Sexual Health: A public health challenge in Europe

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Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark
Tel: (+45) 3917 17 17
Fax: (+45) 3917 1818
www.euro.who.int/entrenous

Chief editor
Dr Gunta Lazdane
Editor
Dr Lisa Avery
Editorial assistant
Jane Persson
Layout
Kailow Creative, Denmark.
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Print
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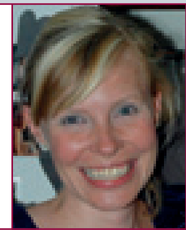
EDITORIAL

Gunta Lazdane



Lisa Avery

Sexual and reproductive health (SRH); the phrase has become standard in most regions of the world. Yet 17 years ago, at the International Conference on Population and Development (ICPD), the expanded concept of reproductive health "…including family planning and sexual health" was as revolutionary as the call for public health investment in SRH for poverty reduction and sustainable development.

The ICPD Programme of Action was instrumental in promoting a positive view of sexual health, recognizing the relevance of sexuality, equity, quality, information and education, services and rights and responsibilities to the achievement of good SRH at both the individual and societal level. Since then the field of sexual health has evolved. Sexual health, sexuality and sexual experiences are now recognized as lifelong processes with varying needs and implications along the life course. Sexual health, while linked directly and indirectly to reproductive health, recognizes the desire of couples and individuals to have fulfilling and pleasurable relationships and encompasses issues beyond fertility and reproduction. Thus sexual health is no longer viewed as just a component of reproductive health, but as its own entity, a necessary condition for the attainment of positive reproductive health.

Given these positive advancements, why is it then, that in this issue of Entre Nous, the question being asked is why is "sexual" so often lost in SRH? The answer, quite simply, is that it is a question that needs to be asked in order to continue to make progress in this field.

According to the current WHO working definition sexual health is "… a state of physical emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained an maintained, the sexual rights of all persons must be respected, protected and fulfilled." Yet far too often research, policies and programmes tend to adopt a limited definition of sexual health and focus on negative outcomes or risk behaviour, such as unplanned pregnancy, sexually transmitted infections, including HIV, or other diseases such as malignancy. Shifting public health approaches from a focus on prevention, treatment and care of poor sexual health to one that encompasses a broader concept of sexual health promotion and well-being has remained a challenge.

With its rich religious, political, social and cultural diversity, increasing migration and varying age demographic profiles, the shift to such a holistic approach to sexual health is particularly relevant to the WHO European Region. Being able to understand sexual health within these varying social, economic and political contexts is essential for the continuous social and economic development of both individual Member States and the Region. Member States need to be aware of their country's sexual health profile and how they are performing when it comes to creating an environment that promotes and affirms sexual health. Governments and civil society need to know what barriers exist to attaining sexual health goals and what strategies are in place or exist to promote sexual health. Are laws and policies in place that protect vulnerable populations from exploitation and ensure individuals' right to information and services regardless of age, ethnicity, sex, religion or sexual orientation? Is promotion of sexual health done in a way that is sensitive to social norms and gender equity? Is a holistic approach taken recognizing the importance of other domains such as education and economics? Does the health system provide comprehensive, affordable, accessible, quality sexual health care in an equitable manner?

Clearly the answers to these questions will vary from country to country and depend on the social and cultural norms. The pages of this issue of *Entre Nous* are filled with examples from across the Region that highlight the progress that has been made in sexual health and the broader concepts of sexual well-being. While the topics or approaches may vary, what remains consistent is the underlying fundamental belief that sexual health is an integral part of overall health and well-being. The time has come to recognize that sexual health is an essential part of public health and requires relevant attention. We are sexual beings and sexual health issues are relevant to us all. This issue of *Entre Nous* serves as a starting point for this important discussion, but from a public health approach, much more needs to be done to ensure positive sexual health and quality of life.

Gunta Lazdane, MD, PhD,
Programme Manager,
Sexual and Reproductive Health,
Division of Noncommunicable
Diseases and Health Promotion,
WHO Regional Office for Europe,
gla@euro.who.int

Lisa Avery,MD, MIH,
Editor, Entre Nous
avery@cc.umanitoba.ca

ADVANCING SEXUAL HEALTH WITHIN THE WHO GLOBAL REPRODUCTIVE HEALTH STRATEGY

Background

Human sexuality is profoundly shaped by an individual's social, cultural, political and religious contexts. How a culture and society treats sexuality can determine whether an individual is safe or unsafe, healthy or ill, rich or poor, educated or not, treated with justice or with contempt. Sexuality plays a critical role in determining a woman's social status and her ability to safeguard her health and human rights against violence, disease, and unwanted pregnancy, to survive pregnancy and childbirth, and to manage her fertility. Sex can be an arena for hotly contested dispute among power holders in societies, and can result in discrimination, abuse and violence based on gender and sexual orientation (1). Sex can put people at risk or make them vulnerable to diseases as evidenced by high rates of morbidity and mortality from sexually transmitted infections (STIs) and HIV/AIDS. Adolescents are particularly vulnerable to the risks of unwanted pregnancy, unsafe abortion, maternal mortality, STIs, violence and sexual exploitation.

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

The WHO and sexual health

In 2004, the 57th World Health Assembly approved the WHO Global Reproductive Health Strategy that defined the promotion of sexual health as a core aspect of sexual and reproductive health care.

While sexual heath is often subsumed under reproductive health, a series of technical consultations, some sponsored by WHO, have concluded that sexual health is in fact a wider term and that the two concepts intersect and overlap, as well as having distinct issues. While most policies and programmes on reproductive health are aimed at women and men of reproductive age, older people, adolescents and individuals and couples of all sexual orientations require information that responds to their sexual rather than, or as well as, their reproductive health needs.

For two decades before and since the Reproductive Health Strategy, WHO has led global efforts to build knowledge on sexuality, its determinants and relationship to other aspects of health, such as mental health and general health, well being and maturation; to update and reach consensus on definitions of sexual health and sexuality; to identify challenges and opportunities in measuring and addressing sexual health; and to define evidence-based strategies that countries and regions might adopt in order to promote sexual health according to their specific contexts.

In 2010, WHO published *Developing sexual health programmes. A framework for Action (2)*. The framework addresses five domains: laws, policies and human rights; education; society and culture; economics; and health systems. Using a multisectoral rights-based approach, the framework outlines elements of a programmatic response, together with key entry points for the promotion of sexual health by providing information and support for both broad-based and targeted community education initiatives. The framework emphasizes the need to coordinate inputs across all sectors that can influence sexual health outcomes, in order to achieve shared goals for programming on sexual health. Within the five domains, a number of entry points for promoting sexual health and healthy sexuality are identified. Some examples of key entry points are outlined below.

Laws and policies

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

Education

Within the domain of education, entry points include providing comprehensive education on sex and relationships to young people in school; capacity building in sexuality and sexual health for health workers, teachers, social workers, youth workers and other professionals; and targeting community-based strategies, such as outreach work and peer- and media-based education, to meet the needs of young people who are not in school or who may be especially vulnerable.

Society and culture

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

Economics

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

Health systems

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

Conclusion

Sexual health is a broad and complex field that offers many entry points for action and strategic investment. Directing attention and resources to sexual health as outlined in this broad framework can be a powerful means for countries to achieve improved public health, social justice and gender equality, and health equity.

Claudia Garcia Moreno, M.D, M.Sc,
Coordinator,a.i. Gender, Rights,
Sexual Health and Adolescence,
Department of Reproductive
Health and Research,
WHO headquarters,
garciamorenoc@who.int

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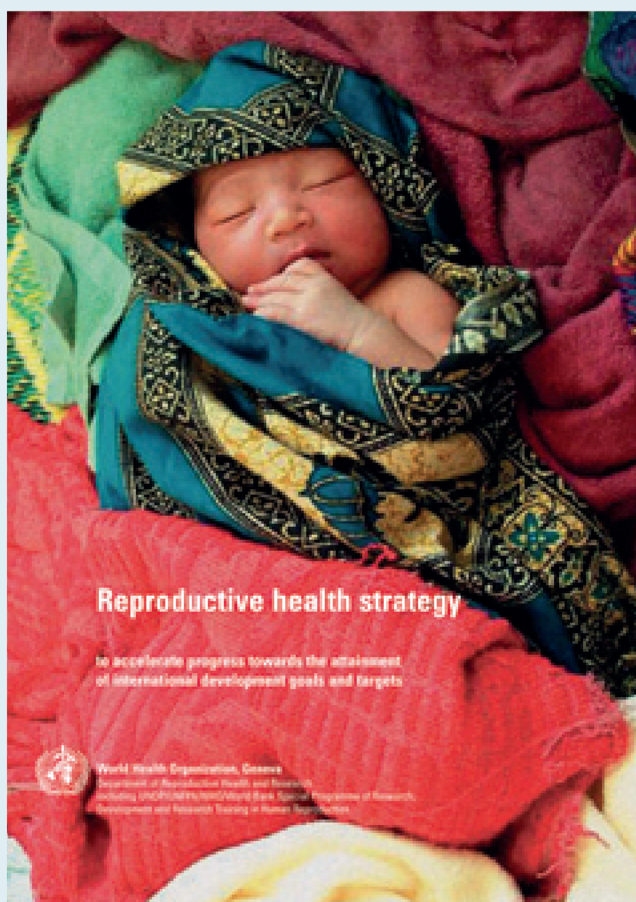

Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets Global strategy adopted by the 57th World Health Assembly, WHO, 2004.
(Available on http://www.who.int/reproductivehealth in English, French, Russian and Spanish)

SEXUAL RIGHTS – A NEW PARADIGM IN ADDRESSING SEXUAL AND REPRODUCTIVE HEALTH (SRH)

Sexual rights are human rights related to sexuality. Numerous human rights have a direct bearing upon sexuality and sexual health, such as the right to liberty and security of the person, the right to be free from torture and inhuman and degrading treatment, the right to private and family life, the right to non-discrimination and the right to information and education.

Sexuality is an important part of being human and should be recognized as a positive aspect of human life. However, individuals experience different barriers to the fulfillment of their sexual rights that can prevent them from attaining the highest standard of physical and mental health.

While advancements have been made, there is still work to be done. For example, young people all over the world face barriers in life related to fear, stigma, violence, ignorance and cultural and religious beliefs that limit their possibility to live healthy and fulfilling lives (1). These barriers can be demonstrated by (but are not limited to) a lack of access to comprehensive and non-judgmental SRH and rights education and information, a lack of youth friendly SRH services, and exposure to bullying and coerced sex. It is important that young people are informed on their rights and the specific SRH policies in their countries so that they are able to understand when their rights have been violated.

Young people should be given support to feel empowered to make decisions affecting themselves in consideration of their evolving capacities. Likewise, more attention should be given to the *invisible* populations that are included in the system and have rights but whose sexual health needs are not taken into account such as people over 50, homosexuals and lesbians, trans-genders, sex workers, drug users, people living with HIV and people with learning disabilities. Young lesbians and homosexuals, for example, should be able to be themselves without fear of homophobic bullying which can be very distressing and in turn lead to self hatred, internalized homophobia and subsequent poor mental health. People with learning disabilities are at greater risk of being sexually abused if they are unable to recognize what is non-consensual or abusive behaviour and if they are unaware of their right to say "no". More needs to be done for people living with HIV who have been affected by human rights violations in healthcare settings (e.g. HIV testing without consent; breach of confidentiality; coerced sterilization; advised not to have children due to HIV status).

Sexual Rights: an International Planned Parenthood Federation (IPPF) declaration

In May 2008, the Governing Council of the IPPF adopted "*Sexual Rights: an IPPF declaration*" to complement the "*IPPF Charter on Sexual and Reproductive rights*" (1995). This Declaration is fundamental to the realization of IPPF's vision and mission. The Federation created this tool for their own service provision, programming and advocacy work, and also for the wider public. It aims to explicitly identify sexual rights and support an inclusive vision of sexuality that is free from stigma and discrimination.

Sexual Rights: an IPPF declaration is grounded in core international human rights treaties; it is based on authoritative interpretations of these international standards and additional entitlements related to human sexuality that are implicit in them. It draws on the documents emanating from important UN conferences, and it is also informed by the findings and recommendations of several UN Special Rapporteurs.

The Declaration is broken down into a series of ten rights articulated around seven principles.

Under Principle 1 of the Declaration, IPPF identifies sexuality *as "an integral part of the personhood of every human being." … "Sexual rights are universal human rights based on the inherent dignity and equality of all human beings." … "IPPF recognizes the importance of creating a favourable environment in which every individual may enjoy all sexual rights in order to be able to take an active part in processes of economic, social, cultural and political development. Sexuality is an aspect of human and social life which is engaged always with the body, the mind, politics, health and society."*

Principles 2 and 6 of the Declaration offer new approaches in regard to sexual rights.

Principle 2 addresses adolescents needs and specifies that *"The rights and protections guaranteed to people under age eighteen differ from those of adults, and must take into account the evolving capacities of the individual child to exercise rights on his or her own behalf." … Societies must create environments in which children can achieve their optimal capacities and where greater respect is given to their potential for participation in, and responsibility for, decision-making in their own lives."* According to Principle 6, *"Sexual rights may be subject only to those limitations determined by law for the purpose of securing due recognition and respect for the rights and freedoms of others and the general welfare in a democratic society."*

The Declaration also highlights the obligation States have to respect, protect and fulfill the sexual rights of all. The full text of Sexual Rights: an IPPF Declaration can be found at: http://www.ippf.org/en/Resources/Statements/Sexual+rights+an+IPPF+declaration.htm

Sexual rights in action

The IPPF European Network has encouraged its Member Associations to use the Declaration as guidance in the integration of their commitment to respect, protect and advance sexual rights throughout their activities; and to reinforce and enhance their ongoing policies, strategies and programmes. The Declaration is now available in 23 languages and a number of Member Associations (staff and volunteers) have either referred, directly or indirectly, to it in a range of innovative activities.

IPPF EN youth network (YSAFE) – Young people and sexual rights. Young people can avail of their rights as can be seen through the work of the young

Marie-Agnès Lenoir

Ada Dortch

volunteers from the IPPF EN European youth network (YSAFE). Some YSAFE members recently carried out small-scale projects to raise awareness on the realities of girls' SRH and rights. In one of these projects, Olga from the Czech Republic has led her youth group to establish a growing network of youth friendly gynecologists in the country (2). Each doctor is now committed to the principles of what it means to be youth-friendly (e.g. respecting the rights to privacy, health and personal autonomy, etc.), and is identified to young women seeking gynecologist services by a sticker on their door.

Spain – Sexual (and Reproductive) Rights Campaign. The IPPF Member Association of Spain, FPFE, mentioned the IPPF Sexual Rights Declaration in their Charter on Sexual Rights and Reproductive Rights and is now launching a national Sexual (and Reproductive) Rights Campaign throughout the country with two main supporting materials: a folder with a definition and a statement of each right (http://fpfe.org/files/t_pdf/carta_de_derechos.pdf) and a short documentary film (http://vimeo.com/17630636).

Albania – Becoming more aware about sexual rights. IPPF's Albanian Partner, the Albanian Center for Population and Development (ACPD) conducted peer education activities where young volunteers delivered comprehensive information and education about sexuality, reproduction and rights to their peers, especially among hard-to-reach groups such as Roma, former sex workers and young people living in rural and suburban areas. In total, 500 young people have supported the process of dissemination of the IPPF Sexual Rights Declaration throughout the country. The translation of the Declaration into the Albanian language is helping to promote young people's active participation in the workshops and strengthen ACPD's voice when advocating for SRH and rights at the national level.

Switzerland – Sexual rights and the National HIV/AIDS Programme. The Swiss Federal Office of Public Health (SFOPH) has launched a new National Programme for HIV/AIDS and Other Sexually Transmitted Infections 2011-2017. As the leader responsible for directing and managing the National HIV/AIDS Programme, the SFOPH works in close cooperation with other Swiss federal agencies, cantonal authorities and NGOs such as the IPPF Member Association of Switzerland, PLANeS. The Sexual Rights Declaration has served as a reference source in the establishment of the new HIV programme and PLANeS will be working closely with the SFOPH in implementing the new strategy.

The Former Yugoslav Republic of Macedonia– a framework for sexuality education. Since 2009, the Health Education and Research Association (HERA) clearly positioned itself not just as a service-based NGO but also as an organization that has the capacity to strongly advocate for and support SRH and rights. HERA made a significant step forward in 2010 with the publication of the Macedonian Framework for Comprehensive Sexuality Education (available, in English, via http://www.hera.org.mk/webcontent/file_library/materijali_eng/framework%20SE_EN%20.pdf). The document is based on national policies and programmes for SRH, the "IPPF Framework for Comprehensive Sexuality Education", the WHO's "Standards for Sexuality Education in Europe" and UNESCO's "International Technical Guidance on Sexuality Education". This framework is aimed at decision makers and should be used in the further development and implementation of comprehensive sexuality education in the country.

Marie-Agnès Lenoir,
Communications Officer,
The International Planned Parenthood Federation European Network,
mlenoir@ippfen.org

Ada Dortch,
Programme Officer and
youth focal point,
The International Planned Parenthood Federation European Network,
adortch@ippfen.org

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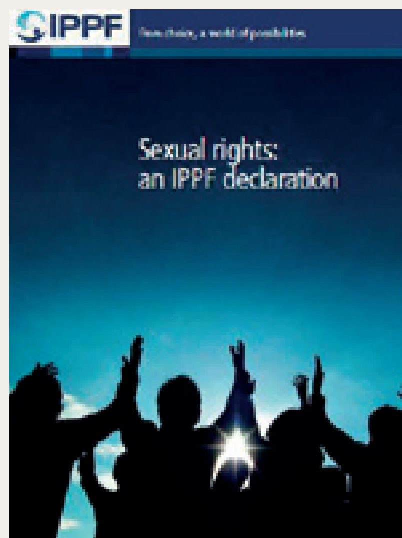


Other IPPF publications that are helpful for understanding sexual rights, including sexual rights of young people.

Sexual Rights in Action, case studies from around the world (http://www.ippf.org/en/Resources/Reports-reviews/Sexual+rights+in+action.htm)

Exclaim!: A young people's guide to "Sexual Rights: An IPPF Declaration" (available via www.ippf.org in April 2011)

Guide for Developing policies on the sexual and reproductive health and rights of young people in Europe(http://www.ippfen.org/NR/rdonlyres/4A7E8620-5009-4170-918B-E2891FC4161B/0/policyguide.pdf)

SEXUAL HEALTH IN THE WHO EUROPEAN REGION

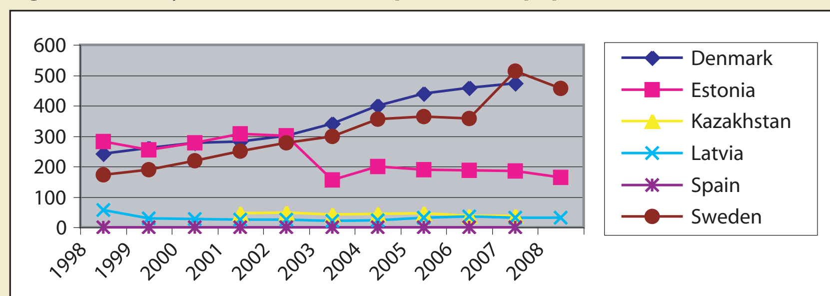
If we were to pose the question "What is the status of sexual health (SH) in the WHO European Region?" to policy makers, programme managers or individual members of society, we may receive very different answers. The reply depends on a number of factors such as: knowledge of the internationally accepted definition of SH; which of the 53 WHO Member States a person represents; country of origin; understanding of public health; and many other factors.

Information and data are key to understanding the current situation. Encouragingly, sexual behaviour and the status of SH has recently been monitored through a number of national surveys in Ireland, Spain and other European countries. Yet as surveys move from the west to the east of Europe the focus often narrows from a broader concept of sexual and reproductive health (SRH) to maternal health. Thus, lack of available and comparable data make it difficult to present or compare the SH situation in the European Region. Based on what information is available, the following sections summarize what we currently know about SH in the Region.

Laws and regulations

SH depends on the existing national legal setting. Most of the counties in the Region have approved laws prohibiting discrimination on the basis of age, gender identity, sexual orientation and physical and intellectual disabilities. Laws usually require full and free consent of the parties to a marriage. WHO has developed a Human Rights and Sexual and Reproductive Health Tool (1) assisting countries to evaluate whether national legislation does not create obstacles in accessing information and quality services to all population groups, including the most vulnerable. Two countries have piloted this tool: the Republic of Moldova evaluated a broad spectrum of SRH, whereas Tajikistan focused mainly on the health of adolescents. Detailed analysis of the national legislation in all 53 countries has not been carried out; however, the major challenges remain SH of minors and issues related to sexual violence.

Figure 1. Chlamydia - incidence rate (per 100 000 population)



Source: http://data.euro.who.int/cisid/

Sexuality education

The correlation between education level and SH status has been well documented. In fact, "Whether sexuality education is mandatory?" has been suggested as an indicator to monitor SH (2). Information about sexuality education in 26 European countries was collected and published as part of the SAFE Project: A European partnership to promote the SRH and rights of young people" (3) (financed by the European Commission and conducted by the IPPF European Network, WHO Regional Office for Europe and Lund University). The analysed data confirmed that there is a wide variation in the age when school based sexuality education starts (from 5-6 to 14-18 years), of available standards (more than one third of countries do not have sexuality education standards) and professionals responsible for teaching (3). Several countries in the Region have approached the WHO requesting assistance in developing core sexuality education standards for schools. This request has materialized and Standards for Sexuality education were launched in October 2010 (more pp 14-15).

Sexual behaviour and SH outcomes

While a number of small scale studies have been carried out to monitor the trends of sexual behaviour, the Health Behaviour in School-aged Children Survey (HBSC) is the only one that uses consistent methodology and includes more than 40 countries (www.hbsc.org) (4). This study provides an overview of sex disaggregated data on experience of sexual intercourse, condom and pill use of 15 year old adolescents. Due to its 4 year resurvey cycle, it also allows trends in these behaviours to be monitored and analysed. The average age of first intercourse has declined in many European countries and variations between males and females in different countries can be substantial. The proportion of sexually-active 15-year-old people who report using a condom the last time they had sexual intercourse ranges from 65% in Slovakia to 91% in Greece for boys and from 61% in Romania to 95% in Spain for girls (4). One possible explanation for poor motivation in condom use and decreased perception of risk is that of lack of knowledge and/or access to SRH services, alcohol consumption or drug and substance abuse prior to having sex. These same factors also results in a high number of induced abortions in the Region, especially among women younger than 19 years of age (5). Implementation of the European Action plan on Alcohol that will be discussed in the WHO European Regional Committee in September this year is focusing on actions that prevent both – alcohol use and unsafe sex.

The incidence of several STIs in many countries is not well documented, but information from Scandinavian countries that have good screening and monitoring systems in place confirms that the incidence of Chlamydia infection is increasing (Figure 1). In addition, despite the fact that contraceptive prevalence is one of the indicators for Millennium Development Goal 5, the comparative, reliable

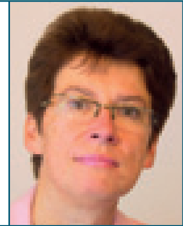
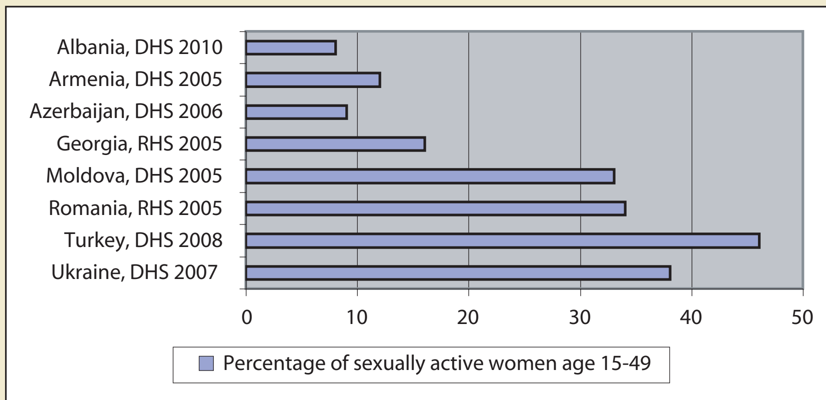


Figure 2. Current use of modern contraception (DHS/RHS data)



data on prevention of unintended pregnancies is limited. Effective contraception remains a challenge in many countries of the European Region (Figure 2).

An often neglected, but very important aspect of SH, is sexual satisfaction and quality of one's sexual life. "Sexual function and dysfunction" are problematic terms and may depend on social and medical attitudes to sexuality. Many people do suffer from low sexual desire and inability to achieve orgasm; men can experience erectile dysfunction and premature ejaculation and women can experience pain during intercourse and vaginismus. If not responded to, sexual dysfunction can cause great suffering, damaging an individual's ability to form or sustain intimate relationships. They are associated with common mental illnesses, depression and a low quality of life score. The impact of chronic illnesses (cancers, cardiovascular diseases, diabetes) is an important contributor to the quality of SH, yet to date its inclusion in assessments of SH is often neglected. Currently available data on the relationship between the two is small scale and lacks a public health approach. The Action Plan for implementation of the European Strategy for the Prevention and Control of Non-communicable Diseases (2011-2016), developed by the WHO Regional Office for Europe in close collaboration with experts, includes concrete actions to ensure that this problem is addressed by national policies and programmes.

Gender based violence also remains a challenge, with 20-65% of women in Europe having experienced intimate partner violence. Often it is accepted as cultural norm by society, but several Member States are leading the way in tackling this important public health issue (www.euro.who.int/en/what-we-do/health-topics/health-determinants/gender/activities/gender-based-violence).

Conclusion

Significant progress has been made in the European Region in understanding SH, its relationship with non-health sectors and why the promotion of SH is of critical importance in the public health field. The SH status and trends vary from country to country, highlighting the fact that individual, country specific approaches are needed to improve SH. With this in mind, the WHO has recently developed two documents: 1) "*Developing Sexual Health Programmes*" (6) and 2) "*Measuring sexual health: conceptual and practical considerations and related indicators*" (2) that may help policy makers evaluate the present status of SH in their country, develop SH programmes and monitor their implementation.

Gunta Lazdane, MD, PhD,
Programme Manager, Sexual and Reproductive Health,
Division of Noncommunicable Diseases and Health Promotion,
WHO Regional Office for Europe,
gla@euro.who.int

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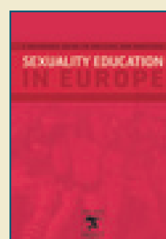

Sexuality education in Europe. A Reference Guide to Policies and Practice. The Safe Project, 2006.

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www.ippfen.org

IMPROVING SEXUAL HEALTH OUTCOMES IN SCOTLAND

Introduction

Scotland, along with the rest of the United Kingdom (UK), has one of the highest rates of teenage pregnancy in western Europe. It is also renowned as a culture in which issues such as sexual health and relationships are not discussed openly. The Scottish Government and local statutory and voluntary agencies are working hard to change this perception and to create a culture in which individuals and communities can enjoy better relationships and improved sexual health outcomes.

Background

The overarching purpose of the Scottish Government is "to create a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth" (1). A key theme to the Scottish Government's approach is that all public services should be better aligned to achieve common goals to create a more successful Scotland. The Scottish Government's purpose is supported by five strategic objectives – to make Scotland wealthier and fairer, smarter, healthier, safer and stronger and greener. These are supported by 15 national outcomes that describe what the Government wants to achieve over a ten-year period.

The healthier objective aims to "help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care." (1) All government targets include a clear focus on tackling health inequalities.

Improving Sexual Health

Respect and Responsibility, the national sexual health strategy (2), was launched by the Scottish Executive (now Scottish Government) in 2005 in order to improve Scotland's sexual health outcomes. The strategy includes a range of actions to improve sexual health services and education across Scotland. In 2007, an independent review of the strategy considered its progress to date and suggested that, having achieved an initial goal of enhancing the provision and accessibility of sexual health services in Scotland, the focus should shift towards achieving cultural change and an increase in activity that addressed the wider social factors that impact on sexual health.

The review led to the creation of a set of National Outcomes for Sexual Health 2008-2011 (http://www.scotland.gov.uk/Topics/Health/health/sexualhealth/SHOutcomes).

The long term outcomes where the government would like to see improvements are:

- Reduced levels of regret and coercion,
- Reduced levels of unintended pregnancy, particularly in those under 16 but also to see a reduction in the number of repeat abortions in all ages,
- Reduced levels of sexually transmitted infections (STIs), recognizing that there will first of all have to be an increase due to increased testing,
- Increased access to sexual health information and uptake of services,
- Reduced levels of HIV transmission, particularly amongst men having sex with men, and
- Reduced levels of undiagnosed HIV, particularly amongst men having sex with men and African populations.

It was intended that these outcomes would be achieved through the implementation of evidence informed interventions delivered in a consistent way across Scotland but adapted to meet local needs. This is very important - although Scotland is a relatively small country with a population of around five million, it varies greatly in terms of population, deprivation and health outcomes across the regions. Opportunities for sharing evidence, practice, knowledge and experience are needed to ensure that high quality and best practice is achieved across this diverse nation.

What are the barriers?

Public perception of sexual health issues does not often meet with reality. Surveys in Scotland have shown that the public rate their own knowledge of sexual health as high. Yet behaviours show that this knowledge is not then put into practice. Many do not identify when they have engaged in behaviour that could have put them at risk for an unintended pregnancy or STIs. In one study, a local NHS service provided women with a supply of emergency contraceptives to keep at home for use in case of emergency. The researchers discovered later that many women had not used the pills because although they had had unprotected sex on more than one occasion they did not equate that with being at risk for pregnancy (3).

Media representation of sexual health issues in Scotland does not help to challenge people's perceptions of the issues. Reporting is often sensationalized and based upon stereotypes and polarized views rather than promoting positive relationships and the benefits of maintaining good sexual health (see figures 1 and 2). For example, any reference to the promotion of condoms, especially for young people, often leads to accusations of promoting promiscuity despite condoms being an effective barrier to STI transmission if used correctly.

In Scotland, as with many other countries, levels of sexual ill health are highest in particular communities – those in areas of high deprivation, young people and men who have sex with men. Sexual health cannot, and should not, be separated from other risk taking behaviours. Unfortunately, the evidence of what works to improve outcomes amongst these groups is not always strong and has on occasion led to inaction or delay on the part of agencies working with these groups. We are, however, trying to create a culture whereby interventions are evidence based and if evidence does not exist, it is our job to create, evaluate and share interventions that contribute to the evidence base.

Barriers also exist within health and education systems. Sexual health is unlikely to ever be prioritized over issues such as heart disease and sitting exams, but there is a need for greater recognition of the potential long term impact of not addressing sexual health issues. Teenage

Dona
Milne

pregnancy, for example, has an impact on both the mother and the child. It is estimated that teenage pregnancy costs the NHS in the UK £63 million (4) and we cannot underestimate the potential negative impact on the mother who finishes her education at an early age. It is also estimated that every £1 invested in contraception saves the NHS more than £11 in additional welfare costs (4). Furthermore, UK data suggests that £1.1 billion could have been saved if HIV infections diagnosed had been prevented – not an insignificant economic and human cost (5).

Overcoming the barriers – Challenging the culture

Challenging stigma and discrimination is a key task for everyone working in the area of sexual health. Coordinating prevention activities and having clear messages delivered through social marketing activities are useful approaches with the general public. Scotland has a new sexual health website that has begun to create a more positive tone around public messaging (http://www.sexualhealthscotland.co.uk).

This isn't enough on its own and the introduction of community development activities at local level is recognized as the most effective way to address issues with those groups most at risk.

Overcoming the barriers – Leadership and Performance Management

Increased capacity and leadership within sexual health services and health promotion activities has led to improvements in the effectiveness of interventions, which will, in the longer term, lead to improvements in health outcomes. It may feel a bit too like management speak, but bringing together all agencies and identifying clear roles and responsibilities has led to increased accountability and delivery. Performance management is undertaken regionally and nationally and results are published.

Overcoming the barriers – Measuring Impact

For too long we have measured impact of effectiveness only on levels of teenage pregnancy, abortion and STIs. Whilst these are important, there are wider issues that need to be considered and routine data sources cannot answer all of the questions we have. We are considering more effective ways to assess public attitudes, intentions and behaviours, not just in relation to sexual health but also to other areas such as alcohol and drug use, gender based violence and socio-economic factors.

Next Steps

Specialists in Scotland are working with Government to prepare a framework for sexual health and blood borne virus activity for the next five years. This is being developed in a time of great economic constraint, although we have managed so far to retain many of the resources allocated for the coming year and hope this will continue for the forthcoming government spending review. This could be an opportunity for sexual health – we will be required to reconsider how we spend our more limited time and resources. We have a phrase in Scotland that is often used when we question why we do one thing over another, the response is sometimes "It's aye been" (roughly translated as "because we always have done it").

This is the time to question some of that activity, perhaps more rigorously than we have done in the past. I would propose it is a time for focusing our efforts on where they can have the biggest impact, such as interventions in areas of deprivation, targeting groups at highest risk, whilst providing opportunities for those who are able to self manage and carry on and do so with limited input from professionals. I am not sure if this is what Michael Marmot meant by "proportionate universalism" but it could work for sexual health in Scotland.

Dona Milne
Specialist in Public Health,
NHS Lothian,
Dona.Milne@nhslothian.scot.nhs.uk

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Figure 1.

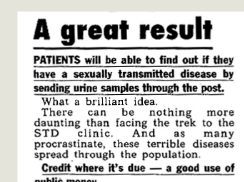
METRO Friday, November 30, 2001

Sex diseases rampant in age of promiscuity

BY DAVID FICKLING

HOW TO BEAT INFECTIONS

Figure 2.



A great result

PATIENTS will be able to find out if they have a sexually transmitted disease by sending urine samples through the post.

What a brilliant idea.

There can be nothing more daunting than facing the trek to the STD clinic. And as many procrastinate, these terrible diseases spread through the population.

Credit where it's due — a good use of public money.

SEXUAL HEALTH (SH) OF YOUNG PEOPLE IN THE WHO EUROPEAN REGION

This article is a summary of a paper presented at the WHO European Regional Meeting on "Challenges in improving SH in Europe", Madrid 28-29 October 2010. It describes and analyses the most recent levels and trends in some core adolescent SH indicators in Europe.

Changing conditions of young people

Nowadays young people remain in the education system much longer than before; they marry and have children later in life, and long before that they start having intimate relationships. Sexual contacts before marriage have become the rule; this new reality has to be recognized. Modern, reliable contraception has become widely available in large parts of the Region. On the other hand, over the past decade or two, the cyberspace revolution, (particularly Internet pornography, webcams, social websites and mobile phones), has created a fundamentally new environment, with new opportunities, but also risks for young people's SH, which we are only just beginning to understand. With changing values, norms, social conditions and opportunities for making intimate contacts, the challenge for society is to provide the conditions that enable adolescents to move safely through this life phase, where sexuality is concerned and otherwise.

Maturation and first sexual intercourse

The age at first intercourse has clearly declined in recent decades. For example, in France the median age at first sex for women went down from 20.7 in 1954-1958 to 17.6 in 2004-2005 (1). Most other European countries display a similar trend. Most young people in Europe nowadays start having sex at around age 17. Data also shows that the gender gap is narrowing, with girls approaching the average age of boys at first intercourse (2).

Results of the most recent Health Behaviour in School Aged Children (HBSC) study in 2005/6 (see Figure 1) indicate that at that age 15, 24% of girls and 30% of boys say they have already experienced sexual intercourse (2). In northern European countries girls indicate a slightly earlier start than boys, but in southern countries this is reversed. The latter may be caused by boys over- and girls under-reporting sexual experience.

Contraceptive access and use

Access to contraception includes financial, psychological, and service delivery aspects. In some countries, contraception is included in (public) health insurance systems. Sometimes special arrangements have been made for adolescents, like in the Netherlands and in Germany where prescriptions for contraceptives are free for those under the age of 21. Sexual and reproductive health (SRH) services should generally be youth-friendly; in some settings the establishment of special youth services might be necessary to allow adolescents access to services.

Contraceptive use varies greatly among young people in Europe. According to the 2005/2006 HBSC study the highest rates of condom use are reported by boys from Greece (91%) and Switzerland (89%), and the lowest rates by boys from Slovakia (65%) and Sweden (69%) (2). Oral contraception is used much more frequently in western than eastern European countries (see Figure 2).

Teenage pregnancy and abortion

Teenage birth rates in Europe vary between a high of 42 births per 1000 15-19 year old girls in Bulgaria and a low of 4 per 1000 in the Netherlands (3). The rate is generally low in western Europe, with the exception of England, where it is 24, and high in central and eastern Europe, with the exception of Slovenia that has a very low rate of 5 (3). In the vast majority of European countries this rate is still declining.

Access to legal abortion varies across Europe. Except for Poland, (Northern) Ireland and Malta, abortion is available either on the woman's request, or on broad social and medical grounds. Central and eastern Europe have shown dramatic declines in abortion rates, also among young people. Compared to other world regions, abortion rates in western Europe are very low, at about 12 per 1000 women of reproductive age (4).

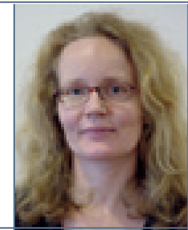
Sexually transmitted infections (STIs)

In many societies, STIs are perceived as being linked with "immoral behaviour", thus people infected with an STI are often stigmatized. For young people and adolescents, the stigma associated with STIs poses an obstacle to accessing health care services and seeking out proper treatment. In the last 10 years, the number of chlamydia cases has increased tremendously, with young people disproportionately affected, although this is partly due to a higher rate of diagnosis and detection (5). The spread of gonorrhoea is much more limited. HIV infection rates in Europe are relatively low. They are highest in eastern Europe, at 179 per million inhabitants, and lowest in central Europe at 15 per million (5). Young people (aged 15-24) are responsible for 13% of new infections, which is relatively low (5).

Sexual abuse and violence among adolescents

Sexual abuse and violence among young people remains an underestimated problem, characterised by lack of data on the one hand and by its extremely complex nature on the other. A recently conducted youth survey in the Netherlands found that 15.8% of female and 7.5% of male respondents have experienced (a threat of) sexual violence (6). A Swedish study confirmed that girls are much more often victims of sexual abuse: the prevalence rate of penetrative abuse was 13.5% for girls and 5.5% of boys (7). Much more research is needed in this field.

Evert Ketting



Christine Winkel-mann

Figure 1. Percentage of 15-year olds who have had sexual intercourse (2).

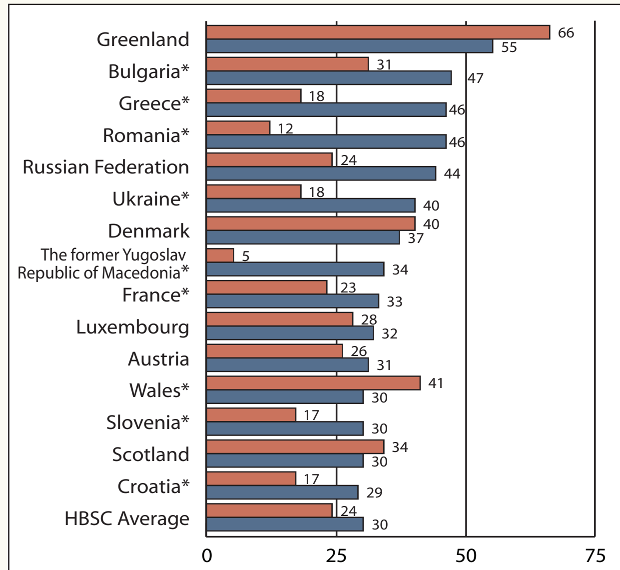
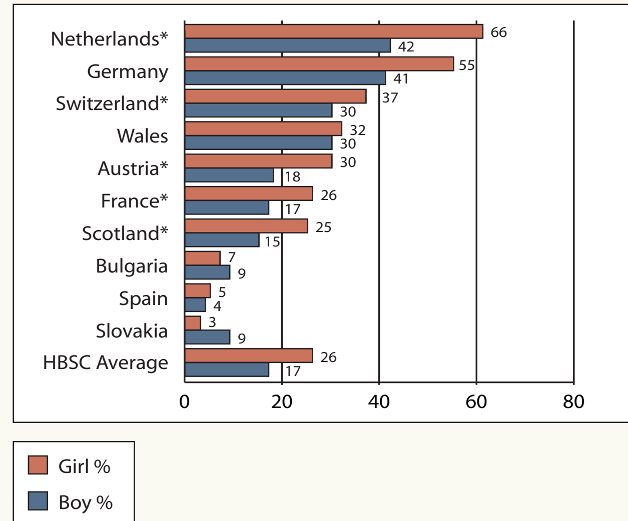


Figure 2: Percentage of 15 year olds using oral contra-ception at last intercourse (2).



**indicates a significant gender difference (at p<0.05)*

Positive SH indicators

Since SH means that people have the right to experience their sexuality in a satisfactory manner, it is promising that recently some attention is being paid to positive and not only negative aspects of SH. Recent studies indicate that young people in Europe are generally happy with their sexual life: in Germany 80% of boys and 60% of girls perceive their first sexual intercourse as a nice experience (8); in Spain 85.8% of male and 64.7% of female age 16-17 reported satisfaction with their first sexual experience (9); and in the Netherlands among 12-25 year olds three quarters of both sexually active boys and girls were (very) satisfied with their sexual relationship (10). While it appears that sexual relations of young people can be (very) satisfactory, it must also be noted that many are not satisfied, particularly girls at their very first experience.

In conclusion

The SH of young people in Europe has generally improved during the past decades, yet in spite of improvements, the gaps between countries in relation to the indicators listed in this article are still too large. Two important steps need to be taken: 1) holistic sexuality education needs to be introduced in schools to increase knowledge, build positive attitudes and develop skills and 2) easy access to SRH services needs to be guaranteed through either the introduction of special services for adolescents or strengthening of existing services to be more youth-friendly.

Evert Ketting, MD,
Senior Research Fellow,
Radboud University,
Nijmegen Department of
Public Health, Netherlands,
e.ketting@tip.nl

Christine Winkelmann, PhD,
WHO Collaborating Centre for
Sexual and Reproductive Health,
Federal Centre for Health Education
(BzGA),
Cologne, Germany,
Christine.Winkelmann@bzga.de

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STANDARDS FOR SEXUALITY EDUCATION IN EUROPE

Introduction

A new publication *"Standards for Sexuality Education in Europe – a framework for policy makers, educational and health authorities and specialists"* (1) by the Federal Centre for Health Education (BZgA) in Germany and the WHO Regional Office for Europe was released in the fall of 2010. It serves the purpose of improving sexuality education in the WHO European Region.

Sexuality education is a very important means of countering many of the challenges related to sexual health. Adolescents and young people in Europe are affected by high or rising rates of HIV and other sexually transmitted infections (STIs), unintended teenage pregnancies, sexual violence and many other issues (2). Most importantly knowledge about sexuality is increasingly perceived as a human right. Young people have the right to know about sexuality in terms of both risks and enrichment, in order to develop a positive and responsible attitude towards it. In this way, they will be enabled to behave responsibly not only towards themselves, but also towards others in the societies they live in.

The process

This initiative to develop standards for sexuality education was launched by the WHO Regional Office for Europe in 2008 and developed by the Federal Centre for Health Education (BZgA), a WHO Collaborating Centre for Sexual and Reproductive Health, in close cooperation with an international group of experts. This group comprised 19 experts from nine western European countries, with various backgrounds, ranging from medicine to psychology and social sciences. All of them had extensive experience in the field of sexuality education, in either a theoretical or a practical way. Governmental and nongovernmental organizations, international organizations and academia were also represented in a process extending over one-and-a-half years.

The document was developed as a response to the need for sexuality education standards that has recently become apparent in the WHO European Region, which comprises 53 countries, covering a vast geographical region from the Atlantic to the Pacific oceans. Most western European countries now have national guidelines or minimum standards for sexuality education, but no attempt has been made to recommend standards at the WHO European Region or European Union level. This document is intended as a first step in filling this gap for the entire WHO European Region.

At the WHO European Regional Meeting on "Challenges in improving sexual health in Europe" (Madrid 28-29 October 2010), the Standards were officially launched and introduced to representatives of more than 30 European countries.

A holistic approach to sexuality education

At the core of the "Standards" is a concept of holistic sexuality education which is not only based on the acknowledgment of sexual and reproductive health and rights, but also stresses positive approaches towards sexuality. The term "sexuality" is understood in the broadest possible sense, including emotions, relationships, the human body, etc. This broad understanding overcomes the still dominant narrow approach to sexuality which only focuses on "real" sexual activity, and lays the foundations for a concept of lifelong sexuality education, starting at birth and continuing throughout life.

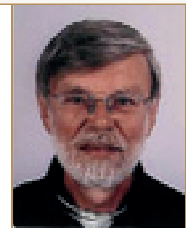
Holistic sexuality education gives children and young people unbiased, scientifically correct information on all aspects of sexuality and, at the same time, helps them to develop values, attitudes and skills to act upon this information. Thus it contributes to the development of respectful, open-minded attitudes and helps to build equitable societies.

Traditionally, sexuality education has focused on the potential risks of sexuality, such as unintended pregnancy and STIs. This negative focus is often frightening for children and young people. Moreover, it does not respond to their need for information and skills and, in all too many cases, it simply is felt to have no relevance to their lives.

A holistic approach, based on an understanding of sexuality as an area of human potential, helps children and young people to develop the essential skills they need to determine their own sexuality and their relationships at the various developmental stages. It supports them in becoming more empowered so that they can live out their sexuality and their partnerships in a fulfilling and responsible manner. These skills are essential for protecting themselves from possible risks. Sexuality education is also part of a more general education, and thus affects the development of the child's personality. It not only helps to prevent negative consequences linked to sexuality, but can also improve the child's quality of life, health and well-being. In this way, sexuality education contributes to health promotion in general.

Image 1. Consultation in Cologne.

Christine Winkel-mann



Evert Ketting

Structure of the document

The document is divided into two main parts. The first part gives an overview of the underlying philosophy, rationale, definitions and principles of sexuality education and the elements it comprises. It introduces the wider concept of holistic sexuality education and argues why this is especially important for young people and adolescents.

At the heart of the second part of the document is a matrix showing the topics which sexuality education needs to cover for successive age groups. The six age-groups (0-4, 4-6, 6-9, 9-12, 12-15, 15 and up) mirror closely the psychosexual development of children and adolescents. For each of the age groups and each of the eight thematic categories ("The human body and human development", "Fertility and reproduction", "Sexuality", "Emotions", "Relationships and lifestyles", "Sexuality, health and wellbeing", "Sexuality and rights", and "Social and cultural determinants of sexuality"), the matrix specifies which information is to be given, what skills should be acquired and what attitudes should be fostered. The last part is geared more towards the practical implementation of holistic school-based sexuality education, although the Standards are not intended to be an implementation guide.

Next steps

A month after the official launch of the Standards, the WHO Regional Office for Europe and the German Federal Centre for Health Education invited representatives from ministries of health, ministries of education and civil society organizations working in the field of sexual and reproductive health to a consultation in Cologne. Representatives from eight eastern and south-eastern European countries and from central Asia, who had all identified reproductive health as part of a bilateral biannual collaboration agreement between the Ministries of Health and the WHO Regional Office for Europe, joined the consultation (see image 1). At the meeting, the "Standards" were introduced and possibilities for their implementation in the participating countries were jointly explored.

The meeting also provided an opportunity to discuss the sexual health of adolescents and the situation of sexuality education in their respective countries. Participants analysed challenges in the national implementation of sexuality education and discussed ways to use the Standards to improve it. All participating countries warmly welcomed the Standards and stressed how greatly needed they were.

The country representatives agreed on a large number of next steps to be taken at national level to promote the Standards, ranging from translation and national adaptation of the Standards to the revision of existing curriculums, calling meetings with national stakeholders, identifying possibilities for implementing pilot projects and developing materials based on the Standards.

The Federal Centre for Health Education and the WHO Regional Office for Europe will support the implementation process in various ways. By the end of 2011, an implementation strategy will be published to supplement the Standards and give practical guidance to countries and interested parties about how to proceed with the introduction of holistic sexuality education or the expansion of existing programmes.

The Standards have been translated into a number of languages. A Russian and a German version will be published in spring 2011, and Turkish, Dutch, Latvian and Spanish versions are also in preparation. The Finnish translation was finalized by the end of 2010. Professor Dan Apter, Chief Physician and Director of The Sexual Health Clinic at Väestöliitto (Family Federation of Finland), explains: "The structure of the Standards for Sexuality Education in Europe: – information, skills and attitudes by age groups – is a model we highly appreciate. Our way to give sexuality education has been too much warnings and threats – sexuality education should approach sexuality as a positive power and as a part of well-being from baby to adult. These issues were topical at the end of 2010, when there were plans to change the structure of curricula in schools. Health-care authorities pointed out that health education and sexuality education have to be a compulsory subject for everyone and have to start even earlier than before, because puberty starts earlier than before" (3).

These developments show that there has been a widespread need in the European Region for guidance to improve the quality of sexuality education. The ultimate beneficiaries will be children and adolescents who will not only receive relevant and adequate information but also learn the skills to protect their own health and that of others while at the same time develop a positive attitude towards sexuality.

Christine Winkelmann, PhD,
WHO Collaborating Centre for Sexual and Reproductive Health, Federal Centre for Health Education (BzGA),
Cologne, Germany,
Christine.Winkelmann@bzga.de

Evert Ketting, MD,
Senior Research Fellow,
Radboud University,
Nijmegen Department of Public Health, Netherlands,
e.ketting@tip.nl

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CHALLENGES OF THE SEXUAL HEALTH (SH) OF THE ELDERLY IN EUROPE

Introduction

There has been a surge of medical and sociological interest in the sexuality of older people and this reflects a cultural shift in attitudes towards sex and aging.

National surveys of sexual activity

The quantity and quality of sexual experiences among Swedish 70 year olds has increased over the last 30 years (1). The proportion of 70 year olds who reported sexual intercourse increased amongst all groups. For married men it increased from 52% to 68%, for married women from 38% to 56%, in unmarried men from 30% to 54% and in unmarried women from 0.8% to 12%. Men and women from the later birth cohorts reported higher satisfaction with sexuality, fewer sexual dysfunctions, and more positive attitudes to sexuality in later life than those from the earlier birth cohorts.

In the European Male Ageing Study (2), the largest population based study of ageing in elderly men in Europe (a random population sample of 3369 men aged between 40 and 79 years of age), more than 50% of the subjects reported the presence of one or more common morbidities including hypertension (29%), obesity (24%) and heart disease (16%). 30% of the men reported erectile dysfunction (ED) and 6% severe orgasmic impairment, both of which were closely associated with ageing. 55% complained of ED in the oldest age group (greater than 70 years of age) but 49% reported at least one sexual intercourse (greater than 20% more than before) weekly. 24% reported masturbation, 58% petting and over 75% thinking about sex in the previous four weeks.

A telephone survey of 1500 individuals in the UK amongst middle aged and older people found that 69% of men and 56% of women reported having sexual intercourse during the past year. The most common problems for men were early ejaculation (20%) and ED (18%) whereas for women it was a lack of sexual interest (34%) and a lack of pleasure in sex (25%). Only 26% of men and 17% of women had discussed their problem with a doctor (3).

In a study of participants of mean age 81 years, where 56% were women, 18% of the women and 41% of the men were sexually active; the most commonly reported sexual activity was intercourse for men and masturbation for women. The most commonly cited reason for being sexually inactive in women was no desire whereas for men it was ED. Only 4% of the women (compared to 36% of the men) reported initiating a discussion about sexual function with their physician in the past year whereas 7% of the women (compared to the 32% of men) reported that their physician had enquired about the topic in the proceeding year. 32% of the women (and 86% of the men) felt the physicians should initiate discussion about sexual function (4).

The importance to patients

Recent analysis of the attitudes of general practitioners in the United Kingdom revealed that many have the tendency to consider that SH may not be a 'legitimate' topic for discussion with the older age group (5). However studies indicate that a significant proportion of older people would welcome enquiry into their sexual well being (3).

Ratings of the importance of sex for participants from general practice settings in the UK found that participants who did not consider sex to be of any importance to them had neither a current sexual partner nor felt they would have another sexual partner in their life time. Those participants who had a current sexual partner attributed at least some importance of sex but barriers to being sexually active led them to place less importance on sex, particularly when health problems and widowhood were experienced (6).

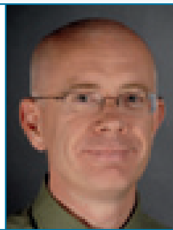
Older adults with a current partner and/or who are sexually active are more likely than those who are sexually inactive to rate sex as being a 'very' or 'extremely' important priority in their lives. Where sexual activity becomes less frequent, many older people believe this is 'a normal part of aging' or 'normal in a relationship of a long duration' thus possibly allowing older people to cope with changes in their sexual life (7).

Common issues associated with aging affecting sexuality

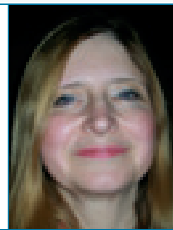
Lima et al (8) identified that the degree of obesity, particularly those with massively obese body states have consistently low free testosterone levels. Reducing dietary intake is a life style change that can be initiated by the physician. Likewise an increase in exercise can be beneficial. In a study of middle-aged men (45-60 years of age), a positive correlation was found between erectile function and the calories used in physical activity (5).

These findings are supported by a prospective study of risk factors for ED comparing 22 086 men who were healthy and had good or very good erectile function prior to 1986 who were reviewed thereafter in 2000. Obesity (multi variate relative risk (RR) 1.9) and smoking (RR 1.5) were associated with an increase risk of ED whilst physical activity (RR 0.7) was associated with a decreased risk of ED. The authors concluded that reducing the risk of ED may be a useful and unexploited motivation for men to engage in health promoting behaviours (9).

Obese women (body mass index of greater than 30) reported significantly less satisfaction with their sexual life, more frequent symptoms of urinary incontinence during intercourse, more often fear of urine leakage during intercourse and higher tendency towards avoiding intercourse. They also reported more frequent feelings of guilt and disgust during intercourse. Urge and stress urinary incontinence was more common and has a greater impact on sexual function in obese women (10).



Kevan Wylie



Alison Wood

Yasir Abbasi

A review by Eden & Wylie (11) explored how the symptoms and psychology of menopause and aging can affect women's overall quality of life, highlighting references to sexual well-being, and how these factors relate to problems of female sexuality in order to examine what is currently known about the relationship between menopause, aging and quality of sexual life.

Many illnesses can impair sexual functioning: endocrinologic illnesses including thyroid disease and diabetes mellitus; cardiovascular problems such as high blood pressure, impaired circulation, heart attacks, strokes and ageing blood vessels; and arthritis, back pain and other joint or muscle problems can be disabling. Since arousal is regulated by the nervous system, any neurological illness can affect sexual functioning in several ways as can the effect of medication. Mental health difficulties can affect sexual functioning, by diminishing energy and motivation for sexual activity as well as lowering self-esteem, and indirectly due to prescribed antidepressant medication. In patients with dementia that is progressing, changes within existing relationships, redefining sexual intimacy and changes with reduced interest in sex are areas which may need further consideration. For some there may be sexual aggression and an excessive interest in sex or there may be inappropriate sexual behaviour. The misrepresentation of domestic violence may lead to embarrassment for both the partner and other care providers.

Conclusions

Sexual function and activity may decline as people age. Comorbidity is more common and other factors such as prescribed medications, life cycle changes and relationship changes can all affect sexual function and satisfaction. Culture, religion and education can influence sexual function as can financial limitations on both health service provision and access to the various treatment opportunities.

Kevan Wylie, MD, Professor
University of Sheffield, UK &
University of Sydney, Australia,
Vice President, European Federation of Sexology,
k.r.wylie@sheffield.ac.uk

Alison Wood, MD,
SHSC NHS Foundation Trust,
Alison.Wood@shsc.nhs.uk

Yasir Abbasi, MD,
SHSC NHS Foundation Trust,
Yasir.Abbasi@shsc.nhs.uk

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CHALLENGES OF SEXUAL HEALTH (SH) AMONG PEOPLE LIVING WITH HIV (PLHIV) IN EUROPE

Introduction

The increasing effectiveness of HIV treatment has enabled PLHIV to remain sexually active after their HIV diagnoses for many years. However, in many parts of Europe, PLHIV cannot fully enjoy their SH and rights. This article, based on the background paper developed for the WHO European Regional Counterparts' Meeting on *'Challenges in improving SH in Europe'* (Madrid, October 21-22, 2010) deals with the specific SH challenges PLHIV may encounter in Europe today.

Two notions serve as starting points: Firstly, while the SH needs of PLHIV are quite similar to those of their uninfected counterparts, there are also some important biological, psychosocial and contextual differences, such the role of other sexual transmitted diseases (STIs) as co-morbidities, HIV-related stigma or difficulties with disclosure of HIV status. Secondly, there is a great diversity with respect to HIV in Europe. Underlying factors that drive the epidemic, and its epidemiological outcomes, differ largely across the countries. For instance, countries in eastern Europe now have the fastest-growing HIV epidemic in the world, and the number of HIV-positive people almost tripled between 2000 and 2009 in this region (1). There are important social, cultural and epidemiological differences among the most affected key populations including men who have sex with men, migrants from regions with generalized HIV epidemics, people who use drugs, sex workers and young people.

From prevention of HIV to comprehensive SH promotion

SH promotion for PLHIV has been a sensitive issue for quite some time with a primary focus on prevention of sexual HIV transmission. Currently, this discourse is more nuanced integrating a holistic view (including *physical, emotional, mental and social well-being related to sexuality*), and has shifted towards also discussing sexual rights of PLHIV. This paradigm shift has been informed by biomedical research on the greatly reduced HIV transmission risk between couples of different HIV status (i.e. The Swiss Statement) (2).

Other guidance documents developed in global consultation with PLHIV, such as 'Positive Health, Dignity and Prevention' (3) and the 'Guidance Package on Advancing the Sexual and Reproductive Health (SRH) and Human Rights of PLHIV' (4), have further contributed to a renewed focus emphasizing a human rights-based approach to promoting the SH for PLHIV.

SH of key affected populations

Men who have sex with men (MSM)

Increasing incidences of new HIV infections have been observed among MSM, mainly in western Europe. Factors that may explain this include an increase in unprotected sex, with a concomitant increase in STIs (e.g. syphilis, hepatitis C), the existence of sexual networks, and mental health problems, which may cause an increase in the use of alcohol and/or drugs, which in turn is often associated with sexual risk behaviour. Commonly reported sexual health problems refer also to sexual functioning, such as reduced libido or erectile dysfunctions. Although the majority of MSM are concerned with preventing transmission of HIV to their sexual partners, clinical service providers have to do more to reach MSM with high risk behaviour with appropriate safer sex messages.

Migrants

One in five of all new heterosexual HIV infections reported in 2008 occurred among migrants stemming from high endemic regions (1). Migrants often present late for HIV testing, already at advanced stage of HIV disease. This jeopardizes their health prognosis, and is a missed opportunity for HIV prevention. Asylum-seekers and refugees may have specific needs in relation to SRH, such as their culturally grounded desire to have children, or unmet family planning needs when arriving from their counties of origin. Culturally-sensitive and migrant-friendly SRH services should be scaled up and community mobilization efforts strengthened, since migrants often have difficulties accessing health systems in their host countries due to their vulnerable socio-economic position, HIV-related stigma and specific language and cultural barriers.

People who use drugs

Intravenous drug use (IDU) is a driving factor behind the HIV epidemic in many European countries, especially in eastern Europe where 45% of all HIV cases are due to IDU (1). Most relevant for good SH of HIV positive people who use drugs is access to HIV treatment and opioid substitution therapy, both of which has been shown to be restricted. While IDUs have comprised up to 80% of all HIV cases in some eastern European countries, they constituted less than 40% of those receiving treatment (1). PLHIV who use drugs also need specific SH support, such as treatment of STIs, support for safer sex, family planning, and harm reduction measures.

Sex workers

Sex work has become an increasingly important factor in the HIV epidemic in some regions in eastern Europe. Sex workers may face multiple risks: transactional sex for supporting drug use may link HIV infection, drug use and sexual transmission. In addition, sex workers may have an increased risk of sexual violence or may have been forced into sex work because of their migration status. To meet their SH needs, sex workers need access to HIV testing and HIV treatment, when diagnosed HIV-positive, but also to comprehensive and integrated services, such as psychosocial and psychosexual support and medical check-ups for STIs.

Young people

Eastern European countries are faced with much higher numbers of young PLHIV than western Europe, due to inequity in access to HIV treatment, among other reasons. In Bulgaria, for instance, almost two thirds of all people living with HIV are between 15 and 29 years old (1).

Christiana Nöstlinger

Manjula Lusti-Narasimhan

Christoforos Mallouris

Georgina Caswell

Young PLHIV are confronted with specific SH challenges at a very sensitive time of their development: developing a sexual identity while having to cope with HIV. This poses challenges mainly for care facilities, such as adherence to medication, clinic visits, disclosure to peers and sexual partners, condom use and family planning. Besides quality HIV care, that should integrate SRH issues relevant to the adolescent transition period, young PLHIV should be able to experience the same gender-specific, developmentally appropriate sexuality education as all young people.

Recommendations

The following recommendations arose from the working group discussions during the meeting.

- *International organizations* should promote SH for key affected populations. More than 15 years after the International Conference on Population and Development in Cairo (1994), there is still no consensus definition of SH. A jointly agreed definition of SH and rights would greatly support many stakeholders. There are many international evidence-based guidance documents and tools available that aim at SH promotion for PLHIV, but they need to be disseminated more widely, and translated into local languages.
- On the level of *service provision*, the need for integrated services was confirmed. SH check-ups (e.g. for human papillomavirus infection and related cancers, as well as for other STIs), and SH counselling should become an integral part of routine service provision. For instance, a minimum set of validated standard questions to assess patients' SH could be helpful. Integrating SH counselling in routine service provision requires improved capacity, training of service providers and stronger interdisciplinary cooperation between different professions. Currently, many service providers deliver 'positive prevention', but very rarely does it encompass a comprehensive, rights-based definition, nor does it involve PLHIV in determining how these services are delivered. Problems identified also relate to reproductive health. Across Europe, PLHIV do not all receive the same treatment and cannot exert the same rights as people who are (assumed to be) HIV negative. Gaps were noted in areas such as assisted reproduction, infertility treatment, and sexual counselling for safe and satisfying sex lives.
- Since many contextual components influence SH, recommendations for *governments and policy-makers* closely relate to legal conditions. Governments should be supported not to criminalize PLHIV. In this sense, the Swiss statement has delivered supportive evidence, but has not yet significantly impacted national legal frameworks. All regulations of mandatory HIV testing should also be removed; testing and counselling should be scaled up in the eastern European regions, however, not pursuing HIV detection alone, but as a tool to achieve universal access to HIV treatment and care. As stigma and discrimination are of widespread concern throughout Europe, issues of solidarity with PLHIV should be supported instead, for instance by targeted public awareness campaigns.
- Finally, recommendations for the *civil society* referred to the needed recognition that non-governmental organizations (NGOs) have an important role in advocacy, especially in confronting stigma and discrimination, and the criminalization of HIV transmission. This recognition must also be reflected in government support, since the NGO sector in the HIV field has been fighting for financial survival. Yet, civil society plays a vital role in the psychosocial support, which enables PLHIV to take better control of their SH and well being.

Christiana Nöstlinger, PhD,
Unit of HIV/STI Epidemiology and Control,
Institute of Tropical Medicine,
Antwerp,
cnoestlinger@itg.be

Manjula Lusti-Narasimhan, MD,
Department of Reproductive Health and Research,
WHO headquarters,
lustinarasimhanm@who.int

Christoforos Mallouris, PhD,
Global Network of People Living with HIV,
cmallouris@gnpplus.net

Georgina Caswell, MA,
Global Network of People Living with HIV,
gcaswell@gnpplus.net

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SEXUAL HEALTH (SH) OF MIGRANTS IN EUROPE: SOME PATHWAYS TO IMPROVEMENT

Introduction

Migration movements in Europe recently increased in size and complexity. According to most recent figures published by the International Organization of Migration, in 2010, some 72.6 million migrants lived in Europe and central Asia (1). This means that a third of all migrants in the world live in Europe; and that migrants represent 8.7% of the total European population. More than half (52.3% or 36.5 million) are women, with a higher proportion in eastern than in western Europe (57.3% - 49%) (1). However, to date there is no universally accepted definition of migrants. Depending on the phase in the migration cycle, the mode of travel and the legal status, different types of migrants can be defined: asylum seekers, refugees and documented and undocumented migrants. In 2009, UNHCR reported that Europe housed 2 005 900 refugees, received 358 600 lodged asylum claims and 15 100 or 81% of the 18 700 worldwide unaccompanied children claims (2). According to these UNHCR data, women and girls represented about 44% of the refugees and 40% of the asylum-seekers in Europe (2).

Although migration has long been of interest in public health, migrants are not necessarily disadvantaged in all areas of health. However, research findings indicate that migrants in Europe may suffer from traumatic experiences they were going through prior to or during the migration process. They suffer from higher maternal morbidity and mortality, experience poorer pregnancy outcomes, have less access to sexual and reproductive (SRH) services including family planning and safe abortion services, report higher levels of HIV and other sexually transmitted infections, and are more likely to become victims of sexual and gender-based violence and harmful cultural practices as female genital cutting (FGC) (3).

Right to SH of migrants in the European Union (EU)

The right to health, including SH, is embedded within a wide range of international instruments in the area of human rights, women's and children's rights. Another set of instruments, addresses the right to health for specific groups of migrants. This international framework has been enriched with legal instruments and policy tools from the Council of Europe, the WHO Regional Office for Europe and the EU. It is commonly accepted that the migration process may lead to ill health and that health care systems of the host countries may not be responsive enough to the specific needs of migrants. Protection of migrants' health and access to quality care are therefore recognized as a human right, vital to migrants' integration and essential for good public health and well being for all.

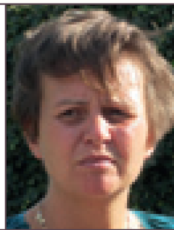
Anchoring (sexual) health of migrants in a rights framework makes national governments accountable to act according to the recognized norms and standards. On occasion, states accept certain procedures showing compliance with substantive provisions of the agreements. In other cases, states develop plans settings targets relevant to the topic at hand. A recent EU-wide study, for example, revealed that 22 European Member States had a national action plan to combat violence against women and that 15 of them also addressed specific forms of violence such as intimate partner violence, honour-based violence, forced marriage and FGC (4).

The enigma of SH of migrants in the EU

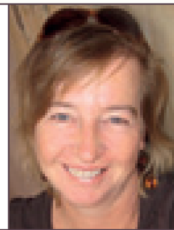
Few data are available about migrant health and health care utilization by migrants in Europe. This can be explained by a variety of technical and political reasons ranging from health research favouring homogeneous groups; perceiving ethnicity registration in clinical records as discriminatory; high mobility of migrant populations; and a great variability in the main denominators of citizenship, residency and immigration. Taking into account these difficulties, there are only a few national health surveys and surveillances available that include indicators of migration. In addition, Europe lacks nation-wide and cross-country surveys on SH and prevalence of sexual violence (SV) and/or FGC. Most studies on violence within the general population inquire about intimate partner violence or violence against women only. Thus, detailed information on SH of migrants in Europe is rather scarce and limited to small-scale studies.

The Hidden Violence is a Silent Rape Study, revealed that refugees, asylum seekers and undocumented migrants (n=223) in Belgium and the Netherlands do have knowledge on what SH entails and personal responsibility for taking good care of one's SH (5). However in daily practice, they are predominantly focusing on physical aspects and are mainly seeking SH information in the medical sector as well as in their direct personal relations. Furthermore, this study demonstrated that young refugees, asylum seekers and undocumented migrants in Europe are extremely vulnerable to several types of gender-based violence and, specifically, to SV. Perpetrators were often revealed to be national citizens taking advantage of their powerful position of providing services to these migrants who depend on them (5). Other studies demonstrate that migrants often lack knowledge about the health system and available SRH services of the host country (6). When migrants are trying to access SRH care, they face multiple barriers. One of the most important obstructing factors is their legal status as it influences the extent to which they have and perceive access to health and social services, and to protection before the law (4). As for undocumented migrants, current legislation in Europe does not guarantee access to health care everywhere and tends to become more restrictive. Furthermore, health care providers often lack skills in culturally competent communication; they are unaware of migrants' entitlements to SRH services and support available and they lack knowledge in screening, prevention or treatment of SV and/or FGC.

Ines Keygnaert



Jessika Deblonde



Els Leye

Marleen Temmer-man

Some pathways to improve SH (promotion) of migrants

Data collection: The diversity in the definition of migrant status and lack of data hamper European-wide cross-national comparisons. This situation calls for specific actions. First, the harmonization of denominators and definitions of migrants is a prerequisite for any further action. Second, the implementation of a fixed set of migrant health indicators in national or international health surveys is imperative. Third, in order to promote the SH of migrants effectively, it is paramount to conduct qualitative in-depth research on migrants' health concepts and their health-seeking behaviour. Finally, an assessment of migrants' risks of SV victimization and perpetration, their needs for adequate SRH care, as well as gaps and barriers in the current provided information is urgently called for. To address these needs, a practical guide with does and don'ts on how to include migrants in studies would be beneficial.

Accessibility to services: Given the human rights basis, SH care should be accessible to all, regardless of residence status. These services should be able to deal with SH of migrants, SV and FGC. Health care providers should at minimum know how to refer when not having adequate skills or time to give appropriate care to migrants with health problems related to SV or FGC. In addition, it is indispensable that European services directed to migrants develop and implement comprehensive, culturally competent and gender-sensitive SV prevention and response policies and measures. An example is the "Senperforto Frame of Reference for Prevention of SGBV in the European Asylum and Reception sector" (7).

Awareness raising: It is crucial that culturally competent and gender sensitive sensitization and awareness raising campaigns on SH and prevention of SV, including risk and protective factors are set up in every European country. Migrants should be informed about their rights, the judicial and health system in the host country as well as about laws regarding SV and FGC and residence granting based on victimization and trafficking.

Evaluation programmes: In conclusion, long-term evaluation of the effectiveness of any SH promotion programme and prevention of and response to SV programme is needed to understand their impact on the health and well-being of migrants, and to clarify the relationship between the different determinants in migrant SH. It is essential that migrants with different residence status and from multiple cultural backgrounds participate in such an evaluation and formulation of future programme development. In support of this, The European Network for Promotion of Sexual and Reproductive Health of refugees, asylum seekers and undocumented migrants in Europe and beyond (EN-HERA!) developed a Framework for the Identification of Good Practices in Sexual and Reproductive Health Promotion. This framework is available at: http://www.icrh.org/projects/en-hera-the-european-network-for-the-promotion-of-sexual-and-reproductive-health-rights-of-.

Ines Keygnaert,
Researcher and PhD Fellow,
International Centre for
Reproductive Health (ICRH),
Ghent University

Jessika Deblonde,
Researcher,
ICRH, Ghent University

Els Leye,
Senior Researcher, Senior Project
Coordinator and Team Leader
"Gender Based Violence,"
ICRH, Ghent University

**MarleenTemmerman, MD,
Professor,**
Gynecology and Obstetrics,
Director, ICRH, Ghent University

For further information contact:
ines.keygnaert@ugent.be

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THE SEXUAL HEALTH (SH) OF DEAF PEOPLE AND THOSE WITH DISABILITIES IN THE WHO EUROPEAN REGION

Introduction

Deaf people and those with disabilities (PwD) constitute about 10% of the population across Europe. Over recent years, there has been increasing acknowledgement of PwD's place within society and of their rights to determine their own lives, to health, employment, education, relationships and more. The United Nations Convention on the Rights of People with Disabilities (UNCRPD) was ratified in 2008 and has been signed by over 147 countries and ratified by 99 to date (26/03/11) (1). However, in spite of the wide recognition of PwD's rights, the issue of their SH and wellbeing continues to be a neglected area, one that has received limited attention or has been actively quashed. Yet positive SH is an unmet social good, vital to the wellbeing of all PwD, and one important part of the acknowledgment of their humanity and personhood (2). After much debate, the UNCRPD included references to women's sexual and reproductive health (SRH) (Article 25), alongside commitments to independent living (Art.19) and to marriage, reproductive and family planning education and protection of fertility (Art.23) (3). Yet there continues to be a range of limitations – political, attitudinal and socio-cultural - to opening this issue up further.

Sexual activity, identity, education and health

PwD are held by many to be asexual, childlike and incapable of sexual activity. Thus they generally receive very limited education, support or information about sex and sexuality. There is little acceptance of their desire for a sex life or of their need to actively express their sexuality, as would be considered the norm for their non-disabled peers (4). This lack of acknowledgment disguises the many ways in which their SH and wellbeing can be at risk. The limited sexual and relationship education PwD receive tends to focus on abstinence and avoidance of sex, engendering a sense of anxiety and fear amongst many of them. For example, people with Intellectual Disabilities (PwID) are often heavily protected and chaperoned, the repetitions of dire warnings leading them to develop a fear of sexual contact. For those with severe physical impairments, the practical assistance necessary to enable them to have sex – to position themselves in bed, to get access to assistive devices – is limited both in its geographical spread and in the level of understanding of these requirements. Those who are blind, deaf or who have other sensory impairments, living as they are often do outside the friendship circles of non-disabled people, lack access to informal sources of information. With formal written or spoken sexual education rarely directed towards PwD, many of them are left uninformed about the need to not only protect themselves from STIs, HIV, pregnancy and other specific sexual risks, but also about the pleasures offered by sex and relationships(5).

As for non-disabled people, acceptance of sexuality tends towards the norm, to heterosexuality. PwD who are lesbian, gay, bisexual, trans, queer or intersex (LGBTQI) – or who want to explore different sexualities - face a particularly hard time as many, including non-disabled LGBTQI people, deem it inconceivable that they might express a non-heterosexual identity. Despite themselves having experience as an oppressed minority, LGBTQI people may still discriminate against gay and queer PwD.

In general, PwD live in greater poverty than non-disabled people within their society, denied access to employment, without privacy or a place of their own to live, all of which restricts their options for developing relationships in privacy. Women with disabilities tend to face greater difficulties in all these areas, all of which are reflected in their reduced expectation of marriage compared with men with disabilities. Many PwD have received a restricted and segregated general education, have had limited exposure beyond their home or residential institution and thus have little experience of living within a wider community or of the patterns of courting and relationship development within their culture and community. Most of the popular social meeting spaces are not accessible to PwD, either physically and/or because of the prejudiced attitudes of staff who refuse entry to nightclubs, cafes and bars citing such reasons as 'a fire hazard', 'off putting to other customers' or 'dangerous'.

One hidden yet wide spread problem is that of the risk to PwD, especially women and children, of sexual abuse and violence (6). This is particularly high in the context of residential care, from assistants, and even the family members who support them in their homes. Women with disabilities face abuse that ties eugenic anxieties in with gendered specific assaults on reproduction, including forced abortions and forced sterilizations. There has been a dangerous silence about the levels and extent of abuse and this lack of acknowledgement has been exacerbated by a failure to believe the testimony of PwD, especially PwID, when they have tried to complain. Many PwD have low self-esteem and poor confidence levels, which make it more difficult for them to report experiences of abuse, to resist unwanted sexual pressures and to establish for themselves their own sexual desires and thus to build relationships.

Personal change

One big change that is required is to challenge the public prejudice against PwD as having a sexual identity and as being sexually active individuals. When was the last time you saw popular media(film, play or music video) that included PwD as both part of their audience and amongst the cast of actors and singers, representing them in contexts associated in the public imagination with sexiness, attraction and relationships?

PwD themselves have been fighting for the right to express their sexuality and they require support for their organizations that are advocating this. Young PwD entering adolescence need support to

Janet Price

develop self-confidence and should not be over-protected by parents, a concern of many young PwD. As with all adolescents, PwD need to pay attention to their SH, to learn to discuss their relationship with partners and, if having penetrative sex, to ensure that they use condoms appropriately as protection against STIs, HIV and pregnancy (7).

Older people form a growing proportion of those with disabilities and yet, despite common assumptions of impotence, they often do not lose their sexual desire. Whether they experience difficulty in moving limbs after a stroke, limb pain due to arthritis, increasing visual loss or disorientation due to dementia, sexual desire can remain a source of great pleasure and even solace in the face of losses. They too need to be given the privacy, advice and support necessary to enable them to experience their sexuality safely and as they desire.

There is a growing movement arguing that PwD should be offered practical support and assistance to meet their sexual desires, whether it be assisting them into a particular position for sex, providing them with a sex toy, organizing the support of a trained sex-worker, or addressing how to reduce spasms or other reactions that affect some during sex. Every adult should be enabled to enjoy sex.

Service change

Disabled people need to obtain assistance through a much broader provision of accessible and relevant SH services and sexual education. Existing services such as STI clinics, contraceptive advice, young people's SRH services, sexual abuse support and counseling services, and elder care should be made accessible and welcome deaf people and PwD as users. The availability of a Sign interpreter and of audio-information should be advertised as part of the service. There is a growing body of educational material available directed to and/or inclusive of PwD but it is still limited in scope, and in its cultural and language range. As it becomes more widely available, it needs to address the variety of learning styles of differing groups of PwD. One excellent example of entertainment/education is a web-soap, *The Specials (www.the-specials.com)*, featuring teenagers with intellectual disabilities who share a house and live together. It includes examples of different relationship and sexual dilemmas the characters face from hand holding to when to have the first kiss, to understanding homosexuality to marriage, addressed with humour, drama and wit.

Conclusion

In engaging with PwD's sexuality, the recognition that it is as varied as, or more so than non-disabled people's sexuality, offers the opportunity for us all to question sexual norms and values (8). The pressure to conform with idealized styles of appearance and ability, the expectation of athleticism as part of sexual acts, the focus on youth, and the balanced proportions and air-brushed images of perfection all represent an unrealizable set of aims, unachievable by most sexually active individuals, disabled or not, for most of their lives, and by the majority of us for ever. Notions of sexuality that encompass the unbalanced, the differently proportioned, the less fit, the breathless or slow-moving, the very large or small, that recognize beauty in unexpected places and that include the all-embracing, desirable, desirous sides of our sexual selves would offer us all greater potential and support in moving towards sexual wellbeing.

Janet Price,
Sexual Health Consultant,
Janeteprice41@yahoo.co.uk

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A PROFILE OF YOUNG PEOPLE'S SEXUAL BEHAVIOUR: FINDINGS FROM THE HEALTH BEHAVIOUR IN SCHOOL-AGED CHILDREN STUDY

The Health Behaviour in School-aged Children (HBSC) is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe. Every four years HBSC collects data on 11, 13 and15 year old's health and wellbeing, including sexual health (SH). In 2006, twenty–nine countries surveyed students about their SH. The findings below are based on data collected from 47 515 15-year-olds and are adapted from the previously published study "How well protected are sexually active 15 year olds across Europe and Canada? Data from the 2006 WHO-HBSC study" (1).

What do we know about young people's sexual behaviour?

Sexual initiation

It is known that early sex has implications for self-perceptions, social status and future health behaviour. Unprotected and poorly protected intercourse brings the risk of unintended pregnancy and of sexually transmitted infections (STIs).

Evidence suggests that rates of adolescent pregnancy are decreasing (2). However, the average age of first having sex has declined in industrialized countries, while in many nations there has been a reported rise in STIs (2). Thus, while the risk profile may be changing, early and poorly protected sexual intercourse remain of central relevance to public health.

More than a quarter of surveyed 15 year olds reported having had sexual intercourse (boys: 29.4%; girls: 24.1%), with no or minimal changes between HBSC surveys (Figure 1). In most countries boys were more likely than girls to report having had sex; gender differences of more than 10% existed in eight countries.

No strong geographical patterns in reporting being sexual active are found among boys, while among girls, prevalence is lower in south eastern and eastern European countries and highest in northern Europe. Low prevalence might reflect persistance in certain countries of traditional gender norms that allow or even encourage more freedom and experience for boys than girls. In contrast, the higher prevalence observed among northern European girls (in some cases even a reversal of gender patterns) may indicate an erosion of such gender stereotypes, and may also suggest that as the equality gap narrows, young women paradoxically engage in more risk behaviours. Further research needs to be done in order to better understand how this impacts girls' health, and why girls adopt risk behaviours, rather than boys adopting protective behaviours.

Early sexual initiation has been associated with other risk behaviours, such as substance use (3), and with more frequent psychosomatic complaints among boys and lower health-related quality of life among girls (4). We need to further increase our understanding of how early sexual initiation interacts with other risk behaviours, and identify protective factors which minimize risk factors, and/or promote safer sex.

Protection against STIs and pregnancy

Condoms and contraceptive pills are considered the most appropriate methods of protection for most sexually active adolescents, and the use of a dual method - both contraceptive pill and condom at the same time– confers effective protection against pregnancy and moderate protection against STIs .

The HBSC study asked young people to indicate which of a series of contraceptive options (condoms, oral contraceptive pills and withdrawal) they, or their partner, had used at last intercourse. In 8 nations, biological or natural contraceptive methods were added to the list. Students responses were classified into "well protected" (condom or contraceptive pill use) or "poorly protected" (including withdrawal).

Of the young people that reported being sexually active, up to 90% were well protected against pregnancy at last intercourse by the use of condoms or contraceptive pills. The proportion of well-protected students increased (by more than 5% in 7 countries) between 2002 and 2006 (5). As Figure 2 indicates, condoms are the most commonly reported contraception among 15-year-olds at their last sexual intercourse, with all countries reporting such use above 65%. Condom use was more frequently reported by boys than girls (about their partner) in most countries.

Contraceptive pill use (with or without other contraception) was much lower, ranging from 4.4% in Spain to 51.9% in the Netherlands. Sole use of the contraceptive pill ranged from less than 1% to 23.5%. In almost all countries, contraceptive pill use was more likely to be reported by girls than boys (about their partner), Ukraine being the only significant exception. Rates of contraceptive pill use were relatively low in many Baltic, eastern and central European countries. This may reflect a lack of sexual education provided to this age group, cultural differences in attitudes towards oral contraception, or more substantial barriers (e.g., price, availability) in accessing contraceptive pills in these countries.

The percentages of students who reported dual use of condom and contraceptive pill, ranged widely from less than 5% to almost one third. In almost half of countries dual contraceptive use was reported by fewer than 10% of 15 year olds.

Poorly protected

However, an important minority, the "poorly protected", find themselves at substantial risk of pregnancy and/or transmission of STIs. On average, over a third of all students surveyed do not report condom use at last intercourse, and thus are at risk of STIs. Similarly although most report being well protected against pregnancy with either the contraceptive pill or condoms, a risk remains for up to a quarter of students. Policy makers and researchers need to develop a greater understanding of this large minority group, in particular regarding what would motivate them to adopt efficient protective measures.

Table 1 presents the numbers and percentages of students who reported use of withdrawal or natural methods. There are

Emma-nuelle Godeau

Saoirse Nic Gabhainn

Josefine Magnus-son

Cara Zanotti

Figure 1. Prevalence of sexual intercourse among 15 year olds by country and gender

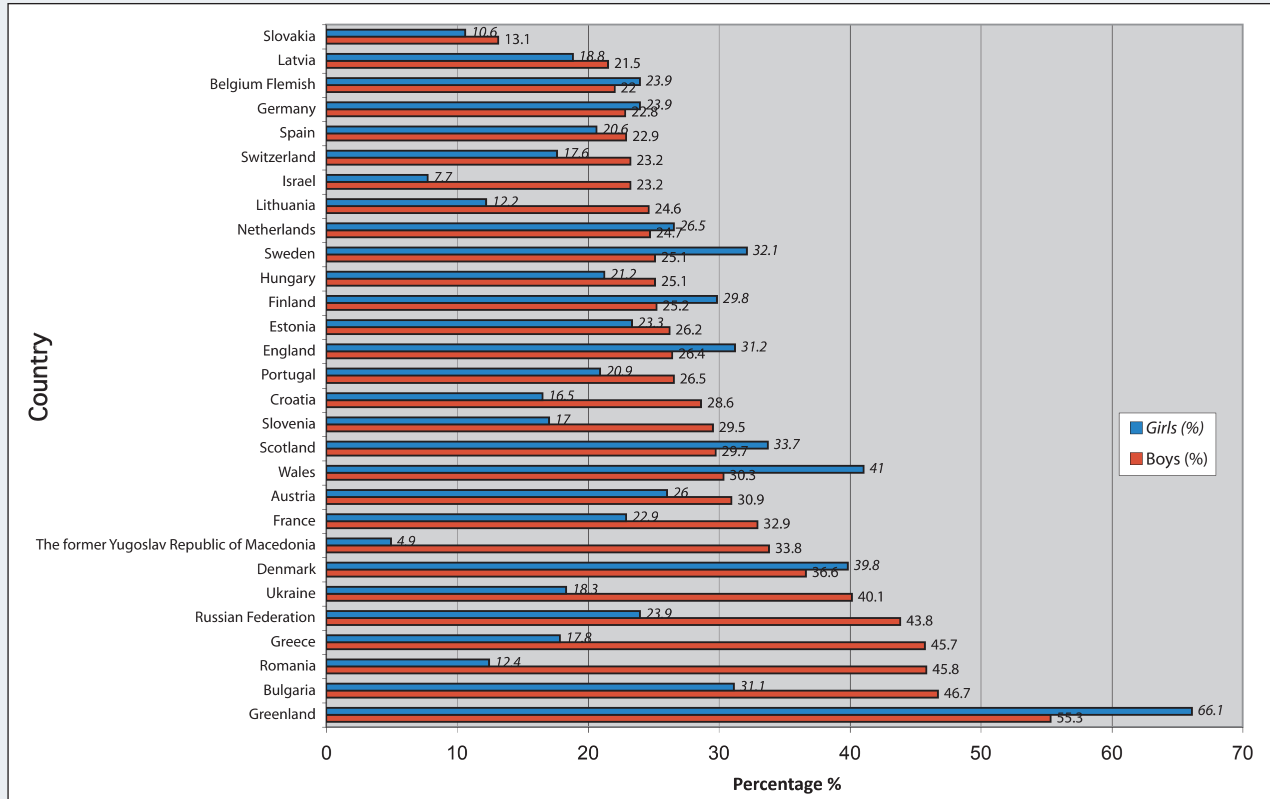

Figure 2. Prevalence of well protected students; reporting condoms only, contraceptive pill only, dual use at last intercourse, by country

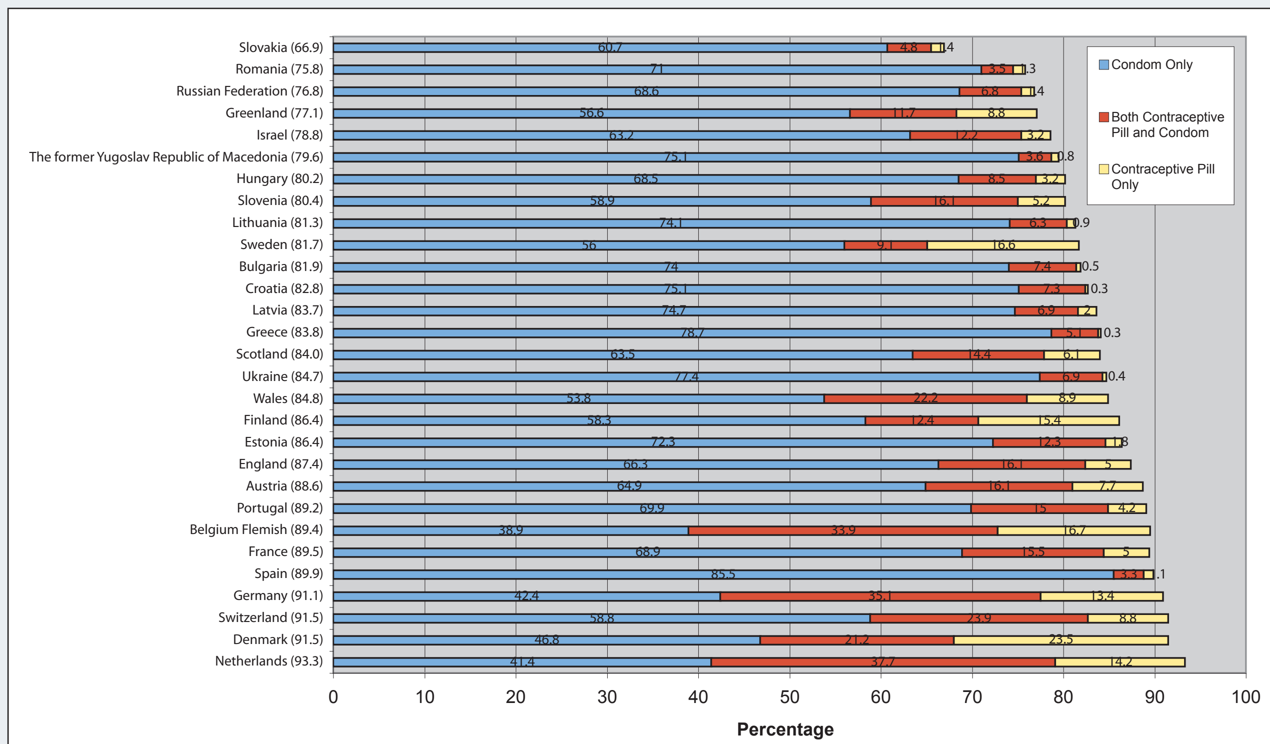

Table 1: Prevalance of withdrawal and 'natural' methods of contraception during last sexual intercourse for all sexually active 15 year olds and for those who were 'poorly' protected, by country.

Country	Withdrawal		'Natural' methods	
	All sexually active n (%)	'Poorly' protected n (%)	All sexually active n (%)	'Poorly' protected n (%)
Austria	13 (3.3)	6 (7.7)	3 (0.7)	3 (3.8)
Belgium (Flemish)	62 (17.2)	39 (47.6)	…	…
Bulgaria	103 (16.5)	71 (43.3)	…	…
Canada	49 (9.8)	26 (15.6)	…	…
Croatia	45 (12.7)	22 (23.1)	25 (7.1)	11 (12.0)
Denmark	27 (4.8)	14 (11.0)	…	…
England	43 (10.6)	27 (22.3)	…	…
Estonia	47 (12.3)	35 (36.4)	30 (7.8)	23 (24.0)
Finland	26 (6.0)	12 (7.2)	…	…
France	42 (7.0)	27 (18.6)	…	…
Germany	38 (6.9)	21 (18.1)	…	…
Greece	73 (18.5)	34 (33.0)	…	…
Greenland	19 (9.3)	10 (7.8)	…	…
Hungary	45 (18.1)	22 (27.2)	…	…
Israel	25 (16.0)	11 (33.0)	15 (9.6)	4 (12.1)
Latvia	18 (7.3)	12 (15.6)	…	…
Lithuania	44 (13.1)	28 (29.2)	…	…
The former Yugoslav Republic of Macedonia	36 (10.0)	24 (30.0)	…	…
Netherlands	35 (10.1)	21 (53.8)	…	…
Portugal	16 (5.2)	9 (9.8)	…	…
Romania	43 (11.4)	25 (21.4)	…	…
Russia	105 (13.2)	66 (12.7)	…	…
Scotland	56 (8.5)	39 (17.3)	57 (8.7)	33 (14.6)
Slovakia	9 (6.2)	4 (5.9)	…	…
Slovenia	53 (15.2)	35 (40.2)	22 (6.3)	18 (20.7)
Spain	67 (12.1)	47 (7.9)	…	…
Sweden	46 (10.8)	20 (20.0)	…	…
Switzerland	25 (8.8)	15 (28.8)	6 (2.1)	3 (5.8)
Ukraine	58 (11.4)	42 (47.2)	25 (5.4)	0 (0.0)
Wales	34 (7.2)	14 (16.7)	…	…

still very wide cross-national differences, with reported use of withdrawal at last intercourse ranging from 3.3% in Austria to 18.5% in Greece. In 17 countries it exceeded 10% of sexually active 15 year olds. Over a third of students in Estonia, Slovenia, Bulgaria, the Ukraine, Flemish speaking Belgium and the Netherlands reported using solely withdrawal at last intercourse.

Closing Remarks

Between 2002 and 2006 there was a 5% increase in protected intercourse observed in 7 countries. We need to gain a greater understanding of the national policy initiatives and contexts, such as access to different forms of services, contraception or SH education, which contributed to this behavioural change. This information, together with specific data on early pregnancies and STI's will assist policy makers in developing effective policy and, in turn improve young people's SH and behaviour.

Emmanuelle Godeau, MD, PhD,
Assistant to the medical consultant of the Chief Education Officer,
Rectorat de Toulouse,
UMR Inserm U1027,
University Paul Sabatier

Saoirse Nic Gabhainn, PhD,
Senior Lecturer in Health Promotion,
School of Health Sciences,
National University of Ireland

Josefine Magnusson,
Research Fellow, Child and Adolescent Health,
Centre for Research in Primary and Community Care,
University of Hertfordshire

Cara Zanotti,
HBSC Communications Officer,
HBSC International Coordinating Centre,
The University of Edinburgh

And Members of the HBSC Sexual Health Group

For more information please contact:
emmanuelle.godeau@ac-toulouse.fr

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EMERGENCE OF RESISTANT *NEISSERIA GONORRHOEAE*: BAD NEWS FOR SEXUAL HEALTH

Manjula Lusti-Narasimhan

Francis Ndowa

Background

With an estimated 88 million new gonococcal infections each year, *Neisseria gonorrhoeae (N. gonorrhoeae),* one of the most common STIs, is demonstrating increased antimicrobial resistance (AMR) to cephalosporin's, antibiotics that are the last available alternative to treat this condition, globally (1).

Gonococcal infections have critical implications for SRH, including maternal and newborn health, with known adverse outcomes such as:

- a fivefold increase of HIV transmission;
- infertility, with its cultural and social implications;
- inflammation,
- chronic and acute lower abdominal pain in women;
- ectopic pregnancy and maternal death;
- first trimester abortion; and
- severe neonatal infections that may lead to blindness and disseminated gonococcal infections (1).

The financial costs of these complications as well as the disability-adjusted life years are very high and add to the global health burden resulting from unsafe sex.

Current situation

Evidence of decreasing susceptibility of *N. gonorrhoeae* to cephalosporins is becoming more widespread, being reported in North America, Europe, Asia and the Pacific (2, 3). Treatment failures to oral cephalosporins have been reported in England, Japan and China (Hong Kong) (2), giving rise to concerns that, in the worst-case scenario, gonococcal infections may become untreatable with the existing medications.

Unrestricted access to antimicrobials, inappropriate selection and overuse of antibiotics, suboptimal quality of antibiotics, as well as inherent genetic mutations within the organism has contributed to the development of this resistance.

Implications

The emergence of different forms of resistance in *N. gonorrhoea* is often followed by a rapid spread of the disease. This is not a problem only of the poor as recent data treatment failures are emerging from the more developed countries (3). These data likely represent only the tip of the global health burden as surveillance data from resource-constrained settings are scarce and a silent epidemic of antimicrobial resistance may be occurring.

Interventions that can make a difference

Leaders in public health must build upon lessons learnt and respond with the following actions:

- Effective gonococcal infection prevention and control, using appropriate treatment regimens;
- Put in place effective drug regulation and control;
- Strengthen antimicrobial resistance surveillance, especially in countries with a high burden of gonococcal infections;
- Capacity build to establish regional networks of laboratories to establish quality control and use of gonococcal culture methods;
- Systematic monitoring of treatment failures by developing standard case definition of treatment failure and protocols for monitoring;
- Support research into newer molecular methods for monitoring and detecting antimicrobial resistance; and
- Identify and research alternative effective treatment regimens for gonococcal infections.

The WHO gonococcal antimicrobial surveillance programme (GASP), ensures a successful implementation of an evidence-based response plan that includes:

1. In collaboration with Member States, supporting countries to strengthen laboratory capacities to isolate and culture the pathogens and perform antimicrobial susceptibility tests through re-training of health-care providers and laboratory technicians;
2. Working with WHO Collaborating Centres and other international and national reference centres to maintain and distribute standardized WHO reference strains of N. gonorrhoeae to ensure comparability and validity of antimicrobial resistance data;
3. Producing and disseminating standards for performing antimicrobial susceptibility testing;
4. Facilitating exchange of information and technologies, including mapping of drug resistance patterns to highlight the situation; and
5. Highlighting the threat of untreatable gonococcal infections within key initiatives such as the Global Health Initiative and the UN Secretary General's Plan of action for Women and Children to stress the consequences of untreatable gonococcal infection on the SRH of women and men, newborns and people living with HIV and underscore the need for research and production of new treatments.

Manjula Lusti-Narasimhan,
Department of Reproductive Health & Research,
WHO headquarters,
lustinarasimhanm@who.int

Francis Ndowa, MD
Coordinator, Controlling Sexually Transmitted and Reproductive Tract Infections Team,
Department of Reproductive Health & Research,
WHO headquarters,
ndowaf@who.in

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IMPROVING SEXUAL HEALTH IN EUROPE: KEY FINDINGS AND RECOMMENDATIONS FROM THE EUROPEAN REGIONAL MEETING OF NATIONAL COUNTERPARTS

Background

Both the 2004 WHO Global Strategy on Reproductive Health and the 2001 WHO Regional Office for Europe's Regional Strategy on Sexual and Reproductive Health (SRH) have promotion of sexual health (SH) as one of their core concepts and guiding principles (1, 2). However promotion of SH continues to remain a challenge. Attainment of the vision of positive SH for all requires a better understanding of sexuality and sexual behaviour, as well as shared information on policies and programmes, and best practices of their implementation.

In response to this need, the WHO Regional Office for Europe, in collaboration with the Ministry of Health and Social Policy of Spain, International Planned Parenthood Federation European Network and the Federal Centre for Health Education (BZgA) WHO Collaborating Centre for Sexual and Reproductive Health in Cologne, Germany organized the meeting "*Challenges in Improving Sexual Health in Europe*" held in Madrid, Spain from October 21-22, 2010. Policy makers, national counterparts in SRH, WHO and other UN representatives and civil society organizations convened with the aim of expanding the traditional perception of SH and improving SH via a health systems framework. Key thematic foci for the meeting were:

- Existing SH strategies and policies;
- Evaluation of SH status; and
- The SH of select target groups: adolescents and young people, migrants, people living with disabilities, people living with HIV and older/aging population.

Using these key thematic areas, participants discussed challenges and achievements and developed recommendations for further improving the SH of the 5 target groups in the European Region: adolescents, people with disabilities, people living with HIV, migrants, and older people.

Key findings

While each of these 5 groups faces unique challenges (highlighted in the preceding articles of this issue) several cross cutting themes were identified as barriers and facilitators to positive SH for all groups.

Lack of a positive approach to SH: Across all target groups the predominant recurrent theme was that of a consistent focus on sexual ill health with a very biomedical approach, rather than a more holistic perception that incorporates general emotional, mental and social wellbeing. This was true at both the individual and societal level. Such an approach limits our ability to understand sexuality and sexual behavior and to develop and evaluate policies and programmes that guarantee equitable access to SH information and care. Encouragingly, several recent national surveys (Latvia, Spain) have begun to explore broader SH issues, incorporating questions on satisfaction and pleasure (3, 4).

Lack of data, standardized indicators and monitoring processes: Internationally comparable data is important for planning, implementing and evaluating inclusive, equitable SH policies and programmes. Yet data are almost nonexistent for people living with disabilities, and data for all remaining target groups tend to focus on indicators of dysfunction or ill SH (STI rates, pregnancy rates, erectile dysfunction); data on positive indicators of SH are scarce. In addition, currently there is no standardization as to types of indicators or monitoring that should be used to collect data on both sexual ill and good health. Data are also often not reported disaggregated for sex and/or age. This means that there is a lack of comparability across the Region. The Health Behaviour in School Aged Children survey was recognized as one of the few standardized surveys in the Region that provides comparable data on SH for males and females aged 15 (5).

Lack of appropriate training: Many types of professionals, including health care providers and educators, lack the required skill set to address SH in a holistic way and are uncomfortable discussing sexuality with individuals. In the medical profession, medical training has emphasized diagnosis and treatment of medical problems that focus on sexual ill health. Cultural beliefs about sexuality also influence providers' attitudes towards SH and may impact the access to care for vulnerable groups. For example beliefs that elderly patients are no longer sexually active or that adolescents should not be sexually active hinder these groups ability to have access to the appropriate information and care to ensure positive SH. From an education perspective, despite recognition that knowledge and information are essential for people to limit risk and vulnerability and be sexually healthy, appropriate standards for SH training and curricula development have been lacking. This applies to both teachers and health care providers. The newly developed "*Standards for sexuality education in Europe: a framework for policy makers, educational and health authorities and specialists*" is a welcomed resource that will help address these issues (6).

The role of culture, gender, religion, socio-economic status and education: It is a reality that in many countries sexuality is still seen as taboo due to different views and beliefs about sexual behaviour and sexuality. Culture, gender norms, religion, socio-economic status and education will influence both the way individuals behave sexually, how they seek and access information, care and treatment and how care and education is delivered to them. For example among migrants, young people are often reluctant to ask about sexuality and SH issues from health care providers and more likely to discuss this with family or friends. From the provision side strong religious influences can limit the availability of access to select services such as contraception and abortion or to comprehensive sexuality education. The relationship between all of these factors, individual sexual behaviour and SH outcomes is often underestimated and there is a need for more research in this area. Programmatic or policy interventions to improve SH will only be effective if these relationships are understood.

Lisa Avery

The role of policies and laws: An enabling policy and legal environment is essential for the promotion of SH. Policies and laws can have both positive and negative affects on SH. Fortunately most countries in the European Region have laws that prohibit discrimination based on sexual orientation, physical and intellectual disability, gender identity, religion or age. The varying laws and regulations on assisted reproduction for people living with HIV in the Region, gender based violence, forced sterilization and abortion for people living with disabilities and status of migrants are just some examples of the impact policies can have on SH of individuals. On a positive front in the Region currently 5 countries have developed national SH strategies, half of the Member States have developed and 4 are in the process of developing national strategic documents on SRH.

Moving forward: actions for improvement

Recognizing that accelerating achievement of positive SH in the European Region requires a multi-sectoral, interdisciplinary approach, participants at the meeting proposed actions to improve SH and address these cross cutting themes at the levels of civil society, government and international organizations.

Action by civil society

- Involvement of civil society organizations and individuals, especially from the 5 target groups, in the development of appropriate SH strategies, programmes and policies;
- Involvement of civil society organizations and individuals in the development of culturally competent and gender sensitive awareness, advocacy and sensitization campaigns about SH and rights, with an emphasis on vulnerable groups;
- Involvement in complementing existing SH service provision (medical or educational); and
- Monitor the actions of governments and international agencies on addressing positive SH.

Action by governments

- Eliminate laws that promote discrimination, criminalization and stigma;
- Promote national surveys that collect data on broader aspects of SH, including sexual behaviour and health;
- Implement intersectoral sexual health policies and programmes that ensure a rights based approach;
- Ensure training on SRH and specific vulnerabilities, for all those involved in health service provision, education, research and funding;
- Promote national surveys that collect data on broader aspects of SH, including sexual ill and good health, sexual behaviour and satisfaction;
- Develop standardized SH indicators and the use of age and sex disaggregated data;
- Promote the use of both qualitative and quantitative date in research that targets SH;
- Eliminate laws that promote discrimination, criminalization and stigma;
- Implement mandatory sexuality education curriculum that is based on a positive holistic, life course approach; and
- Ensure access to quality SH services, equity, confidentiality and privacy.

Action by international organizations

- Facilitate the development of standardized SH indicators and collection of age and sex disaggregated data;
- Facilitate the development of culturally competent and gender sensitive standards for SH services;
- Support governments with the development and implementation of rights based SH strategies, polices and programmes;
- Facilitate sharing of best practices and successful evidence based interventions;
- Advocate for sustainable resources from the government for supporting and scaling up successful SH programmes for all individuals, including the most vulnerable; and
- Support the development and implementation of appropriate monitoring and evaluation of SH programmes and policies.

Conclusion

Despite the progress that has been made since the International Conference on Population and Development in 1994, attaining positive SH for all remains a challenge. Meetings such as this one allow for much needed reflection on the state of SH in the WHO European Region, the successes and challenges to date and the comprehensive actions, at both individual and societal levels, that are required to continue to improve SH.

Lisa Avery, MD, MIH
Editor, Entre Nous,
avery@cc.umanitoba.ca

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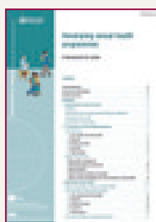
RESOURCES



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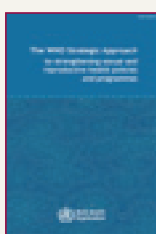

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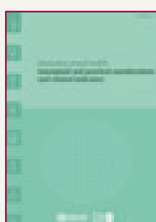
Designed for programme and policy makers this useful document involves a three-stage process for assisting countries to assess SRH needs and priorities, test policies and programme adaptations to address these needs, and then scale up successful interventions. Available in English, French, Russian and Spanish at
http://www.who.int/reproductivehealth/publications/strategic_approach/RHR_07.7/en/index.html



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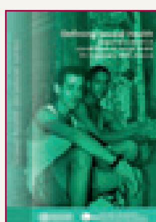
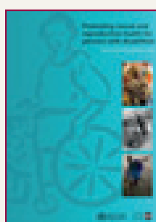
As part of the process for monitoring progress towards the goal of universal access to SRH, this document summarizes the proposed indicators and areas for future research in sexual health as determined by a joint WHO/UNFPA technical consultation in 2007. Available in English at
http://www.who.int/reproductivehealth/publications/monitoring/who_rhr_10.12/en/index.html



Defining sexual health. Report of a technical consultation on sexual health, 28–31 January 2002, Geneva. WHO, 2006.

The result of a joint WHO/World Association of Sexology technical consultation, this document summarizes and defines the areas where WHO and its partners could provide guidance to national health managers, policy-makers and care providers on how better to address sexual health. Available in English at
http://www.who.int/reproductivehealth/publications/sexual_health/defining_sh/en/index.html



Promoting sexual and reproductive health for persons with disabilities. WHO/UNFPA, 2009.

Intended for SRH experts and advocates this guidance note outlines a general approach to programming that can be used for promoting positive SRH of people with disabilities. Available in English at
http://www.who.int/reproductivehealth/publications/general/9789241598682/en/index.html

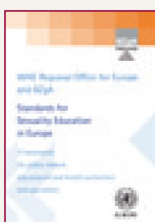
The *Lancet* Sexual & Reproductive Health Series. WHO, 2006.

A series of papers and editorials on SRH, whose main objective was to advance evidence-based advocacy and put SRH more prominently on the international public health agenda. Preprint versions of the papers are available in English at
http://www.who.int/reproductivehealth/publications/general/lancet_articles/en/index.html. The journal publications of these papers can be viewed on the Lancet website: www.thelancet.com

Lisa Avery

Framework for Comprehensive Sexuality Education. IPPF, 2006, updated 2010.

Designed to help increase access to comprehensive, youth friendly, gender-sensitive sexuality education, this framework is a useful tool for all involved in sexuality education. Available in English at **www.ippf.org.**



Standards for Sexuality Education in Europe. A framework for policy makers, educational and health authorities and specialists. WHO Regional Office for Europe and Cologne, BzgA, 2010.

Developed under the guidance of BzGA, WHO Collaborating Centre and the WHO Regional Office for Europe the standards provide step-by-step instructions and a detailed matrix to support health and education professionals in their efforts to guarantee children accurate and sensitively presented information about sexuality. Available in English at:
http://www.bzga-whocc.de/?uid=072bde22237db64297daf76b7cb998f0&id=Seite4486.

Promotion of sexual health: recommendations for action. PAHO, 2011.

The result of consultation between PAHO and the World Associationon of Sexology this document outlines how to redefine and promote sexual health both within and outside of the health sector. Available in English at:
http://www.paho.org/English/AD/FCH/AI/PromotionSexualHealth.pdf

Useful websites

World Association for Sexual Health: www.worldsexology.org

European Federation of Sexology: www.europeansexology.com

The Kinsey Institute: www.kinseyinstitute.org

Sexuality and U: www. sexualityandu.ca

International Planned Parenthood: www.ippf.org

International Planned Parenthood European Network: www. ippfen.org

Upcoming events

20th World Congress for Sexual Health: Glasgow, UK, June 12-16, 2011. Information available at: http://www.worldsexology.org/

8th Biennial Conference of the International Association for the Study of Sexuality, Culture and Society (IASSCS): Madrid, Spain, July 6-9 2011. Information available at www.iasscs.org/2011conference or contact 2011conference@iasscs.org

2nd Congress of the World Association of Medical Sexology: Vina del Mar, Chile, October 26-28, 2011. Information available at http://www.congresodesexologia.com

International Academy of Sex Research 37th Annual Conference: Los Angeles, USA, August 10-13, 2011. Information available at www.iasr.org.

15th World Meeting on Sexual Medicine: Chicago, USA, August 26-30, 2012. Joint meeting of the International Society for Sexual Medicine and the Sexual Medicine Society of North America.

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WHO Regional Office for Europe
Division of Noncommunicable Diseases
and Health Promotion
Sexual and Reproductive Health
(incl. Making Pregnancy Safer)
Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark
Tel: (+45) 3917 17 17
Fax: (+45) 3917 1818
www.euro.who.int/entrenous

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