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Promotion of Sexual Health

Recommendations for Action

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World Health Organization (WHO)
In collaboration with the

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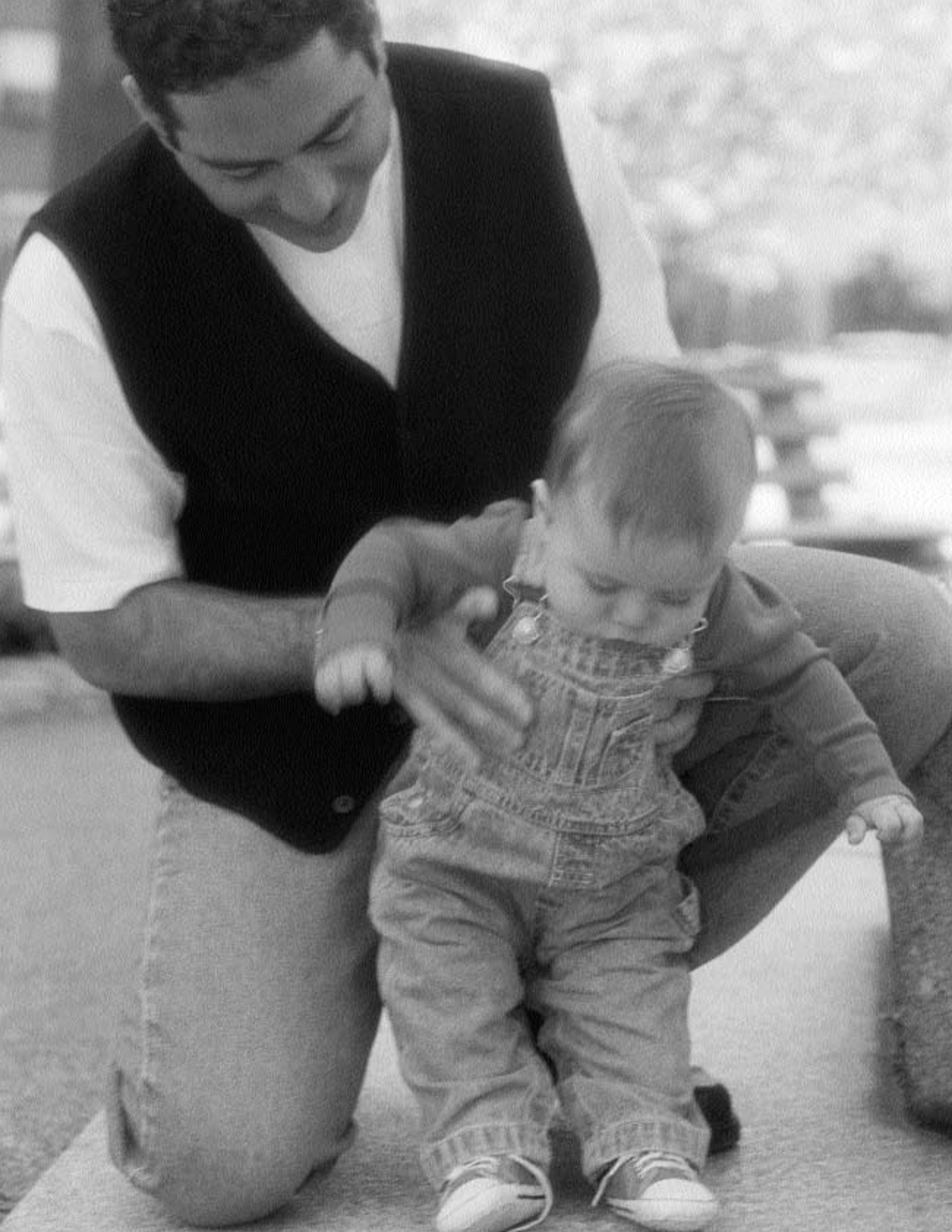

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Background and Objectives

Historical Background

A Meeting on Education and Treatment of Human Sexuality: The Training of Health Professionals was convened by the World Health Organization (WHO) in Geneva from 6 to 12 February 1974. The participants were invited to attend on the basis of their special knowledge and experience in teaching, research, or clinical practice in the field of human sexuality in various countries. The meeting was asked to make a critical review of, and to develop recommendations in, the following areas:

- the role of Sexology in health programs, particularly in family planning activities;
- the content and methodology of teaching in human sexuality to the health professions;
- the identification of treatment and counseling models suitable to meet the priority needs in various sociocultural contexts and to be practiced by general health workers;
- the initiation, organization, and implementation of teaching and treatment programs in human sexuality;
- the international services for reference and coordination in the field of Sexology.

The conclusions of this meeting were reported in the document *Education and Treatment in Human Sexuality: The Training of Health Professionals*.[1] This was a historic document that paved the way for improved training of health professionals to provide the necessary sexual education, counseling and therapy. It also served as a stimulus for the development of the field of Sexology and sexual resources centers throughout the world.

Two subsequent meetings of the European Office of the WHO have addressed issues relating to this document.[2] However, the reports were not widely disseminated and hence, the actions proposed were not widely undertaken as suggested.

In the twenty-five years that have elapsed since the publication of the first document, many developments have occurred in the field of human sexuality and other related fields of knowledge. These developments have enriched our understanding and awareness of the complexity of the sexual education, counseling and treatment. Research has identified approaches and interventions that are effective, and those that are not. The emergence of new problems, notably the HIV/AIDS pandemic, has raised our awareness of current urgent needs for enhanced sexuality training and a much more concerted and comprehensive approach to addressing sexuality problems.

In order to extend and enhance previous efforts, the Pan American Health Organization (PAHO) in collaboration with the World Association for Sexology called a regional consultation to re-examine how to promote Sexual Health including the role of the health sector in the achievement and maintenance of Sexual Health. This document is the result of this consultation held in Antigua Guatemala, Guatemala, on May 19 to 22, 2000.

Rationale

Some of the most relevant developments concerning Sexual Health have occurred in the past twenty-five years. These developments include:

- Advances in knowledge about different aspects of human sexuality. This has been achieved through theoretical inquiry, biomedical, psychological, sociological and anthropological research, epidemiological surveillance and clinical work—that have contributed to the development of an extremely complex field, transcending each of the individual disciplines it encompasses.

- The emergence of the HIV pandemic and increased awareness of the impact of other sexually transmitted infections.[3] The effective control of these problems relies upon successfully changing the behaviors and sexual practices of people. The ability to promote behavioral change is, therefore, highly dependent on an adequate understanding of human sexuality. [4]

- Formation of a solid body of knowledge originated in the writings and views of feminist scholars. This knowledge indicates that societies are articulated and regulated by a complex and pervasive set of rules and assumptions that permeate every aspect of the society and the very construction of knowledge. The gender perspective has shown that any consideration of human sexuality cannot be complete if it ignores the cultural concepts of "masculinity" and "femininity."[5]

- Definition and consolidation of the field of reproductive health. In particular, the priority consideration given to reproductive health, including Sexual Health, in the Program of Action of the International Conference on Population and Development.[6]

- Recognition of violence, including sexual violence, especially against women, children and sexual minorities, as a serious public health issue.[7]

- Recognition of sexual rights as human rights. Sexual rights have been explicitly recognized and stated by groups such as the International Planned Parenthood Federation[8] and by the World Association for Sexology.[9] However, sexual rights have often only been recognized in their reproductive dimension as in the 1994 International Conference on Population and Development (ICPD) in Cairo, as well as at the Fourth World Conference on Women (Beijing, 1995).[10] A more comprehensive stance needs to be taken to achieve full recognition of sexual rights.

- Increased advocacy by social movements for recognition, respect and the protection of the rights of "minorities" (such as gay, lesbian, and transgender individuals.)

- Development of effective and safe medications to modify and improve the sexual functioning of individuals. This has prompted renewed interest in the prevalence and consequences of sexual dysfunctions and compulsive sexual behavior.[11]

Consultation Objectives

The objectives of the present consultation were as follows:

- To develop a conceptual framework for the promotion of Sexual Health

- To identify Sexual Health concerns and problems in the Region of the Americas

- To suggest actions and strategies to achieve and maintain Sexual Health

Conceptual Framework

It is essential to have commonly agreed-upon, precise definitions of the terminology used in the fields of human sexuality and Sexual Health. Obviously, such definitions of key concepts are necessary in order to effectively communicate, disseminate information and develop specific actions and programs aimed at the promotion of Sexual Health. However, arriving at a consensus about the efficacy of such has proven difficult.

Human sexuality as a concept defies easy definition. The difficulty arises mainly from the fact that the definition is a process of abstraction,[12] and as such, is influenced by the particular socio-cultural and historical context and process in which the definition is constructed.

Another problem in trying to define human sexuality is that the distinction between sex and sexuality are not often made. Consequently, there is often confusion about what the terms sex and sexuality actually mean. The term "sex," in its common usage and in many settings, refers to different notions. The following quotation illustrates this situation: "We learn very early on from many sources that 'natural' sex is what takes place with members of the 'opposite sex'… …The term refers both to an act and to a category of a person, to a practice and to a gender."[13]

In order to construct an appropriate framework for the consideration of Sexual Health, basic concepts referring to sex and sexuality need to be defined and their definitions agreed upon. As a step forward, the experts working group attending the regional consultation suggests the following definitions:

Basic Concepts

Sex

Sex refers to the sum of biological characteristics that define the spectrum of humans as females and males.

The usual meaning of the term "sex" in colloquial language includes its usage as an activity (e.g., having sex) and as a set of behaviors (e.g., sex roles). However, for conceptual precision, it was agreed that for technical discussions and documents the usage of the term "sex" be restricted to the biological dimensions.

Basic Concepts of Sex, Sexuality and Sexual Health

SEX
Sex refers to the sum of biological characteristics that define the spectrum of humans as females and males.

SEXUALITY
Sexuality refers to a core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love, and reproduction. It is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles, relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors. While sexuality can include all of these aspects, not all of these dimensions need to be experienced or expressed. However, in sum, our sexuality is experienced and expressed in all that we are, what we feel, think and do.

SEXUAL HEALTH
Sexual health is the experience of the ongoing process of physical, psychological, and sociocultural well being related to sexuality. Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. For Sexual Health to be attained and maintained it is necessary that the sexual rights of all people be recognized and upheld.

Table 1. Basic Concepts and Definitions of Sex, Sexuality and Sexual Health

Related Concepts to Sexuality

GENDER

Gender is the sum of cultural values, attitudes, roles, practices, and characteristics based on sex. Gender, as it has existed historically, cross-culturally, and in contemporary societies, reflects and perpetuates particular power relations between men and women.

GENDER IDENTITY

Gender identity defines the degree to which each person identifies as male, female, or some combination. It is the internal framework, constructed over time, which enables an individual to organize a self-concept and to perform socially in regards to his/her perceived sex and gender. Gender identity determines the way individuals experience their gender and contributes to an individual's sense of sameness, uniqueness and belonging.

SEXUAL ORIENTATION

Sexual orientation is the organization of an individual's eroticism and/or emotional attachment with reference to the sex and gender of the partner involved in sexual activity. Sexual orientation may be manifested in any one or a combination of sexual behavior, thoughts, fantasies or desire.

SEXUAL IDENTITY

Sexual identity is the overall sexual self identity which includes how the individual identifies as male, female, masculine, feminine, or some combination and the individual's sexual orientation. It is the internal framework, constructed over time, that allows an individual to organize a self-concept based upon his/her sex, gender, and sexual orientation and to perform socially in regards to his/her perceived sexual capabilities.

EROTICISM

Eroticism is the human capacity to experience subjective responses that elicit physical phenomena perceived as sexual desire, sexual arousal and orgasm, and usually identified with sexual pleasure. Eroticism is constructed both at individual and societal levels with symbolic and concrete meanings that link it to other human dimensions.

EMOTIONAL ATTACHMENT

Emotional attachment is the human capacity to establish bonds with other human beings that are built and maintained through emotions. Emotional attachment is constructed both at individual and societal levels with symbolic and concrete meanings that link it to other human dimensions. Love represents an especially desirable kind of emotional attachment.

Table 2. Related concepts and definitions of gender, gender identity, sexual orientation, sexual identity, eroticism, emotional attachment, sexual activity, sexual practice, safer sex, and responsible sexual behavior. *(Continues on next page)*

Table 2. Related Concepts to Sexuality
(continued from page 13)

SEXUAL ACTIVITY

Sexual activity is a behavioral expression of one's sexuality where the erotic component of sexuality is most evident. Sexual activity is characterized by behaviors that seek eroticism and is synonymous to sexual behavior

SEXUAL PRACTICE

Sexual practice is a pattern of sexual activity that is exhibited by an individual or a community with enough consistency to be expected as a behavior.

SAFER SEX

Safer sex is a term used to specify sexual practices and sexual behaviors that reduce the risk of contracting and transmitting sexually transmitted infections, especially HIV.

RESPONSIBLE SEXUAL BEHAVIORS

Responsible sexual behavior is expressed at individual, interpersonal and community levels. It is characterized by autonomy, mutuality, honesty, respectfulness, consent, protection, pursuit of pleasure, and wellness. The person exhibiting responsible sexual behavior does not intend to cause harm, and refrains from exploitation, harassment, manipulation and discrimination. A community promotes responsible sexual behaviors by providing the knowledge, resources and rights individuals need to engage in these practices.

Sexuality

Sexuality refers to a core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love, and reproduction. It is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles, relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors. While sexuality can include all of these aspects, not all of these dimensions need to be experienced or expressed. However, in sum, our sexuality is experienced and expressed in all that we are, what we feel, think, and do.

Previous WHO consultations either did not provide a definition of human sexuality[14] or offered imprecise concepts.[15] As defined here, sexuality refers to the additional components of our sexual nature (the human characteristic of being sexed). The human capacity of understanding and ascribing meanings both symbolic and concrete, to experiences and concepts are the bonding forces of sexuality. There is general agreement in the literature that sexuality refers to the individual and social meanings of sex, in addition to the biological aspects of sex.[16]

While sexuality can include eroticism, emotional attachment, love, sex, gender, and reproduction,[17] not all these dimensions need to be expressed. Sexuality is present throughout the life span, although the various expressions and influences affecting sexuality may differ across time.[18] It is circumscribed by a particular historic and cultural context, therefore, being organized and organizing mores, traditions and values. Its full development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love.

Besides the agreement that the socio-cultural components (shared meanings) of sexuality are critical for the conceptualization of human sexuality, there is a clear trend in theoretical approaches that sexuality refers not only to the reproductive capabilities of the human being, but also (and in many instances, mainly) to pleasure.[19]

Another component of sexuality, emotional attachment/love has been considered in the work of some theoreticians.[20] Psychoanalytical literature includes considerations of love, love pathology and sexuality usually in a language in which love is indistinguishable from other sexual expressions such as erotic attraction.[21] However, some recent findings discuss the possibility of a distinct neurobiological system that regulates attachment and pair bonding in animals[22] and performs the same function in humans.[23]

Sexual Health

Sexual health is the experience of the ongoing process of physical, psychological, and socio-cultural well being related to sexuality.

Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. For Sexual Health to be attained and maintained, it is necessary that the sexual rights of all people be recognized and upheld.

Historically, different groups have used the term “Sexual Health” to mean different things. For some, the term has been used as a euphemism for information on sexually transmitted infections; for others, it has been used to promote a narrow approach to education on reproduction. It should be clear from the above definition that in this document, a comprehensive meaning of the concept is proposed. The World Health Organization states that “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”[24] The clarity apparent in this definition becomes less obvious when it is applied to behavior. There is an ongoing debate on the implications of defining health as that definition relates to behavior. There are points of view that do not conceptualize health as a matter that should be concerned with behaviors and lifestyles.[25] They question the valid-

ity of health definitions that relate to a value-defined framework[26] and propose that health be defined only in terms of measurable indicators of clearly defined conditions.

Central to this controversy is the debate of values and health. Some theorists define health in a value-free fashion; others defend the value-defined concept of health.[27] Still others question the very feasibility of value-free scientific propositions.[28] The expert working group recommended that a more plausible position is one that recognizes that scientific activity, and therefore, science-based health care and promotion cannot be performed from a totally value-free stance, and thus, value-defined propositions, definitions and concepts are unavoidable. It should be clear from the above definition that in this document, a comprehensive meaning of the concept is proposed. The World Health Organization states that "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." The WHO health definition is perhaps the best example of this, where health is basically defined in terms of well being. Well being is understood to be a value-defined state.

Thus, the expert working group agreed that establishing a definition of Sexual Health is both possible and desirable provided that the definition is derived from, and embodies the concept of sexual rights.

The basic definitions of sex, sexuality and Sexual Health are summarized in Table 1. Related concepts of sexuality are defined in Table 2.

Sexual Rights

Human rights are inherent to human beings; however, recognition of inherent rights does not create rights per se.

Human rights are above cultural values. If a particular culture has a practice that contravenes a human right, the cultural value should be changed, as in the case of the cultural practice of female genital mutilation.[29] The human rights approach to health promotion has been explicitly stated in the case of the promotion of reproductive
health.[30]

The recognition of sexual rights is evolving. Human rights are those principles that are universally perceived as protecting human dignity while promoting justice, equality, liberty, and life. Since protection of health is a basic human right, it follows that Sexual Health involves sexual rights.

The expert working group strongly recommends that international organizations such as the WHO and other United Nations agencies promote and serve as advocates to achieve a consensus on the World Association for Sexology's statement of universal human sexual rights (See Table 3).

World Association for Sexology's Declaration of Sexual Rights

The right to sexual freedom.

The right to sexual autonomy, sexual integrity, and safety of the sexual body.

The right to sexual privacy.

The right to sexual equity.

The right to sexual pleasure.

The right to emotional sexual expression.

The right to sexually associate freely.

The right to make free and responsible reproductive choices.

The right to sexual information based upon scientific inquiry.

The right to comprehensive sexuality education.

The right to Sexual Health care.

Table 3. This list is taken from the Declaration of Sexual Rights issued by the World Association for Sexology; the full text of this declaration is presented in Appendix I.

CHARACTERISTICS OF SEXUAL HEALTH

Sexual health can be recognized both at the individual and societal level. At the individual level, there are specific behaviors that have been identified that characterize the sexually healthy individualxxxi and these are presented as Life Behaviors of the Sexually Healthy Individual. The groups of experts suggest adopting this list that has been validated in several countries (See Table 4).

SIECUS List of Life Behaviors of a Sexually Healthy Adult

A sexually healthy adult would:

- Appreciate one's own body.
- Seek further information about reproduction as needed.
- Affirm that human development includes sexual development that may or may not include reproduction or genital sexual experience.
- Interact with both genders in respectful and appropriate ways.
- Affirm one's own sexual orientation and respect the sexual orientation of others.
- Express love and intimacy in appropriate ways.
- Develop and maintain meaningful relationships.
- Avoid exploitative or manipulative relationships.
- Make informed choices about family options and lifestyles.
- Exhibit skills that enhance personal relationships.
- Identify and live according to one's values.
- Take responsibility for one's own behavior.
- Practice effective decision-making.
- Communicate effectively with family, peers, and partners.
- Enjoy and express one's sexuality throughout life.
- Express one's sexuality in ways congruent with one's values.
- Discriminate between life-enhancing sexual behaviors and those that are harmful to self and/or others.
- Express one's sexuality while respecting the rights of others.
- Seek new information to enhance one's sexuality.
- Use contraception effectively to avoid unintended pregnancy.
- Prevent sexual abuse.
- Seek early prenatal care.
- Avoid contracting or transmitting a sexually transmitted disease, including HIV.
- Practice health-promoting behaviors, such as regular check-ups, breast and testicular self-exam, and early identification of potential problems.
- Demonstrate tolerance for people with different sexual values and lifestyles.
- Exercise democratic responsibility to influence legislation dealing with sexual issues.
- Assess the impact of family, cultural, religious, media, and societal messages on one's thoughts, feelings, values, and behaviors related to sexuality.
- Promote the rights of all people to accurate sexuality information.
- Avoid behaviors that exhibit prejudice and bigotry.
- Reject stereotypes about the sexuality of diverse populations.

Table 4. List of Life Behaviors of a Sexually Health Adult adopted by The Sexuality Information and Education Council of the United States (SIECUS).

Sexual health can also be identified at a societal level. The expert working group identified several characteristics of a sexually healthy society and these are presented in the following Table 5.

Characteristics of a Sexually Healthy Society

Societies that prioritize and protect the Sexual Health of their members have the following characteristics:

Political commitment. The State recognizes that Sexual Health is a fundamental Human Right and takes the responsibility of promoting Sexual Health.

Explicit Policies. Social institutions, including governmental agencies, formulate, develop and implement public policies involving clear and precise directions for protecting and promoting Sexual Health as a fundamental human right.

Legislation. Laws to protect the sexual rights are necessary to promote Sexual Health. Specifically, legislation is necessary that protects the vulnerable from exploitation (e.g., child prostitution), recognizes the rights of all persons to integrity of the body (e.g., protection from genital mutilation), protects the rights of sexual minorities to such fundamental human rights as education, health, and employment (e.g., anti-discrimination legislation), and promotes equity across sexual dimensions (e.g., equal opportunity legislation).

Good Education. A necessary component of a sexually healthy society is universal access to age-appropriate, comprehensive sexuality education across the lifespan.

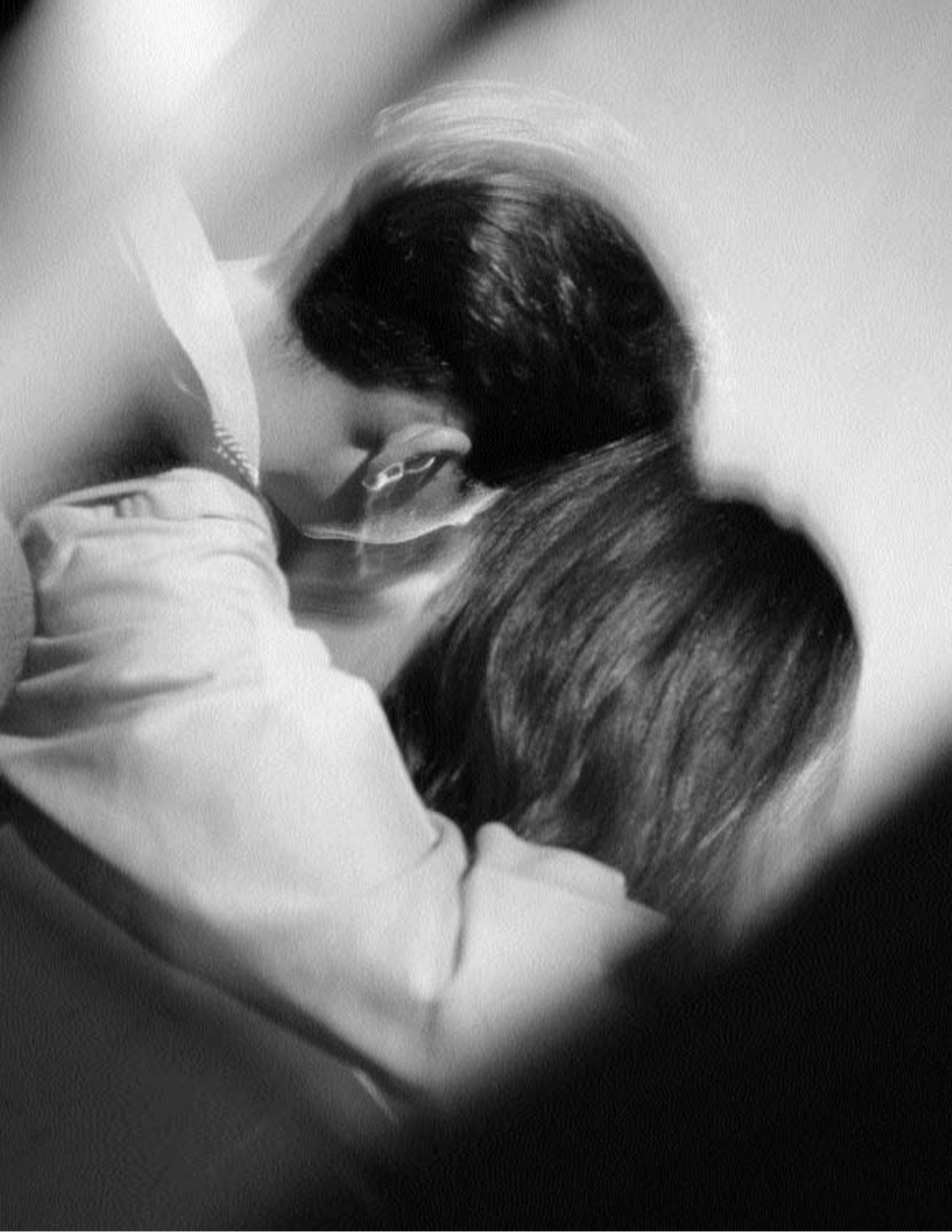
Sufficient Infrastructure. To ensure persons have access to services, an infrastructure of professionals and paraprofessionals specializing in sexual concerns and problems is necessary. This includes the provision of training programs for professionals to specialize in Sexual Health.

Research. A society committed to the Sexual Health of its members will support adequate and sound research to address the Sexual Health related clinical, educational and public health concerns. This includes both research on emerging concerns (e.g., new infections), and behavioral surveillance to monitor preventive health concerns (e.g., rates of unsafe sex in high-risk subpopulations, rates of sexual violence, prevalence of sexual dysfunctions, etc.).

Adequate Surveillance. Surveillance is necessary to monitor biomedical and behavioral markers of Sexual Health concerns and problems.

Culture. A culture of openness to, and prioritization of, Sexual Health is necessary. Such indicators as the quality of media reporting on Sexual Health concerns, and the degree to which public health messages regarding serious threats to Sexual Health can be openly promoted can measure the culture.

Table 5. Characteristics of a Sexually Healthy Society



Sexual Health Concerns and Problems

Sexual Health concerns and problems are present whenever life situations related to sexuality require interventions by individuals and/or society due to their impact on wellness and quality of life. The variety of these concerns and problems is very wide, ranging from conditions that are perceived as "part of life" to those that constitute a threat to well being and even, to life. However, all of them demand attention from all segments of society including the health sector both through prevention and appropriate comprehensive care.

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.

HIV/AIDS Pandemic. Sexual health concerns and problems impact various areas of human activity at individual and social levels. For example, the global spread of HIV, mainly through unprotected sexual intercourse, has resulted in around 35 million infected people and over 19 million deaths worldwide since the beginning of the epidemic. Communities at large bear the effects of the AIDS pandemic to the extent that there are around 13 million children and young people orphaned as a result of HIV-related death of one or both parents. Furthermore PAHO estimates there are 2.5 million people currently living with HIV in the Region of the Americas.

The HIV/AIDS pandemic has brought to public attention the extreme seriousness of sexually transmitted infections. One million people die each year from reproductive tract infections, including sexually transmitted infections (STIs) other than HIV/AIDS. It has been estimated that 333 million new cases of STIs may occur globally each year.

Violence. The World Development Report (1993) of the World Bank estimated that women aged 15 to 44 years lose a significant amount of Discounted Health Years of Life (DHYLs) due to rape and domestic violence, which may be related to gender inequity, and irresponsible behavior. Studies show that rape survivors have high rates of persistent post-traumatic stress disorder and make up the largest single group diagnosed with the disorder. Rape victims are nine times more likely than non-victims to attempt suicide and to suffer major depression. Furthermore, 50 to 60 percent of the victims experience sexual dysfunction, including fear of sex and problems with arousal. A study based on the records of the Maternity Hospital of Lima, Peru, revealed that 90 percent of young mothers aged 12 to 16 had become pregnant because they had been raped. In Costa Rica, an organization working with adolescent mothers reported that 95 percent of its pregnant clients under 15 were victims of incest.[32]

The impact and importance of gender related problems (in particular those related to gender inequality) are widespread, and the importance of addressing the issue and solving the problem has been recognized worldwide.[33]

Sexual Dysfunctions. The problem of sexual syndromes has recently been highlighted. The prevalence of sexual dysfunctions has been established for some populations. For example, in the United States, a prevalence rate of 43% for females and 31% for males is reported.[34] Sexual dysfunctions have been correlated with lower levels of quality of life,[35] and to other health problems: heart disease, hypertension, diabetes, associated medications, and high indexes of anger and depression.[36]

Although the above mentioned figures may seem very dramatic, they are only the tip of the iceberg in a field that is just emerging as a public health issue. Any actions to reduce the magnitude and severity of situations affecting Sexual Health require a comprehensive and ample approach that surpasses the curative paradigm of health care.

Sexual health concerns are life situations that require preventive and educational actions by society to ensure its members attain and maintain Sexual Health. Sexual health problems are the result of conditions, either in an individual, relationship, or a society, that require specific action for their identification, prevention and/or treatment and therefore, eventual resolution. The necessary level of training for professionals also differentiates these two categories. Sexual problems usually need clinically trained professionals for their solution, whereas sexual concerns can be addressed and managed by a variety of professionals often not needing specialized clinical training.

The expert working group recommends that the following sexual concerns and problems be addressed as a means of advancing societies towards Sexual Health (See Box V).

Sexual Health Concerns

The following list is not exhaustive but rather examples and illustrations of sexual concerns. Each of these concerns allows the appropriate assessment of information, counseling and/or care needs that demand actions from governmental and non-governmental agencies and institutions including the health sector.

Box V. Sexual Health Concerns

1. Sexual health concerns related to body integrity and to sexual safety
- Need for health-promoting behaviors for early identification of sexual problems (e.g., regular check-ups and health screening, breast and testicular self-exam)
- Need for freedom from all forms of sexual coercion such as sexual violence (including sexual abuse and harassment)
- Need for freedom from body mutilations (i.e. female genital mutilation)
- Need for freedom from contracting or transmitting sexually transmitted infections (including but not limited to HIV/AIDS)
- Need for reduction of sexual consequences of physical or mental disabilities
- Need for reduction of impact on sexual life of medical and surgical conditions or treatments

2. Sexual health concerns related to eroticism
- Need for knowledge about the body, as related to sexual response and pleasure
- Need of 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

3. Sexual health concerns related to gender
- Need for gender equity
- Need for freedom from all forms of discrimination based on gender
- Need for respect and acceptance of gender differences

4. Sexual health concerns related to sexual orientation
- Need for freedom from discrimination based on sexual orientation
- Need for freedom to express sexual orientation in safe and responsible manners within a values framework respectful of the rights of others

Box V. Sexual Health Concerns
(Continued from page 23)

5. Sexual health concerns related to emotional attachments
- Need for freedom from exploitative, coercive, violent or manipulative relationships
- Need for information regarding choices of family options and lifestyles
- Need of skills, such as decision-making, communication, assertiveness and negotiation, that enhance personal relationships
- Need for respectful and responsible expression of love and intimacy
- Prevention and appropriate care of couple maladjustment and distress
- Appropriate management of separation and divorce

6. Sexual health concerns related to reproduction
- Need to make informed and responsible choices about reproduction
- Need to make responsible decisions and practices regarding reproductive behavior regardless of age, gender and marital status
- Access to reproductive health care
- Access to safe motherhood
- Prevention and care for infertility

Sexual Health Problems

Sexual problems are the result of conditions, either in an individual, relationship, or a society, that require specific action for their identification, prevention and/or treatment and therefore, eventual resolution.

In the past, the use of the term “pathology” to denote sexual problems has created considerable controversy. The usual and clear cut meaning of the term pathology in other areas of health care is frequently lost when it is applied to sexual problems and concerns due to the nature of the problems experienced. Therefore the expert working group recommends the use of the term “sexual problem” rather than “pathology” to refer to Sexual Health problems.

Another recommendation is the use of syndrome level classification. Clinical syndromes define a cluster of symptoms and complaints that seriously inhibit the exercise of the individual’s sexual rights and alter his/her Sexual Health.

There are a number of advantages of taking a syndromic approach. Syndromes are easy to identify. Awareness of the presence of the problem both in health personnel and the general public is easier to create when problems are known at a syndrome level. A syndrome level classification also is more succinct and can be used for epidemiological considerations. Much of what is currently known about epidemiology of some of these categories is at a syndrome level.[37] In categories such as sexually transmitted infections preventive and curative actions can be taken effectively from a public health perspective if a syndromic approach is taken.[38]

On the other hand, many sexual problems are caused by a rather complex variety of etiologies. For example, in sexual dysfunctions the need for etiology based diagnosis persists even when the syndrome has been identified.[39] A syndrome level classification helps in reminding that the listed categories are syndromes, not etiologically classified clinical entities. For the above reasons the expert working group strongly recommends that a syndromic approach to the classification of Sexual Health problems be undertaken.

Clinical syndromes are rather artificial categories that are created with broad agreement between professionals. There is considerable consensus in many of the clinical syndromes presented in the proposed classification: sexual dysfunctions are a good example of the process of consensus. In other categories such as compulsive sexual behavior syndromes, process of consensus is still in its initial building stages.

Sexual problems, therefore, are presented here as syndromes. Each of these problems allows the appropriate assessment of information, counseling, prevention, early identification, need for further diagnostic evaluation, and course of treatment, rehabilitation and/or care needs that demand actions from governmental and non-governmental agencies and institutions including the health sector. Sexual problems are divided into the following syndrome categories (See Table 6, pp. 26-27):

Sexual Health Problems (Clinical Syndromes)

1. Clinical Syndromes that Impair Sexual Functioning (Sexual dysfunctions)

- Hypoactive sexual desire
- Sexual aversion
- Female sexual arousal dysfunction
- Male erectile dysfunction
- Female orgasm dysfunction
- Male orgasm dysfunction
- Premature ejaculation
- Vaginismus
- Sexual pain syndromes (including dyspareunia and other pain conditions)

2. Clinical Syndromes Related to Impairment of Emotional Attachment/Love (also known as Paraphilias)

- Exhibitionism
- Fetishism
- Frotteurism
- Pedophilia
- Sexual masochism
- Sexual sadism
- Fetishist transvestism
- Voyeurism
- Unspecified paraphilia

3. Clinical Syndromes Related to Compulsive Sexual Behavior

- Compulsive cruising and multiple partners
- Compulsive fixation on an unattainable partner
- Compulsive autoeroticism
- Compulsive love affairs
- Compulsive sexual behavior in a relationship.

4. Clinical Syndromes Involving Gender Identity Conflict

- Childhood Gender Dysphoria
- Adolescent Gender Dysphoria
- Adult Gender Dysphoria
- Intersex syndromes
- Unspecified Gender Identity Syndrome

5. Clinical Syndromes Related to Violence and Victimization

- Clinical syndromes following being sexually abused as a child/minor (Including but not limited to post-traumatic stress disorder)
- Clinical syndromes following being sexual harassed
- Clinical syndromes following being sexually violated or raped
- Clinical phobia focused on sexuality (e.g., homophobia, erotophobia)
- Clinical syndromes related to engaging in threat or acts of violence focused on sex or sexuality (e.g., raping another person)
- Patterns of unsafe sexual behavior placing self and/or others at risk for HIV infection or/and other sexually transmitted infections.

Table 6. Sexual Health Problems (Clinical Syndromes)

Table 6. Sexual Health Problems (Clinical Syndromes)
(continued)

6. Clinical Syndromes Related to Reproduction

- Sterility
- Infertility
- Unwanted pregnancy
- Abortion complication

7. Clinical Syndromes Related to Sexually Transmitted Infections
(An etiological classification is included in Appendix II)

- Genital Ulcer
  - Non-vesicular
  - Vesicular
- Oral ulcer
  - Non-vesicular
  - Vesicular
- Rectal ulcer
  - Non-vesicular
  - Vesicular
- Discharge
  - Urethral
  - Vaginal
  - Rectal
- Lower abdominal pain in women
- Asymptomatic sexually transmitted infections and infestations (including HIV)
- Acquired Immunodeficiency Syndrome (secondary to HIV infection).

8. Clinical Syndromes Related to Other Conditions

- Clinical syndromes secondary to disability or infirmity.
- Clinical syndromes secondary to physical or mental illness
- Clinical syndromes secondary to medication or other medical and surgical interventions
- Colorectal conditions
- Clinical syndromes secondary to other conditions

Actions and Strategies to Promote Sexual Health

The attainment of health is a priority in all societies. For Comprehensive Health to be achieved, Sexual Health must be promoted and maintained. The considerable advances in the Region of the Americas in many areas of health care would be reinforced by a renewed emphasis on the prevention and care of sexual concerns and problems. In particular, there have been significant efforts in the area of reproductive health and the prevention and control of HIV/AIDS. The expert working group agreed that the basic goal of improving health could be achieved in a more efficient manner if a more comprehensive approach to sexuality, such as the conceptualization proposed in this document, is taken.

Sexual health is a comprehensive concept. Actions and strategies aimed to its attainment and maintenance should improve health and, therefore, increase personal and societal well being.

In addition to a comprehensive approach to improving health, the expert working group agreed that recognition of human rights is an effective way of promoting social, political, legal, and cultural changes. The WHO has recognized health as a basic Human Right.[40] Promotion of Sexual Health required changes in society, policies, laws and culture and therefore its promotion within a human rights approach is recommended.

For example, the United Nations Development Program (UNDP) established an official policy that states:

> Human Rights are based on respect for the dignity and worth of all human beings and seek to ensure freedom from fear and want. Rooted in ethical principles (and usually inscribed in a country's constitutional and legal framework), human rights are essential to the well being of every man, woman and child. Premised on fundamental and inviolable standards, they are universal and inalienable.[41]

The expert working group recommended the following five goals for governmental and non-governmental agencies and institutions including the health sector of the Region of the Americas:

Goal 1. Promote Sexual Health including the elimination of barriers to Sexual Health.

Goal 2. Provide comprehensive sexuality education to the population at large.

Goal 3. Provide education, training and support to professionals working in Sexual Health related fields.

Goal 4. Develop and provide access to comprehensive Sexual Health care services to the population.

Goal 5. Promote and sponsor research and evaluation in sexuality and Sexual Health and the dissemination of the knowledge derived from it.

The expert working group also identified a number of strategies for the implementation of the above list of goals. They are considered in the following sections.

GOAL 1

Promote Sexual Health Including the Elimination of Barriers to Sexual Health

Sexual health is to be promoted in all members of society. The expert working group stressed the need to recognize the sexual rights of all individuals, including persons with mental and physical disabilities.

Efforts to promote Sexual Health will be more efficient if all components of sexuality are taken into account, instead of utilizing only partial approaches. Accordingly, integration of Sexual Health into public health programs should include provisions for the dimensions of Sexual Health (e.g., emotional attachment/love development, gender development and, reproductive health).

Erotic pleasure is a dimension of the human being that has been frequently denied as a positive, rewarding, health promoting and basic human need. Recent evidence has shown that the importance of erotic experience has implications even at the physiological level.[42]

Erotic pleasure has been even more strongly stigmatized when it is experienced as autoeroticism (usually referred to as masturbation). However, there is no evidence in the scientific literature of the deleterious effects of this behavior. Moreover, there is consensus among clinical sexologists that promotion of autoerotic behavior is beneficial in the treatment of a variety of sexual dysfunctions. In addition, the value of autoeroticism has been found to be an important tool in the promotion of safer sexual behavior.[43]

Furthermore, the stigma about sexual pleasure has caused the elimination of any mention to pleasure in many sexuality education programs. This omission affects health care seeking behavior. People with problems or concerns regarding their sexual pleasure seek professional help with much less frequency than would be expected in view of the prevalence of Sexual Health problems.[44]
The importance of healthy emotional attachment/love cannot be underestimated. There is a long-standing awareness among behavioural scientists of the importance of a healthy and loving environment. In more biologically oriented studies, early life experiences involving touching have been shown to be necessary component of development and critical for maturation of the central nervous system.[45]

Strategy 1.1 Integrate Sexual Health into public health programs.

There is abundant evidence that public health concerns and problems are better approached if actions for prevention and treatment are integrated into broader health programs. Although specific actions implemented in specific programs are required, it is indispensable to have Sexual Health integrated into public health programmes.

The following specific actions for this strategy were identified:

- *Develop specific national Sexual Health strategies and plans.*
- *Promote legislation that ensures the feasibility of the national Sexual Health strategies.*
- *Integrate a Sexual Health approach into existing health programs.*
- *Develop indicators of Sexual Health to be used in policy and program development and evaluation.*
- *Promote consensus in the definition and classification of sexual problems.*
- *Develop best practice guidelines for sexual problems.*[46]

Strategy 1.2 Promote gender equality and equity and eliminate gender-based discrimination.

Since the groundbreaking work of theoretical and empirical feminism, more and more evidence has emerged as to the links between gender and health.[47] Particularly the ICPD and Beijing Conferences have contributed to the idea than unless gender is taken into account, health-related developmental goals are unattainable.

To achieve this strategy, actions are required that cover a very wide spectrum—from changes in policies that seem not related to health issues, to awareness building as to the specific health needs of women and men. These actions go beyond the recognition that sexual relations are gender relations. Notwithstanding the debate that places conceptually gender within sexuality or gender and sexuality as part of one system, it is obvious that Sexual Health cannot be approached without due consideration to gender and its power implications.

Some of the components of this strategy include:

- *Advocacy to introduce and change public policies that have an impact on gender disparities such as promoting schooling and formal education for girls*
- *Introduction of a gender perspective in the planning and implementation of Sexual Health services. For example such simple matters as taking into account the differences in time availability for men and women to attend health care facilities.*
- *Ensuring that comprehensive sexuality education always includes gender analysis and particularly stresses the right of men and women to sexual equity and equality.*
- *Encouraging actions that facilitate men to discuss and understand changes in gender roles and "the new masculinity." This is an important area due to the possible threat that changes in the status of women may pose to male sexuality, particularly in those societies in which the latter is linked to dominance and supremacy.*
- *Awareness-building for all health providers as to their own biases regarding gender.*

Strategy 1.3 Promote responsible sexual behavior.

Responsible sexual behavior is expressed at individual, interpersonal and community levels. It is characterized by autonomy, honesty, respectfulness, consent, protection, pursuit of pleasure, and wellness. The person exhibiting responsible sexual behavior does not intend to cause harm, and refrains from exploitation, harassment, manipulation, and discrimination. A community promotes responsible sexual behaviors by providing the knowledge, resources and rights individuals need to engage in these practices.

To be sexually healthy, persons must behave in a responsible manner; therefore, responsibility is one of the most important values to be promoted. Focusing on responsible sexual behavior can produce cost-effective results reducing burdens on society in terms of morbidity and improving well being. Components of this strategy are:

- *Inclusion of responsibility as a value to be promoted in all sexuality education programs.*
- *Implementation of adult education programs, specifically addressing the needs of parents, as they are the most immediate and efficient agents in promoting sexually responsible behavior.*
- *Involvement of mass media in introducing the issue of responsible sexual behavior in their messages, via addressing the issue directly in specific broadcasts or publications, or establishing specific campaigns.*
- *Introducing legislation to promote sexually responsible behavior.*

Strategy 1.4 Eliminate fear, prejudice, discrimination, and hatred related to sexuality and sexual minority groups.

Fear, prejudice, discrimination and hatred related to sexuality and sexual minority groups are obstacles to Sexual Health. Fear arises from ignorance and misinformation. There is abundant evidence that individuals develop healthier behavior as their knowledge increases.[48]

Research has shown that persons with fears and negative attitudes have a greater risk of behaving in unhealthy ways. Erotophobia is a negative affective-evaluative response to the pleasurable components of sexuality. Erotophobic persons are less likely to plan on having sexual intercourse in the future and have been shown to have more negative reactions to talking openly about sexuality, and to fail to acquire contraceptives prior to sexual activity.[49]
Homophobia is the irrational fear of persons with homosexual orientation. In many cases it is the basis of criminal acts. There are reports that link homophobia to cognitive inhibition. Overt rejection, discrimination, or violence towards gays and lesbians have been linked to a variety of health and development problems,[50] use of denial and isolation as coping styles,[51] the ability to develop intimacy,[52] more frequent risk taking sexual behavior[53] and a diminished quality in the health care provided by health professionals.[54] Among the other characteristics that represent threats or obstacles to health, the concept of homonegativity has been suggested to increase understanding of the psychosocial dynamics of the development of negative attitudes towards homosexual persons.[55]

Some of the components and specific actions of this strategy include:

- *Promote the understanding of the spectrum of female and male identities along a range including heterosexual, homosexual, bisexual, bigender, transgender.*
- *Decrease homophobia both among individuals of all sexual orientations.*

Strategy 1.5 Eliminate sexual violence.

The deleterious effects of sexual violence have been well documented.[56] The promotion of Sexual Health and sexual rights as human rights will contribute to the reduction and elimination of sexual violence. Specifically, the promotion of gender equality and equity, and the elimination of gender based discrimination, which have been specifically linked to the generation and maintenance of sexual violence, as well as comprehensive sexuality education, will lower rates of violence. Actions towards the elimination of sexual violence include:

- *Recognition of sexual violence in its various forms.*
- *Introduction of effective legislation to reduce sexual violence.*
- *Promotion of a culture of reporting sexual violence.*
- *Promotion of health seeking behavior for victims of sexual violence.*
- *Promotion of health care for sexual aggressors that in many instances could benefit from treatment.*

GOAL 2

Provide comprehensive sexuality education to the population at large.

There was a clear consensus among the expert working group that comprehensive sexuality education, considered as a life-long process that informally and formally provides and transforms knowledge, attitudes, skills and values related to all aspects of human sexuality,[57] is one of the best investments a society can make when promoting Sexual Health among its people.

Comprehensive sexuality education should begin early in life, should be age and developmentally appropriate, and should promote a positive attitude towards sexuality.[58]
Sexuality education must provide people with a knowledge base of human sexuality. In addition, it is recognized that sexual information alone is not adequate. Sexuality education must also include skills development in addition to acquisition of knowledge.

Strategy 2.1 Provide school-based comprehensive sexuality education.

Comprehensive school-based sexuality education acts as a building block for Sexual Health across the lifespan of an individual and therefore requires particular attention. School, in most countries, is the single institution that nearly every person comes in contact with at some stage in their life. This is the ideal setting for providing sexuality education; hence governments need to mandate this kind of education in schools. There has been a considerable amount of research that has identified the characteristics of effective sexuality education.[59-61] A summary of these characteristics of comprehensive sexuality education is presented in Appendix III.

Strategy 2.2 Integrate sexuality education into the general curriculum of educational institutions as appropriate.

In addition to school based sexuality education, to reach the goal of providing comprehensive sexuality education to the population across the life span, all education institutions must play a role. In particular, tertiary institutions can promote Sexual Health by establishing adult human sexuality curricula.

Strategy 2.3 Provide comprehensive sexuality education to persons with mental and physical disabilities.

Persons with mental and physical disabilities have the same rights to comprehensive sexuality education as other persons. Because persons with mental and physical disabilities may have special needs and circumstances, and may sometimes be at increased vulnerability regarding the ability to make sexual decisions, comprehensive sexuality education should be a priority for these populations.

Strategy 2.4 Provide access to comprehensive sexuality education to special populations (e.g., prisoners, illegal immigrants, the institutionalized, homeless).

Historically, the sexuality education needs of two groups have been neglected. Institutionalized persons (prisoners, the hospitalized, and those in long-term "care" situations) and those with no or only marginal access to education (including illegal immigrants and the homeless). Where institutionalized persons are concerned, those legally responsible for these persons have an ethical responsibility to provide access to education that assists the person to advance his/her Sexual Health while avoiding serious risks (e.g., HIV and other STDs). For those lacking access to educational opportunities, the government has an ethical responsibility to provide appropriate outreach and education.

Strategy 2.5 Provide access to comprehensive sexuality education to other populations (e.g., legal immigrants, minority language groups, refugees).

Like institutionalized persons and persons without access to education, another group of persons – those with greater barriers to accessing education – has been identified at higher risk for Sexual Health concerns. Immigrants (including refugees), those persons who do not speak the dominant language of a country, have a right to comprehensive sexuality education. Where possible, education should be integrated into existing educational programs for these populations.

Strategy 2.6 Integrate mass media into efforts to deliver and promote comprehensive sexuality education.

The importance of the mass media in influencing social norms has been widely recognized. Any effort in promoting health should be accompanied by the involvement of the mass media, using all current and future channels of communication: electronic (radio and television), printed and internet based media. Mass media professionals have a responsibility to their communities and, in the case of Sexual Health, this responsibility should not be avoided.

Examples of the utilization of mass media for promoting reproductive health and the prevention of sexually transmitted infections already exist and the results reported indicate that good benefits to health promotion can be achieved.[62]

GOAL 3

Provide education, training and support to professionals working in Sexual Health related fields.

The goal of providing education and training in Sexual Health for a wide range of specialists, other professionals, and paraprofessionals involved in the promotion of Sexual Health, including physicians, nurses, therapists, HIV/AIDS specialists, family planning staff, as well as educators and community advocates is necessary to effectively promote Sexual Health among the population.

Strategy 3.1 Provide education and training in Sexual Health for health and allied health professionals.

Sexual health education for health professionals should be promoted at least at four different levels:

1. Basic Sexual Health education for all health professionals included both in their basic training and in continued educational programs. Health professionals include medicine, nursing, clinical psychology, social work and health practitioners and promoters.
2. Sexual health education for health professionals specializing in reproductive health programs.
3. Sexual health education for professionals specializing in STIs and HIV/AIDS prevention and control programs.
4. Sexual health education and training for professionals specializing in Sexology, including education for sexuality, clinical Sexology (sexual medicine, sexual surgery, sexual counseling and, sexual psychotherapy) and, basic research Sexology.

Specific recommendations regarding the training needs for each of these four groups are provided in Appendix IV. These recommendations describe a general interdisciplinary approach to the training of professionals.

Strategy 3.2 Provide education and training in Sexual Health for school teachers.

Schoolteachers must receive, as part of their training, the knowledge and skills to deliver effective sexuality education. Since sexuality education is proposed as a universal and integrated part of education curricula, such training should be viewed as a compulsory part of any teacher-training curriculum.

Strategy 3.3 Promote Sexology as a profession/discipline.

Sexology, as a discipline was first proposed in 1907.[63] In the last fifty years, great strides have been made in the area of Sexology. Historically, there have been three main areas in Sexology – education, research and clinical service - mainly focusing on the treatment of sexual dysfunctions. Today, new disciplines are aligned with Sexology. The Sexual Health needs of the population have expanded our understanding of Sexology. The emergence of HIV, among other serious sexually transmitted pandemics, has led to the specialization of behavioral epidemiologists and infectious disease public health professionals in

the study of sexual risk behaviors. In turn this has led to large population studies of sexual behavior. From communities at greatest risk for HIV there have emerged community health educators, paraprofessionals specializing in HIV risk reduction counseling and case management for those at risk. In many clinics, nurse-educators play a key role in promoting preventive health care related to physical health (e.g., breast exams), sexual knowledge (e.g., education on Sexual Health risks related to illness), and reproductive counseling. Advances in assisted fertility techniques, and pharmacological innovations in the promotion of sexual functioning have brought specialists from other disciplines together to focus on the Sexual Health needs of patients. Women's and sexual minority health centers have targeted health care to minorities and the underserved, while at the same time, promoting Sexual Health at a community level. An outgrowth of sexual minority movements has been the emergence of lawyers specializing in the rights of minorities, and advocacy groups promoting safe behaviors. Recently, new approaches in the management of the sexual aggressor have expanded the field of clinical Sexology to the treatment of sex offenders.

It is evident that the future of Sexology will involve many new and diverse disciplines collaborating at different levels and serving different functions in addressing Sexual Health needs. As an interdisciplinary science, Sexology is uniquely placed to bring together the knowledge and expertise of specialists, the diverse agendas of various advocacy groups, the health concerns of communities, and the methodologies and interests of diverse disciplines. For this reason, it is critical that Sexology is promoted as a discipline/profession. It is not sufficient for specialists from other disciplines to apply their fields of expertise to the study of Sexual Health. We also need trained Sexual Health specialists who focus exclusively on Sexual Health concerns to address the diverse and specific concerns raised by sex and sexuality.

More specifically, there is a need to:

- Establish training standards for sexual educators, sexuality specialists
- Promote Sexology as a discipline/profession
- Advocate to governments for sexuality training programs for professionals.

GOAL 4

Develop and provide access to comprehensive Sexual Health care services to the population.

Unfortunately the current incidence of many sexual problems makes current prevention efforts insufficient. A large number of persons have sexual problems that demand clinical care. It is also unrealistic that prevention will be able to eliminate all sexual problems in the future. The development of comprehensive Sexual Health care is therefore a critical necessity in all societies, as is the provision of access to this care to the population.

Strategy 4.1 Integrate Sexual Health issues into existing public health programs.

Sexual health is a key public health issue. Although specific actions implemented in specific targeted programs (as outlined in the sections above) are required, it is indispensable to have Sexual Health integrated into existing public health programs. For this reason the expert working group recommends as components the following:

- *Integrate a Sexual Health approach into existing health programs, related directly or indirectly to Sexual Health (e.g., cardiovascular health promotion programs, anti-smoking programs (benefits of not smoking on erectile performance), cancer prevention programs (early detection of CA on mastectomies, cervical cancer screening), health education programs (link between preventive health and sexual performance).*
- *As part of general health assessments, address sexual issues when clients come into contact with public health programs. This can be advanced by review and, where necessary, reform of existing protocols to ensure adequate addressing of Sexual Health concerns. For example, general practitioners, family physicians, and physicians in public health clinics should incorporate Sexual Health screening/history taking into general health assessments.*

Strategy 4.2 Provide access to comprehensive Sexual Health services to the population.

Access to comprehensive health care services is essential. Whilst the expert working group fully recognizes the relevance and cost effectiveness of a preventive approach to Sexual Health, there exist an unfortunately large number of persons already suffering from Sexual Health concerns and problems that create an urgent need for care services to ensure effective treatment.

Sexual concerns and many sexual problems can and should be addressed and solved in primary care settings. Unfortunately, lack of training of primary care providers can be an obstacle to this possibility.

Some Sexual Health problems require the intervention of specially trained individuals for their solution. Therefore, special clinics for the treatment of sexual problems are necessary to address the range of severity of sexual problems.

Strategy 4.3 Provide access to comprehensive Sexual Health services to persons with mental and physical disabilities.

Sexual health services, wherever possible, should be integrated into existing services for persons with mental and physical disabilities.

Strategy 4.4 Provide access to comprehensive Sexual Health services to special populations (e.g., prisoners, illegal immigrants, the institutionalized, the homeless).

Sexual health services, wherever possible, should be integrated into existing services for special populations (e.g., prisoners, illegal immigrants, the institutionalized, the homeless).

Strategy 4.5 Provide access to comprehensive Sexual Health services to other populations (e.g., legal immigrants, minority language groups, refugees).

Sexual health services, wherever possible, should be integrated into existing services for other populations (e.g., legal immigrants, minority language groups, and refugees).

GOAL 5

Promote and sponsor research and evaluation in sexuality and Sexual Health, and the dissemination of the knowledge derived from it.

Research is needed to increase understanding of sex, sexuality, Sexual Health, and sexual behavior and to evaluate the efficacy of prevention strategies, programs, courses and treatments.

Strategy 5.1 Promote sexual research and evaluation.

Both research and evaluation are urgently needed to advance the Sexual Health of individuals and populations. Research is defined here as the systematic study of an area, including the testing of hypotheses, for the purpose of acquiring new knowledge. Evaluation is defined here as the gathering and analyzing of data for the purposes of decision-making, particularly the assessment of Sexual Health program effectiveness.

Strategy 5.2 Promote Sexology as a research discipline.

Sexology, in comparison to other areas of health research, has been neglected in terms of funding, respect, and quality of investigation. These dimensions are not independent. It is an absolute imperative that research on sexuality and sexual behavior of the highest quality be undertaken. To achieve this, as a field, Sexology needs to develop the competence and capabilities of researchers at every level.

Strategy 5.3 Promote sexological research across disciplines (e.g., nursing, sociology, anthropology, psychology, epidemiology, etc.).

Research on sexuality and Sexual Health is not limited to Sexology trained researchers. Promotion of research among other related disciplines is beneficial to the construction of a greater knowledge base and usually permits new and fresh insights of issues related to the complexity of sexuality and Sexual Health. Promotion of this kind of research can improve efforts towards achieving and maintaining Sexual Health.

Strategy 5.4 Ensure that research findings in Sexology are adequately disseminated to policymakers, educators, and service providers to provide a research base for their work.

Research alone is not sufficient. Dissemination of findings is a crucial strategy to ensure that those working in Sexual Health benefit from the knowledge base that sound research creates. Dissemination of research findings is particularly necessary in most of Latin America, where there is a need to create and promote a culture of reporting sound research.

World Association for Sexology

Appendix I

World Association for Sexology's 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 II

Etiological Classification of Sexually Transmitted Infections

Viral infections

- HIV infection
- Acquired Immunodeficiency Syndrome secondary to HIV infection
- Herpes simplex virus infections
    - – Type 1 Herpes simplex virus infection
    - – Type 2 Herpes simplex virus infection
- Human papilloma virus infections
- Cytomegalovirus infection
- Hepatitis B infection
- Other sexually transmitted viral infections

Bacterial infections

- Syphilis
- Gonococci infections
- Chlamydiasis
- Chancroid
- Thricomonal infection
- Gardnerella infection
- Mychoplasma infections
- Other sexually transmitted bacterial infections

Yeast infections

- Candidiasis
- Other sexually transmitted yeast infections

Infestations

- Phthirus pubis crab infestation
- Sarcoptes scabei infestation
- Other sexually transmitted infestations

Appendix III

Characteristics of Comprehensive Sexuality Education

Comprehensive sexuality information has the following primary goals:

- More that the mere acquisition of knowledge and contents, sexuality education should lead to the development of critical thinking leading to the attainment of positive attitudes toward sexuality
- To foster the process through which the individual may recognize, identify and accept him/herself as a sexed and sexual being all through out the life cycle, free from anxiety, fear and guilt feelings
- To foster the development of gender roles that promote respectful and equitable relations between human beings, within a framework of values based on human rights
- To promote the value of the bonding and affective component of human relations beyond dyadic relations
- To promote self-knowledge in relation to the body, as a factor of self-esteem and health care
- To foster pleasurable, conscious, free and responsible sexual behavior towards one self and others
- To promote communication within couples and families, promoting equitable relationships, regardless of sex and age
- To promote shared responsible behavior in regards to family planning, childbearing and the use of contraceptives.
- To promote responsible decisions in the prevention of STIs.[64]

Recent reviews of evaluations of effective sexuality education, teenage pregnancy prevention, and HIV prevention programs have found that quality sexuality education programs:[65]

- Increase knowledge
- Clarify values
- Increase parent-child communication
- Help young people delay the initiation of sexual intercourse, if directed at young adolescents
- Increase the use of contraception and condoms
- Do not encourage young people to begin intercourse and
- Do not increase the frequency of sexual intercourse.

These reviews also describe common characteristics of effective programs. Specifically, they:

- Target specific behaviors
- Are based on a theoretical model for behavior change
- Provide information about the risks of unprotected sexual intercourse and how to reduce risk
- Provide students with an opportunity to practice skills and discuss situations that they find meaningful and realistic
- Address the influence of the media, peers, and culture on teenagers' sexual behaviors and decisions
- Develop and reinforce beliefs and values among students that support their decisions to be abstinent and/or to protect themselves; and
- Include opportunities for students to practice communication and negotiation skills.

There is an extensive experience in sexuality education programs in Latin America. It is suggested that the evidence accumulated on effectiveness of sexuality education programs in North America could be applied to the Latin American countries if these programs:

- Are culturally sensitive and appropriate
- Ensure the full participation of all involved in design, implementation and evaluation processes
- Promote social values such as equity, respect and responsibility
- Provide an understanding of the social context of sexual behavior.

Appendix IV

Curriculum for the Training of Health Professionals in Sexual Health

Basic Sexual Health education should be part of the curricula of all health professionals. There have been a number of good curricula developed for different levels of health professionals and technicians. The implementation of a particular curriculum must take into account the particularities of the country and specific needs of a country/region.

It was suggested that a minimal profile of basic training in Sexual Health for health professionals should be developed for each of the disciplines (medical, nursing, health promoters, etc.) involved.

In any case these minimum profiles should include:

- Basic knowledge of human sexuality
- 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 and, if necessary, referring to the appropriate professional, problems of Sexual Health.

It was also agreed that there is need for establishment and support of continued education for health professionals, due to the changing nature of sexual knowledge and the deficiencies that in many instances still can be observed in the basic training curricula.

A. Sexual Health education for health professionals specializing in reproductive health programs

Health professionals specializing in reproductive health programs should have adequate training in human sexuality. 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. "Sexual health" has been a

common addition to reproductive health programs. Although the definitions of reproductive health include aspects of the complexity of human sexuality, Sexual Health is implied, rather than explicitly stated.

Health professionals specializing in reproductive health should have a more in-depth training in human sexuality issues than the general health practitioner. As in the case of training needs for the general health practitioner, specific curricula should be designed adapted to the specific needs of the country / region, but it is desirable that the abilities 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.

It is therefore suggested that a minimal profile of training in Sexual Health for professionals specializing in reproductive health programs should be developed for each of the appropriate levels (program planners, service providers, educators, community leaders, etc.) involved.

B. Sexual Health education for professionals specializing in STI's and HIV/AIDS prevention and control programs

The magnitude of the threat of the HIV/AIDS epidemic has prompted many governments to set up special programs to prevent and control the epidemic. More recently, it has become clear that the efforts to reduce and control HIV/AIDS could be more effective if actions are linked to a broader approach of controlling and preventing sexually transmitted infections, which, in themselves, besides being a significant threat to health, increase the risk of HIV/AIDS transmission. This threat has created a new type of health professional who works in the planning and implementing of programs with this focus.

The fact that these infections are transmitted through sexual activity makes it indispensable that professionals working in its prevention and control have sufficient training in Sexual Health, especially as it is conceived in this document, where all aspects of human sexuality are taken into account.

Health professionals specializing in STIs and HIV/AIDS prevention and control programs should have training in Sexual Health that gives them an integrated vision of the determinants of human sexual behavior. As in the other cases, specific curricula should be designed to adapt to the specific needs of the country / region, but it is desirable that the abilities include:

- Basic knowledge of human sexuality
- Extensive knowledge in the determinants of responsible sexual behavior
- Extensive knowledge in sexually transmitted infections
- Extensive knowledge in the proven strategies in prevention of STI's transmission

- Basic HIV/AIDS and STIs epidemiological prevalence and incidence knowledge, together with knowledge of epidemiology of common risk behaviors. Such knowledge should include a general knowledge of the epidemic plus specific knowledge relevant to any target populations
- Knowledge of local sexual education programs and ability to refer, where appropriate, clients for educational intervention
- 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, Sexual Health concerns and problems
- Skills to work with target populations, including sensitivity towards and comfort with the sexual practices, concerns, and sexualities of populations at risk

It is also suggested that a minimal profile of training in Sexual Health for professionals specializing in STI's and HIV/AIDS prevention and controls programs should be developed for each of the appropriate levels (program planners, service providers, educators, community leaders, and advocates of minority groups, etc.) involved.

C. Sexual Health education and training for professionals specializing in Sexology

There continues to be a shortage of health professionals who have human sexuality as their focus of training. Professionals of related disciplines (psychology, psychiatry, gynecology, urology) have developed a specialized field of work in problems related to human sexuality, but an integrated approach in their work is difficult to find because their point of views are usually biased by their original training. For these reasons, the expert working group recommends that a special effort should be made in promoting the training of specialists in Sexual Health that, in addition to their original field of training, have sufficient knowledge and skills as to be able to perform the tasks related to their subspecialty field. So far, the experience in different countries has led to the recognition of the following areas of sub specialization of the professionals of Sexual Health:

- Sexuality education
- Clinical Sexology (including sexual medicine, sexual surgery, sexual counseling and sexual psychotherapy)
- Research Sexology.

Sexuality education is the area of Sexology that specializes in sexuality education. Comprehensive sexuality education concerns many individuals, including parents, teachers, community leaders, mass media professionals, and religious leaders, among others. However, there is a need for professionals specializing in the design, implementation and evaluation of programs and specific curricula (on which the rest of the non-specialized educators can rely). Comprehensive sexuality education implies a sexuality education for Sexual Health, also named Sexual Health education.

Professionals in sexuality education should have as a minimum the following areas of expertise covered by their training:

- Knowledge of human sexuality
- Extensive knowledge of education including educational skills to design, implement and evaluate educational programs in human sexuality, particularly from a participatory perspective
- 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, and if necessary, referring to the appropriate professional, problems of Sexual Health.

Clinical Sexology is the area of Sexology that specializes in the prevention and care of sexual problems that pertain to sexual dysfunction syndromes, gender identity syndromes, compulsive sexual behavior syndromes and, syndromes following sexual victimization. Other kinds of sexual problems have been covered by other disciplines due to the specific skills required for their solution: gynecology, andrology and urology in the case of reproductive syndromes and infectology in the case of sexually transmitted infections. However, training in the basic issues of Sexual Health is still desirable for professionals of these disciplines since their original training often lacked an integral approach to human sexuality and Sexual Health as proposed in this document. Each of the areas of clinical Sexology utilizes different therapeutic modalities that require specialized training for its utilization, but it is desirable that professionals dealing with these problems share a basic knowledge in Sexual Health that is still unfortunately fragmentary. Depending on the therapeutic approach utilized, a clinical sexologist can be classified in the following areas: sexual medicine, sexual surgery, sexual counseling and sexual psychotherapy.

Professionals in clinical Sexology should have as a minimum the following areas of expertise covered by their training:

- Knowledge of human sexuality
- Extensive knowledge of Sexual Health concerns and problems
- Knowledge of local sexual education programs and ability to refer, where appropriate, patients for educational intervention
- 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
- Skills in identifying, and etiologically diagnosing problems of sexual problems included in the area of clinical Sexology: (i.e.: sexual dysfunctions, gender (gender identity syndromes), compulsive sexual behavior syndromes and, syndromes following sexual victimization
- Skills in identifying, and if necessary, referring to the appropriate professional, problems of Sexual Health in the other areas such as reproductive syndromes and sexually transmitted infections
- Skills for implementing treatment strategies in their areas of specialization: sexual medicine, sexual surgery, sexual counseling and sexual psychotherapy, as well as skills in referral to the appropriate treatment specialist when the etiologic diagnosis indicates the need for a treatment different from that which the professional is able to provide.

Research Sexology is the area of Sexology, which specializes in the gathering of information to build new knowledge in human sexuality. It utilizes methodologies appropriate to the discipline and area of study. Professionals in research Sexology should have a broad based knowledge and training in human sexuality and Sexual Health in order for them to better perform their specific tasks in research activity.

Professionals in research Sexology should have as a minimum the following areas of expertise covered by their training:

- Basic knowledge of human sexuality
- Extensive knowledge and skills in research methodologies according to their field of specialization
- 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
- Awareness of personal attitudes towards other researchers' disciplines, which should include a respectful attitude that facilitates interdisciplinary investigation
- Basic skills in identifying problems of Sexual Health and if necessary, referring to the appropriate professional
- A commitment to undertaking research only of the highest ethical standards, as promoted through courses and mentoring on research ethics, particularly as they pertain to sexual health research.

It is suggested that a minimal profile of training in Sexual Health for professionals specializing in clinical Sexology should be developed for each of these professional categories: education for sexuality, clinical Sexology (including sexual medicine, sexual surgery, sexual counseling and sexual psychotherapy) and research Sexology.

Appendix V

Resources for Sexual Health

Although there is a considerable shortage in resources for Sexual Health in the Americas, and a recommendation has been issued for their implementation and strengthening, it should be recognized that some important resources already exist that need to be identified and disseminated, in order to optimise economic and human resources.

There are a number of governmental and non-governmental institutions that have developed strategies and work that is relevant for the promotion of Sexual Health. A world-wide partial list of these resources can be found in the Archive for Sexology web site established by the Robert Koch-Institut in Berlin. The information can be retrieved by the Archive for Sexology Web site at: http://www.rki.de/GESUND/ARCHIV/HOME.HTM.

Additional resources can be found in the Web sites of the United Nations Organization specialized bodies and professional organizations:

WHO:	http://www.who.int/
PAHO:	http://www.paho.org/
UNFPA:	http://www.unfpa.org/
UNAIDS:	http://www.unaids.org/
WAS:	http://www.tc.umn.edu/nlhome/m201/colem001/was/

The expert working group recommends that a full listing of resources be produced and disseminated, in order to further implement the actions proposed during this consultation.

Notes

1 World Health Organization. (1975). *Education and Treatment in Human Sexuality: The Training of Health Professionals*.i (Technical Report Series No. 572. The full report is available at: http://www.rki.de/GESUND/ARCHIV/HOME.HTM

2. The first meeting was held in Copenhagen, on 9 and 10 November 1983. The results of this consultation were published in: T. Langfeldt and M. Porter. *Sexuality and family planning: Report of a consultation and research findings.* World Health Organization. Regional Office for Europe. Copenhagen, 1986. The second meeting was held also in Copenhagen from 5 to 7 may 1987. The results of this consultation are reported in an unpublished document: World Health Organization. Regional Office for Europe. *Concepts of Sexual Health: Report on a working Group*. It is available at: http://whqlibdoc.who.int/euro/-1993/EUR_ICP_MCH_521.pdf

3. In spite of all the efforts made in the last decade to curb the spreading of Sexually Transmitted Infections, —including HIV, such infections still represent a serious public health problem in the Region of the Americas. The Pan American Health Organization estimates that there are 1.7 million people living with HIV in Latin America and the Caribbean, and around 1 million in North America. These figures account for the worrying adult prevalence rates in the Region, which reflect the proportion of adults (15 to 49 years of age, using 1997 population numbers) living with HIV/AIDS in the Americas in 1998. Those rates are estimated to be: North America: 0.56%, Latin America: 0.57%, Caribbean: 1.96%. Source: Mazín, R. *Is Promotion Of Sexual Health Relevant To Achieve Public Health Goals*? Keynote address presented at: "Avances en SIDA e Infecciones de Trasmisión Sexual: Retos Para el Tercer Milenio" Congreso Internacional de SIDA. November 24-26, Acapulco, Mexico, 1999.

4. In the developing world to date, there have been relatively few successful HIV interventions that have been clearly demonstrated to be effective. Perhaps the best documented example is in Thailand where recent declines in HIV prevalence and incidence among young Thai men (as well as a sharp decline in reported STIs) have been attributed to a combination of increased condom use and a reduction in sex worker patronage. Source: Joint United Nations Programme on HIV/AIDS (UNAIDS, 1999). *Trends in HIV incidence and prevalence: natural course of the epidemic or results of behavioural change?*

5. Dixon M. R. The sexuality connection in reproductive health. In S. Zeidenstein and K. More (Eds.) *Learning about Human Sexuality: A practical beginning.* The Population Council and International Women's Health Coalition. New York. 1996.

6. Report of The International Conference on Population and Development (Cairo, 5-13 September 1994) United Nations Population Information Network (POPIN) UN Population Division, Department of Economic and Social Affairs, with support from the UN Population Fund (UNFPA).

7. Somewhere in the U.S., a woman is raped every 2 minutes, according to the U.S. Department of Justice. In 1996, 307,000 women were the victims of rape, attempted rape or sexual assault. [National Crime Victimization Survey. Bureau of Justice Statistics, U.S. Department of Justice, 1997.]
Between 1995 and 1996, more than 670,000 women were the victims of rape, attempted rape or sexual assault [National Crime Victimization Survey. Bureau of Justice Statistics, U.S. Department of Justice, 1997]. In 1995, local child protective service agencies identified 126,000 children who were victims of either substantiated or indicated sexual abuse; of these, 75% were girls. Nearly 30% of child victims were between the ages of 4 and 7. [Department of Health and Human Services, Administration for Children and Families, Child Maltreatment, 1995.] Approximately one-third of all juvenile victims of sexual abuse cases are children younger than 6 years of age. [Violence and the Family. Report of the American Psychological Association Presidential Task Force on Violence and the Family, 1996.]. According to the Justice Department, one in two rape victims are under age 18; one in six is under age 12. [Child Rape Victims, 1992. U.S. Department of Justice.] Source: Rape, Abuse and Incest National Network (RAINN) http://feminist.com/rainn.htm. Of males: Approximately one in six boys are sexually abused before age 16. Hopper J., *Sexual Abuse of Males: Prevalence, Lasting Effects, and Resources* http://www.jimhopper.com/male-ab/. A study based on the records of the Maternity Hospital of Lima, Peru, revealed that 90 percent of young mothers aged 12 to 16 had become pregnant because they had been raped. In Costa Rica, an organization working with adolescent mothers reported that 95 per cent of its pregnant clients under 15 were victims of incest. Interactive Population: *Violence against Girls and Women*: http://www.unfpa.org/modules/intercenter/violence/gender2f.htm
8. International Planned Parenthood Federation. *IPPF Charters on Sexual and Reproductive Rights Vision 2000* International Planned Parenthood Federation, 1996.

9. World Association for Sexology. Declaration of Sexual Rights. 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.

10. Report of The International Conference on Population and Development* (Cairo, 5-13 September 1994) United Nations Population Information Network (POPIN) UN Population Division, Department of Economic and Social Affairs, with support from the UN Population Fund (UNFPA).

11. Most notably the advent of sildenafil, and some newer fosfodiesterase inhibitors to treat erectile dysfunction, and the use of selective serotonin re-uptake inhibitors (SSRIs) and other antidepressants to treat premature ejaculation and compulsive forms of sexual behavior. Manecke, R. G.; Mulhall, J.P. Medical treatment of erectile dysfunction. *Ann Med* 1999 Dec;31(6):388-98; Rosen, R.C., Lane, R.M.; & Menza, M. Effects of SSRIs on sexual function: a critical review. *J Clin Psychopharmacol* 1999 Feb;19(1):67-85; Coleman, E., Gratzer, T. Nescvacil, L., & Raymond, N. (2000). Nefazodone and the treatment of compulsive sexual behavior: A retrospective study. *The Journal of Clinical Psychiatry* 61(4), 282-284.

12. Cfr. Rubio, E. Introducción al Estudio de la Sexualidad Humana. In CONAPO (Editor). *Antología de la Sexualidad Humana Vol. 1*. CONAPO, México 1994.

13. Weeks, J. *Sexuality*. Ellis Horwood Limited. Tavistock Publications. London 1986.

14. World Health Organization. *Education and Treatment in Human Sexuality: The Training of Health Professionals*, Technical Report Series Nr. 572, in 1975.

15. The definition of human sexuality in the report of the meeting of 1983 is: "Sexuality is an integral part of the personality of everyone: man, woman and child. It is a basic need and an aspect of being human that cannot be separated from other aspects of life. Sexuality is not synonymous with sexual intercourse, it is not whether we have orgasm or not, and it is not the sum total of our erotic lives. These may be part of our sexuality but equally they may not. Sexuality is so much more: it is the energy that motivates us to find love, contact, warmth and intimacy; it is expressed in the way we feel, move, touch and are touched; it is about being sensual as well as being sexual. Sexuality influences thoughts, feelings, actions, interactions, and thereby our mental and physical health. Since health is a fundamental human right, so must Sexual Health also be a basic human right". (p 5). Langfeldt, T. & Porter, M.. *Sexuality and family planning: Report of a consultation and research findings.* World Health Organization. Regional Office for Europe. Copenhagen, 1986.

16. See for instance the definitions put forward by Ruth Dixon-Muller in: The sexuality connection in reproductive health. In S. Zeidenstein & K. More (Eds.) *Learning about Human Sexuality: A practical beginning.* The Population Council and International Women's Health Coalition. New York. 1996. "Sexual behavior consists of actions that are empirically observable (in principle, at least)… …In contrast, sexuality is a more comprehensive concept that encompasses the physical capability for sexual arousal and pleasure (libido), as well as the personalized and shared social meanings attached to both sexual behavior and to the formation of sexual and gender identities"(p. 139). Or, Ira Reiss in *Journey into Sexuality: an exploratory voyage*. Prentice Hall, Englewood Cliffs New Jersey. 1986: "Human sexuality in all societies consist of those scripts shared by a group that are supposed to lead to erotic arousal and in turn to produce genital response" (p. 20).

17. Cfr. Rubio, E.. Introducción al Estudio de la Sexualidad Humana. In CONAPO (Ed). *Antología de la Sexualidad Humana Vol. 1*. CONAPO, México 1994. Rubio presents a model of human sexuality from a general system theory perspective and defines human sexuality as the result of the (mental) integration of four human potentialities that originate four holons (or subsystems): reproductiveness, gender, eroticism and interpersonal affective bonding. (p.29).

18. See the definition provided by The Sexuality Information Council of the United States: Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. Its dimensions include the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles and personality; and thoughts, feelings, and relationships. The expression of sexuality is influenced by ethical, spiritual, cultural, and moral concerns. Making the Connection: Sexuality and Reproductive Health Definitions of Sexually Related Health Terminology. http://www.siecus.com/pubs/cnct/cnct0001.html

19. Some good examples of this are: Alazate, H.. *Sexualidad Humana*. Editorial Temis. Santa Fe de Bogotá, Colombia (1997). Alzate explains: "Human sexuality... …can be defined as the collection of structural, physiologic, behavioral and socio-cultural, that allow the exercise of sexual function. In its time, sexual function is defined as the conscious and culturally conditioned function, that has derivate itself philogenetically from the reproductive function, but which is exercised in the first place in a pleasant or ludic way (erotic function), and secondarily in a reproductive way, through the use of body zones or organs of special sensitivity" (p.5). In this line there is also the work of Paul R. Abramsom and Steven D. Pinkerton. *With Pleasure: Thoughts on the Nature of Human Sexuality*. New York, Oxford University Press, 1995, where we read: "Sex isn't just for reproduction anymore – it's also for pleasure. The intense pleasure that accompanies sex may serve to motivate copulation and thereby facilitate reproduction, but this is no longer its sole function. Instead human sexuality has bifurcated: reproduction taking one route; unadulterated pleasure another" (p.5).

20. Notably John Money in his *Love & Lovesickness the science of Sex, Gender Difference and Pair-bonding*. The John Hopkins University Press, Baltimore 1981. Other writers (Abramsom, P. & Pinkerton, S.D. *With Pleasure: Thoughts on the Nature of Human Sexuality*. New York, Oxford University Press, 1995. Reiss, I. *Journey into Sexuality: an exploratory voyage*. Prentice Hall, Englewood Cliffs New Jersey. 1986) tend to see love ties as a by-product of erotic pleasure.

21. To give an idea: a search on the following 8 Psychoanalytic Journals: *Journal of the American Psychoanalytic Association, Bulletin of the American Psychoanalytic Association, International Journal of Psycho-Analysis, International Review of Psycho-Analysis, Bulletin of the International Psycho-Analytical Association, Psychoanalytic Quarterly, Contemporary Psychoanalysis, Psychoanalytic Study of the Child* resulted in 864 articles published from 1980 to 1997 where love and sex were considered.

22. The recent evidence of the possible regulation of pair-bonding has been reviewed by Thomas R. Insel: A Neurobiological Basis of Social Attachment *Am J Psychiatry 1997; 154:726 –735*, where the participation of the neurotransmitters oxitocin and vasopressin is demonstrated in lower species, more recently the same group investigators reported the relevance of Dopamine D2 receptors in the prairie vole (Microtus ochrogaster), a monogamous rodent that forms long-lasting pair bonds (Gingrich, B., Liu Y., Cascio. C., Wang, Z. & Insel, T.R. Dopamine D2 receptors in the nucleus accumbens are important for social attachment in female prairie voles. *Behav Neurosci* 2000 Feb;114(1):173-183).

23. Marazziti, D., Akiskal, H. S. Rossi, A. & Cassano, G. B.. Alteration of the platelet serotonin transporter in romantic love. *Psychological Medicine* (1999), 29:741-745.

24. The WHO definition of health is: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." http://www.who.int/aboutwho/en/definition.html

25. The most outspoken writer on this issue is Thomas Szasz who together with other anti-psychiatrists writers has put forward the idea that mental illness is a myth. He recently wrote: " Mental illness is a metaphor (metaphorical disease). The word "disease" denotes a demonstrable biological process that affects the bodies of living organisms (plants, animals, and humans). The term "mental illness" refers to the undesirable thoughts, feelings, and behaviors of persons. Classifying thoughts, feelings, and behaviors as diseases is a logical and semantic error, like classifying the whale as a fish. As the whale is not a fish, mental illness is not a disease. Individuals with brain diseases (bad brains) or kidney diseases (bad kidneys) are literally sick. Individuals with mental diseases (bad behaviors) like societies with economic diseases (bad fiscal policies) are metaphorically sick. The classification of (mis)behavior as illness provides an ideological justification for state-sponsored social control as medical treatment" Thomas Szasz. *Thomas Szasz's Summary Statement and Manifesto* March 1998. http://www.enabling.org/ia/szasz/manifesto.html

26. See Saracci, R. The World Health Organisation needs to reconsider its definition of health *BMJ* 1997;314:1409 (10 May).

27. For a more complete discussion see Ruse, M. *Homosexuality a Philosophical Inquiry*. Basil Blackwell, New York. 1988. In brief, Ruse proposes that health and disease can be defined with either a naturalistic approach (Cfr. Broose, 1977: Health as a theoretical concept. *Philosophy of Science*, 44, 452-73) where views of diseases are seen as value-neutral, or a normativist approach, where normativist theorists argue that disease is a value concept, being defined in terms of functioning as a human person, which involves reference to a value notion of a good life.

28. Of relevance for this discussion with special reference to sexuality research and Sexology is the essay of Ira Reiss: La filosofía de la ciencia aplicada al estudio de la sexualidad humana.. In CONAPO (Editor). *Antología de la Sexualidad Humana Vol. 1*. CONAPO, México 1994, which is a revised version of Reiss, I. The Future of Sex Research and the Meaning of Science. *Journal of Sex Research*. 30: 3-11, 1993.

29. Female genital mutilation (FGM) is a violation of the basic human right to bodily integrity and it involves serious health risks. The body of the girl is mutilated in an irreversible manner at an age where the girl herself is not able to make an independent decision as to whether she wants to go through this procedure. These are the main reasons why FGM should be actively abolished. Besides the serious health risks connected to the procedure itself, FGM increases vulnerability to STDs and HIV. Transmission can occur during the mutilation if the same instrument is used on several girls. Afterwards, the wounds and the increased likelihood of tearing of the skin during sexual intercourse constitute major risks for STDs and HIV transmission. FGM is practiced in as many as 28 African countries and known or suspected to be practiced in a number of developed countries by immigrants from Africa. WHO has estimated that between 85 and 115 million women living in the world today have been subjected to FGM and that 2 million girls under go the procedure each year. UNFPA documents: UNFPA and Adolescence. At: http://www.unfpa.org/ICPD/round%26meetings/ny_adolescent/reports/adoles.htm

30. "Since 1994, there has been a noticeable momentum in policy and program development in reproductive rights and health, with significant progress in the understanding of a human rights-based approach to reproductive health, including family planning and Sexual Health; in moving away from vertical service provision, demographic targets and quotas; and in promoting adolescent reproductive health". Report of the International Forum for the Operational Review and Appraisal of the Implementation of the Programme of Action of the International Conference on Population and Development (ICPD). The Hague Forum. The United Nations General Assembly. Special Session on the International Conference on Population and Development (ICPD) 30 June - 2 July 1999.

31. SIECUS list of behaviors of sexually healthy adults, which was constructed with the consensus of experts not only from the USA but also from such diverse countries as Brazil, Nigeria, and Russia, was created. Sexuality Information and Education Council of the United States. *Making the Connection: Sexuality and Reproductive Health: Life Behaviors of a Sexually Healthy Adult*: http://www.siecus.com/pubs/cnct/cnct0002.html

32. Interactive Population: Violence against Girls and Women:
http://www.unfpa.org/modules/intercenter/violence/gender2f.htm

33. Again, only to illustrate: At least 60 million girls are "missing" from the population due to son-preference, via either sex-selective abortions or neglect. 2 million girls between 5 and 15 years old are put on the commercial sex market every year. Nearly 600 million women are illiterate compared with about 320 million men. Source UNFPA documents: http://www.unfpa.org/modules/intercenter/reprights/empower.htm

34. Laumann, E. O., Paik, A. & Rosen, R. C.. Sexual Dysfunction in the United States: Prevalence and Predictors *JAMA*. 1999;281:537-544.

35. Laumann, E. O., Paik, A. & Rosen, R. C.. Sexual Dysfunction in the United States: Prevalence and Predictors *JAMA*. 1999;281:537-544 . McCabe MP Intimacy and quality of life among sexually dysfunctional men and women. *J Sex Marital Ther*, 23(4):276-90, 1997, Winter. Litwin, M.S., Nield, R.J., Litwin, M.S., Nield, R.J., & Dhanani N. Health-related quality of life in men with erectile dysfunction. *J Gen Intern Med*, 13(3): 159-66 1998 Mar. Fugl-Meyer, A.R., Lodnert, G., Bränholm I.B., & Fulg-Meyer, K.S. On life satisfaction in male erectile dysfunction *Int J Impot Res*, 9(3):141-8 1997 Sept.

36. Feldman, H.A., Goldstein, I. Hatzichristou, D.G., Krane, R.J. & McKinlay, J.B. Impotence and its medical and psychosocial correlates: results of the Massachusetts Male Aging Study. *J Urol* 1994 Jan;151(1):54-61.

37. For instance, the prevalence of sexual dysfunctions is known at a syndrome level: i.e. Laumann, E. O., Paik, A. & Rosen, R. C.. Sexual Dysfunction in the United States: Prevalence and Predictors *JAMA*. 1999;281:537-544.

38. "The difficulties related to the timely collection of disease specific data have led to the concept of collecting information about syndromes. This syndromic approach is used successfully by the poliomyelitis eradication program, which collects data on acute flaccid paralysis (AFP) caused by several infectious or non-infectious diseases, but that will trigger an immediate response from the poliomyelitis surveillance system. The same approach could be applied in areas where rapid laboratory diagnosis cannot be obtained (such as at the periphery of many health systems). Although lacking specificity, the syndromic approach offers: a simple and stable case definition; reliability (as it reports what is actually seen); immediate reporting (as there is no laboratory delay); a wider surveillance coverage allowing for the detection of emerging diseases; and, in some cases, the avoidance of disease-associated stigma. This approach is complementary to a disease-specific list of notificable diseases, and is also being considered in the context of the revision of the International Health Regulations". An integrated approach to Communicable Disease Surveillance Epidemiological Bulletin, Vol. 21 No.1, March 2000: http://www.paho.org/English/SHA/eb_v21n1-vigil.htm

39. The current availability of effective medications to improve erectile functioning illustrates the advantage a syndromic approach to diagnosis. While a male erectile dysfunction syndrome can be effectively symptomatically treated (i.e. improving the erectile function) with medications such as sildenafil, doing so without a proper etiological diagnostic evaluation can obscure the causative factors, and delay the diagnosis of frequent conditions such as diabetes mellitus or hiperlipidemia or, impose a life treatment to a person who might benefit from treatments that can remove the etiologic factors (e.g. performance anxiety). (Cfr. Rubio, E. & Díaz, J. Las Disfunciones Sexuales In: CONAPO (Editor). *Antología de la Sexualidad Humana Vol. 3*. CONAPO, Mexico 1994.

40. Press Release WHO/93:*DIRECTOR-GENERAL SETS OUT WHO STANCE ON HEALTH AND HUMAN RIGHTS.* 8 December 1998 available at: http://www.who.int/inf-pr-1998/en/pr98-93.html

41. United Nations Development Programme. *Integrating human rights with sustainable human development. UNDP policy document* United Nations Development Programme New York, NY January 1998. Available at: http://magnet.undp.org/Docs/policy5.html

42. Komisaruk, B.R. & Whipple, B. Love as sensory stimulation: physiological consequences of its deprivation and expression. *Psychoneuroendocrinology* 1998 Nov;23(8):927-44.

43. Cfr.. Kaplan, H.S. *The New Sex Therapy* Brunner Mazel, New York 1974.

44. In the recent report on prevalence of sexual dysfunction when the help-seeking behavior was analyzed it was found that 10% and 20% of the afflicted men and women, respectively, sought medical consultation for their sexual problems. Laumann, E. O., Paik, A. & Rosen, R. C.. Sexual Dysfunction in the United States: Prevalence and Predictors *JAMA*. 1999;281:537-544.

45. Nicolelis, M.A., De Oliveira, L.M., Lin, R.C. & Chapin, J.K. Active tactile exploration influences the functional maturation of the somatosensory system. *J Neurophysiol* 1996 May;75(5):2192-6. Fleming, A.S., O'Day, D.H. & Kraemer, G.W. Neurobiology of mother-infant interactions: experience and central nervous system plasticity across development and generations. *Neurosci Biobehav Rev.* 1999 May;23(5):673-85.

46. Best Practice, the continuous process of learning, feedback, reflection and analysis of what works (or does not work) and why, is the basis from which UNAIDS, its Cosponsors and partners identify, exchange and document important lessons learned. Best Practice has been shared through exchange forums, networks, Best Practice Collection publications, and technical assistance. In 1998, the Best Practice Collection expanded to over 190 original publications and videos, including joint and Cosponsor publications. The collection includes Technical Update, Point of View, Case Study, Key Material and the SummaryBooklet. The collection can be accessed at: http://www.unaids.org/bestpractice/collection/index.html

47. Several sources register the fact that women live longer than men, but also that they fall ill more frequently and make use of health care more often than men, even if motherhood related services are excluded. These authors propose hypothesis that can be broadly grouped in four categories: 1.differential risks, which are associated to the ways men and women are socialized; 2. differences due to psychosocial factors, for example, women being more capable (socially) to perceive, evaluate and report illness symptoms, also to better adopt the role of "being ill" and to follow medical treatment.; 3. differences due to a sexist bias on part of physicians who tend to perceive women as more fragile than men, and therefore more prone to fall physically of psychologically ill; 4. possible biological differences. (Cfr. Castro, R. y Bronfman M. Teoría fem-

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56. The statistics mentioned in the importance of Sexual Health problems section illustrate: In 1993, the World Development Report of the World Bank estimated that "women ages 15 to 44 lose more Discounted Health Years of Life (DHYLs) to rape and domestic violence than to breast cancer, cervical cancer, obstructed labor, heart disease, AIDS, respiratory infections, motor vehicle accidents or war." Studies show that rape survivors have high rates of persistent post-traumatic stress disorder and make up the largest single group diagnosed with the disorder. And rape victims are nine times likelier than non-victims to attempt suicide and to suffer major depression. Furthermore, 50 to 60 per cent of the victims experience sexual dysfunction, including fear of sex and problems with arousal. A study based on the records of the Maternity Hospital of Lima, Peru, revealed that 90 per cent of young mothers aged 12 to 16 had become pregnant because they had been raped. In Costa Rica, an organization working with adolescent mothers reported that 95 per cent of its pregnant clients under 15 were victims of incest. Interactive Population: Violence against Girls and Women: http://www.unfpa.org/modules/intercenter/violence/gender2f.htm

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63. In 1907 Iwan Bloch published his first truly sexological work under the title Das Sexualleben unserer Zeit (The Sexual Life of Our Time) and stated in its foreword: "The author of the present work . . . is . . . convinced that the purely medical consideration of the sexual life . . . is yet incapable of doing full justice to the many-sided relationships between the sexual and all the other provinces of human life. To do justice to the whole importance of love in the life of the individual and in that of society, and in relation to the evolution of human civilization, this particular branch of inquiry must be treated in its proper subordination as a part of the general science of mankind, which is constituted by a union of all other sciences of general biology, anthropology and ethnology, philosophy and psychology, the history of literature, and the entire history of civilization . . . Hitherto there has existed no single comprehensive treatise on the whole of the sexual life . . . .The time is indeed fully ripe for an attempt to sift . . . the enormous mass of available material, and to present the result from a centralized standpoint". Bloch, I. *The Sexual Life of Our Time*. Translated by Eden Paul, New York: Allied Book Company 1908.

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Participants

Laura Asturias, Feminist Newsletter "La Cuerda," Guatemala

*Juan José Borrás Valls, Jaume I University, Spain

Cecilia Cardinal de Martín, Latin American and Caribbean Regional Committee for Sex Education (CRESALC), Colombia

*Eli Coleman, University of Minnesota, USA

**Esther Corona Vargas, Mexican Association for Sex Education (AMES), Mexico

*Marc Ganem, French Society of Clinical Sexology (SFSC), France

*Debra Haffner, Sexuality Information and Education Council of the United States (SIECUS), USA

*Rubén Hernández Serrano, Central University of Venezuela,Venezuela

Ana Luisa Liguori, John D. and Catherine T. MacArthur Foundation, México

Eleanor Maticka-Tyndale, Univesity of Windsor, Canada

Alexander McKay, Sex Information and Education Council of Canada (SIECCAN), Canada

Frans Mom, HIVOS, The Netherlands

*Emil Man Lun Ng, Hong Kong Sex Education Association, China

*Aminta Parra Colmenares, Central University of Venezuela, Venezuela

*Maria Pérez Conchillo, ESPILL Institute of Sexology, Psychology and Medicine, Spain

**Oswaldo M. Rodrigues, Center for the Studies and Research in Human Behavior and Sexuality (CEPCoS), Brazil

**Rodolfo Rodríguez Casteló, Catholic University of Guayaquil Ecuador, Ecuador

B. R. Simon Rosser, University of Minnesota, USA

*Eusebio Rubio Aurioles, Mexican Association for Sexual Health (AMSSAC), México

William R. Stayton, Widener University, USA

Esiet Uwemedimo Uko, Action Health Incorporated, Nigeria

Bernardo Useche, University of Caldas, Colombia

* Members of the World Association for Sexology (WAS) Advisory Board
** Members of the Executive Committee of the Latin American Federation of Sexology and Sexual Education (FLASSES) which is one of the regional federations of the WAS.

Secretariat

Fernando José Amado Luarca, Pan American Health Organization, USA

Nathalie Brinck, Pan American Health Organization, USA

Bilali Camara, Caribbean Epidemiology Center/Pan American Health Organization, Trinidad and Tobago

Carmen A Valenzuela, Pan American Health Organization, Guatemala

Martine de Schutter, Pan American Health Organization, USA

Rafael Mazín, Pan American Health Organization, USA