rights was a fundamental, initial step forward in the global promotion of sexual health.

The second step in this process has been the recognition that broadly-based initiatives to foster human development must invariably address sexuality and sexual health as evidenced by, for example, the WHO (2004b) *Reproductive Health Strategy*. As these steps forward in the understanding of the centrality of sexuality in human rights and health were occurring, advances in the scientific study of human sexuality (sexology) from a range of fields including biology and medicine, behavioral and social psychology, sociology and anthropology were making it possible for programs aimed at preventing sexual health problems as well as sexual health enhancement to be increasingly effective.

Recognition of the Importance of Addressing Sexuality and Sexual Health as Key Elements in Realizing the United Nations Millennium Development Goals

Parallel to the recognition of sexual rights as human rights has been the growing recognition that the attainment and maintenance of sexual health for individuals, couples, and families is a necessary prerequisite for the sustained social and economic development of communities and nations. According to Girard (2005), at the international level, the years that began with the 1994 International Conference on Population and Development (ICPD) have been marked by significant progress in the recognition by governments of sexual health as an essential dimension of overall health and consequently, of human development. The ICPD Programme of Action (PoA) adopted by 184 countries provided the first definition of sexual health negotiated and agreed upon by national governments from around the globe. It situated sexual health within a broader rubric of reproductive health care and recognized the important multifaceted contribution that sexual health makes to human well-being.

> ...Reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproductive and sexually transmitted diseases (UN, 1994, par. 7.2.).

Other international documents have recognized and emphasized the importance of sexual health within the broader constellation of human well-being. For example, the PAHO (2000) *Promotion of Sexual Health: Recommendations for* Action stressed that if overall health is to be achieved, sexual health must be promoted and maintained.

> Sexual health concerns and problems are important to address and find solutions for not only because they undermine sexual health, and therefore the general health of the individual, family, and society, but also because their presence might signal other health problems. Moreover, sexual health concerns and problems may generate, and/or perpetuate other problems in the individual, family, community and population at large (p. 15).

In September of 2000, the United Nations General Assembly adopted Resolution 55/2, the *United Nations Millennium Declaration* (UN, 2000). The Millennium Declaration was rooted in fundamental values: freedom, equality, solidarity, tolerance, respect for nature, and shared responsibility. The Millennium Development Goals (MDGs) that were derived from the Millennium Declaration and adopted by world leaders at the United Nations Millennium Summit in 2000, articulate objectives for resolving some of the most complicated and urgent social problems of our time. They are commonly accepted as a framework for measuring development progress and as a tool to help governments and advocates mobilize resources and implement programs that ensure sustainable and equitable development worldwide. At the United Nations Millennium Summit, world leaders committed, through the MDGs, to measurable goals for addressing a basic range of problems including poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. To varying degrees, these issues affect all the regions and peoples of the world. At their essence, the MDGs are aimed at improving the human condition and promoting the most basic of human rights.

United Nations Millennium Development Goals (MDGs)

1. Eradicate Extreme Poverty and Hunger
2. Achieve Universal Primary Education
3. Promote Gender Equality and Empower Women
4. Reduce Child Mortality
5. Improve Maternal Health
6. Combat HIV/AIDS, Malaria and Other Diseases
7. Ensure Environmental Sustainability
8. Develop a Global Partnership for Development

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The MDGs are necessarily broad in scope, placing eight basic objectives at the centre of the global agenda. Meeting these broad global objectives must inevitably require addressing those specific factors that make the attainment of the broader objectives possible. For most of the MDG's, these specific factors directly or indirectly involve sexuality and sexual and reproductive health. The WHO's global *Reproductive Health Strategy* adopted at 57th World Health Assembly in May 2004 explicitly recognized the links between the MDG's and sexual and reproductive health. At a broad level, the WHO (2004b) strategy recognizes not only that sexual and reproductive health is an important determinant of the well-being of individuals, couples, and families, it is also fundamental to the development of communities and nations. With respect to the MDG's specifically, The WHO (2004b) notes that,

> Of the eight Goals, three – improve maternal health, reduce child mortality and combat HIV/AIDS, malaria and other diseases – are directly related to reproductive and sexual health, while four others – eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, and ensure

> environmental sustainability – have a close relationship with health, including reproductive health (p. 7).

With respect to reproductive health, women without access to sexual and reproductive health information and services will be less able to plan their families and will be at increased risk for STI/HIV and other negative health consequences, all of which directly facilitate poverty. The implications are clear. "Reproductive health is thus crucial, not only to poverty reduction, but to sustainable human development" (UNFPA, 2003, p. iv). More generally, the reciprocal relationship between establishing sexual rights, the attainment and maintenance of sexual health, and the achievement of the broader objectives of the MDG's is increasingly recognized.

> If they are to achieve sexual and reproductive health, people must be empowered to exercise control over their sexual and reproductive lives, and must have access to related health services. While these rights, and the ability to exercise them, constitute an important value in themselves, they are also a condition for well-being and development. The neglect and denial of sexual and reproductive health and rights are at the root of many health-related problems around the world (WHO, 2004a, p. 2).

Awareness of the reciprocal relationship between sexual and reproductive health problems and specific fundamental indicators of over-all well-being, such as poverty, are increasingly recognized. Sexual and reproductive health problems are both a cause and a consequence of poverty. This linkage is explicitly and succinctly pointed out by Family Care International (2005) who point out that,

> Poor sexual and reproductive health impacts the economic well-being of individuals, families, and communities by decreasing individuals' productivity and participation in the labour force. For example, early childbearing perpetuates the cycle of poverty by disrupting girls' schooling, limiting women's and girls' employment opportunities, and reducing investments in the well-being of women and their children. At the same time, the costs of treating sexual and reproductive injuries and illnesses can drain meager incomes, exacerbating individual and household poverty (p. 3).

Over the years it has been increasingly recognized that sexual and reproductive health promotion efforts have a direct beneficial impact on these aspects of people's lives. What has been perhaps less clear to policy makers but which is of crucial importance is the recognition that breaking the cycle of poverty requires the provision of effective sexual health education and services delivered in an environment that encourages individuals to act on their own behalf. For example, the report, *Adding It Up: The Benefits of Investing in Sexual and Reproductive Care* (Singh, Darroch, Vlassoff & Nadeau, 2003) extensively documents the extent to which investments in sexual and reproductive health care services can make valuable contributions to wider development goals. Indeed, with respect to the MDG's specifically, the report concludes that "sexual and reproductive health is essential to achieving all of these goals" (p. 30).

The recent WHO (2007, in press) *Developing Sexual Health Programmes: A Conceptual Framework and Basis for Action* provides a comprehensive approach to sexual health promotion recognizing that there are a wide variety of determinants of sexual health including legal, political, religious, economic, and socio-cultural influences. Effective societal wide sexual health promotion must not only involve the health and education systems but must also be addressed through the implementation of appropriate laws and policies. These efforts must include addressing the economic inequalities that are associated with and underlie the occurrence of many sexual health related problems. The WHO conceptual framework recognizes and incorporates the crucial fact that to be successful, sexual health promotion programming must be designed and implemented with the input, cooperation and acceptance of the communities involved.

In both the developed and developing world we are faced with persistently high, and in some cases, increasing rates of sexually transmitted infections including HIV, unintended pregnancy, and unsafe abortions. These problems are particularly acute in the developing world where they present fundamental obstacles to meaningful progress in alleviating morbidity, mortality, and poverty. Gender-based

discrimination involving sexual norms and practices as well as coercive sex forced upon women and children compound these problems. The onslaught of HIV/AIDS in Africa is definitive example of how a multitude of specific sexual norms and practices, in the absence of wide spread and sustained evidenced-based sexual health promotion efforts, has facilitated an epidemic that has taken millions of lives as well as exacerbated and directly contributed to extreme poverty.

Taken together, the range of sexual and reproductive health problems facing the global community is extensive and their impact on the human condition is immense. According to the WHO (2004b),

> …aspects of reproductive and sexual ill-health (maternal and perinatal morality and morbidity, cancers, sexually transmitted infections and HIV/AIDS) account for nearly 20% of the global burden of ill-health for women and some 14% for men. These statistics do not capture the full burden of ill-health, however. Gender-based violence, and gynaecological conditions such as severe menstrual problems, urinary and faecal incontinence due to obstetric fistulae, uterine prolapse, pregnancy loss, and sexual dysfunction – all of which have major social, emotional and physical consequences – are currently severely underestimated in present global burden of disease estimates. WHO estimates unsafe sex to be the second most important global risk factor to health (p. 15).

Clearly, if global initiatives for sustained development are to be successful they must specifically incorporate evidence-based sexual health promotion programs.

The developing world suffers a disproportionate burden from sexual and reproductive health problems and this poses an important obstacle to the development of these regions of the world. In addition, it should be noted that sexual and reproductive health problems also place a significant burden on the health and well-being of individuals and families in the developed world. For example, from the United States we have *The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior* (U.S. Surgeon General, 2001) which acknowledges the extent to which many of these same problems result in considerable morbidity and mortality in that country and are strongly associated with social and economic disadvantage. A comparative study of adolescent sexual and reproductive health in five developed countries clearly suggested that access to sexual and reproductive health education and clinical services is often insufficient and a lack of access to education and services is correlated with higher rates of teenage pregnancy and STI infection (Darroch, Frost, Singh and the Study Team, 2002).

Sexual Health for the Millennium Reflects the State of the Art in the Science of Sexual Health Promotion

The WHO (2007, in press) provides a conceptual framework for developing and implementing effective sexual health promotion programs that reflect a multi-sector approach. The *Sexual Health for the Millennium* technical document provides a complementary and in-depth research-based examination of key issues in sexual health promotion that provides additional evidence-based support for the WHO conceptual framework. A key component of the timeliness and relevance of *Sexual Health for the Millennium* and technical document is that they come at a time when advances in the extraordinarily diverse discipline of sexology make it increasingly evident that well supported and well designed sexual health promotion programs can be successful in reaching their objectives and, as a result, have a significant and wide-ranging positive impact on the health and well-being of the people thy reach. For example, advances in behavioral science applied to STI/HIV and unintended pregnancy prevention as well as sexual health education for youth have dramatically increased the potential effectiveness of such programs. Epidemiological understanding of the biological and social dynamics that drive the spread of STI/HIV within communities and across borders has advanced significantly. Studies in the fields of sociology and anthropology have given us a much greater understanding of sexual norms and practices within diverse social and cultural contexts. Medical knowledge and clinical intervention related to sexual function as well as reproduction and fertility control now have a growing potential to improve quality of life.

The eight declaration statements of *Sexual Health for the Millennium* and technical document represent and give substance to the next logical and progressive step in the global promotion of sexual health (See Appendix IV and V for a description of the process of developing the Declaration and the technical document and acknowledgements of those who participated in this process). The declaration statements identify eight key areas in the realm of sexual health where we must move forward. Sexuality and sexual health are broad and diverse concepts that touch on innumerable aspects of the human condition. *Sexual Health for the Millennium* not only confirms the role that promoting sexual health must play in achieving the MDGs, this document specifies and elaborates on eight distinct but inter-related aspects of sexual health that play important roles in affecting human development. To meaningfully and effectively contribute to the achievement of the MDGs, sexual health promotion programs must address the totality of human sexuality. For example, to effectively promote HIV sexual risk reduction, sexual health promotion programs must reflect and incorporate the reality that sexual relationships include gender and power dynamics and that the desire for intimacy and pleasure plays an instrumental role in shaping sexual behavior. In sum, *Sexual Health for the Millennium* conceptualizes sexual health as multi-dimensional and specifically identifies and examines eight specific goals that together encompass an integrated and comprehensive approach to sexual health promotion. Finally, this technical document describes specific necessary actions that are specific to each of the eight goals of the declaration.

The Sexual Health for the Millennium Declaration

The promotion of sexual health is central to the attainment of wellness and well-being and the achievement of sustainable development and more specifically to the implementation of the Millennium Development Goals. Individuals and communities who experience well-being are better positioned to contribute to the eradication of individual and societal poverty. By nurturing individual and social responsibility and equitable social interactions, promotion of sexual health fosters quality of life and the realization of peace. Therefore we urge all governments, international agencies, private sector, academic institutions and society at large, and particularly, all member organizations of the World Association for Sexual Health to:

1**. Recognize, promote, ensure and protect sexual rights for all**
Sexual rights are an integral component of basic human rights and therefore are inalienable and universal. Sexual health is an integral component of the right to the enjoyment of the highest attainable standard of health. Sexual health cannot be obtained or maintained without sexual rights for all.

2**. Advance toward gender equity**
Sexual health requires gender equity and respect. Gender-related inequities and imbalances of power deter constructive and harmonic human interactions and therefore the attainment of sexual health.

3. **Condemn, combat, and reduce all forms of sexuality related violence**
Sexual health cannot be attained until people are free of stigma, discrimination, sexual abuse, coercion and violence.

4. **Provide universal access to comprehensive sexuality education and information**
To achieve sexual health, all individuals, including youth, must have access to comprehensive sexuality education and sexual health information and services throughout the life cycle.

5. **Ensure that reproductive health programs recognize the centrality of sexual health**
Reproduction is one of the critical dimensions of human sexuality and may contribute to strengthening relationships and personal fulfillment when desired and planned. Sexual health encompasses reproductive health. Current reproductive health programs must be broadened to address the various dimensions of sexuality and sexual health in a comprehensive manner.

6. **Halt and reverse the spread of HIV/AIDS and other sexually transmitted infections (STIs)**
Universal access to effective prevention, voluntary counseling and testing, comprehensive care and treatment of HIV/AIDS and other STI are equally essential to sexual health. Programs that assure universal access must be scaled up immediately.

7. **Identify, address and treat sexual concerns, dysfunctions and disorders**
Since sexual concerns, dysfunctions and disorders impact quality of life, it is critical to recognize, prevent and treat sexual concerns, dysfunctions and disorders.

8. **Achieve recognition of sexual pleasure as a component of holistic health and well-being**
Sexual health is more than the absence of disease. The right to sexual pleasure should be universally recognized and promoted.

It is essential that international, regional, national and local plans of action for sustainable development prioritize sexual health interventions, allocate sufficient resources, address systemic, structural and community barriers and monitor progress.

Conclusion

We have arrived at a point in history where it is increasingly evident that advances in sexual science have measurably improved the capability of well designed and supported sexual health promotion programs to effectively address a number of problems that inhibit or prevent individuals from leading healthy and productive lives. As the WHO (2004b) *Reproductive Health Strategy* suggests, "The number of evidence-based best practices in reproductive and sexual health care has grown substantially, and the scope of behavioral research and of internationally recognized standards, norms and guidelines has broadened" (p. 9). In turn, *Sexual Health for the Millennium* declaration and technical document illustrates and embodies the advances in the science of sexual health promotion that have placed the field in an unprecedented position to contribute to human development and make an indispensable contribution to the broad objectives of the MDG's.

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Chapter One[1]

Recognize, Promote, Ensure and Protect Sexual Rights for All

Sexual rights are an integral component of basic human rights and therefore and inalienable and universal. Sexual health is an integral component of the right to the enjoyment of the highest standard of health. Sexual health cannot be obtained or maintained without sexual rights for all.

The placement of sexual rights as the first item in the World Association for Sexual Health's (WAS) declaration *Sexual Health for the Millennium* is consistent with the growing recognition of human rights as foundational requirements for health (Farmer, 1999; Mann, Gruskin, Grodin & Annas, 1999) which is connected to the acknowledgment that sexual health cannot be achieved and maintained without respect for human rights (WHO, 2007, in press).

In its *Gender and Reproductive Health Glossary,* the secretariat of the World Health Organization (WHO) proposes a working definition of sexual rights as "human rights related to sexual health". It thereby places sexual rights securely within the domain of the array of human rights that are already recognized in international treaties and conventions (WHO, 2002a; 2006). This working definition also states that sexual rights "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 in relation to sexuality;
- sexuality education;
- respect for bodily integrity;
- choice of 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 working definition concludes that, "The responsible exercise of human rights requires that all persons respect the rights of others" (WHO, 2002a; 2006).

Sexual rights as outlined above can be identified as an underlying presence within all of the eight *Millennium Development Goals* (MDGs) (United Nations, 2005). The availability of quality sexual and reproductive health services, information and education in relation to sexuality; protection of bodily integrity; and the guarantee of the right of people to freely choose sexual and marriage partners, to make decisions about child bearing, and to pursue satisfying, safe and pleasurable sexual lives are grounded in and contribute to gender equality and the empowerment of women (MDG 3); to access to primary education, particularly for girls (MDG 2); to reduction of infant and child mortality, especially of female children (MDG 4); to improvements in maternal health and mortality (MDG 5); to decreasing vulnerability to HIV/AIDS, STIs and other health threats (MDG 6); and also to reduction of poverty (especially among women) (MDG 1). Thus, it is evident that achieving sexual rights for all people will not only contribute to sexual and reproductive health, well-being and quality of life but will also advance the MDGs.

Sexual Rights: Some Hurdles to be Cleared

Despite the alignment of sexual rights with human rights, the broad international support for numerous human rights treaties and consensus statements (Office of the United Nations High Commissioner for Human Rights, 2004), and the health and development gains of a rights-based approach (Farmer, 1999; Hendriks, 1995; Mann,

1. This chapter closely follows the background paper written by Eleanor Maticka-Tyndale and Lisa Smylie. Additional input was informed by the WAS Expert Consultation in Oaxaca, Mexico and feedback from reviewers (see Appendix IV and V).

Gruskin, Grodin & Annas, 1999), attempts to reach international consensus on sexual rights have faced obstacles (Correa & Parker, 2004; Girard, 2005; Petchesky, 2000) that are, nevertheless, not insurmountable.

Religious and Cultural Barriers

As normative statements, international human rights agreements may represent a challenge to the authority of the state, the cultural structures and/or the religious organizations (Cook, 1995). Sexual rights may be particularly contentious because they address aspects of life that are considered to belong in the private and sacred domain and are grounded in cultural and religious beliefs about the nature of human existence and its relation to the fundamental power of life, as well as the nature and perpetuation of core groups such as family and clan. These are set out in cultural and religious belief systems and moral codes that are neither dependent on nor responsive to science or democratic process (Plummer, 2003). Within these cosmovisions, health and development are not prioritized above adherence to cultural or religious beliefs and moral codes. In fact, ill health, suffering, and even death may be viewed as necessary trials or passages, or even as inevitable consequences of transgressions of cultural and religious norms. A sexual rights approach may be seen as violating the nature of humanity as understood in religion and culture. This explains, for example, the vehement opposition from Pakistan's representatives (a stand that was endorsed by other countries) to the inclusion of sexual orientation in a draft resolution to the Commission on Human Rights in 2003, claiming it was an insult to the world's 1.2 billion Muslims (as cited in Saiz, 2004: 57) and similar opposition of Roman Catholic and Muslim clerics to inclusion of references to homosexuality in the 1994 International Conference on Population and Development Program of Action (ICPDPoA) (United Nations, 1994), the Beijing Platform for Action (Beijing) (United Nations, 1995) and the United Nations General Assembly Special Session on HIV/AIDS (UNAIDS, 2002) platforms and resolutions (Bayes & Tohidi, 2001; Girard, 2005; Parker, di Mauro, Filiano, Garcia, Munoz-Laboy & Sember, 2004).

Concerns of Critical, Feminist and Globalization Theorists

Critical theorists have also challenged a rights and health-based approach to sexuality. They underline the implications of framing sexual rights within a health paradigm as compared to a paradigm of citizenship. Miller (2001) points out that "although locating sexuality with health may liberate it from the strictures of religion, culture and morality, it places sexuality under the normalizing control of health and medicine". Historically (and currently) health and medicine have imposed a tyranny of 'nature' and biological determinism that does not acknowledge the socially constructed nature of sexuality or the capacity of individuals and cultures to find pleasure and 'naturalness' in diverse practices and experiences. Consider, for example, the pathologization of the otherwise universal practice of masturbation or of all same sex adult consensual sexual contact despite historical and contemporary examples of cultures where this is a normatively bound practice. Consider also the relatively recent, and in some circles still contentious, removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (APA).

Those working in the globalization arena alert us to its more undesirable tactics and consequences. Van Eerdewijk (2001) calls our attention to the ways in which western ethnocentrism leads researchers to take their own circumstances as the "norm," thus applying their own values in interpreting their observations rather than searching out the values of others. Boyle and Preves (2000) draw our attention to political tactics that move a western agenda forward without concern for the preferences, attractions and desires of local people, thereby denying their right to autonomy as a people. Plummer (2003) challenges the relevance of universal and abstract rights devoid of local contexts, histories and stories to creating an ethic for the global world of the 21st century.

Theorists of rights, sexuality and globalization point out that rights doctrines stemming from a health rationale pay little attention to the work of social constructionists and the evolving understandings of sexuality grounded in post-modern acknowledgements of shifting and diverse subjectivities, knowledge and experience (Hawkes, 2004; Richardson, 2000; Weeks, 1989; 2000), or the power differentials between genders, groups and nations in determining international agendas and norms. This has led some feminist scholars such as Oriel (2005) to question whether the sexual rights agenda has adequately taken account of women's rights relative to those of men, particularly given the still prevalent power differentials between men and women. Further, Miller (2001) calls our attention to the need to reconcile fundamental incompatibilities between the centering of human rights as compared

to public health, particularly if we advance the position that rights are essential to health.

These concerns related to new conceptualizations of sexuality within a health and rights paradigm can perhaps be understood if we acknowledge the inherently dialectical nature of change (Balakrishnan, 2001). Liberation from old forms of oppression brings both new freedoms and new oppressions. Thus, the tyranny of the community is replaced by the tyranny of the individual. Centering the rights of the individual may threaten the well-being and very existence and identity of some individuals, groups or communities. Consequently, opposition to *rights* may best be understood as a warning that alerts us to the inevitability of competing or conflicting goals and the need to proceed with due caution, being alert to new losses as well as gains and recognizing that the *best* that may be achieved is a new balance.

The Need For Sexual Rights

Despite these debates, international organizations advocating for the rights of women and children, and of gay, lesbian, bisexual and transgendered persons, such as Human Rights Watch and Amnesty International, as well as Rapporteurs to various UN Committees, have been in the forefront of documenting on-going violations of sexual rights and their consequences for the health, well-being and very life of men, women and children. To enable all people to enjoy the highest attainable standard of sexual health, various needs stemming from universally agreed upon ethical principles must be met.

A) The Need for Autonomy in Sexual and Reproductive Health Decision-Making

Women's autonomy in sexual decision-making and their right to sexual and reproductive health care are denied in the legal prohibition of birth control and abortion services that force them to access illegal and often unsafe abortions (WHO, 2004). But even the availability of birth control and abortion do not guarantee women's right to reproductive self determination. Organizations in Latin America have documented the performance of surgical sterilization or insertion of IUDs on indigenous and otherwise marginalized women without their consent in Peru and Mexico (Castro & Ervitie, 2003). Among Julie Mertus'(2001) review of numerous reproductive and sexual rights problems in Central and Eastern Europe was the involuntary sterilization of Romani women in Slovakia. In countries that prohibit sexual activity outside of marriage, sexual and reproductive health services are commonly denied to unmarried women (Amado, 2003; Shirpak, Mohammad, Maticka-Tyndale, et al., 2006, in press).

B) The Need for Guarantees of the Freedom to Seek, Provide, and Receive Sexual Health Information and Education

The sexual information and education needs of women and girls are poorly met in many countries as illustrated, for example, in restriction of much school-based sex education in the United States to abstinence-only programs (Arnold, Smith, Narrison & Springer, 1999; Jones, 2002); inconsistent provision of sex education in Canada (Barrett, King, Levy, Maticka-Tyndale, McKay & Fraser, 2004); absence of or scattered access to sex education in much of Latin America, Africa, the Middle East and Asia. When education for sexual health *is* available, it may be inappropriate to the needs of many women and girls as evidenced in the ABC (Abstinence, Be Faithful, Condoms) approaches to HIV prevention education that dominate in subSaharan Africa. These assume personal autonomy and control over sexual decision-making and further dis-empower and alienate the vast majority of girls and women who lack such autonomy and control (Van Donk, 2006; Whelan, 1998).

Forms of sexual activity that are pathologized, criminalized, non-normative, or whose existence is ignored or denied are either absent from or portrayed as such in sexual education programs. Often those who practice them have no access to information, education, or services except those that portray them as deviant, perverse, diseased or ill. Thus, in countries where homosexuality is considered a disease, even health care providers, researchers and educators are taught to approach it as illness or crime. Similarly, where polygamy is criminalized, adults in consensual polygamous unions (and their children) lack access to the rights, protections and services afforded to those in legally recognized marital unions (Maticka-Tyndale, 2002, 2003). Where sado-masochistic practices are criminalized, willing participants may be subject to arrest and criminal prosecution with no consideration of the consensual nature of their practice (e.g., Richardson, 2000: 112). In many countries people with disabilities are assumed to have a lack of capacity for sexual decision-making and for sexual activity, and thus have been denied rights to sexual self-determination

and to sexual health services to meet their needs (DiGiulio, 2003; Tilley, 2000; Zola, 1988). This is most evident with respect to persons diagnosed with severe mental illnesses or who are mentally retarded (Dybwad, 1976; Zola, 1988). The sexual capacity and interests of the elderly are similarly denied with husbands and wives placed in separate chronic care facilities and the elderly in these facilities not afforded the privacy and respect required to engage in safe, pleasurable and satisfying sexual lives. The right of sex workers to engage in consensual sexual activities is likewise denied through the criminalization of sex work. The absence of information, education and sexual health services is considered to be a contributing factor to poor sexual health including sexually transmitted infections, unwanted pregnancy, sexual violence, sexual dysfunction, poor reproductive health outcomes, and to ultimately jeopardize the right to pursue a satisfying, safe and pleasurable sexual life (WHO, 2007, in press).

C) The Need to Protect People against Violence and Violation of Bodily Integrity

Verbal abuse, harassment, violence, violation of bodily integrity, and murder or capital punishment are commonly used by the state and its agents, and implicitly condoned when used by civil society, to punish men, women, boys and girls who violate cultural norms of sexual conduct. The death penalty may be, and is, imposed for a conviction of homosexuality in countries governed by *shari'a* (Islamic) law (Amado, 2004; Ottoson, 2006). In Egypt, health professionals in Medical Forensics units violate the bodily integrity of those arrested on suspicion of homosexual activity with forced and repeated anal examinations in an attempt to determine their guilt (Long, 2004). India provides a further example of the collusion of health professionals and police in what Narrain (2004) describes as a Hindu nationalist backlash that has led to "rigorous and harsh policing" with criminal proceedings or forced medical treatment for those discovered in same sex activities. In Zimbabwe, Namibia, Zambia, Botswana and Uganda government leaders have launched campaigns of hate against homosexual people, inciting and condoning civil abuse of expected homosexuals and directing police to aggressively pursue, arrest and prosecute them (Human Rights Watch and IGLHRC, 2003). Homosexual men are harassed, intimidated, and assassinated with the complacency of the society at large in Jamaica and other Caribbean countries. Reports submitted to the United Nations Special Rapporteur on Torture and those prepared by Amnesty International document police torture and rape of gay, lesbian and transgendered persons while in police custody in India, Somalia, Turkey, Afghanistan, Egypt, Mexico, and Venezuela as well as refusal of police to investigate rape and murder of homosexual persons by civilians (Amnesty International, 2005; Long, 2001). In the United Kingdom, Australia, the United States, and Canada a defense of *homosexual panic* has been successfully used to obtain a lower sentence for perpetrators of violence against gay men (Howe, 2000).

Violence in the form of rape, sexual torture, honour killings, beatings and disfigurement are also used by agents of the state and members of civil society to control and punish women and girls who have transgressed cultural norms of sexual conduct (Amado, 2004; Abu-Odeh, 2000; Fried & Landsberg-Lewis, 2000; Spatz, 1991; Zuhur, 2005). Most recently, attention has been drawn to the rape, sexual torture, forced childbearing and forced marriage of hundreds of thousands of women as part of armed conflicts in the former Yugoslavia, Somalia, Burma, Kashmir, Sierra Leone, Rwanda, Angola and various Latin American countries (Heyser, 2006; Hughes, Mladjenovic & Mrsevic, 1999; Human Rights Watch, 2003; Human Rights Watch/Africa, Human Rights Watch Women Rights Project, & La Fédération Internationale des Droits de l'Homme, 1996; La Luz, 2000; Mladjenovic & Hughes, 1999). Rape and sexual violence against women and girls have also been documented in U.S. prisons (Human Rights Watch, 1996), refugee settlements, and as part of human trafficking (Blum & Kelly, 2000; Mertus, 2001; Olujic, 1995). Such violence has been linked to unwanted pregnancy, STI and HIV acquisition, poor maternal and infant health, sexual dysfunction, and inability to make sexual choices and negotiate sexual encounters in a way that minimizes a woman's health risks (Garcia-Moreno & Watts, 2000; WHO, 2002b).

Female genital mutilation (FGM) continues to be practiced on girls and women despite the documented threats to health (WHO, 1998) and heightened risks to both women and their infants during childbirth (Banks, Meirik, Farley, Akande et al., 2006). Male infant circumcision, although very different in purpose and nature from FGM, is considered by some groups as an abuse against male infants since, according to their argument; it is an irreversible cutting of genitalia without the consent of the individual (i.e. the infant). This practice is still routinely performed among Muslim and Jewish

populations as an essential religious ritual and for the majority of male infants born in the United States, South Korea and the Philippines against the claims of American, Canadian, British, Australian and European physicians' and pediatricians' associations that there is insufficient evidence of health benefits to recommend the routine practice of circumcision (American Academy of Pediatrics Task Force on Circumcision, 1999; American Medical Association, 1999; Australian College of Paediatrics (1996); Fetus and Newborn Committee, 1996).

D) The Need to Ensure Self-Determination and Autonomy in Sexual Decision-Making

At the most fundamental level, sexual rights embody the right to participate in sexual acts with whom one chooses, if one so chooses, and to pursue one's own route to sexual pleasure and fulfillment. That is, to self-determination and autonomy free from coercion, force, punishment, or discrimination. At the local level where people live their lives, self-determination and autonomy are both guaranteed and limited by law and social custom. Laws governing age of consent or majority determine, for example, when youth have access to legal guarantees of autonomy as well as when they are held fully accountable and governed by legal limitations to autonomy. Thus, below the age of majority, youth are not granted the right to consent to sexual practices, partnerships, or to access certain services. It is a paradox that marriage, even if not consensual, grants in some places the majority of age to individuals, including the right to engage in consensual sexual activity. In addition to laws governing age of consent, laws in many countries also set limits on the free choice of sexual partners and sexual acts. Often restricted are sexual activity or marriage between people of the same sex, between those who are not married, between partners with certain lineage relationships to each other, as well as sexual activity for immediate material gain and when there are more than two partners involved. These restrictions apply even when there is consent among all parties.

Sexual activity between persons of the same sex is most often regulated through *sodomy laws* in which anal intercourse (and sometimes other practices such as oral sex) is criminalized. Such laws exist in over 80 countries (Amado, 2004; Khaxas, 2001; Ottoson, 2006; Saiz, 2004; Samelius & Wagberg, 2005). Marriage for same sex couples is likewise restricted in most countries, denying them the well-established health and social benefits that accrue from marriage (Herdt & Kirtzner, 2006). Niveau et al. (1995) further document denial of the right to marriage on the part of transsexuals in countries where, for example, there is no mechanism for changing civil status despite complete surgical and hormonal transformation of biological sex characteristics (e.g. UK, France).

It is not uncommon for heterosexual women to be denied the right to choose their sexual partners, to choose whether and with whom they will marry, to decide whether or not to engage in sexual activity, to be free from sexual activity to which they do not consent, and to expect that their bodily integrity will be respected. For example, in Turkey, where an unmarried woman cannot decide to engage in sexual activity, virginity testing is conducted by state physicians at the request of parents or other community authorities and against the will of women and girls themselves (Girard, 2001; Lai & Ralph, 1995; Tambiah, 1995). Female genital mutilation is used in countries in the Middle East, Northern and subSaharan Africa, and Asia to control the sexual activity and enhance the acceptability and attractiveness of girls and women (Amado, 2004; Bop, 2005; Igras, Muteshi, Wolde Mariam & Ali, 2004; Jaldesa, Askew, Njue, & Wanjuru, 2005; Lewis 1995; Shaaban & Harbison, 2005; WHO, 1999). Women's organizations in Peru and other Latin American countries have documented challenges to women's right to autonomy in sexual decision-making on the part of personnel in public health facilities, particularly when women are poor or members of minority ethnic communities (Comité de America Latina y el Caribe para la Defensa de los Derechos de la Mujer and Center for Reproductive Law and Policy, 1999). In an attempt to control the spread of HIV, in 2001 the government of Swaziland ordered a five-year ban on sexual relations for unmarried women, including abstinence from even shaking hands with males (Girard, 2001).

Child marriage and early childbearing – below the age at which independent consent is considered possible in international treaties – has been documented in Asia, Africa and the Middle East (Bruce & Clark, 2004; Germain, 2005; ICRW, 2004; Lai & Ralph, 1995; Save the Children, 2004). In countries where the decision of whether, when and whom to marry rests with the father or male relatives, the consent of girls and women is not necessarily sought, constituting forced marriage (Amado, 2004). Once married, women in many countries, particularly in the Middle East, Northern Africa and Latin America, but also in Ireland, cannot

leave the marriage, since they are denied access to, or severely limited in their ability to access, divorce (Amado, 2004; Fried & Landsberg-Lewis, 2000; Shephard, 2000).

Finally, while the exchange of sex for immediate material gain (commonly referred to as prostitution, and in more contemporary jargon as sexual work), even when there is consent between parties, falls outside the criminal codes in *some of its forms* in only 12 countries (Australia, Brazil, Canada, Costa Rica, Denmark, Germany, Netherlands, New Zealand, Spain, Sweden, Switzerland, and the states of Nevada and Rhode Island in the United States), UN agencies report the trafficking of hundreds of thousands of women and girls, against their will, from Africa, Asia, and Eastern Europe for purposes of sexual labor (UNDP, 2000; UNFPA 1999, 2000; UNICEF, 2001; United Nations 1994, 1999, 2000).

E) The Need to Recognize, Promote, Ensure and Protect Sexual Rights for All to Achieve the Millennium Development Goals

There is an extensive literature on the close connections among the MDGs. Gender inequities and women's lack of power exacerbate and are at the root of much of the world's poverty and of maternal and child health. Poverty is also a prime determinant of maternal and child health and the three collectively influence access to and completion of primary education (especially for girls). Poverty, health, education and being female create and exacerbate conditions of vulnerability to HIV, AIDS, malaria and other diseases. Collectively, poverty, health, education, and especially HIV/AIDS and malaria, through their effects on individuals, families and communities place greater stresses on the physical environment. Experience has clearly demonstrated that these can only be effectively addressed through a coalition among nations, the eighth MDG.

The remaining chapters in this document address, individually, how the promotion of sexual health in reproductive health programs, the provision of access to universal sexuality education, the promotion of gender equity in sexuality, the eradication of sexual abuse and violence, the recognition of sexual pleasure as a component of well-being, the eradication of STI`s including HIV/AIDS, and combating sexual disease and dysfunction contribute to achieving the MDGs. Official acknowledgement of sexual rights would set legal and policy guarantees for these recognitions, eradications, access, provisions and promotions which could then be used to develop appropriate programming, service delivery, and legal action. Consequently it is through these mechanisms that sexual rights contribute to the MDGs. Since the debates on sexual rights at ICPD and Beijing, there has been increasing evidence of legal and policy changes that embody the sexual rights listed in WHO's working definition.

F) *The Need for Protective Laws and Policies*

Violence against women has been addressed in legal reform in 24 countries in the past decade (WHO, 2002b). In Morocco, a new family law passed in 2004 gives women equality in the family (Amado, 2004), and Iran is considering modification to its family law that will place the same requirements on husbands to fulfill the sexual needs of their wives that have been the long-term legal obligation of wives with respect to their husbands (Iran news paper July, 27th 2005). These contribute to gender equity, the experience of a sexually pleasurable and fulfilling life, and to respect for women's right to self-determination in the choice of marital and sexual partners, without fear of punishment.

Women's right to reproductive self-determination is supported by change in abortion laws. Since 1995, fifteen countries have passed laws liberalizing access to abortion. Included among these are Benin, Burkina Faso, Chad, Guinea, Mali and Nepal which formerly had some of the most restrictive laws. Five countries, however, (El Salvador, Ireland, Hungary, Poland, Russian Federation, and the United States) have made access to abortion more legally restrictive (Center for Reproductive Rights, 2005).

Respect for women's bodily integrity, and protection of the sexual and reproductive health and the health and life of infants born to them (Shaaban & Harbison, 2005) is evidenced in the passage of laws criminalizing female genital cutting in 9 industrialized and 11 African countries since 1995 (CRIP, 2006; Rahman & Toubiah, 2000). However, as evidenced in examples from several countries, and also experienced in the work of one of the authors (Maticka-Tyndale) in Kenya, such laws have often driven the practice underground (e.g., BBC, 2004a; WHO, 1999) increasing the health risks (BBC, 2004b). As mentioned above, concern for the bodily integrity of boys is evidenced in the policies set by various national medical associations ((American Academy of Pediatrics Task Force on Circumcision, 1999; American Medical Association, 1999; Australian College of Paediatrics (1996); Fetus and Newborn Committee, 1996) that discourage routine

circumcision of male infants on the grounds of "insufficient evidence of its beneficial health effects".

G) *The Need for Positive Rights and Enabling Conditions*

Positive rights and enabling conditions are those that speak to the ability of persons to act as they choose and to make their own decisions. There has been a gradual move toward recognition of the right of same sex couples to marry, adopt and raise children, and to benefit from the social and legal status of spouse in a growing number of countries. As of June, 2006, Belgium, Canada, Netherlands, Spain, and the state of Massachusetts in the United States provided for marriage regardless of the sex of members of the couple (IGLHRC, 2006). In 1994, South Africa became the first country to incorporate nondiscrimination based on sexual orientation in its constitution.

Information, education and sexual and reproductive health services are advocated as sexual rights themselves and also comprise a component of the enabling conditions that make it possible for people to act on other sexual rights. The WHO *Conceptual Framework* (WHO, 2007, in press) outlines shifts that have occurred in the delivery of sexual and reproductive health services from needs-based to rights-based approaches. Services have been expanded to address the sexual and reproductive health needs of couples as well as women, and of those outside the reproductive years. There are also gradual shifts from addressing merely sexual disease and ill-health to promoting sexual well-being and pleasure, although these are taking longer to be realized (WHO, 2007, in press). Several programs have begun to incorporate programming for men, particularly in relation to gender equity or violence (e.g., Guedes, Stevens, Helzner & Medina, 2002).

An increasing number of countries are moving forward to provide effective HIV prevention programming to youth through schools (see Kirby, Laris, & Rolleri, 2006 for a review) and communities (see Maticka-Tyndale & Brouillard-Coyle, 2006, in press, for a review). The Government of Kenya's mandate in 2001 of one AIDS lesson a week in all primary and secondary school grades supported the rights of children and youth to information and sex education related to HIV and AIDS. The government's adoption, in 2005, of an in-service and pre-service training programme for all primary school teachers on HIV/AIDS prevention education further supported that right (Maticka-Tyndale, Wildish, & Gichuru, 2004; Wildish & Gichuru, 2006, in press).

Several organizations in Latin America are working from a sexual rights orientation (e.g., Profamilia, Horizons, Instituto Promundo, the Jamaica Family Planning Association, and the International Planned Parenthood Federation). They have launched interventions designed to establish more gender equitable norms in communities, specifically addressing situations of violence against women in Brazil, Jamaica , Colombia, and Venezuela (Guedes, Stevens, Helzner, & Medina, 2002; IPPFWH 2001a, 2001b; Pulerwitz, Barker, Segundo & Nascimento, 2006). Religious leaders have been mobilized in Uganda (Kagimu, Marum, Webwire-Mangen, Nakyanjo, Walakira, & Hogle,1998), Malawi (Willms, Arratia, Makondesa, 2004), and Thailand (Maund, 2006; Sangha Metta, 2006) to empower youth and adults alike and to deliver information and education for HIV prevention and care that often involves reinterpreting religious doctrine to provide otherwise contentious information (Wolderhanna, Kingheim, Murphy, et al., 2005). In Canada, coalitions of organizations representing sex workers and university-based researchers have used rights-based approaches to research and advocate for legal and policy changes to support the programmatic work of sex worker organizations that target the health, safety and well-being of sex workers (e.g., STAR, 2005).

Finally, Cabal, Roa and Sepulveda-Oliva (2003) remind us that courts, using international treaties, provide a venue for bringing about change, especially when there is a disconnect between international, constitutional and legislative norms and the realities of people's lives (Cabal, Roa and Sepulveda-Oliva, 2003). Organizations in Latin America have pioneered use of courts and international litigation as strategies to improve national legislation and policies to the benefit of women and girls (see Cabal, Roa and Sepulveda-Oliva, 2003: p. 51-2 for more details).

These illustrations of legislation, policy and programs that promote sexual rights have been developed in the absence of any international treaties or formal recognitions of sexual rights per se. Instead, they have used international human rights conventions or local agreements to advance these initiatives. The existence of a sexual rights dialogue has been sufficient to advance these actions.

Overcoming the Complexities of and Challenges to Sexual Rights

While evidence of the need for and possibilities resulting from a formal acknowledgement of sexual rights appears

compelling, the complexity and challenge of achieving such an acknowledgement must be recognized. It is of paramount importance to raise two such challenges:

- The challenge of expanding the domain of a rights-based approach;
- The challenge of developing and rolling out a method for reaching international acknowledgement of sexual rights.

The challenge of expanding the domain of a rights-based approach

While *sexual rights* are not explicitly referenced in any UN treaties or conventions, defense of sexual rights is well grounded in the provisions of virtually all existing human rights treaties and conventions and has figured prominently in the debates, resolutions, and reports to UN commissions set up to monitor progress toward realization of treaty provisions. Two examples are the General Comment issued by the commission on the International Convention on Economic, Social and Cultural Rights calling for nondiscrimination based on sexual orientation (CESCR, 2000) and the recent report of Paul Hunt, Special Rapporteur to the United Nations arguing for the recognition of sexual rights (Hunt, 2006). The persistence of violations to human rights related to sexuality, despite wide endorsement of such treaties and conventions and the actions taken by watchdog committees, alerts us to the limitations of such treaties and conventions in advancing a rights agenda. We are reminded by legal scholars and rights advocates such as James Wilets (1997) of three key limitations of such treaties and agreements. First, although most are widely endorsed (Office of the United Nations High Commissioner for Human Rights, 2004), they are non-binding in nature and defer to national laws and customs when issues are in contention. Thus, for example, in states whose medical professionals view homosexuality as a disease whose public expression fosters its spread (as is the case in most Islamic countries), what have been presented in this paper as violations of rights are seen instead as consistent with the right to treatment of people suffering from a disease and the right of the public to protection from the spread of a preventable disease.

Second, treaties and agreements address the responsibilities of states and agents of States, but have little or no influence over civil society. This is illustrated in the examples of Egypt, Kenya and other countries where, despite bans on female genital cutting, it is still practiced. It is also seen in Canada (and other countries) where, despite laws prohibiting hate crimes as well as physical assault, gay men are still the victims of assaults and murder perpetrated by private citizens or vigilante groups (Janoff, 2005).

Third, the legal frameworks accessed through rights agreements are better able to forbid or prevent physical harm than to promote positive rights (e.g., the right to pursue a satisfying, safe and pleasurable sexual life) or to ensure that enabling conditions necessary for the realization of rights are in place. This is particularly salient when we consider that the exercise of many rights is premised on the idea of consent (consensual relationships, sexual acts, marriage). Research in diverse settings has raised the question of whether consent is possible without enabling conditions. Economic and social conditions may, for example, place severe limitations on possible alternatives. Thus, young girls consent to sexual relations or marriage when they have no other way to meet economic needs or to hold a socially endorsed status in their community (Maticka-Tyndale, Gallant, Brouillard-Coyle, et al., 2005; Sanyukta, Greene & Malhotra, 2003). Similarly, widows may consent to sexual intercourse with a male relative or community member in order to maintain their economic and social position in the community (Luginaah, Elkins, Maticka-Tyndale, Landry & Muthui, 2005). The role of economics is also evident in Romania and other countries in Central and Eastern Europe where legal and often free abortions are used for birth control rather than high cost, difficult to access contraceptives (Mertus, 2001; Yamin, 2004) raising the question of whether women have freely chosen methods to control their fertility or have been coerced by economic circumstances.

These limitations illustrate the divide between international treaties and agreements, or even national laws, and the local realities of people's lives where a multiplicity of interdependent conditions influence the actions they take. The consequences of a disconnect between raising awareness of rights and having enabling conditions in place for the actualization of such rights is poignantly illustrated in events reported in Ilam province, Iran. Raising women's "awareness and demands" through education in Ilam province is credited with contributing to a substantial rise in suicide rates among women in the province in 2004. Heyran Pour-Najaf, an advisor to the Ilam governor, reasoned that women had immolated themselves to protest "appalling family conditions" when they were unable to attain the "rights" of which they had learned (Ilam Suicide High Rate, February 28, 2005). Finally, the at

times conflicting goals of human rights and public health are illustrated in global differentials in HIV prevalence and in policies that are credited with either maintaining low or in decreasing incidence. Great care must be taken in interpreting information pointing at the association between positive health outcomes and legislation restrictive of sexual rights. For example, globally, HIV incidence has been lowest countries with particularly restrictive laws related to sexual autonomy (e.g., Middle East, Senegal) or that have implemented public health measures that restrict human or sexual rights such as in Cuba's early policy of quarantine of HIV-positive people. Similarly, Thailand's decrease in HIV incidence is credited, in large part, to its policy of mandatory condom use in brothels; a policy which violates the right to self-determination and which, on these grounds, was opposed by several wealthy countries and international groups. While gains can be documented with prescriptive, restrictive approaches, especially at initial the initial stages of a health program or initiative, backlashes may occur as a result of behavioral disinhibition caused by oppressive conditions and attainment of physical health without complete wellness and well-being.

The challenge of developing and rolling out a method for achieving international consensus

Sexual rights cut to the core of deeply held beliefs about the nature of being human, individual and group identities, and the moral order. As such, they stir heated debate and resistance that has prevented any movement toward consensus or acknowledgement. Zygmunt Bauman, in *Post-Modern Ethics,* provides a convincing argument for the need for a novel approach to addressing global ethical dilemmas, such as that posed by sexual rights (Bauman, 1993). Plummer (2003) and Correa and Parker (2004) describe such an approach, consisting of open, reciprocal, communicative dialogue for establishing international codes and consensus. The approach is consistent with what Miller identifies as a key principle underlying human rights work, i.e. the participation of individuals and groups in defining and resolving the issues that affect them (Miller, 2001).

Such participatory action approaches are increasingly used in local work with populations that have otherwise been excluded from setting agendas, priorities and designing programs (Horizons, 2002; Maticka-Tyndale & Brouillard-Coyle, 2006, in press). It is also seen in the dialogic projects of the National Issues Forum, the Public Conversations Project, and the Public Dialogue Consortium (Pearce and Littlejohn, 1997) and in the process used by the former Surgeon General of the United States to establish a consensus statement about sexual health (Satcher, 2006). Participatory action is particularly salient in the case of sexual rights where differences exist not only *across* cultural and religious groups, but also *within* them. The differences within groups are seen in the example of Islam where despite the opposition of conservative Islamic groups to wording in recent rights-based agreements and programs of action (Parker et al., 2004; Petchesky, 2000), several Muslim scholars have presented the argument that Islam is consistent with and supportive of a rights-based approach (e.g. An-Naim, 2004; Chase & Alaug, 2004; Senturk, 2005). Similar differences in interpretation of religious doctrine are evident within all faith-communities (see, for example, documents on the website of the Religious Institute on Sexual Morality, Justice and Healing: www.religiousinstitute.org, or Catholics for Free Choice: www.cath4choice.org). This suggests that there is a place for dialogue within faith communities.

Participatory action approaches could be applied internationally to move the global community further in the direction of consensus on contentious sexual rights issues. This would, however, require commitment of all parties to work towards consensus and to engage in critical examination and open communication about their own positions, to accept critical examination of their position from the outside, and to respectfully hear and duly consider the positions of others.

Necessary Actions

Three recommendations to move sexual rights forward emerge from the discussion presented in this section:

1.1. Location of Sexual Rights within the Existing Human Rights Context

Deborah Cook has demonstrated the close alignment between reproductive rights and existing human rights treaties and conventions (Cook 1995). Such work has produced a template that can be used to demonstrate to courts, ministries and governments how reproductive rights fit with existing commitments and obligations. Bearing in mind the existing international covenants related to human rights and other regional instruments such as European, American and African conventions, governments and international organizations and agencies should be encouraged to endorse the sexual

rights agenda through recognizing, promoting, respecting, ensuring, and protecting human rights and fundamental freedoms as essential to sexual health.

This approach would serve to locate sexual rights within existing treaties and conventions and provide them with access to the full weight of the monitoring and enforcement mechanisms of these conventions.

1.2.Participatory Action and Dialogic Projects

Participatory action or dialogic projects that bring together divergent perspectives on sexual rights are essential to identifying common ground and advancing consensus on sexual health and rights. WAS or WHO and their member organizations and regional offices are potentially best placed to facilitate the required research, identify the relevant parties, and initiate discussions within and between regions of the world to bring the views, perspectives and concerns of different cultural, religious and social perspectives to the issue of sexual rights.

1.3.The Monitoring and Evaluation of Sexual Rights Advances

While several examples of legislation, policy and programs advancing sexual rights are presented here, a more complete documentation of such approaches together with a system for monitoring and evaluating outcomes resulting from changed legislation, policy and programs would provide lessons for government, non-government and private sector organizations working to advance sexual rights. In the reviews conducted for this chapter, no scientific evaluations of rights-based approaches to sexual health were located. What is most often produced as evidence that rights-based approaches "work" is that changes in law and policy result in increased numbers of people availing themselves of the new opportunities that these provide. Thus, liberalization in access to divorce, abortion and birth control has always been followed by rises in divorce rates, abortions, and birth control use. What the corollary and long term implications are for health, well-being and quality of life remain unknown. Evaluation is needed to examine both beneficial and potentially harmful consequences of the absence and the presence of a rights-based approach.

Conclusions

Sexual rights, as with all human rights, are looked to for their liberatory potential. The great hope presented by sexual rights together with the concerns raised by nation-states and theorists alike suggest that work must move forward with humility, i.e. recognizing the profound liberatory as well as the oppressive powers of rights as they change long established and respected social relationships that have been central to the security, as well as the oppression, of individuals and communities alike. This requires work on several fronts. Government, non-government and multilateral organizations must continue delivering and expanding rights-based sexual health approaches. At the same time, more work is needed in developing a broader, more empowering conception of sexual rights that is capable of cutting across localized divisions and struggles to serve as a foundation for a transformed public health praxis (Parker et al., 2004). This work must involve multiple partners from different cultural and religious backgrounds as well as from diverse disciplines and sectors. As this work moves forward, it is essential to be alert to both its liberatory and oppressive potentials. As Richard Collier (2000) suggests in his examination of changes in family law and Ken Plummer (2003) in his discussion of developing an ethics of intimate citizenship, we need to ask whether we are losing an ethic of obligation and care in our focus on rights of the individual. Sexuality, after all, exists and is experienced not only within the individual, but in relationships: relationships with partners, with children, with parents and with fellow community members. It will be in striking a balance between rights and obligations, between caring for self and caring for others that we will strike the balance and develop sexual rights that benefit health, well-being and quality of life of entire communities and move nations forward toward achieving the *Millennium Development Goals*.

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Chapter Two[2]

Advance Toward Gender equity

Sexual health requires gender equity and respect. Gender-related inequities and disparities of power deter constructive and harmonic human interactions and therefore the attainment of sexual health.

Introduction

Millennium Development Goal 3 calls for the promotion of gender equality and women's empowerment. At the time of the Millennium Declaration the primary target advocated for measuring progress for MDG 3 was gender disparities in access to education. The U.N. (2005) Millennium Task Force on Education and Gender Equality expanded the range of progress indicators to include health and nutrition, access to opportunities in the work force, and participation in government. Furthermore, the Task Force has clearly acknowledged that "Achieving Goal 3 requires guaranteeing women's and girls sexual and reproductive health and rights" (U.N., 2005, p. 53). It has been clearly and unambiguously demonstrated in this technical document and elsewhere that the provision and universal access by girls and women to schooling and, sexuality education and clinical services is a necessary pre-requisite to achieving the MDGs. However, the dispensation of these services, as crucial as they are, is not sufficient to empower women to exercise the right to gender equality. Genuine equality for girls and women in achieving the right to sexual health will require not just access to education and services, it will require increasing levels of autonomy of sexual expression and equality of power within sexual relationships. Achievement of the human right to sexual health demands the autonomy for girls and women to enter into sexual relationships on their own accord and on an equal footing with their partners.

MDG 3 utilizes the term "gender equality". It is important to consider that this term is subject to different interpretations but is generally defined as equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society at large.(WHO 2001) . In other words, in its narrow definition, gender equality means simply treating men and women the same. However, to fully and adequately address the need for girls and women to achieve sexual and reproductive health rights requires that we recognize that men and women have different experiences and needs with respect to sexuality and sexual health. To achieve sexual health, therefore, all people, but particularly girls and women, require gender equity and respect.

> The concept of gender equity recognizes that men and women have different life experiences, different needs, different levels of power and access to decision-making levels in our society, differing expectations by others and different ways of expressing illness. Gender equity strategies recognize that gender leads to different social economic and political opportunities for women and men.
>
> The concept recognizes that women and men have different needs and power structures and that these differences should be identified and addressed in a manner that rectifies imbalances between the sexes. Gender equity strategies seek to achieve fairness and justice in the distribution of benefits and responsibilities between women and men, and recognize that different approaches may be required to produce equitable outcomes (NSW Health, 2000, p. 2).

[2] This chapter was informed by the background paper written by Elizabeth Castillo Vargas and Adriane Little Tuttle. Additional input was informed by the WAS Expert Consultation in Oaxaca, Mexico and feedback from reviewers (see Appendix IV and V).

It is this more nuanced conceptualization gender equity that must form the basis of sexual and reproductive health programming that will meaningfully address sexuality related power imbalances and enable girls and women to achieve full sexual and reproductive health rights.

According to the WHO (2003),

> The MDGs explicitly acknowledge that gender – what a given society believes about the appropriate roles and activities of men and women, and the behaviours that result from these beliefs – can have a major impact on development, helping to promote it in some cases while seriously retarding it in others (p. 1).

The need to promote the empowerment of women in the realm of reproductive health was recognized by the International Conference on Population and Development (ICPD)(UN, 1995). Furthermore gender-based violence and sexual coercion, sex trafficking, female genital mutilation, and forced early marriage have been identified as some of the manifestations of gender inequality that must be addressed in order to achieve the MDGs (UN, 2006).

Many of the most basic gender inequalities that pervade nearly all cultures are deeply rooted in prevailing, entrenched attitudes and norms towards sexual behaviour. It has been made clear in the literature on sexual health and global development that increased access for women and girls to sexual and reproductive health is an essential enabling factor in reaching the goal of gender equality(e.g., U.N., 2005;2006).

Access to services, however, is insufficient. It is necessary to also recognize that the inequitable gender norms and practices enacted in sexual relationships cannot be isolated . from gender equality in wider social, economic, and political relations. In other chapters of this declaration and technical document, female genital mutilation, sexual violence against girls and women, the sexual trafficking of girls and women (see Chapter 3), as well as the disproportionate burdens of HIV/AIDS and STIs that are bourn by women (see Chapter 6) has been amply demonstrated. These expressions of gender inequality related to sexuality cannot be resolved without purposefully addressing the entrenchment within most cultures of gendered norms which essentially place control of sexuality and sexual behaviors in the hands of men.

Several theoretical frameworks emphasize the relationships between gender inequalities and sexuality. (Weeks, 2003; Butler, 1990) A useful framework is in scripting theory (Gagnon, 1990). This theory provides a useful framework for studying and analyzing the cultural construction of gender roles and has been used effectively to examine gender inequality in sexual relations (See O'Sullivan, Harrison, Morrell et al, 2006). Modification of gender inequitable sexual scripts may begin with an affirmation of girls and women's basic human rights to sexual health and gender equality.

The Imbalance of Power: Sexual Scripts for Sexual Behavior Enact Gender Inequality

Gender power imbalances can relate to sexual partnerships (number, timing, choice and social identity of partners); sexual acts (their nature, frequency, voluntary/involuntary); the sexual meanings given to specific behaviors (male/female gender roles related to sexuality, ideal images of manhood and femininity, beliefs about virginity, etc); sexual drives and enjoyment (how they contribute to sexual identity, gender differences in perceptions of sexual pleasure) (Dixon-Mueller, 1993; Spicehandler, 1997). These imbalances of power are played out in a culturally dominant *script* for sexual interaction between men and women and in most contexts the script places the control of sexual activity in male hands. As Dixon-Mueller (1993) puts it, "Interpersonal sexual scripts are played out in the context of hierarchal social structures in which some people have the power to determine the sexual and reproductive lives of others" (p. 279).

Psychological and social elements of reproductive behavior are shaped to some extent by physiology and psychological determinants. Nevertheless, all gender related behavior, including most prominently, sexual activity, is shaped by cultural traditions and expectations. It is these forces that largely write the script for sexual behaviour. In brief, the sexual script is the experiential and behavioral guide that each of us

learns from our culture about how to be sexual (Gagnon, 1990). In most societies, gender and sexual conduct are closely linked and the scripts for how men and women are expected to behave sexually are clearly delineated. As Gagnon suggests,

> Scripts for sexual encounters from the opening phase to the couple separating are now acknowledged to be entirely gendered, with men conventionally expected to conduct themselves assertively, to make the first move and to lead in the subsequent steps, and to be knowledgeable in the ways of sexual practice….Women are expected to be more passive, more compliant at the beginnings of sexual interactions, and pleased and responsive as such interactions progress (p. 15).

O'Sullivan et al., (2006) caution that while some generalizations are possible concerning the applicability of this script, "….it is important to note that such generalizations need to be understood as being contingent on specific specific gender paradigms and sociocultural contexts" (p. 100). Given the wide variety of distinct cultures across the globe, the basic script for heterosexual sexual activity is remarkably consistent across cultures with respect to the gendered power imbalance it enacts. In playing out this dominant sexual script boys and men and girls and women are conforming to typically rigid conceptualizations of masculinity and femininity for which it is often very difficult for individuals to make even subtle personal revisions without risking derision, humiliation, or worse. Wiederman (2005) describes the confining nature of these scripts. For boys and men, the script dictates that they should be goal directed, in control, and assertive in the pursuit of sexual activity and self-pleasure. Girls and women play their complementary role in the script by showing restraint, emphasizing emotional-relational concerns over physical pleasure, but finally ceding control and giving in to male desire.

> That females' standards typically represent a barrier each male must overcome fits well with the competitive and achievement-oriented aspects of masculine gender roles. Masculinity calls for being proactive and able to outdo one's opponent, and unfortunately this is a stance many young men take in relation to early sexual relationships. In many cases, male-female differences in sexual roles set up a dynamic of polar extremes; the more he pushes for sex, the more defensive she has to be, and vice-versa. For many couples, it can seem as though he is obsessed with sex and that she is completely indifferent or disinterested (Wiederman, 2005, p. 498).

Not only do these prevailing ideas constrict people's ability to form mutually beneficial relationships, they also place women and girls in a disadvantaged position with regard to sexual and reproductive health. Dixon-Mueller (1993) gives some apt examples:

> ….cultural definitions of masculinity and femininity influence people's perceptions of the use or nonuse of a contraceptive method – or of such particular methods as condoms or sterilization – as unmanly or unfeminine, quite apart from whether the methods are considered safe or effective. How do people's perceptions of what is masculine or feminine, or of the nature of their sexual relationships, or of the meaning of particular sexual acts influence their decisions about contraception or pregnancy termination? In turn, how does contraceptive use or the experience of abortion – that is the separation of the act of intercourse from its reproductive consequences – affect people's perceptions of their own or their partner's masculinity or femininity, of the quality of their relationships, of the meaning of their sexual acts? (279).

Amaro (1995) points to the various ways in which culturally determined gender roles influence and define the interpersonal relationships in which sexual behaviors occur and the gender inequitable nature of these relationships often places girls and women at much greater risk for negative sexual health outcomes, particularly HIV infection. As an

example, Amaro cites Pleck, Sonestein and Ku's (1993) analysis of large-scale survey data of Black, Latino, and White teenage boys in the United States which found that those who scored higher in traditional masculine ideology were less likely to have sex in the context of an intimate relationship, more likely to view male-female relationships as adversarial, less likely to use condoms, and less likely to believe that it is a male's responsibility to prevent pregnancy.

Studies that have explored and shown the relationships between gender role stereotypes related to sexuality and relationship power and their implications for sexual health have been conducted in many parts of the world but the first study was done in the US (Pulerwitz, Amaro, De Jong et al., 2002), Ghana (Ampofo, 2001), South Africa (Varga, 2003), Mexico (Marston, 2004), Nicaragua (Sternberg, 2000), and Thailand (Tangmunkongvorakul, Kane, & Wellings, 2005). For example, Pulerwitz et al. found that young women in the United States who perceived that they had low levels of power in their relationships were much less likely to use condoms than women who experienced high levels of relationship power. In their study of young people's access to health care in Thailand, Tangmunkongvorakul, Kane and Wellings found that young women's access and standard of care related to sexual health was compromised by gender double standards favoring males and that this led to young women to seek unsafe, clandestine abortions.

In describing gendered expectations for behavior related to sexuality, Ilkaracan and Jolly (2007) illustrate additional examples of the oppressive nature of prevailing gender scripts for both males and females.

> …social influences around sexuality affect us all. Gender is one of those influences, i.e., expectations about how women and men, boys and girls, will behave differently from each other (as well as expectations that everyone will be either male or female, and not transgender). Those who conform to these expectations, such as girls who undergo female genital mutilation or have an early marriage, may suffer to fit their sexualities into limited and unequal channels. Boys may pay a price too. For example, in places as diverse as Turkey, Pakistan and Brazil, many boys are taken to brothels by their fathers, brothers or friends at an early age without feeling willing or ready for such an experience, and sometimes finding it traumatizing (p. 4).

Langen's (2005) research in Botswana and South Africa provides a vivid example of how gender power imbalance in sexual interactions curtail women's ability to protect themselves from HIV infection. Langen concluded from her studies that the public health community must come to see sexual health as "the business of men" not just women because simple educational messages instructing people to "use a condom" are much less effective if they do not address these gender power imbalances. Without the involvement of men and boys in sexual and reproductive health programming, it will not be possible to genuinely empower women and girls. Men and boys must be educated so that they are fully informed of the consequences of their sexual behaviors and encouraged to take responsibility for their own sexual health and take equal responsibility for the sexual health of their partners.

Promoting Gender Equitable Sexuality

It is increasingly recognized that the basic principles of human rights extend to sexual rights (WAS, 1999, WHO, 2004). The issue of gender inequality related to sexuality therefore falls precisely within the realm of human rights (Ilkkaracan & Jolly, 2007). These authors point out that resistance and retrenchment in the area of human rights has frequently been based on the argument that cultural traditions, often specific to gender and sexuality, can be held up to legitimately curtail basic human rights. They also note that appeals to cultural tradition that have been used to justify discrimination against gays and lesbians have also functioned to curtail the sexual autonomy of women. However, the notion that culture tradition ought to limit human rights is waning in many parts of the world. While respect for cultural tradition remains a justifiable priority, progressively larger proportions of the global community are moving towards a recognition of women's right to reproductive and sexual health as evidenced by the ICPD endorsed definition of reproductive health (U.N., 1994) as well as a recognition of the importance of gender equality to global development as evidenced by MDG 3. In other

words, the conditions for meaningful progress in moving towards gender equality in sexuality are increasingly falling into place.

Positive change is possible. An innovative program conducted in Rio de Janeiro, Brazil focused on addressing gender norms among young men as a strategy to reduce HIV risk (Pulerwitz, Baker, Segundo, & Nascimento, 2006). The program combined interactive group education sessions for young men led by adult male facilitators with a community-wide social marketing campaign to promote condom use that emphasized gender-equitable messages. Among the positive findings of the program's evaluation study was that support for inequitable gender norms among young men at baseline was significantly associated with HIV risk behavior, the program was able to effectively promote gender equitable norms, and therefore lower HIV/STI risk. A similar program conducted with men aged 18-29 in Mumbai, India was successful in encouraging young men to critically discuss gender dynamics and health risks as well as in advancing gender equitable norms related to sexuality (Verma, Pulerwitz, Mahendra, et al., 2006). In their study of the gender dynamics in the primary sexual relationships of rural South African women and men aged 18-24, O'Sullivan et al., (2006) found that the traditional sexual script of male assertiveness and control and female passivity predominated but that some young men and women had begun to internalize more gender equitable norms for sexual relationships. The authors note that there is a lack of new models of sexual relationship behavior and that the voices of men and women expressing egalitarian norms could be utilized as peer leadership in sexual health promotion programs.

For girls and women accessing health care, particularly when it is reproductive health care, the issues of sexual partnerships, sexual acts, sexual meanings, and sexual drives/enjoyment should be addressed with individuals as part of the services offered. In some cultures, males may hold their physicians in very high regard and, thus, these professionals may be ideally placed to speak with men and boys about gender equitable norms for sexual behavior. For boys and men who may seek out health care less often or not at all, school-based education, media campaigns, and community opinion leaders influential with males (e.g., sports stars) can be utilized to endorse social/cultural norms that promote gender equality in the sexual realm.

Conclusion: Promoting Change at All Levels of Society

The process of achieving gender equality has been gradual with progress being uneven across the many different cultures of the world. There can be no doubt, however, that among the greatest changes in the social fabric of the world community during the twentieth century was a significant trend to question rigid patriarchal social structures and to move towards more gender equitable societies. In many ways, the strides that many cultures have taken in pursuit of gender equality have been part of a larger process of extending fundamental and basic human rights to oppressed and marginalized communities that have suffered discrimination based upon race, ethnicity, religion, class, gender, sexual orientation, disability, and age. Clearly, the process of attaining basic human rights by all peoples of the world is in its infancy. And, in many cultures the same may be said with respect to the human right of equality for girls and women. In articulating key priorities for global development, the United Nations has definitively recognized the centrality of gender equality, making it one of the eight MDGs. Furthermore, it has been recognized and demonstrated that many of the MDGs (i.e., reduce child mortality, improve maternal health, combat HIV/AIDS) are tied in various ways to the attainment of girls and women's right to sexual and reproductive health. These rights, however, cannot be fully realized without basic equality of power within sexual relationships. Clinical programs related to sexual health can and should address these inequalities. However, such programs, in-of-themselves, cannot bring about the profound social change required to transform the communal and individual level scripts that shapes all aspects of our sexual behavior.

Leadership in advocating for social change with respect to sexuality and gender equality must permeate all levels of society. Political, religious and cultural opinion leaders should advocate for gender equality in all realms of life including interpersonal relationships and sexuality. Fathers and mothers must teach their sons and daughters that equality means that girls and women should have equal power in determining and negotiating sexual behavior

with their partners and that this equality of power extends to all types of sexual relationships including marital relationships. Sexuality education programs taught to youth in schools and other settings must be gender sensitive as well as encouraging participants to think about sexuality and relationships from the standpoint of principles of human rights, including gender equality. Popular entertainment media (music, movies/television, video, internet) is often infused with sexual imagery and the makers of popular media should be encouraged to create representations that model gender equality, not reinforce traditional sexual scripts that perpetuate inequality. In sum, all levels of society must work collectively in order to realize meaningful change in the realm of sexuality and gender equality. Failure to address gender imbalances in sexuality and relationships will cripple broader efforts to promote sexual health and to achieve MDG 3 in particular but also the Millennium Development Goals in general.

Necesssary Actions

2,1 The discourse of rights as it has been applied to the right of girls and women to equality and sexuality education and services in international agreements and covenants must explicitly include the fundamental right to autonomy and equality within sexual relationships.

2.2 Policy makers and public opinion leaders must speak openly of the fact that a substantial and important component of gender inequality is related directly to an imbalance of power in sexual relationships.

2.3 Fathers and mothers and families play key roles in contributing to the formation of the gender roles of their sons and daughters. They should be encouraged and assisted in helping their children to develop gender equitable roles. Fathers, in particular, can be instrumental in encouraging their sons to embody gender equitable conceptions of masculinity.

2.4 To effectively reach their stated objectives sexuality education programs, particularly those aimed at youth, must address the gender-based dynamics within sexual relationships and assist students in developing and implementing gender equitable behavior.

2.5 Media portrayals, whether it is through music or visual representation, frequently model in subtle and blatant forms, sexual scripts for young people. The modeling of gender equitable sexual scripts in popular media has the potential to make a powerful contribution to societal-wide gender equality. The entertainment industry should, therefore, be strongly encouraged by governments and the public at large to become a force for positive change with regard to sexuality and gender.

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Chapter Three [3]

Condemn, Combat, and Reduce all Forms of Sexuality Related Violence

Sexual health cannot be attained until people are free of stigma, discrimination, sexual abuse, coercion and violence.

Introduction

According to the World Health Organization (WHO, 2003) "sexual violence is ubiquitous; it occurs in every culture, in all levels of society and in every country of the world" (p. 1). The victims of sexual violence are young, old, male and female, although women and girls are disproportionately the victims of all types of sexual violence. The individual and societal consequences of sexual violence are vast. A significant reduction, if not eradication of sexual violence will directly impact upon achieving gender equality, improving infant and maternal health, as well as interrupt in a number of ways, the epidemiological spread HIV/AIDS. As such, the fight against sexual violence is an important component of attaining the Millennium Development Goals (MDGs). This chapter will outline the role of reducing sexual violence in achieving the MDGs, define sexual violence, summarize the prevalence and consequences of various forms of sexual violence, and discuss and list strategies and recommendations to reduce sexual violence.

The Role of Reducing Sexual Violence in Achieving the Millennium Development Goals

In a recent report, the WHO (2005a) noted that the connection between preventing violence against women and the MDGs is a reciprocal one. That is, "working towards the MDGs will reduce violence against women; and preventing violence against women will contribute to achieving the MDGs" (p.1). The same WHO report also recognized sexual violence and intimate partner violence (intimate partner violence often includes coerced sexual acts) as fundamental manifestations of the global problem of violence against women. It must be stated and recognized by governments and other public institutions in clear and certain terms that the achievement of MDG 3 (Empower Women and Promote Equality Between Women and Men) and MDG 6 (Reverse the Spread of Disease, Especially HIV/AIDS and Malaria) cannot be achieved without a reduction and eventual elimination of sexual violence. In addition, the rape of girls and women results in unintended pregnancy which, as detailed in other sections of this document, has important implications for the achievement of a number of the MDGs.

Sexual violence negatively impacts upon girls and women's lives in multiple ways, but first and foremost sexual violence prevents girls and women from exercising the most basic and essential human rights. Sexual violence against girls and women not only reflects the profound gender inequality that exists globally, sexual violence also acts as a means of enforcing and perpetuating gender inequality. The centrality of gender equality for sustainable human development has also been firmly established and recognized by much of the international community including various United Nations conferences and declarations such as the 1993 UN *Declaration on the Elimination of Violence Against Women*. The UN *Millennium Declaration* makes the connection through MDG 3. Although gender-based violence must ultimately be addressed as a fundamental issue of human rights, it is relevant in the context of promoting sustainable development to note its economic implications. According to a World Bank report (Bott,

3. This chapter was informed by the background paper written by Ine Vanwesenbeeck. Additional input was informed by the WAS Expert Consultation in Oaxaca, Mexico and feedback from reviewers (see Appendix IV and V)..

Morrison & Ellsberg, 2005) "Gender-based violence poses significant costs for the economies of developing countries, including lower worker productivity and incomes, lower rates of accumulation of human and social capital, and the generation of other forms of violence both now and in the future" (p. 12). Given the centrality of sexual violence as a component of gender-based violence, the issues raised by the WAS declaration on the critical need to eliminate sexual violence and abuse must be addressed and utilized by the international community as a critical and necessary component of the Millennium Development Goals process.

Defining Sexual Violence

The World Health Organization (2002) defines sexual violence as

> any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relation to the victim, in any setting, included but not limited to home and work (p.149).

Sexual coercion, which itself can be seen as a form of violence, can involve physical force, psychological intimidation, blackmail or other threats or may occur when the victim is unable to give consent, for instance when drugged, asleep or mentally incapable of understanding the situation. Other descriptors closely related to sexual violence, sometimes used synonymously, are: gender-based violence, violence against women, and domestic violence. Violence that is perpetrated against a person because of his or her sexuality and/or because of his or her actual or presumed sexual behaviour can also be considered a form of violence. Thus, physical violence and intimidation directed at gay, lesbian, bisexual, and transgendered persons also constitutes a form of sexual violence.

The WHO (2002) specifies 11 different types of sexually violent acts:

- rape within marriage or dating relationships;
- rape by strangers;
- systematic rape during armed conflict;
- unwanted sexual advances or sexual harassment, including demanding sex in return for favours;
- sexual abuse of mentally or physically disabled people; sexual abuse of children;
- forced marriage or cohabitation, including the marriage of children;
- denial of the right to use contraception or to adopt measures to protect against sexually transmitted diseases;
- forced abortion;
- violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity;
- forced prostitution and trafficking of people for the purpose of sexual exploitation (p. 149-150)

Sexual violence is nearly always gender-based and disproportionately directed at girls and women. For example, the UN *Declaration on the Elimination of Violence against Women* includes a definition of violence against women that clearly captures the extent to which sexual violence is involved in the harm of women. The Declaration defined violence against women as

> physical, sexual and psychological violence occurring in the family and in the general community, including battering, sexual abuse of children, dowry-related violence, rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women, forced prostitution, and violence perpetrated or condoned by the state (UN, 1993).

Prevalence of Sexual Violence

The prevalence of various forms of sexual violence is, in many regions of the world, difficult to determine. Most instances of sexual violence are not reported to the police and are not well recorded by survey research. In other words, the scope of sexual violence is not well documented and is vastly underreported. Most of what we know about prevalence and incidence of

sexual violence stems from police statistics, clinical settings and population-based survey research. But there is a wide range of figures reported, depending on the country, setting and/or sample studied, the definitions of sexual violence used and data collection methods and procedures. There is enormous cultural variation in the degree to which individuals are willing and have the capacity to report sexual violence and there is equal variation in the extent to which police departments and governments record the relevant figures.

Paradoxically, higher figures may be reported in countries where sexual violence has been the subject of public debate, where attitudes towards sexuality and sexual violence have become more open, and where awareness of sexual violence among the population has risen. In these countries, acts of sexual violence are more likely to be reported. The prevalence of sexual violence may well be higher in those countries where sexuality and sexual violence are not talked about openly, where being a victim of sexual violence is a source of shame and ostracism, and where some forms of sexual violence are normatively accepted if not condoned. The WHO (2002) *World Report on Violence and Health* notes that, globally, the number of instances of sexual violence reported to police represents only a tip of the iceberg of the actual prevalence and that survey research captures only an additional small percentage of actual cases. Thus, the statistics presented below should be viewed with caution and in many cases significantly under-estimate the magnitude of the problem.

Child sexual abuse and forced sexual initiation

In addition to the limitations discussed above, the prevalence of child sexual abuse (CSA) may be particularly susceptible to under reporting. For example, young children may not recognize the inappropriateness of the act, particularly if the perpetrator is known to them, and disabled children may not have the capacity to report it (Sapp & Vandeven, 2005). Nevertheless, the available data are suggestive of the scope of the problem. According to Sapp and Vandeven (2005) a review of the available research suggests that, world-wide, the prevalence of CSA ranges from 11-32% for females and 4-14% for males and that in the United States studies have found that 22.3% of females and 8.5% of males reported experiencing sexual abuse. A review of the data from sub-Saharan Africa indicated incidence rates of CSA of 7-36% for females and 3-29% for males (Lalor, 2004). In a multi-country study of the Caribbean, close to half of sexually active females reported that their first sexual intercourse was forced (Halcon, Beuhring & Blum, 2000 cited in WHO, 2002).

Sexual assault/rape

According to Tavara's (2006) review of studies from both the developing and developed world examining the prevalence of sexual violence, 10-33% of women of reproductive age have been forced to have sex at least once in their life. In a series of country studies conducted by the UN (cited in WHO, 2002), the percentage of women that reported they had been sexually assaulted in the previous five years ranged from 0.8-4.5% in Africa, 1.4-5.8% in Latin America, 0.3-2.7% in Asia, and 2.0-6.0% in Eastern Europe. There is relatively little data concerning the prevalence of sexual violence against men. According to the WHO (2002) studies from the developed world indicate that 5-10% of men report a history of CSA and a few population-based studies of the percentage of males reporting that they have ever been the victim of sexual assault found prevalence rates of 3.6% in Namibia, 13.4% in Tanzania to 20% in Peru.

Sexual Violence as a weapon of war

Systematic rape as an instrument of war has left millions of girls and women dead, traumatized, forcibly impregnated, or infected with HIV or other STIs. There is little accurate data available concerning the number of girls and women who have been raped as a part of war (Watts & Zimmerman, 2002; Gottschall, 2004). Rape as an instrument of war has existed throughout human history. Using a wide range of sources, Gottschall compiled a partial list of countries where during the 20th century mass rapes were reported to have been conducted by military or paramilitary forces. This list includes Afghanistan, Algeria, Argentina, Bangladesh, Belgium, Brazil, Burma, Bosnia, Cambodia, China, Congo, Croatia, Cyprus, East Timor, El Salvador, Germany, Guatemala, Haiti, India, Indonesia, Italy, Japan, Korea, Kosovo, Kuwait,

Liberia, Mozambique, Nicaragua, Pakistan, Peru, Philippines, Russia, Rwanda, Serbia, Sierra Leone, Somalia, Turkey, Uganda, Vietnam, Zaire, and Zimbabwe.

Intimate partner sexual violence

Intimate partner violence perpetrated by husbands, wives, boyfriends, girlfriends, and ex-partners is extremely common and a large percentage of these assaults are in the form of sexual violence. The WHO (2002) review of population-based studies from around the globe on the percentage of adult women reporting attempted or completed forced sex by an intimate partner at some point in their lives found rates ranging from 6.2% in Yokohama, Japan to 42.0% in Durango, Mexico, 46.7% in Cusco, Peru, 29.9% in Bangkok, Thailand, and 25.0% in Midlands Province, Zimbabwe. A more recent WHO (2005a) multi-site study involving 10 countries found the percentage of women reporting that they had been sexually assaulted by a partner to range from 6% in Japan and Serbia and Montenegro to 59% in Ethiopia with most sites falling between 10% and 50%. A survey of men in Cape Town, South Africa found that 15.3% reported that they had committed sexual violence against an intimate partner in the previous decade (Abrams, Jewkes, Hoffman & Laubsher, 2004).

Trafficking and forced prostitution

Reports published by the United States Department of State (cited in UNFPA, 2005) indicate that between 600,000 and 800,000 people are trafficked each year, the majority for the purposes of sexual exploitation and approximately 2,000,000 children, mostly girls are believed to be sex slaves in the commercial sex industry. These figures do not include women and girls who are bought and sold for sexual exploitation within countries. According to the International Organization for Migration (cited in Watts & Zimmerman, 2002) the number of women trafficked each year, mostly for the purposes of forced prostitution, from different regions of the world is enormous with 250,000 coming from Asia, 100,000 from the former Soviet Union, 175,000 from eastern and central Europe, 100,000 from the Caribbean and Latin America, and 50,000 from Africa. The WHO (2002) notes that significant numbers of trafficked women and girls are sent to North America and Europe.

Female genital mutilation

According to the WHO (2000) between 100 million and 140 million girls have been the victims of female genital mutilation (FGM) (i.e., the partial or total removal of the external genitalia for cultural, religious, or other non-therapeutic reasons) and up to 2 million girls are subjected to the procedure each year. The practice occurs in 28 African countries and is found in parts of the Middle East and Asia.

Consequences of Sexual Violence

The negative impact of sexual violence on the individual victim and on society is wide-ranging and far-reaching. The devastating impact on the victim causes physical and psychological trauma that unfolds in a myriad of ways. Because sexual violence takes many forms and therefore affects victims in a range of ways it is difficult to briefly catalogue and summarize its impact on the individual and society. Discussed below are only some of the many consequences of sexual violence.

Physical consequences

In discussing the impact of sexual violence on the individual it should be recognized from the onset that the victim may well be killed in course of or in the aftermath of a sexual assault. A violent sexual assault may itself cause death or the victim may be subsequently murdered.

Depending on the degree of physical force used, physical trauma, both genital and extragenital, may or may not be evident (Tavara, 2006). The most common types of gential injuries include tears, bruising, abrasions, redness and swelling of the posterior fourchette, labia minora, hymen, and/or fossa navicularis (WHO, 2003). Non-genital physical injuries often include bruises and contusions, lacerations, ligature marks to ankles, wrists, and neck, pattern injuries (i.e., hand prints, finger marks, belt marks, bite marks) and anal or rectal trauma (WHO, 2003).

The short term physical consequences of FGM include severe pain, shock,

haemorrhage, urine retention, and ulceration of the genital region while longer term consequences include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia and other sexual dysfunctions, and difficulties with childbirth (WHO, 2000).

Mental health and psychosocial consequences

The psychological consequences of sexual violence vary considerably from person to person. However, there can be little question that psychological impact of sexual violence on the victim is often severe and debilitating. These short and long-term (lasting for many years) outcomes include rape trauma syndrome, post-traumatic stress disorder, depression, anxiety, social phobias, increased substance use, suicidal behaviour, eating disorders, and sleep disturbances (WHO, 2003).

A number of studies have found an association between sexual assault and the development of sexual dysfunctions among victims which may persist for years. In particular, a review of the literature suggests that many women experience a significant reduction in sexual pleasure and satisfaction and that over the long-term many women experience sexual dysfunctions related to desire and arousal (Van Berlo & Ensink, 2000).

Sexual violence and HIV/AIDS

Although in the Western world HIV/AIDS is sometimes thought of as a disease primarily affecting men who have sex with men, it is important to recognize that globally about half of those living with HIV/AIDS are female. In parts of the developing world, such as sub-Saharan Africa, a majority of persons with HIV/AIDS are female (WHO, 2005b). It is clear that many cases of HIV/AIDS are tied in one way or another to sexual violence against women. The perpetrators of sexual violence rarely use condoms, and because the often physically coercive nature of sexual violence results in genital trauma, victims are at extremely high risk of sexually transmitted infections including HIV infection (Tavara, 2006; WHO, 2003). Studies from Africa clearly demonstrate the link between sexual coercion and increased risk for HIV infection for women (Population Council, 2004). For example, one study from South Africa (Dunkle et al, 2004, cited in WHO, 2005b) found that women who had a violent or controlling partners had an HIV infection rate 50% higher than other women and that abusive men were more likely than non-abusive men to be HIV+.

It is important to understand that sexual violence increases women's HIV risk in multiple ways. As the WHO (2001) report on sexual violence and HIV notes, "This violence can contribute to women's increased risk of HIV infection both directly through forced sex and indirectly by constraining women's ability to negotiate the circumstances in which sex takes place and the use of condoms" (p. 7). A fear of violence can easily prevent a woman from suggesting or insisting on condom use (Maman, Campbell, Sweat, & Gielen, 2000). In addition, the risk for STI and HIV is particularly high for women who have been trafficked for purposes of sexual exploitation (WHO, 2002).

Sexual Violence and Unintended Pregnancy

Rape frequently results in unintended pregnancy (Stewart & Trussel, 2000). For example, a study from the United States found that 5% of rape victims become pregnant as a result of the assault (Holmes, Resnick, Kilpatrick, & Best, 1996) while a study from Ethiopia found that 17% of adolescent women who were raped became pregnant (Mulugeta, Kassaya, & Berhane, 1998 cited in Tavara, 2006). In many parts of the world, girls and women who find themselves pregnant as a result of rape are forced to either have the child or put their lives at risk with "back-street abortions" (WHO, 2002, p, 162). Needless to say, a girl or woman who has given birth to a child as a result of rape has been unable to elect the time when her children are born.

The Context and Root Causes of Sexual Violence

A thorough discussion of the multiple causes of sexual violence is beyond the scope of this brief report. Nevertheless, nearly all of these causes are rooted in an inescapable and fundamental factor that must be grasped and confronted if meaningful progress toward eliminating sexual violence is to occur. First and foremost we must clearly understand and accept that most forms of sexual violence are related to, and occur in the context of gender inequality and that sexual violence against women is more

likely under relatively strong patriarchal regimes. Cross-cultural research provides evidence that the greater the asymmetry in power between the sexes is to the disadvantage of women in a given culture, the more likely control of female sexuality as well as sexual violence against women occurs (Wood & Eagly, 2002).

It is in this context of gender inequality and control that sexual violence must be understood. As summarized by the WHO (2003),

> Sexual violence is an aggressive act. The underlying factors in many sexually violent acts are power and control, not as is widely perceived, a craving for sex. Rarely is it a crime of passion. It is rather a violent, aggressive and hostile act used as a means to degrade, dominate, humiliate, terrorize and control women. The hostility, aggression and/or sadism displayed by the perpetrator are intended to threaten the victim's sense of self (p. 9).

Strategies to Reduce/Eradicate Sexual Violence

Throughout the world, sexual violence is pervasive and deeply rooted. An effective approach to reducing sexual violence must therefore be broadly-based, addressing the issue at the international, national, community, and individual levels of society.

International/National Action and Advocacy

The international community must play a pivotal role reducing sexual violence. International recognition of the scope of the problem and the damaging effects of sexual violence on the individual and on society is an initial first step but such recognition must be followed up by action. International treaties, such as the UN (1979) *Convention on the Elimination of All Forms of Discrimination Against Women* set standards for national legislation and provide a lever to campaign for legal reforms. In particular the shift from a needs-based approach to a rights-based approach to sexual health has been important in relation to sexual violence. The human rights framework has, among other things, helped to officially recognize the experience of violence as a violation of human rights, it has helped challenge the false public/private dichotomy of international law, has provided a feminist vocabulary for international political documents, and has played a role in forming coalitions: "The status of women of all regions and the diverse violations to their human rights, which were previously hidden and silenced, have all surfaced, linking local movements to a global women's movement that continues to grow"(Obando, 2004, online). For further progress to be made, future international treaties and declarations focusing on human rights and/or economic/social development must explicitly recognize, name, and address sexual violence as a significant impediment to human well-being and progress.

National governments, because they possess substantive political and legal power, will play the most important role in eradicating sexual violence. Governments must adopt policies that explicitly recognize the problem of sexual violence. They must introduce and enact effective legislation that makes all forms of sexual violence illegal (e.g., FGM, marital rape) and includes the prosecution and punishment of perpetrators of sexual violence. National governments must also launch public awareness campaigns to discourage sexual violence and promote gender equality. Such campaigns must also encourage the victims of sexual violence to access health care. Such campaigns must also seek to educate and motivate boys and men to resist sexual violence both in their own lives and in the lives of other men.

In some cases, national governments have taken steps to reduce sexual violence (Kelly, 2005: WHO, 2002). For example, some governments have implemented relatively simple measures to encourage the reporting of sexual violence and improve sensitivity among police and judiciary. Some have created dedicated domestic violence units and sexual crime units, employed female examiners/investigators to perform forensic examinations with female victims, used female court officials, and created women-only police stations and courts for rape offences. The WHO (2002) notes that legal reforms in many places have included broadening the definition of rape, reforming rules on sentencing and on admissibility of evidence, and removing requirements for victims accounts to be corroborated.

Health and Education Sector Actions

Health care facilities such as hospitals and clinics must be properly equipped to receive, assess, counsel, and treat the victims of sexual violence. Adequate medical/health services specific to the needs of sexual violence victims are often lacking. Facilities are often not victim friendly and health care providers often lack training in sexual violence and forensic evidence collection. Wide spread dissemination and implementation of the WHO (2003) *Guidelines for Medico-Legal Care for Victims of Sexual Violence* would represent a leap forward in the care of victims of sexual violence.

As noted above, FGM is a form of sexual violence that damages the health and well-being of millions of girls and women. Although it is linked to sometimes deeply held cultural and religious traditions, there is hope that professional and community groups working together can make meaningful progress in discouraging the practice of FGM. The WHO (2002) describes a campaign in Egypt in which government, health organizations, and religious leaders have united in their opposition to FGM. Similar efforts are required in African countries where FGM is still common. To be successful, it will be important that local programs addressing FGM are tailored to the specific cultural and/or religious factors influencing the practice of FGM. The participation of community opinion leaders is vital if such programs are to succeed.

Sexuality education programs for youth, where they exist, very often focus narrowly on HIV/STI and basic reproduction but do not directly address either gender equality or sexual violence. Some progress in being made in providing high quality sexual health education to increasing numbers of youth around the world (See chapter 4). Such programs provide an ideal opportunity to educate youth, during a time in life where basic attitudes and values concerning sexuality are formed, on issues relevant to sexual violence prevention.

Community-Based Actions

There are a wide range of community-based actions involving public health agencies, community groups, media, as well as many others that can play an active role in reducing sexual violence. They are to numerous to adequately address here (see WHO, 2002, 2003) but a few examples that target men are mentioned below.

The media can be used effectively to raise awareness and to campaign against sexual violence. The WHO (2002) cites several examples from South Africa and Zimbabwe where billboards, radio, and television have been used to communicate anti-sexual violence messages. In addition, influential public figures, such as sports stars, need to be increasing utilized to voice opposition to sexual violence and communicate healthy messages concerning sexuality and gender equality to young men. Sports organizations such as the Fédéération Internationale de Football Association (FIFA) are ideally placed to reach hundreds of millions of boys and men around the world with educational messages to combat sexual violence. Involving media and sports organizations in efforts to reduce sexual violence holds considerable promise as they have significant potential to fundamentally transform values and customs that support the culture of sexual violence.

Necessary Actions

3.1 The political-legal domain

- advocate for gender equality and women's human rights
- promote women's economic rights and strengthen the economic position of women
- repeal laws and policies that are discriminatory in relation to gender and sexuality
- challenge political structures and legislation unsupportive of (women's) sexual rights
- promote legislation against sexual violence and harassment
- monitor adherence to international treaties, laws and other relevant mechanisms
- sensitize legal and justice systems to sexual violence and the needs of victims
- disseminate understandable legal information to inform people about their legal rights
- advocate for funding of programmes on gender equality and of sexual health services
- advocate for 'good leadership' and strengthened national commitment
- advocate for an equal distribution of wealth and against war

3.2 The domain of (public health) education
- raise awareness of and campaign against sexual violence
- involve men and offer alternatives to sexually aggressive machismo
- establish public-private partnerships in campaigning against sexual violence
- promote primary prevention of sexual violence
- develop developmental and parent support approaches for the prevention of CSA
- develop and implement comprehensive sexuality education programmes for all, including youth
- involve the education sector and involve youth
- develop and implement well-tailored programmes in specific risky settings
- develop and implement appropriate empowerment and skills-building programmes
- integrate sexual violence into HIV/aids prevention programmes
- make schools safe for girls
- fight homophobia and violence in schools

3.3 The health care domain
- develop a comprehensive health sector response to the impact of sexual violence
- build capacity for integrated sexual health services
- incorporate (responses to) sexual violence in the curricula for health personnel
- promote pre- and in-service training and skills-building for health care workers
- adhere to WHO (2003) standards in support and care for victims
- implement theory based and gender sensitive treatment methods for victims
- implement theory based treatment and relapse prevention methods for perpetrators
- make the health care system safe for women and girls
- fight homophobia, discrimination and stigma in the health care setting

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Chapter Four [4]

Provide Universal Access to Comprehensive Sexuality Education and Information

To achieve sexual health, all individuals, including youth, must have access to comprehensive sexuality education and sexual health information and services throughout the life cycle.

Introduction

As noted at various points in this document, improving, maintaining and promoting sexual health will play a significant and indispensable role in achieving many of the *Millennium Development Goals* (MDGs). The eight goals outlined in *Sexual Health for the Millennium* declaration statement are highly inter-related. Universal access to comprehensive sexuality education is closely related, and indispensable to the other sexual health objectives stated in the declaration all of which have educational components. Individual and community awareness as well as knowledge and acceptance of sexual health issues are pre-requisites for positive change. Universal access to comprehensive and consistent sexuality education is an essential component in the development of any successful strategy to promote sexual health in the new millennium.

As affirmed in the declaration statement, comprehensive sexuality education is a process which ought to ought to occur over the life-span. Our need for sexuality education does not cease with puberty. The life course developmental periods of childhood, adolescence, young adulthood, middle age, and later life are all characterized by different but equally important sexuality related developmental tasks and sexuality education needs (Delamater & Friedrich, 2002). Youth however, warrant special emphasis in our call for universal access to comprehensive sexuality education, particularly with respect to the proposition that wide-spread implementation of sexuality education programming will make a meaningful contribution to the MDGs. It is also important because the provision of high quality sexuality education to children and youth offers a foundation for knowledge, attitudes and skills that are essential to the attainment of optimal sexual health, which can evolve with their changing needs through out the life span.

Due to nearly universal access to schooling for youth in the developed world, schools are often viewed as the ideal forum for implementing sexuality education. In the developing world, on the other hand, access to schooling has traditionally been severely limited with unequal opportunity according to gender, income and geographic location. School-based sexuality education, therefore, held little promise of reaching a plurality of youth in many communities. However, this is changing. As documented by Loyd (2006), in her background paper for the U.N. Millennium Project, more and more young people in developing countries, especially females, are attending school up to and through the pubertal years. As Loyd illustrates, school attendance in-it-self can have beneficial implications for sexual and reproductive health. Just as importantly, the rapid growth of school attendance, although access is still far from universal, presents a tremendous opportunity to scale up

4. This chapter was informed by the background paper written by Doortje Braeken and Melissa Cardinal. Additional input was informed by the WAS Expert Consultation in Oaxaca, Mexico and feedback from reviewers (see Appendix IV and V).

comprehensive sexuality education. It is crucial that as school systems are created and expanded, renewed and reformed, comprehensive sexuality education takes place as a component of the core curriculum. Justification for inclusion will rest, in part, upon demonstrating the links between sexuality education and sexual and reproductive health and community development as envisaged by the MDGs.

With respect to general education, the primary purpose of educating children is to prepare them for life. Hence, we teach them to read, write, problem solve, think creatively etc. These are the skills they will use throughout their life times. With respect to sexuality education more specifically, the information and skills people acquire as children and youth will influence their choices and impact on their general sexual health as adults. Childhood, puberty and adolescence are critical periods for the development of sexuality. Basic knowledge, formative attitudes, and healthy practices that are learned before or as sexual activity begins are much more likely to be carried forward consistently and into adulthood. For example, there is evidence to suggest that young people who use condoms the first time they have intercourse are significantly more likely to use condoms when they are older compared to those who have first intercourse without condoms (Klavs, Rodrigues, Wellings, et al., 2005; Shafii, Stovel, Davis et al., 2004). Thus, it is vital that youth be reached with comprehensive sexuality education before becoming sexually active because for many youth around the world, first sexual intercourse, if it is voluntary, can and does occur anytime after the onset of puberty. It is also important that school-based comprehensive sexuality education is linked to complementary education that occurs in the community and in the home.

Comprehensive Sexuality Education in the Context of Global Sexual Diversity

To say that the global community is far from unified with respect to sexual values, beliefs customs, and patterns of behavior is to state the obvious. This diversity warrants sustained recognition and consideration in the formulation of strategy and policy directed towards developing and implementing comprehensive sexuality education programs that contribute on a global scale to the attainment of the MDGs.

> Matters related to sex and reproduction are sensitive – enmeshed in issues of culture and ideology of social institutions and personal identities. In many countries, various cultural groups have different understandings and positions on SRH (and on associated service provision). Public discussion and attention may be limited so political divisions can be avoided or because there is stigma attached. SHR has only become a fit topic for international discussion and consensus within the last 10-15 years (UN Millennium Project, 2006, p. 4).

This observation gives us just a taste of the unique culturally specific contexts in which sexuality education programs for youth occur – or don't occur – across the globe. The substance and character of these programs, or the lack of them, are often a very clear and precise reflection of the cultural beliefs towards sexuality that exist in the community. Clearly, religious, political, and social-moral stances on sexuality divide the global community and this is a fundamental obstacle to a unified, shared approach to the development and implementation of the comprehensive sexuality education necessary to impact on not only the HIV/AIDS epidemic but on a host of other issues such as gender equality and family planning. A very basic international unity of approach and recognition of the need for comprehensive sexuality education is required to underpin international agreements pertaining to sexual and reproductive health and rights, to secure funding for programs, to share expertise, and to ensure community engagement, active participation and ownership of programming. Given the vast cultural diversity of beliefs related to sexuality, where do we begin in developing a global strategy for comprehensive sexuality education?

Germain and Woods (2005) in writing about the need for an integrated approach to HIV prevention note that "Global politics do not make HIV prevention strategies easy or straightforward to operationalize" (p. 59). They propose, following the lead of the 2005 UNAIDS Prevention Strategy, that prevention programs be grounded in the components of human rights,

comprehensiveness, and an evidence base. A platform incorporating these three components for proposing universal access to high quality, comprehensive sexuality education follows.

Human and Sexual Rights

Existing commitments by governments to human rights and non-governmental agencies to sexual rights provides us with a substantive and workable beginning point to advocate for universal access to comprehensive sexuality education within a broader framework of sexual health promotion. As noted elsewhere in this document, the WHO (2005) *Working Definition of Sexual Rights* states that sexual rights based upon already recognized national laws and international human rights documents includes the right of all persons, free of coercion, discrimination and violence to, among other things, obtain information about sexuality and receive sexuality education.

The call for universal access to comprehensive sexuality education is inseparable from, and a key component of the demand to respect and promote human and sexual rights. It is the recognition of basic human and sexual rights that must provide the philosophical foundation for a global perspective on comprehensive sexuality education. As discussed in more detail below, care must be taken to not inject external presumptions concerning either the meaning and purpose of human sexuality or the precise definition of comprehensive sexuality education that go beyond the basic rights that have been the basis for international agreement. These conceptions must be internally derived within the specific ethno-cultural communities in which sexuality education is to be provided.

Comprehensiveness

In describing comprehensive sexuality education, SIECUS (2001) specifies a number of key concepts such as human development, relationships, personal skills, sexual behavior, sexual health and society and culture. Very often the term comprehensive sexuality education suggests that programs aimed at sexual risk reduction address both delay of first intercourse or abstinence and condom/contraceptive use as viable preventive measures. In this sense, the term comprehensive sexuality education is simply used as a way of distinguishing such programs from so-called "abstinence-only" programs which only promote refraining from sexual activity and do not address other options, such as condom use, for people who are or who will become sexually active. However, comprehensive sexuality education is a much broader term which implies a rights-based approach that takes into account gender and is culture sensitive.

Together, the rights articulated in the WHO (2004) *Working Definition of Sexual Rights* emphasize access to sexuality information and autonomous decision-making. As stated above, and for the purpose of this section, the definition of comprehensive sexual health education is one which includes and respects basic human rights, provides broad based and accurate information and enables motivational and skill building opportunities which enable individuals to make autonomous, informed decisions about their sexual and reproductive health. In many western countries and some developing nations these ideas and what they imply for the specifics of sexuality education programs are well articulated and suitable for those cultures (see, for example, SIECUS, 1991; Health Canada, 2003). The Pan American Health Organization (PAHO, 2000) has made the provision of comprehensive sexuality education to the population at large one of its stated goals in promoting sexual health. The PAHO recommendations include a specific nine-point outline of the meaning and purpose of comprehensive sexuality education that are consistent with a human and sexual rights perspective and can be effectively applied to that region. In many other countries and regions, culturally specific and appropriate conceptions of comprehensive sexuality education have yet to be specified as the foundation for programming that reach large numbers of youth. Initiatives to do so will be essential in establishing universal access to comprehensive sexuality education.

In some countries, but most particularly in the United States, funding and advocacy for abstinence-only sexuality education programs is widespread. If we agree that the ethical foundation of comprehensive sexuality education is rooted in basic human rights and sexual rights that confer to each individual the indisputable right to autonomous and informed decision making, then we must also agree that abstinence-only programs fall out side this basic ethical perspective. Programs that, by design, withhold the information necessary for individuals to

make voluntary, informed decisions are unethical and from the perspective of sexuality education presented here, a violation of human rights. Abstinence-only programs have been repeatedly shown to be ineffective in promoting and sustaining behavioral change. In addition a large majority of abstinence-only sex education programs have been shown to be ineffective in preventing sexual activity or in reducing HIV/STI or unintended pregnancy. While a few abstinence-only programs have been shown to modify attitudes towards abstinence and sexual behavior over short periods of time (up to six months), no evaluated abstinence-only program has resulted in delayed intercourse among abstinence program participants over longer periods of time compared to control groups or groups receiving broad-based sexual health education (Bennett & Assefi, 2005). Despite U.S. federal government backing, including hundreds of millions of dollars in funding, a recent review of program evaluations designed to measure the impact of abstinence-only interventions implemented in the United States shows that they are not only ineffective but potentially detrimental to public heath.

> Abstinence-only programs show little evidence of sustained (long-term) impact on attitudes and intentions. Worse, they show some negative impacts on youth's willingness to use contraception, including condoms, to prevent negative sexual health outcomes related to sexual intercourse. Importantly, only in one state did any program demonstrate short-term success in delaying the initiation of sex; none of these programs demonstrates evidence of long-term success in delaying sexual initiation among youth exposed to the programs or any evidence of success in reducing other sexual risk-taking behaviors Abstinence-only programs show little evidence of sustained (long-term) impact on among participants (Hauser, 2004, p. 4).

Given the evidence noted above, funding and implementing abstinence-only programs should be considered as a poor use of valuable human and financial resources which could be deployed to the planning, implementation and evaluation of coordinated, cost-effective, evidence based programming. The abstinence-only approach restricts the provision of information to one specific strategy for HIV/STI and unintended pregnancy prevention, purposefully excluding information that can be utilized by those who are or inevitably will become sexually active. Thus, the abstinence-only approach is exclusionary, reflecting a narrow and specific point of view The comprehensive approach, on the other hand, is conceptually inclusive rather than exclusive, presenting information on multiple strategies (including abstaining from sexual activity, delaying first intercourse, reducing the number of sexual partners, as well as practicing safer sex) for HIV/STI and pregnancy prevention. In contrast to abstinence-only programs, comprehensive sexuality education programs ensure that decisions about whether to have sex or not, decisions about if and when to have children, and decisions about how to protect oneself and one's partner from HIV/STI are informed decisions based on choices that all people, including youth, have a right to make based on their own self-defined values as well as the values of their families and communities. As opposed to the ineffectiveness of abstinence-only programs in reaching their behavioral objectives, there is evidence to suggest that more comprehensive sexuality education programs are able to help youth who have not been sexually active, to delay first intercourse (e.g., Jemmott, Jemmott & Fong, 1998). That comprehensive sexuality education is likely to be more effective than abstinence-only programming in enabling youth to delay first intercourse may well be due to the fact that well developed comprehensive sexuality education programs engage youth in the process of informed decision making, enabling them to actively make choices to protect and enhance their sexual health. Abstinence-only programs discourage youth from weighing alternatives and making choices based on their own realities, needs, traditions, and values.

Evidence-Based Sexuality Education

The objectives of HIV/STI prevention and, perhaps to a slightly lesser extent, unplanned pregnancy prevention are included in all conceptualizations of comprehensive sexuality education programs for youth across the globe. Certainly, it is in meeting these objectives that universal access to

comprehensive sexuality education contributes most significantly to attaining the MDGs.

There is growing and unequivocal evidence derived from peer-reviewed published studies evaluating the behavioral impact of well designed sexual health interventions that leads to the definitive conclusion that such programs are capable of significantly reducing sexual risk behavior among youth (For reviews of this literature see Alford, 2003; Bennett & Assefi, 2005, Jemmott & Jemmott, 2000; Kirby, 2000; 2001; 2005).

With respect to HIV/AIDS prevention specifically, there is also clear definitive evidence that educational interventions have the potential to significantly reduce high risk sexual behaviour among individuals, including youth. Albarracin, Gillete, Earl et al. (2005) conducted a comprehensive review and meta-analysis of 354 HIV prevention interventions implemented from 1985 to 2003 in 33 different countries. Collectively, the interventions were shown to have increased knowledge of HIV, as well as increase positive attitudes toward condom use, change norms and intentions, improve behavioral skills, and increase actual condom use. The Albarracin et al., analysis also revealed effective prevention education strategies for different groups including youth. More generally, there is an extensive body of HIV/STI prevention evaluation research indicating positive behavioral outcomes for interventions targeting adolescents, street youth, STI clinic patients, women, heterosexually active men, men who have sex with men, and communities (CDC, 2001; McKay, 2000).

The vast majority of the HIV/STI and pregnancy prevention evaluation literature concerning youth examines interventions implemented in the developed world (i.e., United States and Europe). However, evidence of the effectiveness of prevention interventions from the developing world is growing. In a recent review of controlled studies in both the developed and developing world that employed experimental or quasi-experimental designs to evaluate the impact of sexual health and HIV education programs on the sexual behavior of youth, Kirby, Laris, & Rolleri (2005) identified programs from Brazil, Thailand, Kenya, Nigeria, Belize, Mexico, Chile, Tanzania, and Nambia that either helped individuals delay first intercourse, reduce their number of sexual partners, or increase condom use. Wang, Hertog, Meir, et al. (2005) reported on a comprehensive sexuality education program in China that resulted in increased condom and contraceptive use.

The literature providing evidence of the effectiveness of comprehensive sexuality education is compelling but it should not be construed as suggesting that all existing or prospective programs will be effective in reaching their objectives. One of the crucial lessons that we must learn from past experience is that there is no generic form of all-purpose sexuality education that can be effectively applied to all audiences or contexts. We must learn from both our successes and failures in order to create the most effective programs possible. Fortunately, we have already learned a great deal about the necessary ingredients of effective sexuality education. For example, a review and analysis of the existing literature (e.g., Albarracin et al., 2005; Fisher & Fisher, 1998; Kirby, 2005) suggests that programs are most likely to reach their behavioral objectives if they contain the following ten key components:

1. Include a realistic and sufficient allocation of instructional time and financial resources.
2. Provide educators with the necessary training and administrative support to deliver the program effectively.
3. Employ sound teaching methods including the utilization of theoretical models to develop and implement programming (e.g., IMB Model, Social Cognitive Theory, Transtheoretical Model, Theory of Reasoned Action).
4. Use elicitation research to ascertain student characteristics, needs, and optimal learning styles. This includes tailoring instruction to student's ethnocultural background, sexual orientation, and developmental stage.
5. Specifically target negative sexual health outcomes such as HIV/STI infection and unintended pregnancy.
6. Deliver and consistently reinforce prevention messages related to sexual limit setting (e.g., delaying first intercourse, abstinence), consistent condom use and other forms of contraception.
7. Include program activities that address the individual's social and

environmental context including social pressures to engage in unhealthy sexual behaviors.
8. Incorporate the necessary information, motivation, and skills to effectively enact and maintain healthy sexual behaviors.
9. Provide clear examples of and opportunities to practice (e.g., role plays) sexual limit setting, condom negotiation, and other communication skills. In effective programs, individuals are active participants, not passive recipients.
10. Employ appropriate evaluation tools to assess program strengths and weaknesses in order to enhance subsequent programming.

Necessary Actions

Urge national governments and regional and local educational authorities in all countries to:

4.1 Mandate comprehensive, rights-based, gender-sensitive and culturally-appropriate sexuality education as a required component of the school curricula at all levels and provide the required resources.

4.2 Work with community agencies to reach out of school youth and other high risk populations with comprehensive sexuality education.

4.3 Issue guidelines to ensure that sexuality education programs and services are grounded in the principle of fully informed, autonomous decision-making.

4.4 Ensure that sexuality education programs are evidence-based and include the characteristics that have been shown to contribute to effectiveness. This should be done in a way that allows for creativity and community specific needs in the development and evaluation of innovative programs.

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Chapter Five [5]

Ensure that Reproductive Health Programs Recognize the Centrality of Sexual Health

Reproduction is one of the critical dimensions of human sexuality and may contribute to strengthening relationships and personal fulfillment when desired and planned. Sexual health is a more encompassing concept than reproductive health. Current reproductive health programs must be broadened to address the various dimensions of sexuality and sexual health in a comprehensive manner.

Introduction

Sexuality is among the most fundamental aspects of our lives and yet it has long been the silent partner in sexual and reproductive health (SRH) programming. To begin with, securing the recognition that promoting reproductive health is an important and legitimate component of the sustainable development of communities and societies has been slow, uneven, and tenuous. Furthermore, conceptually uniting sexual health with reproductive health under the unitary banner of Sexual and Reproductive Health has, particularly in the international development dialogue, been particularly inadequate. Agreement upon and implementation of high quality sexual and reproductive health programming has often been sacrificed to political, religious, and ideological interests; the end result being the considerable, but avoidable, increased morbidity, mortality and infringement of fundamental human rights.

This chapter provides an overview of the growing recognition that access to sexual and reproductive health care is necessary in order to reach the United Nations Millennium Development Goals (MDGs). This is followed by a discussion of the lack of a positive approach to human sexuality in reproductive health programming, the importance of fully integrating sexuality and sexual health within such programming, and the necessity to adequately train health care providers in human sexuality and sexual health.

The Recognition of Access to Sexual and Reproductive Health Care as Essential to Global Development

The 4th International Conference on Population and Development (ICPD) held in Cairo, Egypt in 1994 and attended by government representatives from 179 countries has been accurately described as a "watershed" in international agreement and acceptance of the concepts of reproductive rights and sexual and reproductive health (Haslegrave, 2004). The conference attendees not only collectively called for universal access to sexual and reproductive health services by 2015, the ICPD definition of reproductive health produced at the conference represented a quantum leap forward in recognizing and understanding the true breadth of reproductive health and the degree to which sexual health and reproductive health are a single entity that cannot be segmented. The definition of reproductive health developed at the ICPD conference appeared to make explicitly clear that sexual health cannot be ignored or extracted from the concept of reproductive health. Not only was reproductive health now legitimately recognized as crucial to the development process, but sexual health was recognized as being inextricably interwoven with it. The full definition of reproductive health that emerged from ICPD bears repeating here:

> Reproductive health is 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

5. This chapter closely follows the background paper written by Victoria Ward and Angela Heimburger. Additional input was informed by the WAS Expert Consultation in Oaxaca, Mexico and feedback from reviewers (see Appendix IV and V).

> reproductive system and to its function and processes. Reproductive health therefore implies that people are able to have satisfying and safe sex life and that they have the capability 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 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. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (UN, 1995).

Among the significant aspects of the ICPD definition of reproductive health was that it did not incorporate sexual health only in terms of fertility control and STI/HIV prevention but also conceptualized sexual health in terms of "enhancement of life and personal relations" and a "satisfying and safe sex life". In other words, the ICPD definition of reproductive health went beyond looking at sexual health simply as a matter of problem prevention and progressively defined it in positive terms. This represented an important shift away from the traditional negatively oriented approach to sexuality to a more positive, life enhancement approach that had long been advocated by health promotion workers addressing reproductive health.

Despite the advances in conceptualizing sexual and reproductive indicated by the ICPD definition, as Correa and Parker (2004) have observed, "…since Cairo, sexuality has increasingly been ignored in (or taken off) the reproductive health agenda" (p. 20). To compound the situation further is the seeming de-emphasis of reproductive health more generally within the global development agenda as evidenced most profoundly be the omission of sexual and reproductive health from the Millennium Development Goals (MDGs) (Glasier et al., 2006). This despite the fact that advances in sexual and reproductive health are so clearly necessary if the overall objectives of the MDGs are to be achieved. Various explanations for the de-emphasis or outright disappearance of sexual and reproductive health have been proffered, ranging from the notion that the ICPD conceptualization of reproductive health was too ambitious to the prioritization of HIV/AIDS in the global health agenda. Others have been more forthright. Glasier et al., (2006) state emphatically that

> Sexual and reproductive health services are absent or of poor quality and underused in many countries because discussion of issues such as sexual intercourse and sexuality make people uncomfortable. The increasing influence of conservative political, religious, and cultural forces around the world threatens to undermine progress made since 1994, and arguably provides the best example of the detrimental intrusion of politics into public health (p. 1).

Fortunately, a number of positive developments have occurred since the exclusion of explicit reference to sexual and reproductive health in the Millennium Declaration. Firstly, several influential non-governmental organizations have issued extensive, research-based reports demonstrating the importance of addressing sexual and reproductive health in order to achieve the MDGs. These included the Alan Guttmacher Institute report *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health* (Singh, Darroch, Vlassoff, & Nadeau, 2003) and Family Care International's (2005) *Millennium Development Goals and Sexual and Reproductive Health*. The

World Health Organization has also played a key role in re-establishing the centrality of reproductive health with it's *Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets* (WHO, 2004a) and more recently, *Accelerating Progress Towards the Attainment of International Reproductive Health Goals: A Framework for Implementing the WHO Global Reproductive Health Strategy* (WHO, 2006). Most importantly, world leaders officially recognized that providing access to reproductive health services as envisaged by ICPD was necessary in order to make progress toward attaining the MDGs as outlined in the *World Summit Outcome* document (UN, 2005).

Finally, this work has culminated in the United Nations (2006) report *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals.* This report acknowledges clearly and explicitly that improved access and delivery of sexual and reproductive health services will significantly contribute to combating HIV/AIDS, promoting gender equality, improving maternal and child health, and fighting poverty. The report specifically recommends incorporating sexual and reproductive health into both national poverty reduction campaigns and national health systems as well as provides an outline of strategies to accomplish these goals.

In sum, although the years following the watershed ICPD conceptualization of reproductive health, that placed sexual health front and center within it, was followed by disappointment, particularly with the exclusion of sexual and reproductive health from the MDGs, recent years have seen significant progress in the re-emphasis of sexual and reproductive health as an instrumental part of the global development process. In addition, it has been noted that access to and delivery of reproductive health services has improved in many parts of the developing world (Haslegrave, 2004; Langer, 2006; UN, 2006). For example, Haslegrave points out that,

> Countries such as Mexico, Ghana, South Africa and Thailand, to name only a few examples, have show considerable success in integrating sexual and reproductive health care into primary health care. In doing so, they have shown that sexual and reproductive must be seen within the context of health in general and not as a separate component. Sexual and reproductive health must be considered in this way so as to ensure that it continues to be regarded as part of "mainstream" health services (p. 16).

Glasier et al. (2006) note that sexual and reproductive health is now fully recognized as being essential for achieving the MDGs, that the World Summit reaffirmed the goals of universal access to reproductive health care by 2015, and that if these two developments are translated into actions, significant progress in sexual health promotion is possible.

The Disconnect Between Reproductive Health Care and a Positive Approach to Sexuality

As the ICPD definition of reproductive health makes clear, reproductive health entails much more than reproductive function, fertility control, and the prevention of STI/HIV, it also includes the "enhancement of life and personal relations". In terms of its impact on human development, the function of human sexuality extends well beyond reproduction as it plays a pivotal role in interpersonal relationships as an expression of intimacy and affection and sexuality is potentially a source of immense pleasure that contributes significantly to quality of life for many people. Sexuality and sexual health are pertinent throughout the lifespan, not just during the reproductive years. Sexuality and sexual health are central to all people whether they are homosexual, bisexual, or heterosexual and whether they reproduce or not. In reality, sexuality should not be viewed as a component of, or add-on to reproductive health. Rather, reproductive health is more accurately seen as one key aspect of a broader, more encompassing sexual health.

The integration of sexuality into public health generally and reproductive health specifically is to conceptualize and define sexuality as a matter of health and well-being rather than as something that should be seen in terms of morality (see Giami, 2002). While public health approaches to sexuality have not excluded moral concerns and have emphasized the importance of equitable and mutually respectful behavior, the acceptance of sexual and reproductive health programs

continues to meet ideological resistance. As Langer (2006) points out with regard to successes and setbacks for ICPD,

> Increased conservatism in some donor countries has taken a heavy toll on the efforts to advance the international agenda on sexual and reproductive health and rights. Indeed, contrary to scientific evidence, conservative forces interpret the ICPD Programme of Action's call for information and services for young people as promoting promiscuity and irresponsible behaviour….This situation exposes millions of women, men, and young people to HIV/AIDS, unwanted pregnancies, and unsafe and illegal abortions (p.1553).

T he disconnect between sexual health and reproductive health is clearly grounded in a traditional and deeply rooted negatively oriented conceptualization of the nature and purpose of human sexuality. Within this paradigm, sexuality and sexual health are not often discussed openly between health care providers and their clients; and at the public policy level, in many cases, initiatives aimed explicitly at sexual health are themselves taboo.

At another, but equally important level, when and where the concept of sexual and reproductive health has been recognized as a legitimate aspect of public health, it has been overwhelmingly oriented towards a conceptualization of human sexuality that emphasizes negative outcomes rather than positive outcomes such as satisfactory sexual activity and relationships. Clearly, the sole emphasis on preventing negative outcomes is more congenial to ideological perspectives that fear that integrating positive outcomes will subvert traditional conceptions of sexual morality. This has led, in many respects, to a desexualization of many reproductive health programs. Parker, DiMauro, Filiano and Garcia (2004) discuss the distinction between negative sexual rights and positive sexual rights; negative sexual rights concern freedom *from*, for example, violence and abuse, whereas positive sexual rights concern freedom *for*, for example, sexual expression and pleasure. Parker et al., note that it has been far easier to advance negative sexual rights than positive sexual rights. To fully integrate sexual health with reproductive health requires that programming appropriately balance positive and negative sexual rights.

Another difficulty that predisposes the sexual and reproductive health field towards a focus on negatives outcomes is that negative outcomes are, in most cases, far easier to quantify and measure as compared to positive outcomes. For example, the incidence and prevalence of sexually transmitted infections can be objectively measured in a number of ways whereas individual's necessarily subjective assessments of their own sexual well-being including improvements in sexual and relationship satisfaction are far more difficult to measure. As the UN (2006) report on sexual and reproductive health puts it, attaining good health is much more than simply avoiding diseases, and this is more the case with respect to sexuality than in other aspects of health:

> Indeed, much of our personal identity as well as our social and personal relationships hinge on this part of our lives – which is closely related to our overall health and well-being. Today's measurement tools are not able to capture such positive aspects of health and well-being (p. 32).

Putting the Sexual back into Sexual and Reproductive Health

As Parker, et al., (2004) point out "Currently, feminists, gay and lesbian activists, and HIV/AIDS nongovernmental organizations (NGO) are fighting to extend the definition of sexual rights to the enablement and even celebration of sexual diversity and sexual pleasure" (p. 368). And, there have been some successes: the focus on positive sexuality in the ICPD definition of reproductive health being first and foremost. Although not an official policy of the organization, it is encouraging that the WHO (2004b) working definitions of sexual rights includes the right to "pursue a satisfying, safe and pleasurable sexual life" (p. 3) as this may enhance the focus on positive sexual health outcomes for sexual and reproductive health programmers who look to the WHO for guidance. We are increasingly seeing more balance between negative outcomes and positive outcomes in approaches to sexual and reproductive health. For example, Health Canada's (2003) *Canadian Guidelines for Sexual health Education* conceptualize sexual health

education as being aimed both at sexual health behavior to prevent sexual problems (i.e., unwanted pregnancy, STI/HIV, sexual harassment/abuse, sexual dysfunction) as well as "sexual health enhancement" (e.g., positive self-worth and self-image in acceptance of one's own sexuality, integration of sexuality into mutually satisfying relationships) (p. 15).

Equally significant is the growing awareness and understanding that "pleasure and prevention" go hand in hand. that recognizing, accepting, and incorporating the fact that people experience sexual desire and seek sexual pleasure into programs aimed at sexual and reproductive health problem prevention will contribute to the effectiveness of such programs (Philpott, Knerr, & Boydell, 2006; Philpott, Knerr, & Maher, 2006). Programs and services addressing reproductive health must fully recognize and account for the reality that reproductive health is deeply and inextricably linked to sexuality and that our sexuality is an expression of our human desire for pleasure and interconnection with others.

The growing recognition that sexual health and reproductive health are inseparable as evidenced by ICPD and that the promotion of sexual and reproductive health is an important in striving to achieve the MDGs as evidenced by the UN (2006) *Public Choices, Private Decisions* document are extremely positive developments. But, as noted previously, most societies around the world are primarily sex negative in orientation and/or anxiety ridden with respect to sexuality. And not surprisingly, as a result, many reproductive health care providers and their clients are uncomfortable with the prospect of discussing what has often been a highly taboo subject. Despite the fact that this culturally imposed silence around sexuality has served to increase the potentially negative outcomes of not addressing sexuality in reproductive health programs, very few reproductive health care providers have been trained specifically address sexuality issues with their clients.

The importance of training reproductive health care workers to fully integrate issues of sexuality in their work has been recognized by the Pan American Health Organization (PAHO) (2000) *Promotion of Sexual Health*: *Recommendations for Action*. According to PAHO, "Due to the obvious connection between reproductive health and human sexuality, it is often assumed that taking care of the reproductive aspects of health will be enough to satisfy the needs posed by the right to sexual health, but this assumption is incorrect" (p. 43). The PAHO recommendations indicate that reproductive health care workers require in-depth training in human sexuality and suggest that sexual health training curricula be adapted to the cultural context in which they are delivered but that the curricula should, at a minimum include:

- Basic knowledge of human sexuality
- Extensive knowledge in human reproduction and the means for its regulation that takes into account broader sexual rights concerns
- Awareness of personal attitudes towards one's own and other people's sexuality which should include a respectful attitude towards persons with different sexual orientations and sexual practices
- Basic skills in identifying, counseling and, if necessary, referring to the appropriate professional, problems of sexual health (p. 44).

Necessary Actions

The integration of sexuality and reproductive health within reproductive health programs has, despite notable setbacks, advanced considerably in recent years. The ICPD definition of reproductive health clearly established the inherent interconnection of sexual health and reproductive health. Although the exclusion of reproductive health from the MDGs was regrettable, the omission has been substantially rectified by the UN (2005; 2006) recognition that promotion of sexual and reproductive health is necessary in order to achieve the MDGs.

The UN (2006) *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals* sets out an operational strategy and a comprehensive series of recommendations including,

- Integrating sexual and reproductive health analyses and investments into national poverty reduction strategies
- Integrating sexual and reproductive health services into strengthened health systems

- Systematically collecting data pertinent to sexual and reproductive health
- Acting on the UN Millennium Project reproductive health Quick Impact initiative.
- Meeting the sexual and reproductive health needs of special populations with unmet needs (e.g., adolescents, men)

These recommendations are laudable and necessary and success in reaching the MDGs will be significantly dependant on the extent to which they are reflected in policy that is translated into concrete action. Furthermore, the relevance to people's lives, as well as effectiveness and success of these initiatives will be dependant upon the degree to which sexuality and sexual health issues are recognized and integrated with reproductive health in programming.

The following are necessary actions to be taken:

5.1 Government and transnational policy and policy statements regarding reproductive health funding and mandating of services must include, in accordance with ICPD, specific reference to sexual health.

5.2 Sexual and reproductive health programming should include a clear commitment that such programming will fully reflect and incorporate the WHO working definitions of sexual rights.

5.3 Sexual and reproductive health programming should recognize and reflect the positive aspects of human sexuality and be aimed in a balanced way towards positive as well as negative outcomes.

5.4 All reproductive health providers should receive, through pre-service and in-service training the knowledge, comfort level, and skills to effectively address sexuality and sexual health in their work.

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Chapter Six [6]

Halt and Reverse the Spread of HIV/AIDS and Other Sexually Transmitted Infections (STIs)

Universal access to effective prevention, voluntary counseling and testing, comprehensive care and treatment of HIV/AIDS and other STI are equally essential to sexual health. Programs that assure universal access must be scaled up immediately.

Introduction

The importance of addressing HIV/AIDS as a fundamental and necessary component of the global development process is clearly recognized and accepted by the international community as evidenced by the *United Nations Millennium Declaration* (UN, 2000) and the eight Millennium Development Goals (MDGs) which include specific reference to the need to reverse the spread of HIV/AIDS. The majority of the over 4 million HIV infections that are currently acquired every year are sexually transmitted, primarily through unprotected sexual intercourse. This fact places sexual health promotion, particularly through interventions intended to reducing risk of exposure to the virus without hampering sexual satisfaction and wellbeing, front and center in the broader effort to stem the HIV/AIDS epidemic and achieve the MDGs.

This chapter begins by documenting the extent and impact of sexually transmitted infections (STI) and HIV/AIDS on the global community with particular emphasis on the developing world. Evidence for the behavioural and cost-effectiveness of STI/HIV prevention and control programming will be presented. In particular, the effectiveness of STI/HIV sexual risk reduction interventions is stressed. Insufficient availability of effective programs along with a lack of access to methods of prevention (e.g. condoms) represent an important obstacle to efforts to contain and reverse the STI/HIV epidemics that are striking the developing world. The importance of respecting the right to informed decision making and the empowerment of young people, women, and men in all aspects of the funding, implementation, and promotion of STI/HIV prevention is discussed. This chapter concludes with recommendations that emanate from this discussion presented in conjunction with UNAIDS (2007) policy recommendations for HIV prevention.

HIV/AIDS: The Numbers Tell the Story

A comprehensive report on global HIV/AIDS statistics is presented in the UNAIDS *2006 Report on the Global AIDS Epidemic*. The numbers clearly indicate the extent to which HIV/AIDS represents a global health calamity and an immense obstacle to development. According to WHO (2006) and UNAIDS (2006) it is estimated that by the end of 2005, between 33.4 million and 46.0 million people were living with HIV, an estimated 4.1 million adults and children became newly infected with HIV in 2005 and approximately 2.8 million people died of AIDS. In sub-Saharan Africa, the region with the largest burden of HIV/AIDS, it is estimated that 24.5 million people aged 15-49 years is infected with HIV. While HIV prevalence appears to have declined in several African

6. This chapter closely follows the background paper written by Sarah Hawkes. Additional input was informed by the WAS Expert Consultation in Oaxaca, Mexico and feedback from reviewers (see Appendix IV and V).

countries such as Kenya and Zimbabwe, it has levelled off at what UNAIDS calls "exceptionally high levels" in others and in other African countries, most notably South Africa where 18.8% of the adult population is HIV+ the epidemic continues to expand (UNAIDS, 2006). With respect to sub-Saharan Africa, it is important to note that half of all new HIV infections occur among people under the age of 25 (Monasch & Mahy, 2006). A similar situation is reported in the Caribbean, the second most affected region in the world after sub-Saharan Africa (PAHO, 2007).

According to UNAIDS (2006), at the end of 2005, 8.3 million people in Asia aged 15-49 were living with HIV. Two thirds of them were living in India. About 1.6 million people in Latin America and 1.5 million in Eastern Europe and Central Asia were living with HIV. The prevalence of HIV in the various regions of the world at the end of 2005 was 6.1% in sub-Saharan Africa, 1.6% in the Caribbean, 0.8% in Eastern Europe and Central Asia, 0.5% in Latin America, 0.5% in North America, Western and Central Europe, 0.4% in Asia, 0.3% in Oceania, and 0.2% in North Africa and the Middle East. Overall, these statistics demonstrate that HIV is a disease that disproportionately affects poor and developing countries.

STIs: A Significant but Often Neglected Global Health Problem

Sexually transmitted infections (STI) account for a significant portion of the morbidity and mortality in the developing world because of their damaging effects on reproductive and child health and their role in facilitating HIV transmission (Aral, Over, Manhart & Holmes, 2006). STI are important co-factors in the growth of the HIV epidemic because they increase the susceptibility of STI infected individuals to HIV infection when they are exposed to the virus and also because they augment the infectivity of people living with HIV by causing an increase in the shedding of HIV in genital secretions. An estimated 340 million curable STIs (Gonorrhoea, Chamydia, Syphilis, Chancroid, Trichomoniasis) are contracted each year and in developing countries, complications from STI's are among the top five reasons that adults seek health care (WHO, 2001). Incidence rates of curable STIs are disproportionately high in the developing world. For example, the curable STI incidence per 1000 rates in 1995 were 254 in sub-Saharan Africa, 160 in South and South East Asia, 145 in Latin American and the Caribbean but only 91 in North America (WHO). Viral STIs (Human papillomavirus [HPV], Herpes simplex virus) are among the most common human infections and also have significant negative health outcomes. The list of negative outcomes resulting from STI is long and includes pelvic inflammatory disease, ectopic pregnancy, chronic pelvic pain in women, miscarriage, premature delivery, neonatal and infant infections, infant blindness, infertility in both women and men, cervical cancer, other genital cancers, liver failure/cancer, and central nervous system disorders (Aral, et al). Complications from STI disproportionately affect women and children, particularly in developing countries where women are relatively disempowered and access to health care is limited. Cervical cancer, caused primarily by HPV, is a leading cause of cancer deaths among women globally and the highest rates of cervical cancer are found in the developing world (Schiffman & Castle, 2005).

HIV/AIDS and STI Prevention: A Prerequisite for Global Development

STI/HIV and the MDGs

In many developing countries HIV/AIDS has such a profoundly crippling effect on the larger society that it inhibits the ability of key social institutions such as schools, health care facilities, law enforcement, civil and social services to function properly if at all. It has been estimated that in developing countries HIV/STI account for 17% of economic losses caused by ill-health (Mayaud & Mabey, 2004). The devastating impact of HIV/AIDS on the economic development of Africa is well documented. It is estimated that the HIV/AIDS epidemic has already reduced average economic growth rates by 2-4% a year across Africa (Dixon, McDonald, & Roberts, 2002).

The prevention of STIs is a major public health priority in its own right and can be linked to the MDG's in multiple ways such as, for example, the linkage between access to effective STI prevention and treatment services and a subsequent beneficial impact on maternal and child health. For example, with an estimated two million pregnant women affected by 'active' syphilis infections annually it is estimated that up to 80% of these pregnancies

will be adversely affected by the infection (Schmid, 2004). Reducing STI prevalence also contributes to the MDGs in that it is well established that persons with ulcerative or non-ulcerative STI are by several orders of magnitude at increased risk for infection when exposed to HIV (Fleming and Wasserheit, 1999). Lack of access to STI prevention, diagnosis, and treatment feeds the HIV epidemic in many developing countries. In other words, effective STI prevention and control programming will not only have a beneficial impact in of-it-self, it will contribute to curbing HIV/AIDS incidence.

Efforts to achieve MDG 6 to reverse and halt the spread of HIV/AIDS will require the commitment of massive but limited resources. It is therefore crucial that STI/HIV prevention and control programs be efficiently delivered and cost-effective.

STI/HIV Prevention Interventions are Cost-Effective

Several highly sophisticated cost-effectiveness analyses of the implementation an array of HIV/AIDS strategies in Africa have been performed (Creese, Floyd, Alban, & Guinness, 2002; Hogan, Baltussen, Hayashi, et al., 2005; Stover, et al., 2006). Hogan et al, assessed the cost-effectiveness of HIV prevention interventions sub-Saharan Africa and South East Asia such as mass media campaigns, VTC, peer education and STI treatment for sex workers, STI treatment for the general population, school-based STI/HIV education, prevention of mother to child transmission, antiretroviral therapy and found that to varying degrees, and depending on the setting, these interventions can be cost effective. In their analysis of the impact and costs of different HIV prevention strategies in Africa, Saloman, Hogan, Stover et al., (2005) concluded that a comprehensive approach that combines prevention and treatment will be most effective in terms of infections prevented and efficient use of resources. From their research on the global impact of scaling up HIV/AIDS prevention programs in the developing world, Stover et al., conclude that,

> Our analyses suggest that both national governments and donor countries would be well advised to ensure that prevention programs are scaled up as soon as possible, because early investment in prevention will both prevent a greater proportion of future infections and reduce future costs for treatment and care by more than the cost of prevention programs (p. 1476).

Evaluated interventions focusing on STI treatment in Africa have been effective in reducing STI and one such intervention conducted in Tanzania reduced HIV prevalence in the adult population by 38% (Auerbach, Hayes, & Kandathil, 2006). Broader cost-effectiveness analysis suggests that management of STIs can substantially reduce the health burden of HIV/AIDS (Hogan, Baltussen, Hayashi, et al., 2005). Both STI and HIV are transmitted primarily through sexual contact and therefore prevention education interventions for HIV and STI are targeting the same behaviours. As a result it is both possible and necessary for HIV and STI efforts to be coordinated (UNAIDS 2001).

Evidence-based Interventions for HIV/STI Prevention

Multiple Prevention Strategies are Required

From their overview of the evidence to date concerning the effectiveness of HIV prevention efforts, Auerbach, Hayes, & Kandathil (2006) state that "There is a large quantity of evidence from experimental and observational research as well as from practical real-world experience in both developed and developing countries. This evidence supports the implementation and scale-up of a number of interventions and strategies". There is widespread recognition that reducing the burden of STI/HIV on developing countries will require the implementation of a variety of prevention, testing, and treatment strategies (Global HIV Prevention Working Group, 2003). Among the strategies that potentially contribute to this goal include STI/HIV prevention behavioural interventions, voluntary testing and counselling (VTC), anti-retroviral therapy, injection drug use treatment and safe injection programs, integration of HIV prevention into family planning programs to reduce mother to child transmission, male circumcision, consistent and correct use of condoms, and effective treatment for STIs, testing of the blood supply (Auerbach, Hayes, & Kandathil, 2006; Bunnell, Mermin, De

Cock, 2006, UNAIDS, 2006). To be effective these specific STI/HIV focused strategies must be implemented in conjunction with broader programs to address social, economic, and gender inequalities that underpin the HIV epidemic in the developing world. As observers of the HIV/AIDS epidemic in Africa and Asia have repeatedly pointed out, with respect to prevention efforts in particular, many women and girls are not in position to act on prevention messages related to abstinence or condom use because these are not under their control (e.g., Murphy, Greene, Mihailovic, & Olupot-Olupot, 2006). Other methods for STI/HIV prevention currently under investigation may improve girls and women's ability to protect themselves from infection. These include improved diaphragms and female condoms; microbicides, drugs for pre-exposure prophylaxis, and eventually effective vaccines (Global HIV Prevention Working Group, 2006).

Sexual Risk Reduction Interventions are at the Core of STI/HIV Prevention

Valdiserri, Ogden, and McCray (2003) summarize HIV prevention as consisting of behavior change interventions, HIV counselling and testing, community level interventions aimed at changing social norms (e.g., mass media campaigns, social marketing within a target group), structural level interventions (e.g., changes in social policies and laws related to HIV risk behaviour) in addition to STI diagnosis and treatment. There is evidence to support all of these avenues of intervention: however it is HIV prevention education focused on equipping individuals with the information and skills to avoid acquiring HIV through sexual transmission that is, and must be, at the core of broader HIV prevention objective. Research has consistently shown that well developed and implemented interventions are effective in reducing STI/HIV sexual risk behaviour. In other words, "…HIV prevention works" (UNAIDS, 2006,). UNAIDS points to successful prevention efforts in Brazil, Thailand, Uganda, Cambodia, Zimbabwe, Haiti, Kenya, and the United Republic of Tanzania.

In general, sexual risk reduction behaviour change interventions seek to help individuals delay the onset of sexual intercourse, reduce the number of sexual partners, and/or increase condom use or other methods of safer sex. For a number of reasons, evaluating the impact of behavioural interventions on human behaviour, particularly sexual behaviour, with precision is difficult. Nevertheless, over the course of the HIV/AIDS epidemic, thousands of evaluations of behaviour change interventions have been conducted. While these studies have varied in their methodological rigor, meta-analytic and systematic reviews of the HIV/AIDS sexual risk reduction evaluation literature provide strong scientific support for the behavioural effectiveness of these interventions. These reviews establish that HIV/AIDS sexual risk reduction interventions have been successful with people living in developing countries (Merson, Dayton, & O'Reilly, 2000), school youth in developing countries (Kirby, Obasi, & Laris, 2006), people living with HIV (Crepaz, Lyles, Wolitski, et al., 2006), men who have sex with men (Herbst, Sherba, Crepaz, et al., 2005), adolescents (Johnson, Carey, Marsh, et al., 2003), drug users (Semaan, De Jarlais, Sogolow, et al., 2002), adults (Neumann, Johnson, Semaan, et al, 2002), and women (Mize, Robinson, Bockting, & Scheltema, 2002).

Despite substantive progress in our knowledge to design and implement effective STI/HIV prevention interventions, we are far from where we need to be in terms of providing access to prevention programming to those who need it most. As noted by UNAIDS (2006),

> The steady growth of the AIDS epidemic stems not from the deficiencies of available prevention strategies but rather from the world's failure to use the highly effective tools at its disposal to slow the spread of HIV. Some 25 years after the epidemic was first recognized, most people at high risk of HIV infection have yet to be reached by HIV prevention, as many policy-makers refrain from implementing approaches that have been shown to work (p. 124).

The Need for Effective HIV/STI Prevention Interventions and Programs in the Developing World

According to UNAIDS (UNAIDS, 2007) HIV/STI prevention interventions must treat people with respect and dignity. The voluntary engagement and participation of

individuals and communities will empower them to act constructively and on their own behalf.

A) The Need to Ensure Wide Access to Effective Interventions

Despite gradual progress, STI/HIV prevention interventions with strong evidence of effectiveness still only reach a minority of those who need them.

In their most recent annual report on the global AIDS epidemic, UNAIDS (2006) indicates that some progress has gradually been made in scaling-up HIV prevention interventions but notes that "…while some countries have significantly increased prevention coverage, prevention programs still only reach a small minority of those in need" (p. 11). In a report titled *Access to HIV Prevention: Closing the Gap*, the Global HIV Prevention Working Group (2003), using data provided from UNAIDS, indicated that globally, among people at risk for HIV, only 5% had access to interventions targeting mother-to-child HIV transmission, 12% had access to VTC, 24% had access to AIDS education, and only 42% had access to condoms. More specifically, in sub-Saharan Africa, 8% of out-of-school youth and a little over one third of in-school youth had access to prevention programs; 6% had access to VTC and only 14% had access to STI services. In East Asia and the Pacific region, HIV prevention behaviour change programs reach only 5% of sex workers, 3% of out-of-school youth and 10% of men who have sex with men (MSM). In Eastern Europe and Central Asia, 40% of in-school youth and 3% of out-of-school youth are reached by behaviour change programs; such programs reach only 4% of sex workers and 9% of MSM. UNAIDS has characterized the situation in sub-Saharan Africa more optimistically, noting that every year increasing numbers of people are exposed to HIV prevention programming but UNAIDS also cautions that "…prevention programmes still reach only a small minority of those in need" (p. 11).

Ultimately, reducing the crippling burden of HIV on developing countries will rely on wide-spread access by young people to effective STI/HIV prevention education. In areas of the world with generalized HIV epidemics, such as sub-Saharan Africa and the Caribbean, the primary mode of HIV transmission is through heterosexual sex particularly among young people (Monasch & Roeland, 2006). In sub-Saharan Africa, nearly half of all new HIV infections occur among young people aged 15 – 24 and women in this age group represent a majority of those infected (UNAIDS, 2006). Although there has been gradual progress in implementing STI/HIV prevention education in the developing world, most youth in these countries do not have adequate access to these programs. In particular, school-based HIV prevention education is lacking. As summarized by Monasch and Roeland, among 30 countries with generalized HIV epidemics in Sub-Saharan Africa participating in a global HIV/AIDS survey, 11 reported that AIDS education was not part of their primary school curriculum and in 6 of the countries, AIDS education was not part of the secondary curriculum. Monasch and Roeland also note that much of the AIDS education being delivered to youth is likely ineffective due to a lack of teacher training and teacher discomfort with teaching about HIV/AIDS and sexuality.

B) The Need to Increase Access to Condoms

The findings of the STI/HIV prevention intervention literature clearly indicate that increasing condom use is among the most likely and substantive positive outcomes of sexual risk reduction interventions. Therefore, the success of STI/HIV behavior change interventions in the developing world will inevitably be dependant on the extent to which condoms are made readily accessible to individuals receiving the interventions. UNAIDS (2006) notes that "Correct and consistent condom use reduces the risk of sexual transmission of HIV by 80-90% - an efficacy rate that exceeds those reported for many of the worlds vaccines" (p. 127). An analysis of the HIV/AIDS prevention literature clearly indicates that the promotion of condom use is an important element of behavior change interventions to reduce HIV infection risk. A meta-analysis of over 350 evaluation studies assessing condom promotion interventions found that programs that contained educational information as well as attitudinal and behavioral skills elements were effective in increasing condom use (Albarracin, Gillette, Earl, et al. 2005). There is also an unequivocal body of research evidence

demonstrating that STI/HIV prevention education that includes the promotion of condoms does not result in more frequent sexual activity or an increase in sexual partners (Smoak, Scott-Sheldon, Johnson, & Carey, 2006). Furthermore, a cost-effectiveness analysis of interventions to reduce the incidence of HIV in Africa concluded that, along with blood screening, prevention of mother to child transmission, and provision of STI treatment, targeted condom distribution should be a priority area for funding of HIV/AIDS prevention in Africa (Creese et al, 2002). However, according to UNAIDS, the global supply of condoms is less 50% of what is needed and that funding for condom procurement and distribution must increase threefold if the HIV?AIDS epidemic is to be halted.

C) The Need for Adequate Funding for STI/HIV Prevention Programming that Respects the Right to Informed-Decision Making

The past quarter century of HIV prevention behavioural intervention research has provided substantial advances in the science of preventing HIV infection (Valdiserri, Ogden, & McCray, 2003). We know a great deal about how to create effective HIV/STI prevention interventions. However, as Ferguson, Dick, and Ross (2006) point out, a projected US $10 billion may well be spent on HIV/AIDS prevention, treatment, and care in the developing world in 2007; "Unfortunately, much of this spending has not been allocated according to the evidence of effectiveness" (p. 318). Given the accumulated evidence concerning the relative effectiveness of sexual abstinence and condom-based sexual risk reduction interventions in general, it is disturbing that some donor countries, such as the United States through it's PEPFAR program (Office of the U.S. Global AIDS Coordinator, 2006), disproportionately direct funds towards sexual abstinence interventions for which there is relatively little empirical support and which may deny program recipients, particularly youth, potentially life-saving information and access to condoms. Given the magnitude and consequences of the HIV/AIDS epidemic, it is nothing less than a moral imperative that government and non-governmental funding of HIV prevention efforts in the developing world be directed towards programs that are evidence-based. At the same time, these programs must respect the right of informed sexual health decision-making.

The A (abstinence), B (be faithful), C (use condoms) condoms approach to HIV/AIDS prevention, encouraged and funded by PEPFAR, that has been the basis for Uganda's successful campaign to reduce HIV prevalence in that country has been the subject of considerable debate with respect to the degree to which each of the ABC components contributed to the decline (e.g., Green, Halperin, Nantulya, & Hogle, 2006; Murphy, Greene, Mihailovic, & Olupot-Olupot, 2006; Okware, Kinsman, Onyango, et al., 2006). Although settling such questions definitively is unlikely, it appears that all three components played a role and as Green et al., suggest "…it makes epidemiological sense to address all three ABC behaviors rather than to promote only one or two components of 'ABC'" (p. 342). Indeed, sexual health promotion programming should, on principle, be aligned with a comprehensive approach to sexuality education that is adapted to local community needs. The comprehensive sexuality education approach suggests that people should receive broadly-based information and skills building opportunities that allow them to make informed choices about their sexual health. Such an approach necessarily includes information on the sexual risk reducing strategies of delaying first intercourse (A), reducing number of sexual partners (B), and adopting safer sex practices (C). It is however also vitally important that the funding and implementation of ABC-based programs reflect the principle of informed decision-making and are therefore balanced in their presentation.

While PEPFAR funding has been crucial to the success of HIV/AIDS programming in Africa, there is a

legitimate concern regarding the extent to which what appear to be the ideologically motivated funding requirements of PEPFAR that preclude a balanced implementation of programming that is consistent with the comprehensive sexuality education approach. In other words, do PEPFAR funding requirements violate the principle of informed choice in sexual health decision-making that are quite rightly viewed as a human right? According to Murphy et al., (2006),

> PEPFAR's ABC guidance contains rules for country teams to follow in developing and implementing their sexual prevention strategies, including parameters on the prevention messages that may be delivered to youths. Specifically, although funds may be used to deliver age-appropriate AB information to in-school youths, ages 10-14 years, the funds may not be used to provide information on condoms to these youths or distribute condoms in any school setting, let alone to youth out of school. And yet as many as 16% of all women in Uganda have sex before the age of 15 years (p. 1446).

It has been suggested that PEPFAR's funding requirements pertaining to the promotion of abstinence and the exclusion of information on condoms and the curtailing of their availability is a reflection of a particular sexual ideology rather than of sound evidence-based public health practice. It is here that PEPFAR's requirements are likely at odds with a comprehensive sexuality education approach based on the right to informed decision making and a balanced presentation of risk reduction strategies. The ideological tension between these two approaches is well expressed by Blum (2004) who writes that,

> For a number of advocates of abstinence there is a fundamental opposition to any sexual contact outside of heterosexual, mutually monogamous marriage, as well as opposition to condoms and a moral/religious opposition to contraception. For many who challenge *abstinence-only* education it is not the *abstinence* but the *only* that is most problematic. At its core are reproductive rights and freedoms vs. the morality of nonmarital sex and the role contraception may play in encouraging it (p. 431).

As Green et al., (2006) note, the debate over the ABC approach "…appears more related to the culture wars in the USA than to African social reality" (p. 335) and as Blum (2004) suggests "The next tragedy for Africa, however, would be if it were to be the battleground for American reproductive politics" (p. 431).

With regard to the moral perspectives towards human sexual behavior that are transmitted in, or reflected by, STI/HIV prevention education programs, a critical distinction must be made between the prerogatives of external governments and bodies that fund interventions and the prerogatives of the communities that will implement them. Funding sources, whether they are national governments, non-governmental organizations, or individuals, are exercising a legitimate prerogative if they insist that donated funds contribute to programs that respect basic sexual and reproductive health rights, UN declarations and agreements. However, funding sources are not exercising a legitimate prerogative if they insist that programs reflect the funding sources sexual ideology including norms for preferred or acceptable sexual behaviours such as sexual abstinence outside of heterosexual marriage. In turn, communities that accept and implement STI/HIV prevention programs funded by external donors should respect the sexual and reproductive health rights of program recipients.

D) The Need to Reduce and Eliminate Social Inequality Related to Sexual Orientation and Gender

Many cultures exhibit profoundly destructive prejudices, norms, and laws toward sexual minorities. These discriminatory acts are a major contributing factor to increased sexual risk behavior. For example, due to the intense homophobia, hatred, stigmatization, and violence directed at sexual minorities, particularly gays, lesbians, bisexuals and transgenderd people, individuals are forced to conceal their true selves

and to live their lives in a state of alienation and fear. Not only is such an environment disempowering with respect to lowering STI/HIV risk it makes reaching sexual minorities with effective prevention education and services extremely difficult. Furthermore, people who live in fear because of their sexual orientation are much less likely to access the health care system which further increases risk. Often, reluctance to access health care is perpetuated by health and medical personal who react to sexual minorities with scorn and rejection. Clearly, this must change.

There is a clear and direct linkage between the empowerment of women in the developing world and reducing the burden of HIV/AIDS on these societies and in achieving all of the MDGs. On multiple levels, gender inequality contributes to the spread of STI/HIV. For example, forced or coerced sex directed against sex workers, trafficked girls and women, and girls and women in intimate relationships plays a significant role in STI/HIV transmission and the global epidemic (WHO, 2000). Several studies from sub-Saharan Africa have clearly shown that gender power imbalances (Langen, 2005) and gender-based violence (Dunkle et al., 2004) increase women's risk for HIV infection. Women who are economically dependant on and/or fear violence from their male partners, and who often play a subservient role in sexual activity are in a poor position to ask for or demand condom use.

While much of the empowerment of women must come in the specific realm of sexuality and sexual health decision making, change must ultimately begin and end at a larger systemic level. As Langen (2005) concluded from her study of women in South Africa and Botswana "Across all levels of society, there is a need to see a social paradigm shift that transforms relationships between women and men, from one of inequality and dominance as is the case in patriarchal societies, to equality, respect and consideration for one another" (p. 188). For example, a stronger commitment to universal and equal access to education for girls will not only allow women to advance economically and share in community social and political leadership, it also linked in numerous was to reduced STI/HIV. As noted by UNAIDS (2006), "Higher education levels for girls are associated with a higher age of marriage, reduced fertility, improved health seeking behaviour, lower vulnerability to genital mutilation, and reduced risk of HIV and other sexually transmitted infection" (p. 136).

In Uganda, one sub-Saharan African country where multiple prevention strategies and structural change has coincided with a significant decline in HIV/AIDS, the linkage between advances toward gender equality and a decline in HIV incidence is apparent. In the words of the Ugandan President, Yoweri Museveni,

> Permit me to tell you the obvious. In the fight against HIV/AIDS, women must be brought on board. In sub-Saharan Africa, most women have not yet been empowered and men dominate sexual relations. To fight this epidemic, the women must be empowered to take decisions about their sexual lives, and women in Uganda have been empowered to participate at all levels of governance. This has made them more assertive of their lives than ever before. To fight AIDS effectively, we must empower women (cited in Murphy et al., 2006, p. 1444).

NECESSARY ACTIONS

Success in halting and reversing the impact of STI/HIV on the global community, and in particular on the developing world, will require a cooperative effort at the international, national, and community levels. For areas hit hardest by HIV/AIDS and who are invariably struggling with widespread poverty, the international community must build upon and add to its considerable, but still unfortunately insufficient allocation of funding and resources to halt and reverse the spread of STI/HIV. The experience of Uganda teaches us that effective national leadership is indispensable in an effective HIV/AIDS strategy.

> Implementing a strong national HIV prevention programme involves more than the selection of an appropriate mix of programmatic actions. It also requires a strong national policy framework that encourages safe behaviours, reduces vulnerability,

> maximizes the accessibility and effectiveness of HIV prevention services, promotes gender equality and women's empowerment, and reduces stigma and discrimination (UNAIDS, 2006, p. 145).

Efforts to reduce the impact of STI/HIV will be largely futile unless communities take active roles in supporting and leading programmes to address STI/HIV. In short, communities must not simply accept programmes, they must take ownership of them. In particular, community opinion leaders ranging from religious and civic authorities to cultural and sports figures must band together in leading their communities in the necessary social and behavioural change that is required to halt and reverse the impact of STI/HIV on communities.

6.1. **Funding and implementation of effective and culturally-relevant and appropriate prevention programs and interventions must be increased.** Current funding and resources for STI/HIV prevention and control directed towards the developing world are significant but insufficient to allow for achievement of the United Nations Millennium Development Goals.

6.2. STI **and HIV prevention programs and interventions should be integrated and addressed as fundamental issues of sexual and reproductive health.** STI/HIV constitute a significant burden on the health and economic well-being of all regions but particularly so for the developing world. Both STI and HIV/AIDS are primarily transmitted through sexual contact. Therefore, they must be taken into consideration when planning and monitoring programs and actions intended to address sexual and reproductive health and family and community health. At the same time, efforts to curb transmission of HIV and STI should not have unwanted side effects on sexual and reproductive wellness and wellbeing.

6.3. **Efforts must be increased to ensure that STI/HIV prevention programs are planned and implemented according to up-to-date knowledge and research on program effectiveness**. A quarter century of behavioural and evaluation research indicates that sexual health risk reduction interventions can be highly effective and this body of research clearly points to the principles of effective programming. Yet, many funded and implemented programs do not adhere to these principles.

6.4. **Funding for condom distribution programs must be increased from current levels**. Condoms are highly effective in reducing STI/HIV transmission and a key outcome of many STI/HIV prevention interventions has and will continue being an increase in condom use. Yet, despite considerable distribution efforts, for many people at high risk for STI/HIV, particularly in the developing world, condoms are not accessible.

6.5. **Donors must be educated and encouraged to not base funding decisions on their own ideological viewpoints concerning sexual morality and both donors and funding recipients should insist and ensure that all programming is consistent with human rights.** Funding decisions for and implementation of STI/HIV prevention programming must fully respect the right of individuals to make fully informed decisions about their sexual health,

6.6. **STI/HIV prevention and control programming must effectively address social inequalities, especially those related to sexual orientation and gender. Political, religious, legal and cultural institutions and opinion leaders must proactively promote broadly-based efforts to reduce social inequality.** It is clear and undeniable that halting and reversing the STI/HIV epidemic cannot occur without a substantive increase in the empowerment of girls and women not only with regard to sexual and reproductive health but also with regard to fundamental aspects of social, economic, and political life.

UNAIDS (2005; 2006) has issued wide-ranging and comprehensive recommendations to underpin national HIV prevention plans including 12 essential policy actions for HIV prevention which are as follows.

- Ensure that human rights are promoted, protected and respected and that measures are taken to eliminate stigma and discrimination.
- Build and maintain leadership from all sections of society, including governments, affected communities, nongovernmental organizations, faith-based organizations, the education sector, media, the private sector and trade unions.
- Involve people living with HIV in the design, implementation and evaluation of prevention strategies, addressing their distinct prevention needs.

- Address cultural norms and beliefs, recognizing both the key role they play in supporting prevention efforts and the potential they have to fuel HIV transmission.
- Promote gender equality and address gender norms and relations to reduce the vulnerability of women and girls to HIV infection, involving amen and boys in this effort.
- Promote widespread knowledge and awareness of how HIV is transmitted and how infection can be averted.
- Promote the links between HIV prevention and sexual and reproductive health.
- Support the mobilization of community-based responses throughout the continuum of prevention, care and treatment.
- Promote programmes targeted at HIV prevention needs of key affected groups and populations.
- Mobilize and strengthen financial, human and institutional capacity across all sectors, particularly in health and education.
- Review and reform legal frameworks to remove barriers to effective, evidence-based HIV prevention, eliminate stigma and discrimination, and protect the rights of people living with HIV or vulnerable to or at risk of HIV infection.
- Ensure that sufficient investments are made in the research and development of, and advocacy for, new prevention technologies.

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Chapter Seven [7]

Identify, Address and Treat Sexual Concerns, Dysfunctions and Disorders

Since sexual concerns, dysfunctions and disorders all have an impact on quality of life, general and sexual health, they should be recognized, prevented and treated.

Introduction

Sexual health is increasing recognized as a fundamental component of overall health and well-being and adequate sexual functioning must therefore be seen as a legitimate and central aspect of health. Yet, nearly all, if not all, cultures around the globe have been reluctant to openly recognize sexual function as a legitimate health issue, even as our medical/scientific understanding of health and sexuality has progressed enormously, particularly over the last century. In other words, while our understanding of sexual function and its role in overall individual and relationship functioning and happiness has evolved, our integration of sexual function into the broader rubric of health has lagged at the level of social and public health policy and political discourse. Although the identification and treatment of sexual dysfunction and disorders has not been at the top of the health policy agenda, it is important to recognize the necessity of addressing sexual concerns, sexual dysfunction and disorders in a broadly-based initiative aimed at meaningfully improving the health and well-being of a population.

Increasingly, public health institutions are recognizing not only the importance of integrating sexual health into overall health programming but they are also increasingly recognizing that sexual health entails more than HIV/STI prevention and reproductive health and includes aspects such as sexual function. For example, the World Health Organization (WHO, 2004) Department of Reproductive Health and Research has begun to focus on sexual health and this new emphasis is based, in part, on the public health importance of sexual dysfunction.

It has been commonly thought that sexual dysfunction has been primarily an issue of concern in North American and Western European countries and was less of a concern in other parts of the world. This perception has, historically, been reinforced by the fact that most of the research investigating the prevalence and impact of sexual dysfunction has been conducted in Western countries. However, in recent years research on sexual dysfunction has expanded dramatically to cover diverse populations from around the world. For example, *The Global Study of Sexual Attitudes and Behaviors* assessed sexual function among adults from 29 countries around the world including non-Western countries such as Algeria, South Africa, Turkey, Morocco, China, Indonesia, Malaysia, Philippines and Thailand. Among the conclusions drawn from this study is that despite considerable cultural variation among the countries studied, a consistent finding was that sexual well-being was correlated with overall happiness in both men and women (Laumann, Paik, & Glasser, 2006).

The Connection between Sexual Function and Overall Health and Wellbeing

It is clear that sexual dysfunctions are strongly correlated with other health conditions. That is, there are common risk factor categories associated with sexual dysfunction for men and women (Lewis, Fugl-Meyer, Bosch, 2004). The directionality of cause and effect between sexual dysfunctions and other health conditions has, with many categories of sexual dysfunction, yet to be fully elucidated but it is clear that there is a close interactive association. In effect, people suffering with sexual dysfunctions are more likely to develop other conditions (e.g.,

7. This chapter was informed by the background paper written by Emil Ng. Additional input was informed by the WAS Expert Consultation in Oaxaca, Mexico and feedback from reviewers (see Appendix IV and V).

depression) and people with other conditions such as cardiovascular disease are more likely to develop sexual dysfunction (e.g., erectile dysfunction). In any case, there is a close association and it illustrates that adequate sexual functioning is properly seen as an important component of not only sexual health but overall health and well-being. According to Sadovsky and Nusbaum (2006),

> Sexual problems have a clear negative impact on both the quality of life and emotional state regardless of age. Learning about specific sexual dysfunctions among men can reveal a variety of as-yet-diagnosed comorbid pathologic conditions such as: (i) depression and other emotional illnesses; (ii) psychosocial stress; (iii) actual cardiovascular disease as well as related risk factors such as hypertension, diabetes, and/or hyperlipidemia; (iv) hyperprolactinemia; and low serum testosterone. Specific sexual dysfunctions among women can reveal pathologic conditions such as: (i) depression and other adverse imitational and psychosocial conditions; (ii) low serum estrogen or testosterone; and/or (iii) vaginal or pelvic disorders (p. 3).

Given the role of sexuality in fundamental aspects of life including reproduction and relationships, it is not surprising that problems with sexual functioning are correlated with reduced subjective well-being. Sexual problems have been linked to and cause diminished quality of life, low physical satisfaction, low emotional satisfaction, and low general happiness (Sadovsky & Nusbaum, 2006). The *National Health and Social Life Survey* in the United States found significant associations between sexual dysfunction feelings of general well-being (Laumann, Paik, & Rosen, 1999). The authors conclude from the data that "With the strong association between sexual dysfunction and impaired quality of life, this problem warrants recognition as a significant public health concern" (p. 544).

The precise relationship between sexual satisfaction and relationship satisfaction is complex; however research does indicate that people with greater relationship satisfaction also report greater sexual satisfaction (Byers, 2005; Yeh, Lorenzo, Wickrama, et al. 2006). Yeh et al. concluded from their longitudinal study of 283 American married couples that "Those who were satisfied with their sexual relations tended to be satisfied and happy with their marriages, and better marital quality, in turn, helped reduce marital instability" (p. 342). This linkage between sexual satisfaction and relationship satisfaction is not limited to couples in North America. *The Global Study of Sexual Attitudes and Behaviors* found that 82% of men and 76% of women agreed with the statement "satisfactory sex is essential to maintain a relationship" (Nicolosi, Laumann, Glasser et al., 2004). As West, Vinikoor, and West (2004) suggest from their review of research on the prevalence and predictors of female sexual dysfunction,

> For the individual with sexual dysfunction, there is a personal cost to her and her partner with respect to their relationship. But there may be societal costs as well, as reflected in divorce rates, domestic violence, single-parent families, and future relationships. These ancillary costs are rarely measured, but without a better understanding of their magnitude, female sexual dysfunction, as a health outcome, will continue to be underappreciated, to the detriment of the individual or society (p. 167).

The Prevalence of Sexual Concerns, Problems and Dysfunctions

Determining the prevalence of sexual concerns, problems, and sexual dysfunctions is very much dependant on the definition used and the methodologies used to assess them.

Sexual Concerns

There is a severe lack of data to indicate the number of individuals who have questions and concerns about their sexual functioning. However, questions and concerns are ubiquitous. People of all ages often perceive that they lack accurate and comprehensive information on a wide range of sexuality related issues including:

- HIV and STI sexual transmission
- Sexual orientation
- Gender roles
- Sexual function

- The appropriate frequency and normalcy of different sexual behaviors
- Infertility
- Contraception and abortion
- Sexual violence and abuse
- Sexuality related aspects of mental and physical illness
- Medical treatments for sexual problems and dysfunctions
- The impact of medications on sexual function
- The impact of physical and developmental disabilities on sexuality and relationships
- Masturbation
- Sexual/reproductive anatomy
- Body image
- Breast and genital size and appearance

Often, the lack of accurate information on these and other aspects of sexuality lead to concerns or uncertainty and anxiety that can have severe impact on self esteem, identity, well being and the capacity to be involved in intimate relationships. Most of these concerns could be could be addressed through comprehensive sexual education or other forums for providing basic information that dispels myths and misinformation. In some cases, the provision factual information is not enough as such concerns may be symptomatic of deeper underlying anxieties and fears. Unfortunately, many people do not feel comfortable addressing these concerns with their health care provider nor do they feel that their health care provider would be sensitive or comfortable enough to address these issues (Marwick, 1999).

Sexual Dysfunctions

A number of definitions for both sexual function and sexual dysfunction can be found in the medical sexological literature and a variety of definitions have been used in their measurement. Nevertheless, there is a general consensus that adequate sexual functioning consists of the three basic stages of desire, arousal, and orgasm. There are also sexual pain disorders. Thus, sexual dysfunction can be defined, at least in part, as an impairment or disturbance in one of these stages (Winze & Carey, 2001). The most common sexual dyfunctions are as follows (Lewis, Fugl-Meyer, Bosch, Fugl-Meyer, Laumann, Lizza, & Martín-Morales, 2004):

- Sexual interest/desire dysfunctions (men and women)

Female Sexual Dysfunctions:

- Sexual arousal disorders
  - Genital sexual arousal dysfunctions
  - Subjective sexual arousal dysfunction
  - Combined genital and subjective sexual arousal dysfunction
- Persistent sexual arousal disorder
- Orgasmic dysfunction
- Dyspareunia
- Vaginismus
- Sexual aversion disorder

Male Sexual Dysfunctions

- Erectile dysfunction
- Early ejaculation
- Delayed Ejaculation
- Orgasmic dysfunction (in men)
- Anejaculation

Most population studies have asked respondents if they have experienced problems related to these stages. The results of these studies indicate problems with sexual functioning are very common within adult populations. A review of the existing epidemiological data indicates that about 40-45% of adult women and 20-30% of adult men have at least one sexual dysfunction (Lewis, Kersten, Fugl-Meyer, et al., 2004). *The Global Study of Sexual Attitudes and Behaviors* found that among sexually active people aged 40 to 80 years, 28% of men and 39% of women reported at least one problem with sexual functioning in the previous year. For men, the most common problems were early ejaculation (14%), erectile difficulties (10%) while for women the most common were lack of sexual interest (21%), inability to reach orgasm (16%), and lubrication difficulties (16%) (Nicolosi et al., 2004). It should be noted that participants were sexually active and it is likely that reported sexual dysfunction rates would have been higher if people who were not sexually active were included. The occurrence of sexual dysfunction is often age related with prevalence increasing as people grow older. However, this is not always the case. For example, in the *National Health and Social Life Survey* in the United States, problems such as inability to reach orgasm and pain during sex were more common among younger women (18-39) than older women (40-59) (Lauman, Paik & Rosen, 1999). Recent studies have found high levels of sexual

dysfunction among women in Nigeria (Ojomo, Thacher, & Obadofin, 2006), Malaysia (Sidi, Puteh, Abdullah, & Midin, 2006) and Ecuador (Yanez, Castelo-Branco, Hidalgo, & Chedraui, 2006) showing that problems with sexual function are truly a global phenomenon that transcend culture.

Sexual Disorders

Sexual disorders are usually classified into paraphilic and non-paraphilic types (Coleman, 1991). The paraphilias are clearly classified in the *Diagnostic and Statistical Manual of the American Psychiatric Association* (DSM-IV). Eight paraphilias are listed:

- Pedophilia
- Exhibitionism,
- Voyeurism,
- Sexual masochism,
- Sexual sadism,
- Transvestic fetishism,
- Fetishism,
- Frotteurism

Prominent and pioneering sexual scientist John Money has identified more than 40 different types of paraphilias, including zoophilia (bestiality), asphyxiophilia (cutting off oxygen to enhance arousal or orgasm), and necrophilia (sex with dead people) (Money, 1986). Paraphilias are marked by an obsessive preoccupation with a socially unconventional sexual behavior that involves nonhuman objects, children or other nonconsenting persons, or the suffering or humiliation of oneself or one's partner. These behaviors are also considered by the majority of people to be socially deviant. However, there are attempts to declassify some paraphilias, such as transvestic fetishism, sadism, and masochism (Moser, 2001). It is important to note that to meet clinical criteria for having a paraphilia, the person must have sexually arousing fantasies, sexual urges, and behaviors that cause clinically significant distress in social, occupational, or other important areas of functioning. Many men and women, for example, cross-dress to varying degrees but do not experience sexual arousal that causes distress. They have been able to integrate their activities into their overall identity and interpersonal relationships. By nature, paraphilic behavior interferes with a person's feeling of well-being and ability to have or form reciprocal love relationships.

There is a lack of epidemiological data on the prevalence of the paraphilic disorders, however these are well recognized as clinical syndromes and some of them are root causes of sexual violence, abuse, and interference in intimate relationships. Many more men than women suffer from paraphilic disorders (American Psychiatric Association, 2000). The lack of epidemiological data is due in part to the absence of a clear definitions and clinical criteria. In addition, many people may have problematic sexual behaviors but do not meet the clinical threshold for paraphilic disorders. Even many sexual offenders, who have violated norms and laws of their societies, do not necessarily meet clinical criteria for paraphilia, although they may be suffering from and need treatment for some other type of psychiatric disorder, (Miner & Coleman, 2001).

While not classified *per se* in the Diagnostic and Statistical Manual of the American Psychiatric Association (APA, 2000), there has been growing recognition that there are another set of sexual disorders which are similar to the paraphilias but involve normative or conventional sexual behavior but in a similar manner they involve sexually arousing fantasies, sexual urges, and behaviors which cause clinically significant distress in social, occupational, or other important areas of functioning (Coleman, Raymond & McBean, 2003). There is even poorer epidemiological data on this type of disorder but have been extensively described in the literature. This type of sexual disorder has been called hypersexuality, hyperphilia, erotomania, perversion, nymphomania, satyriasis, and, more recently, compulsive sexual behavior (CSB) or sexual addiction (Coleman, 1991). While some of these are exotic terms and the nosology and etiology is highly debated among professionals in the area, there is no question that this is a serious mental, sexual, and physical health problem. Nonparaphilic CSB can be impulsive, obsessive and compulsive, driven, out of control, and distressing. No clear category exists for this type of CSB in the DSM nomenclature, but an example is given under Sexual Disorder Not Otherwise Specified (NOS): "distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used" (American Psychiatric Association, 1994). There are at least 7 subtypes of nonparaphilic CSB (Coleman, Raymond & McBean, 2003):

- compulsive cruising and multiple partners
- compulsive fixation on an unattainable partner
- compulsive autoeroticism (masturbation)
- compulsive use of erotica
- compulsive use of the Internet for sexual purposes,
- compulsive multiple love relationships
- compulsive sexuality in a relationship

There is a growing body of literature suggesting an association between compulsive sexual behavior (CSB) and HIV and STI risk behaviors (Kalichman & Rompa, 1995; 2001; Reece, Plate, & Daughtry, 2001; Miner, Coleman, Center, Ross,& Rosser, 2007).

Whether paraphilic or nonparaphilic compulsive sexual behavior, these problems are associated with many other comorbid psychiatric disorders and are linked to sexual health problems – particularly sexually transmitted infections, sexual violence and abuse Kafka, & Prentky, 1994; Black, Kehrberg, Flumerfelt, & Schlosser, 1998; Raymond, Coleman, Ohlerking, Christenson & Miner, 1999). In order to effectively address the MDGs, it is critical that these types of sexual disorders are identified, assessed, and given proper treatment. Beyond structural factors, these individual psychiatric factors can be responsible for a large number of negative sexual health consequences.

Gender Identity Disorders

Comfort with ones gender is a necessary requisite for sexual health and well-being. Individuals who are uncomfortable with their gender identity or suffer from gender identity disorders are at high risk for negative sexual health consequences. Gender identify disorders are defined as an incongruence between one's physical phenotype (male or female) and one's gender identity that is, the felt and self identification as man or woman (American Psychiatric Association, 1994). The experience of this incongruence is termed gender dysphoria. In the most extreme form of gender dysphoria, individuals wish to make their body congruent with their gender identity and this is called transsexualism.

The most recent prevalence information from the Netherlands for the transsexual end of the gender identity disorder spectrum is 1 in 11,900 males and 1 in 30,400 females (WPATH, 2001). Even if epidemiological studies established that a similar base rate of gender identity disorders existed all over the world, it is likely that cultural differences from one country to another would alter the behavioral expressions of these conditions. Moreover, access to treatment, cost of treatment, the therapies offered and the social attitudes towards gender variant people and the professionals who deliver care differ broadly from place to place. While in most countries, crossing gender boundaries usually generates moral censure rather than compassion, there are striking examples in certain cultures of cross-gendered behaviors (e.g., in spiritual leaders) that are not stigmatized (WPATH, 2001).

Between the publication of American Psychiatric Association's DSM-III and DSM-IV, the term "transgender" began to be used in various ways. Some employed it to refer to those with unusual gender identities without a connotation of psychopathology. Some people informally used the term to refer to any person with any type of gender variance. Transgender is not a formal diagnosis, but many professionals and members of the public find this to be a preferred term because of its inclusiveness and lack of assumed pathology (WPATH, 2001). When the wide variety of gender identities and expressions are taken into account, there are no good estimates on the prevalence of individuals who might be defined as transgender.

What is most important is to recognize that not all people identify as either male, female, boy or girl, man or woman. Depending on cultural norms, individuals who do not fit into the binary face varying challenges in developing positive sexual identities, being granted sexual citizenship, healthy relationships and well-being. It is important that these individuals be identified and assisted in their process of positive sexual identity development (Bockting & Coleman, 2007, in press).

Effective Education and Treatment for Sexual Concerns, Problems and Dysfunctions

Many difficulties that people experience related to sexual concerns, problems and dysfunctions can be effectively addressed with the provision of factual information to counter misunderstandings, myths, and ignorance. A lack of scientifically valid information concerning sexual function within the general population is

pervasive and the negative impact of this ignorance is felt around the world. In addition, many instances of sexual difficulties can be satisfactorily resolved through the provision of short-term solution focused therapy delivered by a sufficiently trained counselor, therapist, or front line health care provider.

Physicians and other primary care health providers are ideally placed to inquire about sexual concerns, problems and dysfunction in a non-judgmental and professional fashion that is welcomed by patients (Nusbaum & Hamilton, 2002). Brief assessment of sexual concerns, problems and dysfunction can and should become a standard component of the general health assessment and people should be invited and encouraged by the health care provider to ask questions concerning these issues. For example, individuals experiencing difficulties with sexual function will benefit from factual information on sexual anatomy, the sexual response cycle of both sexes, psychosocial factors (e.g., relationship function, stress) affecting sexual function as well as sexuality related changes associated with aging, pregnancy, menopause, medical conditions, illnesses, and medications. However, data from the *Global Study of Sexual Attitudes and Behaviors* that few physicians in the 29 countries surveyed routinely assess the sexual health of their patients (Moreira, Brock, Glasser, et al., 2005). Although nearly half of the men and women in the survey reported sexual problems, less than 20% sought help from their physicians and only 9% of both men and women reported that their physician had inquired about their sexual health in the previous three years.

Numerous studies have found that physicians are often uncomfortable talking to their patients about sexuality or taking a sexual history, that most medical school curricula do not train them to do so, and that even brief training interventions designed to increase and improve physician-patient communication about sexuality can be effective (McCance, Moser, & Smith, 1991; Ng & McCarthy, 2002; Council on Scientific Affairs, 1996; Rosen, Kountz, Post-Zwicker, T. et al., 2006; Solursh, Ernest, Lewis, et al., 2003; Tsimtsiou, Hatzimouratidis, Nakopoulou, et al., 2006). Barriers to physician-patient communication includes lack of provider comfort, bias, fears of offending the patient, lack of training, and time constraints (Maheux, Haley, Rivard & Gervais, 1999). These findings indicate that physicians and other primary health providers require more and better training to effectively communicate with and educate their patients about sexuality.

Evidence-based recommendations for the treatment of sexual dysfunctions in women (Basson, Althof, Davis, et al., 2004) and men (Lue, Giuliano, Montorsi, et al., 2004) are available. With respect to clinical sexual dysfunctions diagnosed by a health professional, there is growing evidence that medical interventions to treat sexual dysfunctions among men can be effective and can have a meaningful positive impact on health and well-being. For example, research has demonstrated that medical treatment for erectile dysfunction can result in improved long-term psychosocial quality of life for men including increased self-esteem, sexual relationship satisfaction, and relationship satisfaction (Althof, O'Leary, & Cappelleri, et al., 2006a; Althof, O'Leary, & Cappelleri, et al., 2006b). In comparison to men, for women, understanding of the bio-physiology and psychology of sexual function and research on sexual dysfunction including effective treatment is less well developed (Verit, Yeni, & Kafali, 2006). Although safe and effective pharmacologic therapies for female sexual dysfunction have not been firmly established, recommendations for treatment include cognitive-behavioral therapy aimed at changing maladaptive thoughts and unreasonable expectations, correcting misinformation about sexuality, and exploring strategies to improve couple emotional closeness and communication (Basson, 2006). Among some guidelines issued by medical associations, there is support for local estrogen therapy for dyspareunia associated with vulval atrophy and cautious support for selective use of low dose testosterone provided the patient understands the risks involved (for review see Basson, 2006). There is a clear need for more research on the management of female sexual dysfunction that includes long-term treatment outcome studies (Basson et al., 2004).

Evidenced-based treatment for sexual disorders is not as well established. However, there is guidance based upon extensive clinical experience (Bradford, 2000; Coleman, Raymond & McBean, 2003). Combinations of psycho- and pharmacotherapy are often helpful However, there is clear need for further research to support various types of treatments.

Treatment of gender identity disorders has been carefully outlined by the Standards of Care of the World Professional Association for Transgender Health (Meyer, Bockting, Cohen-Kettenis, Coleman, DiCeglie, Devor, Gooren, Hage, Kirk, Laub, Lawrence, Menard, Monstrey, Patton, Schaefer, Webb, & Wheeler, 2001) and international experts in this field (Ettner, Monstrey, & Eyler, 2007). As with sexual disorders, there is still much research and work to be done to develop evidenced-based treatments.

Necessary Actions

7.1 Given the importance of adequate sexual functioning for general sexual health, overall health and well-being, and the health of interpersonal relationships, the assessment and treatment for sexual concerns, problems, and dysfunction should be specifically noted and included in national and international programs and agreement to promote sexual health.

7.2 Sexual function and gender identity are increasingly recognized as key components of overall health and problems with sexual dysfunction and gender dysphoria are associated with other medical conditions and individual and relationship well-being. Therefore, comprehensive sexual health assessment that includes assessing basic sexual function and gender identity should become a standard component of health care.

7.3 Many sexual concerns, disorders and dysfunctions are rooted in a lack of information about sexuality. Information on sexual functioning should be included as an integral component of the comprehensive sexuality education available to all people. Schools, through their sexual health education curricula, and the health sector (physicians, nurses, and other health workers) must play key roles in educating their students and patients about sexual functioning.

7.4 Training programs for teachers, community workers, and health care workers must include, as a standard component, training in sexual dysfunction, disorders and gender problems. Such programs should include specific training on educating clients about sexual function and gender identity development. Physician and nursing training should go beyond providing education to include a specific focus on addressing and treating sexual problems/dysfunctions.

7.5 The development of optimal treatment approaches for sexual concerns, dysfunction, disorders and gender identity problems are in development and more research is needed to develop evidence-based approaches for the majority of these conditions. Allocation of funds for the conduction of this research is necessary and justified by the considerable impact that these problems have in the individual, the couple, and the family and ultimately in the social group at large.

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Chapter Eight [8]

Achieve recognition of sexual pleasure as a component of well-being

Sexual health is more than the absence of disease. Sexual pleasure and satisfaction are integral components of well-being and require universal recognition and promotion

Introduction

Most of the previous seven statements in the *Sexual Health for the Millennium* and the technical document sections supporting them document the ability for sexual health promotion programming to contribute to the Millennium Development Goals (MDGs) by halting and reversing negative outcomes such as STI/HIV, sexual violence, and sexual dysfunction. While these objectives are no doubt of primary importance, they reflect the tendency of the sexual health promotion field as well as policy makers both national and international to focus on negative sexual and reproductive health outcomes. Far less prominent in health promotion policy and programming is a sustained recognition that sexual pleasure is an elemental aspect of human sexuality. That sexual pleasure is the focus of the eighth of eight statements does not reflect a hierarchy of importance with pleasure coming last. Although often ignored or stigmatized, sexual pleasure cannot be an afterthought in sexual health promotion.

To be effective and meaningful in making its contribution to development and human well-being, sexual health promotion cannot segment the essences of human sexuality into parts and address some and pretend that others do not exist. Sexual health promotion programming must recognize and engage the whole of a person's sexuality. Pleasure is arguably, if not definitively the single most powerful motivating factor for sexual behavior. To ignore it is to turn away from the role of sexual pleasure in contributing to human fulfillment and happiness. To ignore pleasure in any aspect of sexual health promotion programming is to present a conceptualization of sexuality and sexual health that is not real and will not connect with people in a way that meaningfully addresses their needs, aspirations, desires and concerns.

That the positive, enriching and pleasure aspects of sexuality are essential to sexual health was recognized within the original internationally accepted definitions of sexual health that were articulated by the World Health Organization (WHO, 1975):"Sexual health is 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." It was also noted that "Fundamental to this concept are the right to sexual information and the right to pleasure." Pleasure was seen as a fundamental human right. The WHO document concluded, "Thus the notion of sexual health implies a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relationships and not merely counseling and care related to procreation or sexuality transmitted diseases."

The link between sexual health and overall health was clearly articulated in the U.S. Surgeon General's (2001) definition of sexual health and the importance of pleasure was also clearly articulated

> Sexual health is inextricably bound to both physical and mental health.
> Just as physical and mental heath problems can contribute to sexual dysfunction and diseases, those dysfunctions and diseases can

8. This chapter was informed by the background paper written by Terence Hull. Additional input was informed by the WAS Expert Consultation in Oaxaca, Mexico and feedback from reviewers (see Appendix IV and V).

> contribute to physical and mental health problems. Sexual health is not limited to the absence of disease or dysfunction, nor is its importance confined to just the reproductive years. It includes the ability to understand and weigh the risks, responsibilities, outcomes and impacts of sexual actions and to the practice abstinence when appropriate. It includes freedom from sexual abuse and discrimination and the ability to integrate their sexuality into their lives, derive pleasure from it, and to reproduce if they so choose (U.S. Surgeon General, 2001, p. 1).

Finally, in an attempt to revise the 1975 definition of sexual health, the WHO (2002; 2006) reasserted the basic principles but clearly added the notion of pleasure in their recently released working definitions.

> Sexual health is a state of physical, emotional, mental and social well-being related 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.

This definition clearly challenged government policies and public health approaches to not just to avoid problems of illness or healthy reproduction, but to promote pleasure as an essential ingredient of well-being (Coleman, 2007). The importance of recognizing and integrating considerations of the role of pleasure in human sexuality does not simply apply to what some might consider the more esoteric aspects of sexual health promotion such as the treatment of sexual dysfunction, it applies in equal measure to programs aimed at STI/HIV prevention, assisting the victims of sexual violence/abuse, sexuality education of youth, fertility control etc. The preceding chapters of this document make clear the vital role that the promotion of sexual health must play if the MDGs are ultimately to be achieved. This chapter illustrates the often overlooked fact that sexual pleasure is a fundamental component of sexual health and of overall human health and well-being. The more that sexual health promotion programs embody the totality of human sexuality, educate, counsel and assist people in ways that recognize and incorporate pleasure, the more likely these programs will meet people's needs, correspond to the reality of the human experience, ultimately reach their objectives and, therefore, have the most impact in contributing to the MDGs.

Sexual Pleasure in Historical Context

Throughout much of human history, passionate love and sexual desire have been viewed as dangerous, a threat to the social, political and religious order (Hatfield & Rapson, 1993). During the current historical period, religion and medicine have had powerful influences on societal norms for sexual health and sexual behavior (Hart & Wellings, 2002) and in some important respects these institutions have inherited and continued the tradition of viewing sexual desire, and by extension, pleasure with varying degrees of suspicion.

It is not possible to make tidy generalizations about the extent to which the major religions have held either "sex negative" or "sex positive" perspectives toward pleasure and sexuality. However, it may be said that in various historical periods, many religions, including Christianity and Islam have focused on the reproductive aspects and function of sexuality. Consequently, they have sought strict controls on sexual behavior particularly outside of marriage between a man and a woman, behavior that does not lead to reproduction (e.g., masturbation) and viewed sexual pleasure, particularly that of women and homosexual men and women, with contempt (For extensive documentation and analysis of religious perspectives toward sexuality throughout history see Bullough, 1980). Numerous scholars have documented the disdain for sexual pleasure expressed by Christian theologians and institutions throughout much of the church's history (e.g., Pagels, 1988).

Masturbation, in particular, has been a contentious topic as its primary purpose is to produce pleasure (Coleman, 2002). Research on

masturbation has indicated that contrary to traditional beliefs, masturbation has been found to be a common sexual behavior and linked to indicators of sexual health. While there are no general indicators of ill health associated with masturbation, it can generate powerfully negative or positive emotions for many individuals. It can be powerfully negative or positive, depending on the interaction between the prevailing societal attitudes and individual attitudes and behaviors (Coleman, 2002).

In fact, research has indicated that masturbation begins early and is an important part of healthy sexual development (Langfeldt, 1981). It is often a marker of sexual development (Bancroft, Herbenick, D., & Reynolds, 2002). Many young people learn about their bodies and sexual responsiveness through masturbation (Atwood & Gagnon, 1987). Masturbation also continues throughout the life span. For example, many adults continue to masturbate even though they are married and have ready access to sexual intercourse (Laumann et al., 1994). Masturbation can also help older people who do not have an available partner to maintain sexual functioning and expression (Leiblum & Bachmann, 1988). It is also a safe alternative to behaviors that carry a risk of a sexually transmitted infection, including HIV. The benefits of masturbation are illustrated by its wide acceptance in sex therapy as a means of improving the sexual health of the individual and/or couple (Heiman, LoPiccolo, & LoPiccolo, 1976; Heiman & LoPiccolo, 1988; Zilbergeld, 1992; Leiblum & Rosen, 1989).

Addressing masturbation within sexual health promotion programming can be controversial; however the available evidence suggests that including masturbation as a topic within comprehensive sexual health promotion is important and necessary. There is a need for more research, including theory development and hypothesis testing, on the impact of masturbation on self-esteem, body image, sexual functioning and sexual satisfaction and the effective incorporation of education about masturbation within sexual health promotion programs.

It must be noted that positive and progressive perspectives toward pleasure and sexuality are emerging from groups from a variety of religious faiths. Nevertheless, it must also be acknowledged that the legacy of a largely negative interpretation of sexual pleasure, particularly if it is experienced in a context contrary to particular religious norms for sexual conduct, by many religious institutions is still with us today and continues to hinder the recognition of pleasure in sexual health promotion efforts in many parts of the world. With respect to international efforts to promote sexual health, the alliance of the United States, the Vatican and conservative Muslim and Catholic states in opposing the recognition of diverse sexual rights, including those related to pleasure, is testimony to the continued influence of conservative religious forces in shaping polices related to sexual health (Ilkkaracan, 2005).

Since the latter half of the 19th century, medicine and medical science has, particularly in the Western world, exercised considerable authority over sexuality and here too we find that sexual pleasure was often seen as pathology. As Hart and Wellings (2002) suggest "The long tradition of representing illness as a punishment for sin was continued when sexual behavior was medicalized and transformed into morbidity" (p. 896). For example, masturbation, homosexual desire and overt sexual interest, particularly if expressed by women was until quite recently seen by medicine as symptomatic of psychiatric illness and perversion.

Although contemporary medicine and some religious institutions have turned the corner in recognizing the positive and beneficial aspects of sexual expression, many remnants of the propensity to focus on the negative outcomes of sexual expression remains with us." Today's public discourse about sexuality is almost exclusively about risks and dangers: abuse, addiction, dysfunction, infection, pedophilia, teen pregnancy, and the struggle of sexual minorities for their civil rights" (Planned Parenthood Federation of America [PPFA], 2003. p. 1).

Although, in most cultures, sexual desire and pleasure receive their widest endorsement within the context of a relationship, sexual desire and pleasure are increasingly coming to be seen as intrinsically positive and rewarding aspects of human experience. While a concern with pleasure is sometimes thought of as a decadent preoccupation of a secular Western culture, it is important to note that many diverse cultures have strong traditions of affirming sexual pleasure. For example, within Brazilian culture the concept of *tudo* or "Everything" refers to the world of erotic experiences and

pleasures (de Freitas, de Oliveira, & Rega, 2004). Indeed, a contemporary discourse of pleasure can be found in many non-western cultures. For example, in Turkey, a country not known for its affirmation of women's sexual pleasure, a grassroots program that emphasized sexual pleasure as a women's human right was conducted (Ilkkaracan & Seral, 2000). Organizations such as the South and Southeast Asian Resource Centre on Sexuality (Patel, online) are raising the issue of pleasure in the context of sexual health. From their review of historical and cross-cultural perspectives on passionate love and sexual desire, Hatfield and Rapson (1993) conclude that the tide of history is in the direction of "….an increasing acceptance of passionate love and sexual desire as legitimate, expressible feelings" (p. 91).

Sexual Pleasure is Necessary and Contributes to Well-being, Happiness and Health

Romantic love is a primary feature of couple relationships and is expressed through sexuality and sexual passion for the partner (Esch & Stefano, 2005). Although social, political and economic differences across time and place can markedly impact upon sexual attitudes and behavior, cross-cultural research has found that people in all societies place a high value on being with a partner for whom there is "mutual attraction-love" (Buss, Abott, Angleiter, et al., 1990). Sexual desire and pleasure are embedded in and a fundamental aspect of the mutual attraction between partners. The mutual sharing of sexual pleasure has been shown to increase bonding within relationships (Weeks, 2002). As Tepper (2000) writes with respect to the neglected rights of people with disabilities to enjoy their sexuality, "Pleasure is an affirmation of life…It can add a sense of connectedness to the world or to each other. It can heal a sense of emotional isolation so many of us feel even though we are socially integrated" (p. 288). In sum, the enjoyment of sexual pleasure plays an important role in contributing to the establishment, maintenance and stability of couple relationships and, without doubt, the quality of couple relationships is fundamental to the health and well-being of individuals and families. While sexual pleasure can be seen as an end in-of-itself, for many, if not most people, sexual pleasure is intertwined with feelings of intimacy and affection for their partner. Sexual desire and pleasure not only facilitate reproduction, they function as a mechanism of social attachment for the couple relationship, an essential kinship structure in all cultures of the world (Fisher, 2002).

At the most foundational level, sexual pleasure is rooted in the most basic of human functions as has been recognized by evolutionary psychology.

> In the context of adaptive behavior and its necessity in evolution, it would appear that the pleasure generated by sexual stimulation, orgasm or intercourse would be selected-for evolutionarily. Consequently, pleasure can be seen as an effective and important adaptive mechanism, the function of which is to ensure the procreation and survival of the species (Esch & Stefano, 2005, p. 182).

To the extent that a society is concerned with the well-being and stability of families generally, and couples specifically, it is in the interests of policy makers to recognize the importance of sexual pleasure and to implement sexual health promotion programs that address sexual pleasure as fundamental to individual and couple health and well-being.

The recent *Global Study of Sexual Attitudes and Behaviors* that examined various aspects of sexual health among a sample of 27,500 men and women aged 40 to 80 from 29 culturally diverse countries around the world offers strong evidence of the importance of pleasure and sexual satisfaction for the happiness and well-being of individuals and couples (Laumann, Paik, Glasser et al., 2006: Nicolosi, Laumann, Glasser et al., 2004). The survey asked participants, among other things, questions about the degree to which they found their relationships to be physically pleasurable and how important sex is to their overall happiness. Over three quarters of men (82%) and women (76%) agreed that satisfactory sex is essential to maintain a relationship and the authors concluded from their findings that despite substantial cultural variation in sexual norms and values, subjective sexual well-being was associated with overall happiness in both men and women.

A White Paper published by the Planned Parenthood Federation of America

(PPFA, 2003) in cooperation with the Society for the Scientific Study of Sexuality extensively catalogues the scientific evidence demonstrating the health benefits of sexual expression. Taken together, the studies cited suggest that partnered sexual activity and/or masturbation can be associated with improved longevity, immunity, pain management, self-esteem and a reduction in stress.

In sum, sexual pleasure helps to cement the primary kinship structure of the couple relationship, contributes to the overall happiness in life of both men and women (whether they are in partnerships or not) and is associated with various aspects of good health. Seen in this way sexual pleasure is not frivolous or unnecessary: it is essential.

The Ongoing Struggle to Incorporate Positive Sexual Rights in Sexual Health Promotion Programs

It is noted elsewhere in this document in relation to reproductive health that the United Nations (UN, 1995) 4th International Conference on Population and Development (ICPD) was, in some senses, a breakthrough in that paragraph 96 of the document defined reproductive health in a positive way, acknowledging that sexual health involves the "enhancement of life and personal relations" and that "people are able to have a satisfying and safe sex life." These can be seen as pleasure positive statements. According to Parker, Dimauro, Filiano, et al., (2004) the key distinction in developing a concept of sexual rights to guide sexual promotion is the distinction between *negative* rights (e.g., freedom *from* sexual violence and abuse) and *positive* sexual rights. "Conceptually, positive sexual rights have been described as enabling conditions necessary for the expression of sexual diversity, health, and pleasure" (Parker et al., p. 374). And yet, it is clear that positive sexual rights, including pleasure affirming approaches to sexual and reproductive health, particularly as they relate to public health policy have, and will continue to meet resistance. As Correa (2002) has noted with respect to ICPD,

> …to call for sexual rights as a protection against pregnancy, rape, disease and violence, is a different matter from affirming these rights in relation to eroticism, recreation and pleasure. This second interpretation was in the minds of many of those who struggled for Paragraph 96. But there are political and conceptual obstacles that make it difficult for the discourse on sexual rights to shift towards this "positive concept" interpretation. In the political domain, persistent attacks by conservative forces on sexuality-related issues constantly push them back under the cover of more acceptable (well-behaved) reproductive, health and violence agendas. In addition, within the health field the dominance of biomedical frameworks constantly pressures "sexual subjects" to remain contained in disciplinary domains (particularly epidemiology and behaviorist frames) (p. 5).

Although ICPD did represent a step forward, progress in implementing sexual health promotion programs that embody a positive conception of sexual rights to include a "discourse of pleasure" (Tepper, 2000) will require international organizations and public health agencies, governments and other public institutions to further expand their conceptualizations of sexual health beyond traditional notions of preventing morbidity and mortality. These institutions, in both policy and practice, must explicitly recognize the importance of positive sexual rights to sexual pleasure and expression in conjunction with the emphasis on the right to freedom from disease, dysfunction and abuse.

The Pan American Health Organization (PAHO, 2000) document *Promotion of Sexual Health: Recommendations for Action* provides an example of an expanded vision of sexual health that acknowledges positive sexual rights and addresses sexual health concerns related to eroticism that according to PAHO "….demand actions from governmental and non-governmental agencies and institutions including the health sector" (p. 17). As articulated by PAHO, these concerns are:

- Need for knowledge about the body, as related to sexual response and pleasure
- Need for recognition of the value of sexual pleasure enjoyed throughout life in safe and responsible manners within a values framework respectful of the rights of others
- Need for promotion of sexual relationships practice in safe and responsible manners
- Need to foster the practice and enjoyment of consensual, non-exploitive, honest, mutually pleasurable sexual relationships (p. 17).

The Need for a Discourse of Desire and Pleasure in Sexual Health Education Programs for Youth and People with Disabilities

The gradual acceptance of the right of youth and people with disabilities to sexual health education has led to the implementation of programs for these audiences in some parts of the world. While some programs have had some success in reaching behavioral targets related to negative outcomes such as STI/HIV infection among youth (e.g. see Kirby, 2005), it is clear that a problem prevention emphasis combined with a near total silence regarding desire and pleasure distorts the reality of human sexuality and may result in programs for youth and the disabled that are irrelevant to their needs (Fine & McClelland, 2006; Nyanzi, 2004; Tepper, 2000). Sexual health education for young people with physical or developmental disabilities can empower them to enjoy personal sexual fulfillment but few people with disabilities have access to such programs (Di Giulio, 2003; Murphy & Young, 2005). Sexual health education programs for youth in nearly, if not all parts of the world focus primarily on the negative aspects of human sexuality and ignore pleasure and sexuality within relationships. From her ethnographic research on sexuality in both East and West Africa, Nyanzi (2004) concluded that sexuality education programs for youth that emphasized risks and "disastrous consequences" with a "concomitant denial of pleasure" have the effect of "putting off adolescents rather than capturing their attention" (p.13). Adolescents, just like adults, are motivated by the search for intimacy and sexual pleasure in their pursuit of relationships (Ott, Millstein, Ofner & Halpern-Felsher, 2006). Sexual health promotion programs for youth and people with disabilities require much more emphasis on positive sexual rights that incorporate basic human needs related to sexual pleasure and fulfillment.

Conclusion

From the standpoint of comprehensive and effective sexual health promotion, sexual pleasure is not frivolous; it is not destructive as it has and often is portrayed. In this chapter, it has been demonstrated that sexual pleasure contributes to human happiness and well-being and is a normal part of human development and development of positive identity and a powerful glue for the intimate attachment between partners. Within the totality of human development, the experience of sexual pleasure and fulfillment must be recognized for what it truly is; a basic human need on par with other basic requirements necessary for a healthy and productive life. This reality must be reflected in sexual health promotion policy and programs aimed at contributing to healthy community development.

Necessary Actions

8.1 The international community is increasingly recognizing and endorsing the concept of sexual rights. However, to-date, community, national and international consensus has overwhelmingly focused on *negative* sexual rights (e.g., freedom from STI/HIV, sexual violence and abuse), often to the exclusion of *positive* sexual rights (e.g., the right to sexual pleasure and satisfaction). To better reflect human reality and meet the needs of individuals and couples, international agreements and priority setting documents should clearly articulate objectives in terms of both *positive* and *negative* sexual rights. Sexual health promotion programs for all groups, including youth and people with disabilities, should embody the reality that sexual pleasure and intimacy are strong motivating factors for sexual behavior and that sexual pleasure contributes to happiness and well-being.

8.2 Educators and health care providers have often been conditioned, through their training, to conceptualize sexual health in terms of *negative* sexual rights. Pre-service and in-service training for sexual health educators and health care providers should place particular emphasis on the promotion of

positive sexual rights for people of all ages in order to counter the prevailing over-emphasis on *negative* sexual rights.

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Appendix I

Description of the World Association for Sexual Health

The World Association for Sexual Health (WAS) is an international organization founded in Rome as the World Association for Sexology (WAS) in 1978. The name was officially changed to the World Association for Sexual Health in 2005.

WAS membership is composed of Regional Federations, National Societies and Institutes and individual supporting members. WAS currently has 124 member organizations and numerous individual members, representing over 53 countries in 5 continents. The WAS brings individuals and organizations together to share scientific information, form networks and promote international and intercultural exchange.

Mission:

The World Association for Sexual Health promotes sexual health throughout the lifespan and through the world by developing, promoting and supporting sexology and sexual rights for all.

WAS accomplished this by advocacy actions, networking, facilitating the exchange of information, ideas and experiences and advancing scientifically- based sexuality research, sexual education and clinical sexology, with a trans-disciplinary approach.

The purpose of the WAS is to advance international cooperation in the field of sexology and by coordinating the activities designed to increase research and knowledge in sexology, including sexuality education, sexual health and the alleviation of sexual suffering.

Activities:

The WAS believes in the importance of both the production of quality research and the application and communication of that sexual knowledge.

WAS work is carried through:

- Sponsorship of the World Congresses of Sexual Health
- Sponsorship of regional or interregional meetings
- International exchanging of information
- Working relations with the World Health Organization, the Pan American Health Organization, the World Psychiatric Association, the International Society of Sexual Medicine, the International Society for the Study of Women's Sexual Health, and other international organizations
- Recognizing outstanding contributions in the field of sexology.

World Congresses of Sexual Health

Beginning in Rome in 1978 through Sydney in 2007, the WAS has successfully sponsored 18 international congresses, attracting thousands of participants from around the world. The 19th World Congress will be held in Gothenburg, Sweden in 2009.

Forming Networks

In addition to its worldwide membership, the WAS has developed formal ties with five prominent regional sexological organizations:

- AFSHR (African Federation for Sexual Health and Rights)
- AOFS (Asian-Oceania Federation of Sexology)
- EFS (European Federation of Sexology)
- FLASSES (Latin American Federation of Sexology)
- NAFSO (North American Federation of Sexuality Organizations)

Intercultural Exchange & Promoting Sexual Health

In furthering its goals of promoting sexual health worldwide and developing cultural and international exchange, the WAS is:

- Assisting in the creation of regional libraries, especially in underdeveloped areas of the world
- Addressing HIV-prevention efforts around the world

WAS Position Statements

In August, 1999, the WAS adopted a "Universal Declaration of Sexual Rights."

The WAS has also adopted position statements condemning:

- Genital mutilation of women
- Sexual torture in prisons
- Gender biased-related incidents
- Discrimination based on gender or sexual orientation

Current officers

President: Eusebio Rubio-Aurioles (Mexico)

Vice President: Rosemary Coates (Australia)
Secretary General: Beverly Whipple (USA)
Past President: Marc Ganem (France)

Secretaries: Monica Rodriguez (Americas)
Antonio Palha (Europe)
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Advisory Committee:

Kevan Wylie (United Kingdom)
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Reiko Ohkawa (Japan)
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Lillemor Rosenqvist (Sweden)

Chiara Simonelli (Italy)

Past Presidents: Romano Forleo (Italy)
Fernando Bianco (Venezuela)
Alan Wabrek (USA)
Ruben Hernandez Serrano (Venezuela)
Eli Coleman (USA)

Ex-Officio Members: Margaret Redelman (18th World Congress)
Antonio Pahla (EFS)
Verapol Chandeying (AOFS)
Ruben Hernandez (FLASSES)
Joseph DiNorcia (NAFSO)
Uwemedimo Esiet (AFSHR)
Juan Jose Borras (Sexual Rights Committee)
Esther Corona (International Liaison Committee)

To Contact WAS:
http://www.worldsexualhealth.org

Membership

National Societies

Associacao Brasileira de Terapia Sexual (ABRATESEX) (Brazil)
American Association of Sexuality Educators Counselors and Therapists (USA)
Asociacion Argentina de Sexologia y Educacion Sexual (AASES) (Argentina)
Asociacion Espanola de Especialistas en Sexologia (Spain)
Asociacion Espanola de Sexologia Clinica (Spain)
Asociación Estatal de Profesionales de la Sexología (AEPS) (Spain)
Asociacion Mexicana de Sexologia AC (Mexico)
Asociacion pro Derechos Sexuales (Spain)
Association des Sexologues Cliniciens Francophones (ASCLIF)(Switzerland)
Association des Sexologues du Quebec (Canada)
Association for the Promotion of Women Status (Thailand)
Association Interhospitalo Universitaire de Sexologie (AIHUS) (France)
Australian Society of Sex Educators, Researchers and Therapists (ASSERT) (Australia)
Austrian Society for Sex Research (Austria)
British Association for Sexual and Relationship Therapy (United Kingdom)
Ceska Lekarska Spolecnost (Czech Republic)
Consexuar, Capitulo De Sexologia De La Asociacion de Psiquiatras Argentinos APSA (Argentina)
CostaRican Association of Sexologists and Related Professionals (Costa Rica)
Dansk Forening for Klinisk Sexologi (Denmark)
Deusche Gesellschaft fur Sozialwissenschaftliche Sexualforschung e V (Germany)
Deutsche Gesellschaft fur Geschlechtserziehung e V. DGG e.V. Bonn (Germany)
Egyptian Association of Marital and Sexual Health (Egypt)
Estonian Academic Society for Sexology (Estonia)
Federacion Española de Sociedades de Sexologia (FESS) (Spain)
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Federazione Italiana di Sessuologia Scientifica (Italy)
Finnish Association for Sexology (Soumen Seksologinem Seura) (Finland)
Greek Society of Sexology (Greece)
Harry Benjamin International Gender Dysphoria Association (USA)
Hong Kong Association of Sexuality Educators, Researchers & Therapists (China)
Hong Kong Sex Education Association (China)
Indian Association of Sex Education, Counselling and Therapy (IASECT) (India)
International Society for the Study of Women's Sexual Health (ISSWSH) (USA)
Israel Society for Sex Therapy (Israel)
Japan Family Planning Association, Inc (Japan)
Japan Society for Adolescentology (Japan)
Japanese Association for Sex Education (Japan)
Japanese Society for Impotence Research (Japan)
Japanese Society of Sexual Science (Japan)
Korean Society of Sexology (Korea)
National Coalition for Sexual Freedom INC (USA)
Nederlandse Vereniging Voor Seusuologie (The Netherlands)
Norwegian Society for Clinical Sexology (Norway)
Polish Sexological Society (Poland)
SASHA (South Africa)
Sex Information and Education Council of Canada (Canada)
Sexpo the Finnish Foundation for Sex Education and Therapy (Finland)
SexualHealth Network (USA)
Sexuality Information & Education Council of the US (USA)
Sexualwissenschaftliche Gesellschaft Ostorreichs (SGO) Austrian Society for Sexology (Austria)
Sociedad Argentina de Sexualidad Humana (Argentina)
Sociedad Brasileira de Estudos em Sexualidade Humans (SBRASH) (Brazil)

Sociedad Chilena de Sexologia y Educacion Sexual (Chile)
Sociedad Chilena para el Estudio de la Impotencia (Chile)
Sociedad Cubana Multidisciplinaria para el Estudio de la Sexualidad (Socumes) (Cuba)
Sociedad Ecuatoriana de Sexologia y Educacion Sexual (Sesex) (Ecuador)
Sociedad Medica Espanola de Sexologia (Spain)
Sociedad Mexicana de Andrologia Medicina Sexual y para Estudio del Hombre Añoso (Mexico)
Sociedad Sexologica y de Educacion Sexual de Puerto Rico (Puerto Rico)
Sociedad Uruguaya de Sexologia (Uruguay)
Sociedad Venezolana de Psicologia Sexologica (Venezuela)
Sociedad Venezolana de Sexologia Medica (Venezuela)
Sociedade Brasileira De Sexologia (Brazil)
Sociedade Portuguesa de Sexologia Clinica (Portugal)
Societa Italiana di Sessuologia (Italy)
Societa Italiana Di Sessuologia Scientifica (Italy)
Societa Italiana per le Ricerca e la Formazione in Sessuologia (Italy)
Societat Catalana de Sexologia (Spain)
Societe Francaise de Sexologie Clinique (France)
Society For Sex Therapy and Research (SSTAR) (USA)
Society for Sexual Education, Treatment and Research (CETAD) (Turkey)
Society for the Advancement of Sexual Health (USA)
Society for the Scientific Study of Sexuality (SSSS) (USA)
Society for the Study of Andrology & Sexology (Singapore)
Swedish Association for Sexology (Sweden)
Taiwan Association of Sexuality Education (ROC)

Professional Institutes

Academie de Sciences Sexologiques (France)
Action Health Incorporated (Nigeria)
Arab Insitute for Sexology and Somato Therapy (France)
Asociacion Mexicana de Educacion Sexual (AMES) (Mexico)
Asociacion Mexicana para la Salud Sexual AC (AMSSAC) (Mexico)
Association of Rabbinical Marriage and Family Counselors (Israel)
Canadian Sex Research Forum Montreal (Canada)
Central Medica de Sexologia-C.M.S. (Colombia)
Centre for Sexuality, Gender Identity and Reroductive Health of the Vancouver Hospital(Canada)
Centro de Educacion y Atencion en La Salud y la Sexualidad (CEASS) (Mexico)
Centro De Sexolgia de Brasilia (Brazil)
Centro Interdisciplinare per la Ricerca e la formazione in Sessuologia (Italy)
Centro Italiano Di Sessuologia (Italy)
Centro Nacional de Educacion Sexual (Cuba)
Centro Privado de Sexologia Clinica y Manejo del Stress (Paraguay)
Center for Studies and Research on Human Behavior and Sexuality CEPCos - (Brazil)
Cepteco (Spain)
Circulo Argentino de Sexologia (Argentina)
Consortium of Thai Training Institutes of STDs and AIDS (Thailand)
CRESALC - Columbia (Colombia)
Department de Sexologie de L'Universitite du Quebec a Montreal (Canada)
Ecole Francaise de Sexologie (France)
El Armario Abierto (Mexico)
Health Horizons Associates LLC (USA)
Institute de Sexologie (France)
Institute for Advanced Study of Human Sexuality (USA)
Instituto Costaricense de Sexologia (ICOSEX) (Costa Rica)
Instituto de Orientacion Familar Y Sexual (INOFYS) (Panama)
Instituto de Psicologia, Sexologia y Medicina Espill (Spain)
Instituto de Sexologia del Desarrollo (Argentina)
Instituto de Terapia de Reencuentro (Spain)
Instituto Paulista de Sexualidade (Brazil)
Istituto Corpo I Mente (Italy)
Istituto di Sessuologia Clinica (Italy)
Istituto Internationale di Sessuologia (Italy)

Istituto Per La Ricerca in Sessuologia Clinica (Italy)
Komaja Foundation (Switzerland)
Lifetime Productions International Ltd (USA)
Mestrado em Sexologia Universidade Gama Filho (Brazil)
Pro Salud Sexual y Reproductiva AC (Mexico)
Program in Human Sexuality (USA)
Sathya Institute Cultural (Brazil)
Severance Institute of Andrology (Korea)
Women's Sexual Health Foundation (USA)
Unidad de Terapia y Educacion Sexual (Venezuela)
Widener University (USA)

Individual Supporting Members

Eduardo Alfonso Aguirre Sandoval (Mexico)
Tomas Alejandro Angulo Mendoza (Peru)
Colonel Azim (Bangladesh)
James Barret (United Kingdom)
Johannes Bitzer (Switzerland)
Raquel Blanco Camacho (USA)
Kelwyn Craig Browne (Australia)
Michael L Brownstein (USA)
Muhammad Haris Burki (Pakistan)
Sylvia Cabrera-Otero (Puerto Rico)
Lidia Calb (Canada)
Consuelo Camacho Murillo (Ecuador)
Claudio Cappotto (Italy)
Verapol Chandeying (Thailand)
Dominique Catón (Switzerland)
Chua Chee Ann (Malaysia)
Bill Cohen (USA)
Rosaria Damiani (Italy)
Dr. Berta Davis (USA)
Ana Cecilia de Blejman (Venezuela)
Bruno Jose de Oliveria Carrraca (Portugal)
Mingyu Deng. (USA)
Maryanne Doherty (Canada)
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Edgard Fankhanel (Puerto Rico)
Jose Manuel Gaytan Galindo (Mexico)
Bruno Carmine Gargiollo (Italy)
Ana Garrett (Portugal)
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Helmut Graupner (Austria)
Arun Gupta (India)
Mary A. Gutierrez (USA)
Kristina Hernborg (Norway)
Luca Incrocci (The Netherlands)
Andrea Irvin (USA)
Abdullah Hamood Issa Al-Taie Muscat (Sultanate of Oman)
Qaiser Javied (Pakistan)
Ryukichi Kato (Japan)
Chung Kim (Korea)
Won-whe Kim (Korea)
Kanwal Kukreja (Canada)
Judy Kuriansky (USA)
Thore Langfeldt (Norway)
Sylviane Larose (Canada)
Alejandro Lopez Deynes (Puerto Rico)
Josep Mª Farreny Tarrago (Spain)
Mark Kim Malan (USA)
Isaka Masanori (Japan)
Melinda Masters (USA)
Cheryl Matthews (Australia)
Gareth J Merriman (Australia)
Naresh Mittra (India)
Mariateresa Molo (Italy)
Anagloria Mora (USA)
Carlos Moreira (Uruguay)
Lucia Nader M (Colombia)
Sara Nasserzadeh (United Kingdom)
Tadhg O'Seaghdha (United Kingdom)
Gemma M. O'Brien (Austrália)
Gema Ortiz Martinez (Mexico)
Eduardo Ulises Pino Aravena (Chile)
Padmini Prasad (India)
K. Promodu (India)
Sathyanarayana Rao (India)
Franz Michael Reistenhofer (Austria)
Pedro Edgardo Rivera Garay (Chile)
R. Oliver Robinow (Canada)
Carlos Rodolfo Rodrigues Carrion (Ecuador)
Leonardo Romero Salazar (Columbia)
B. R. Simon Rosser (USA)
Girish J. Sanghavi (India)
Elena Sepúlveda Parada (Chile)
Julie Shankly (United Kingdom)
Ambrish Singal (India)
Sauren Solanki (United Kingdom)
Karl F Stiefer (Austria)
Glen L. Stimmel (USA)
Catherine Helen Thorne (Australia)
Mercedes Tong de Tang (Peru)
Domenico Trotta (Italy)

Carmen Valcarcel-Mercado (Puerto Rico)
Titus Varghese (USA)
Min Whan Koh (Korea)
Andik Wijaya (Indonesia)
Winston Wilde (USA)
Sauro Yague (Spain)
Oleg Konstantinovich Yatsenko (Russia)
Germanico Zambrano Torres (Ecuador)
Yuri Zarkov (Russia)

Appendix II WAS Declaration of Sexual Rights

Sexuality is an integral part of the personality of every human being. Its full development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love.

Sexuality is constructed through the interaction between the individual and social structures. Full development of sexuality is essential for individual, interpersonal, and societal well being.

Sexual rights are universal human rights based on the inherent freedom, dignity, and equality of all human beings. Since health is a fundamental human right, so must sexual health be a basic human right. In order to assure that human beings and societies develop healthy sexuality, the following sexual rights must be recognized, promoted, respected, and defended by all societies through all means. Sexual health is the result of an environment that recognizes, respects and exercises these sexual rights.

1. **The right to sexual freedom**. Sexual freedom encompasses the possibility for individuals to express their full sexual potential. However, this excludes all forms of sexual coercion, exploitation and abuse at any time and situations in life.
2. **The right to sexual autonomy, sexual integrity, and safety of the sexual body.** This right involves the ability to make autonomous decisions about one's sexual life within a context of one's own personal and social ethics. It also encompasses control and enjoyment of our own bodies free from torture, mutilation and violence of any sort.
3. **The right to sexual privacy**. This involves the right for individual decisions and behaviors about intimacy as long as they do not intrude on the sexual rights of others.
4. **The right to sexual equity.** This refers to freedom from all forms of discrimination regardless of sex, gender, sexual orientation, age, race, social class, religion, or physical and emotional disability.
5. **The right to sexual pleasure.** Sexual pleasure, including autoeroticism, is a source of physical, psychological, intellectual and spiritual well being.
6. **The right to emotional sexual expression.** Sexual expression is more than erotic pleasure or sexual acts. Individuals have a right to express their sexuality through communication, touch, emotional expression and love.
7. **The right to sexually associate freely**. This means the possibility to marry or not, to divorce, and to establish other types of responsible sexual associations.
8. **The right to make free and responsible reproductive choices**. This encompasses the right to decide whether or not to have children, the number and spacing of children, and the right to full access to the means of fertility regulation.
9. **The right to sexual information based upon scientific inquiry**. This right implies that sexual information should be generated through the process of unencumbered and yet scientifically ethical inquiry, and disseminated in appropriate ways at all societal levels.
10. **The right to comprehensive sexuality education.** This is a lifelong process from birth throughout the lifecycle and should involve all social institutions.
11. **The right to sexual health care**. Sexual health care should be available for prevention and treatment of all sexual concerns, problems and disorders.

Sexual Rights are Fundamental and Universal Human Rights

Declaration of the 13th World Congress of Sexology, 1997, Valencia, Spain. Revised and approved by the General Assembly of the World Association for Sexology (WAS) on August 26th, 1999, during the 14th World Congress of Sexology, Hong Kong, People's Republic of China.

Appendix III: The WHO Working Definitions

World Health Organization (WHO)
Working Definitions of Sex, Sexuality, Sexual Health and Sexual Rights*

Sex
Sex refers to the biological characteristics which define humans as female or male.
These sets of biological characteristics are not mutually exclusive as there are individuals who possess both, but these characteristics 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 and religious and spiritual factors.

Sexual Health
Sexual health is a state of physical, emotional, mental and social well-being related 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.

These working definitions were elaborated as a result of a WHO-convened international technical consultation on sexual health in January 2002, and subsequently revised by a group of experts from different parts of the world. They are presented here as a contribution to on-going discussions about sexual health, but do not represent an official WHO position, and should not be used or quoted as WHO definitions.
Reference: WHO. Gender and Reproductive Rights. www.who.int/reproductive-health/gender/sexual_health.html

Appendix IV

Methodology of the Development of the Sexual Health for the Millennium Declaration and Technical Document

The development and completion of the *Sexual Health for the Millennium* declaration and technical document involved an in-depth process of consultation and review that culminated in the final document presented here. The development and publication of *Sexual Health for the Millennium* also represents a natural and logical evolution of the work of the World Association for Sexology (WAS). For example, WAS presented its *Declaration of Sexual Rights* (see appendix II) at the World Congress of Sexology in Valencia in 1997 and subsequently the document was revised and adopted by the General Assembly of WAS in Hong Kong in 1999. WAS has actively contributed to a number of important initiatives that establish international recognition of the vital role of sexuality in peoples' well being and of sexual rights as an important extension of basic human rights as well as recommendations for action to ensure that these rights are realized by people around the world. WAS worked in collaboration with the Pan-American Health Organization to prepare the 2000 report *Promotion of Sexual Health: Recommendations for Action* (PAHO, 2000), and played a leading role in generating the 2002 World Health Organization's *Working Definitions of Sexual Health*.

With the issuance of the United Nations *Millennium Declaration* and the development of the Millennium Development Goals (MDGs), the WAS Advisory Board recognized that the alignment of the broadly-based goals of sexual health promotion within the MDGs to combat poverty, hunger, sickness, illiteracy, and discrimination against women was an important next step in the evolution of global sexual health promotion.

Prior to the 17th World Congress of Sexology in Montreal, 2005, Pierre Assalian, President the Congress, had the vision to use the Congress as an opportunity to develop a declaration that aligned the goals of sexual health promotion with the MDGs. WAS convened a meeting in the Dominican Republic in January, 2005 in collaboration with the PAHO and with input from key leaders from UNICEF, UNFPA, SIECUS and other relevant international groups. A task force of the WAS was formed to further develop the mechanisms for preparing and approving the declaration. All the participants agreed on the purpose and importance of developing a declaration on sexual health for the millennium.

In order to have input from as wide an audience as possible, WAS formulated a plan to create a dialogue on the development of the declaration through a series of round tables at the 17th World Congress of Sexology in Montreal, in July of 2005. In preparation for these roundtables, WAS commissioned a background paper that was written by Françoise Girard (2005) to orientate the participants on the *Millennium Development Goals* on how the promotion of sexual health might be integrated. With input from the participants in the round tables, WAS issued the *Montreal Declaration: Sexual Health for the Millennium* at the 17th World Congress of Sexology.

Following the creation of the *Montreal Declaration*, WAS obtained a grant from the Ford Foundation to develop a technical document to elaborate on and give substance to the *Montreal Declaration.*

To initiate the process of developing the technical document, a select group of recognized experts (see appendix V), each with a specialization in the specific areas of sexual health promotion addressed in the *Montreal Declaration*, were invited to submit background papers that became the foundation for the

chapters of the final technical document. The background papers were then distributed for review by a wider group of experts in sexual health promotion from around the world who then gathered together for a WAS expert consultation Meeting in Oaxaca, Mexico on May 1st and 2nd, 2006 (see appendix V). At this meeting, extensive input was provided concerning the Declaration and technical document. In general, the Montreal Declaration was endorsed with some minor modifications and suggestions. The basis of the technical document was further developed in response to the background papers and various workgroups that were formed around the eight parts of the declaration

Debbie Rogow was also hired as an external evaluator to provide process evaluation of the Oaxaca meeting, the preparation of the technical document, to assess the reception, implementation, and dissemination of technical document. Finally, Ms. Rogow will assist in evaluating the outcome and impact of the technical document.

A draft document was then prepared by Alex McKay of the Sexuality Information and Education Council of Canada under the guidance of Eli Coleman, the Project Coordinator, Rafael Mazin (PAHO), Esther Corona (WAS), and Eusebio Rubio (President of WAS). The various chapters of the draft were then circulated among the various experts who attended the Oaxaca meeting and further input was solicited. A final draft of the declaration and technical document was prepared by the editorial committee and was distributed to all members of the WAS for final consideration during the executive committee, advisory committee, and General Assembly of the World Congress of Sexual Health that was held in Sydney Australia, April 13-19, 2007.

In a number of cases, the draft document is verbatim based upon background papers although the editorial team made various editorial changes varying in degree. We want to clearly acknowledge the work of the background writers but also acknowledge that in many cases significant edits were made to the background papers. The intent is to have the background papers published in their entirety and more reflective of the writers own arguments and supporting evidence in a special forthcoming issue of the International Journal of Sexual Health.

Appendix V

Acknowledgements

Project Coordinator and Senior Editor
Eli Coleman

Co-Editors
Eli Coleman
Esther Corona
Rafael Mazin
Eusebio Rubio-Aurioles

Associate Editor
Alex McKay

WAS Task Force to Develop the Montreal Declaration

Eli Coleman, (Task Force Chair and Past President of the World Association for Sexual Health)
Esther Corona (World Association for Sexual Health)
Carissa Etienne (Pan American Health Organization/World Health Organization)
Rafael Mazin (Pan American Health Organization/World Health Organization)
William Smith (Sex Information and Education Council of the United States)

President of the 17th World Congress of Sexology, Montreal, Canada, 2005
Pierre Assalian

Small Group Facilitators of the Round Tables at the 17th World Congress of Sexology

Juan Luis Alvarez-Gayou (Mexico)
Peter Aggleton (United Kingdom)
Walter Bockting (United States)
Doortje Braaken (The Netherlands)
Vanessa Brocato (United States)
Rosemary Coates (Australia)
Uwem Esiet (Nigeria)
Monica Gonzales (United States)
Selma Gonzales (Mexico)
Prakash Kothari (India)
Sarah Hawkes (United Kingdom)
Ruben Hernandez Serrano (Venezuela)
Terrence Hull (Australia)
Michael McGee (United States)
Emil Ng (China)
Andrea Parrot (United States)
Ursula Pasini (Switzerland)
Rodolfo Rodriguez (Ecuador)
William Smith (United States)
Dennis Sugrue (United States)
Jod Taywaditep (Thailand)
Leonore Tiefer (United States)

Background Writers for the Technical Document

Sexual Rights
Eleanor Maticka-Tyndale (Canada)
Lisa Smylie (Canada)

Gender Equity
Elizabeth Castillo Vargas (Colombia)
Adriane Little Tuttle (Colombia)

Sexual Violence and Abuse
Ine Vanwesenbeeck (The Netherlands)

Sexuality Education
Doortje Braeken (The Netherlands)
Melissa Cardinal (United Kingdom)

Reproductive Health
Victoria Ward (United States)
Angela Heimburger (United States)

HIV/AIDS and STIs
Sarah Hawkes (United Kingdom)

Sexual Dysfunction and Disorders
Emil Ng (China)

Sexual Pleasure and Well-Being
Terence Hull (Australia)

International Expert Consultation
Promotion of Sexual Health:
Advancing Sexual Health in the Millennium

Hotel Victoria
Oaxaca City, México

May 1-2, 2006

List of Participants

Pierre Assalian, MD, CSPQ, Dipl.Psych*
Director Human Sexuality Services
Montreal, Québec, Canada

Sharon Bissell Sotelo, MA
Program Officer
John D. and Catherine T. MacArthur Foundation
México City, México

Walter O. Bockting, PhD*
Associate Professor
Program in Human Sexuality
Department of Family Practice and Community Health
University of Minnesota Medical School
Minneapolis, Minnesota, USA

Jaqueline Brendler, MD.*
Specialist in Gynaecology and Obstetrics (FEBRASGO) and Human Sexuality (SBRASH)
Porto Alegre, RS. Brazil

Beatriz Castellanos Simona, Ph.D.
Sexuality and Reproductive Health Education Specialist. UNFPA Country Support Team for Latin America and the Caribbean
México D.F.

Elizabeth Castillo Vargas
Lawyer and Sexual Health Expert
Profamilia - Colombia
Bogotá – Colombia

Mariela Castro Espín, M.Sc.*
Director of the National Center of Sex Education (CENESEX)
Chairwoman of the Cuban Multidisciplinary Society for the Study of Sexuality (SOCUMES).
Havana, Cuba

Verapol Chandeying, MD., Dip OBGYN (Thai), Dip Reprod Med (Thai), FRCP (Edin)
Associate Professor
Department of OB/GYN
Faculty of Medicine
Prince of Songkla University
Hat Yai, Thailand

Rosemary Coates, Ph.D.*
Professor
Sexology Programmes
School of Public Health
Curtin University
Perth, Western Australia

Esther Corona**
Psychologist
President
Mexican Association for Sex Education (AMES)
Del Tlapan, México

Eli Coleman, Ph.D.**
Professor and Director
Program in Human Sexuality
Department of Family Medicine and Community Health
University of Minnesota Medical School
Minneapolis, Minnesota, USA

Maryanne Doherty, Ph.D.
Associate Dean and Professor
University of Alberta
University of Alberta
Edmonton, Alberta, Canada, T5G 2G5

Uwemedimo Uko Esiet, MD, MPH*
Regional Secretary of WAS for Africa
Co-founder and Director, Action Health Incorporated
Convener, Afirican Federation for Sexual Health and Rights
Jibowu, Lagos
Nigeria

Carissa F. Etienne, MD
Assistant Director
Pan American Health Organization
Washington, DC, USA

Paola Ferroni, PhD
Professor and Director
Centre for International Health
Curtin University
Perth, Western Australia

Marc Ganem, MD*
Past President of the World Association for Sexual Health
President of the French Society of Clinical Sexology
Paris, France

Juan Luis Álvarez Gayou Jurgenson, MD
Director of Prevention and Social Participation
Nacional Center for the Prevention and Control of HIV/AIDS (CENSIDA)
México, D.F., México

Sarah Hawkes, MB, BS, PhD
Clinical Senior Lecturer
London School of Hygiene and Tropical Medicine
London, United Kingdom

Angela Heimburger, MPH
International Planned Parenthood Federation, Western Hemisphere Region
(IPPF/WHR)
New York, New York, USA

Terence H. Hull, Ph.D.
Professor
Demography and Sociology Program, Research School of Social Science
The Australian National University
Canberra, Australia

Pinar Ilkkaracan, M.A.
Co-Founder, Women for Women's Human Rights (WWHR) and Coalition for Sexual and Bodily Rights in Muslim Societies
Istanbul, Turkey

Barbara Jones
Manager
Sexual Health & STI Section
Public Health Agency of Canada
Ottawa, Ontario, Tel: (613)941-7541

Eleanor Maticka-Tyndale, Ph.D.
Canada Research Chair-Social Justice and Sexual Health
Dept. of Sociology & Anthropology

University of Windsor
Windsor, Ontario, Canada

Rafael Mazin, MD, MPH
Regional Advisor on HIV/STI Prevention & Comprehensive Care
Pan American Health Organization/World Health Organization
Washington, DC, USA

Alexander McKay, Ph.D.
Research Coordinator
Sex Information and Education Council of Canada
Toronto, Ontario, Canada

Reiko Ohkawa, M.D.*
Department of OB/GYN
National Hospital Organization
Chiba Medical Center
Chuoku, Chiba, Japan

Hans Olsson, B.Ed
The Swedish Association for Sexuality Education (RSFU)
Stockholm, Sweden

Deborah Rogow, MPH
Evaluation Consultant to WAS
Co-Director of Rethinking Sexuality Education Project for the Population Council
Santa Barbara, California, USA

Eusebio Rubio-Aurioles, MD, PhD.*
President
World Association for Sexual Health
Asociacion Mexicana para la Salud Sexual, A.C.
World Association for Sexual Health
Tlalpan DF, México

Jorge Saavedra López, MD
Director General
Nacional Center for the Prevention and Control of HIV/AIDS (CENSIDA)
México, D.F. 06760

Lisa Smylie, MA, Ph.D. Candidate
Dept. of Sociology/Anthropology
University of Windsor
Windsor, Ontario, Canada

William A. Smith, B.A., Ph.D. Candidate
Vice President for Public Policy
The Sexuality Information and Education Council of the United States (SIECUS)
Washington, DC, USA

Ondrej Trojan, MD
Private Clinic of Psychiatry and Sexology
Prague, Czech Republic

Wilhelmina Maria AnnaVanwesenbeeck, PhD
Rutgers Nisso Groep
Utrecht, The Netherlands

Javier Vasquez
Human Rights Specialist
Area of Technology and Health Services Delivery (THS)/Area of Legal Affairs (LEG)
Pan American Health Organization/World Health Organization

Beverly Whipple, PhD, RN, FAAN*
Secretary General
World Association for Sexual Health
Professor Emerita
Rutgers, the State University of New Jersey
Voorhees, New Jersey, USA

Ninuk Sumaryani Widyantoro
Psychologist
Advisory Board Member of Women's Health Foundation
Kebayoran Baru, Jakarta Selatan, Indonesia

Kevan Wylie, MB, MD, DSM, FRCPsych*
Porterbrook Clinic, University of Sheffield
Royal Hallamshire Hospital
United Kingdom

* Member of the WAS Advisory Board
** Ex-officio Member of the WAS Advisory Board

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