

**Integrating
sexual health interventions
into reproductive health services:
programme experience
from developing countries**



**World Health
Organization**

Geneva, 2005

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Preface

Ten years after the International Conference on Population and Development (ICPD), it is relevant and necessary to review and reflect on progress made in implementing a more holistic and comprehensive view of reproductive health care, as called for in the ICPD Programme of Action. In 1994, the international health community agreed on the need to integrate sexual and reproductive health care services to meet the needs of women, men and adolescents throughout the life-cycle. Integration was seen to provide the best hope and means for quality, comprehensive and cost-effective service delivery. Since that time, however, efforts to integrate services have produced mixed results, and there is now a need to take stock of accomplishments and to suggest where further efforts are needed if countries are to provide quality, comprehensive sexual and reproductive health care.

This document reviews the experiences of developing countries in integrating sexual health issues into reproductive health care services, from 1998 to 2003¹. It attempts to define the challenges posed by integration and highlights the gaps that remain. The document is intended for health programme managers and policy-makers interested in making sexual health services available, through reproductive health care programmes or through the broader public health care system.

Sexual health as a concept encompasses many aspects of reproductive health. However, it goes beyond reproductive health to include broader issues of health and well-being related to sexuality and sexual relationships. Given the challenge of addressing sexuality in many contexts, it is necessary to find ways to initiate discussions and to integrate specific services in the public sphere. This document has been prepared in the context

of the recent establishment of an explicit area of work on sexual health within the WHO Department of Reproductive Health and Research (RHR).

I sincerely hope that it will contribute to the growing debate by bringing together and analysing evidence on how sexual health can be – and is being – integrated into reproductive health care around the world.

Paul Van Look
Director, RHR

¹ A previous WHO paper (Dehne et al., 2000) reviewed the equivalent evidence from 1990 to 1998.

Acknowledgements

The First draft of this document was researched and prepared by a team of researchers from the Royal Tropical Institute of the Netherlands (KIT), on the basis of a review of the literature and key informant interviews conducted at WHO during a series of international meetings on sexual health. It was later revised and updated by a drafting group comprising researchers from KIT, the London School of Hygiene and Tropical Medicine, and WHO. The final draft was also reviewed internally and externally.

Thanks are due to our colleagues at WHO – Nathalie Broutet, Jane Cottingham, Amel Fahmy, Claudia Garcia Moreno, Isaac Malonza, Alison Phinney, and Kristen Vogel-song – who gave their views on the priority concerns in their respective specializations in sexual health. A special thank you goes to Iqbal Shah of the Department of reproductive Health and Research for his review of the complete document.

WHO also thanks: Susannah Mayhew and Linda Morison of the London School of Hygiene and Tropical Medicine for their insightful comments and suggestions; Ilse Egers (KIT) for her tireless search for relevant literature; César Eduardo Wong Alcázar, for research, writing and editorial additions; and John Tyler for his edit of the first draft report, and particular thanks to Patricia Butler for her tireless efforts in editing the final draft

Thanks are also due to the following for their contributions, in the form of reports, articles and communications about projects in which they are currently involved: Inge Baumgarten, German Technical Cooperation, Eschborn, Germany; Sarah Black, Marie Stopes International Australia, Melbourne, Australia; Simone Diniz, Coletive Feminista Sexualidade e Saude, São Paulo, Brazil; Gary Dowsett, Australian Research Centre in Sex, Health & Society, Melbourne, Australia; Kathryn Faulkner, International Planned Parenthood Federation, London, England; Anna Foss, London School of Hygiene and Tropical Medicine, England; Annette Gabriel, German Technical Cooperation, Eschborn, Germany; Wolfhard Hammer, German Technical Cooperation, Eschborn, Germany; Jef Heuberger, KIT, Amsterdam, The Netherlands; Evert Ketting, Utrecht,

The Netherlands; Barbara Klugman, Women's Health Project, University of the Witwatersrand, Johannesburg, South Africa; Els Leye, International Centre for Reproductive Health, Ghent University, Ghent, Belgium; Wong Yut Lin, Health Research Development Unit, University of Malaya, Kuala Lumpur, Malaysia; Joanne Manchester, International Community of Women, Living with HIV/AIDS, Hadstock, UK; Purnima Mane, Population Council, New York, USA; Mpume Mbonambi, Human Sciences Research Council, Durban, South Africa; Christina Neckermann, German Technical Cooperation, Eschborn, Germany; Jessica Ogden, International Center for Research on Women, Washington, DC, USA; Rosalind Petchesky, Hunter College, New York, USA; Susanna Rance, Sexuality Research, La Paz, Bolivia; Ietje Reerink, KIT, Amsterdam, The Netherlands; Gisela Rosenberger, German Technical Cooperation, Eschborn, Germany; Inon Schenker, Hebrew University of Jerusalem, Israel; Carmen Solinap, Development Action for Women in Trade Union Congress of the Philippines., Executive Board Chairperson, Development Action for Women in TUCP, Manila, The Philippines; François Stepman, Vlaamse Inter-Universitaire Raad, Brussels, Belgium; Marleen Temmerman, International Centre for Reproductive Health, Ghent University, Ghent, Belgium; Christine Varga, Human Sciences Research Council, Durban, South Africa.

The Dutch Ministry of Foreign Affairs provided important financial support to the writing of this paper.

Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome	PAHO	Pan American Health Organization
ANC	antenatal care	PHC	primary health care
ART	antiretroviral treatment	PID	pelvic inflammatory disease
ARV	antiretroviral	PMTCT	prevention of mother-to-child transmission (of HIV)
CBD	community-based distributors	PTSD	post-traumatic stress disorder
DALY	disability adjusted life year	RH	reproductive health
DFID	Department for International Development (of the United Kingdom)	RHO	Reproductive Health Outlook
FGC	female genital cutting	RHR	Reproductive Health and Research (WHO Department of)
FGM	female genital mutilation	RTI	reproductive tract infection
FP	family planning	SRH	sexual and reproductive health
GBV	gender-based violence	STD	sexually transmitted disease
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (German Technical Cooperation)	STI	sexually transmitted infection
HIV	human immunodeficiency virus	SWAP	sector-wide approach
ICPD	International Conference on Population and Development	UN	United Nations
IEC	information, education and communication	UNAIDS	Joint United Nations Programme on HIV/AIDS
IGWG	Interagency Gender Working Group	UNFPA	United Nations Population Fund
IPPF	International Planned Parenthood Federation	UNICEF	United Nations Children's Fund
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region	VCT	voluntary counselling and testing (for HIV)
IPV	intimate partner violence	WAS	World Association for Sexology
KIT	Royal Tropical Institute (of the Netherlands)	WHO	World Health Organization
MCH	maternal and child health		
MSF	Médecins sans Frontières		
MTCT	mother-to-child transmission (of HIV)		
NGO	nongovernmental organization		
NIS	Newly Independent States		
PAC	post-abortion care		

Introduction and working concepts

In 1994, at the International Conference on Population and Development (ICPD, 1994), 184 countries reached a landmark consensus on the need for a broad, integrated approach to sexual and reproductive health. Since that time, countries have been struggling to put the concept into practice. The first challenge has been to understand the broad concept of sexual and reproductive health, in order to identify the service interventions that should be added to an existing reproductive health (RH) or maternal and child health (MCH) programme to make it a sexual and reproductive health (SRH) programme. The second, more difficult, challenge has been to develop feasible, acceptable and cost effective strategies for providing these services within the existing, poorly resourced, primary health care programme base (Askew & Berer, 2003).

To create SRH programmes, reproductive health services have to be expanded to better address sexual health. SRH programmes need to give attention to broader determinants of healthy sexuality and well-being. A recent WHO publication, *Conceptual framework for programming in sexual health* (WHO, 2005a), offers a sexual health approach to service design and implementation. It stresses the need to recognize that not all sexual activity is for reproduction, and that other motivational factors, such as pleasure or a sense of obligation, are often more important determinants of individual sexual health and well being. To improve sexual health, programmes must address sexuality throughout the lifespan, from adolescence to old age, for both men and women. They must also recognize the role of power in sexual relationships and how it affects people's ability to make decisions about their own bodies and sexual life, free from violence, discrimination and stigma. Individual decision-making and the ability to make informed choices can also be limited by

social, cultural and legal barriers. Broad sexual and reproductive health care services must recognize and begin to address these constraints through targeted interventions.

Comprehensive sexual and reproductive health care services are usually formed by integrating services that are traditionally vertical or stand-alone. Such integration can potentially save costs and lead to more rational use of services. However, in a context of health sector reform and dwindling resources for health in national budgets, integration efforts are often perceived as being associated with compromise and consolidation of service packages. Overcoming these perceptions represents a significant challenge.

After ICPD, evidence began to suggest a link between a high prevalence of reproductive tract infections (RTIs) and sexually transmitted infections (STIs) and an increased risk of transmission of human immunodeficiency virus (HIV). Operations research in Mwanza, United Republic of Tanzania, showed that a comprehensive community-based STI programme could dramatically reduce HIV transmission rates. This led to a surge of efforts to integrate these two service areas and to find other potentially beneficial links between services. Most progress was made in linking family planning (FP) services for women with maternal health programmes, which were then often renamed as "reproductive health programmes" (Askew & Berer, 2003). Some attention was also given to combining sexual health services whose targets included men – such as STI/HIV prevention and treatment or sexuality education – with family planning or maternal and child health (MCH) programmes, but to a much lesser extent. The present review considers the extent to which countries have been able to link services for women, men, and adolescents, and to address critical issues

such as violence related to gender and sexuality, and examines the implications of those integration efforts for health systems.

1.1 ICPD and sexual and reproductive health and rights

Both conceptually and programmatically, sexual health has tended to be linked to reproductive health, particularly since ICPD, which described reproductive health as *incorporating* sexual health. The subsequent move towards use of the term “sexual and reproductive health” or less commonly “reproductive and sexual health” – terms which continue to have wide currency – embodied the recognition that the two fields are overlapping, but not entirely contained within each other.

Consensus was reached at ICPD on an expanded concept of reproductive health which includes sexual health, both directly and indirectly, and emphasizes the importance of individuals’ access to reproductive and sexual health services, including family planning, the protection and exercise of their rights, and the quality of sexual relationships.

Box 1: ICPD and sexual health

The ICPD Programme of Action emphasized a positive view of sexual health, by stating that reproductive health... implies that people are able to have a *safe and satisfying sex life* and that they have the *capability* to reproduce and the *freedom* to decide if, when and how often to do so’ (paragraph 7.2).

ICPD emphasized the need to:

- Promote “adequate development of responsible sexuality, permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals” (paragraph 7.36).
- Ensure that “women and men have access to information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities” (paragraph 7.36b).

(United Nations, 1995)

Specifically ICPD called for greater attention to sexuality and a variety of aspects of power in sexual relationships by defining reproductive health, in part, as the ability to have a satisfying and safe sex life. ICPD also emphasized the human rights basis of sexual and reproductive rights, as recognized in international human rights treaties, charters and conventions. It stated that reproductive rights include the right of individuals and couples to make an informed choice concerning family planning and other sexual and reproductive health issues, including the “right to attain the highest standard of sexual and reproductive health” (United Nations, 1995). These and other internationally recognized reproductive rights constitute the basis of sexual rights (see Box 2). The Programme of Action, in addition, gave specific attention to the role of men in sexual and reproductive health and the special needs of adolescents.

In order to achieve sexual and reproductive health, people must be empowered to exercise control over their sexual and reproductive lives and to gain access to related health services. While these rights and the ability to exercise them constitute an important value in themselves, they are also a condition for well-being and development. The neglect and denial of sexual and reproductive health and rights are at the root of many health-related problems around the world, such as unwanted pregnancies, unsafe abortion, maternal mortality, sexually transmitted infections including HIV infection, infertility, sexual dysfunction and gender-based violence.

Progress in sexual and reproductive health requires explicit attention to sexuality, sexual power relations, and safer sex, and not only reproductive health issues. The efforts to control the HIV/AIDS pandemic have demonstrated the importance of addressing sexual behaviour and stigma and preventing and managing STIs. Unwanted pregnancies, which can have devastating effects on women’s health and socio-economic opportunities, are often associated with sexual coercion or lack of access to information and services dealing with sexuality and fertility regulation. Gender power imbalances are an important underlying cause of many of these problems; these and other contextual factors influence women’s, men’s, and adolescents’ ability to practise safe sex. In addition, as

expressed in the ICPD Programme of Action, it is important to ensure that sexual relations are enjoyable and satisfying. But discussion of sexual matters, whether between partners or between service providers and clients, is often problematic, since sex remains a taboo issue in many cultures, especially when considered as a source of pleasure separate from reproduction.

Countries are challenged to organize their health systems in a way that provides access to quality sexual and reproductive health care services that respect rights and empower individuals to take control of their sexual and reproductive lives.

1.2 Aim of this document

This document reviews developing country efforts and experiences in integrating aspects of sexual health and sexuality-related services into reproductive and, in some cases, first-level health care services. Where programmes have been evaluated using objective criteria, or are in line with service delivery recommendations of WHO and others, this is noted. Generally, however, the programmes described are simply good examples of how sexual health can be and has been integrated into reproductive health care services and other first-level care.

The paper is intended for health programme managers and policy makers who share an interest and aspiration of making sexual health services available through reproductive health care programmes and in the public health care system more generally.

The objectives are:

1. to describe the health sector response to sexual health needs;
2. to review programme experience of integration of sexual health interventions into reproductive health or first-level care; and
3. to identify information gaps and research needs.

Developing country efforts and experiences are analysed to bring out the following:

- key sexual health issues and dimensions;
- current recommendations on how to address these issues through the public health care systems;
- an overview of how the issues are currently being addressed (integrated or not);
- examples of integration; and
- information gaps.

The document is divided into six chapters. The first provides a general introduction, while Chapters 2-4 relate to population groups for whom sexual or reproductive health care services have traditionally been provided – women, men and adolescents. Chapter 5 focuses on violence related to gender and sexuality and related service delivery issues, while Chapter 6 addresses the health system issues critical to integration of services.

In each chapter, the key sexual health issues and related integration issues are reviewed. Issues of access and models of service delivery are presented. Recommendations, information gaps and research needs are included in each subsection. A short summary of each chapter is provided to facilitate understanding of the key points.

1.3 Working concepts

For many years, the terminology associated with sexual health has lacked clarity and specificity. Since 2000, PAHO and WHO have convened expert consultations to review terminology and discuss how best to promote sexual health. These meetings produced internationally reviewed working definitions of key terms, which will be used in this review (see Box 2).

In addition, a meeting organized by PAHO, WHO and World Association for Sexology (WAS) defined a number of sexual health concerns, related to body integrity and sexual safety, eroticism, gender, sexual orientation, emotional attachment and reproduction (see Annex 1). The meeting also identified various sexual health problems, phrased in

terms of clinical syndromes identifiable by primary health workers. These problems include syndromes related to sexual dysfunction, compulsive sexual behaviour, violence (including sexual abuse, harassment, and rape) and STIs.

1.3.1 Sexual and reproductive health

As mentioned previously the term “sexual and reproductive health” has gained increasing recognition since 1995 (United Nations, 1999). Conceptually, sexual health and reproductive health can be seen as two overlapping areas, although neither fully incorporates the other. While the two areas are intimately connected in many ways, not all reproductive health issues are related to sexual health, for instance birth attendance and prevention of related maternal mortality. Conversely, not all sexual health issues are related to reproduction, e.g. sexual pleasure and prevention of HIV infection during intercourse. Since in some societies sexuality-related issues are too sensitive to be addressed explicitly, the term “reproductive health” is often used and understood to include aspects of sexuality and sexual health.

In this document, we will use the term “sexual and reproductive health” in recognition of the view expressed above that neither area encompasses the other. We will also use “reproductive health”, especially when referring to the integration of sexual health into reproductive health care services.

1.3.2 Reproductive health services and other relevant first-level services

The ICPD Programme of Action (United Nations, 1995) provides an initial description of the components of reproductive health services in the context of primary health care. Based on the ICPD and other international agreements,¹ several authors (Alcala, 1995; Hardee & Yount, 1995) have elaborated a comprehensive list of such services. Hardee

& Yount (1995) revised a number of proposed reproductive health care service packages at the primary care level, arriving at broad categories and specific services or related activities. All packages support family planning, provision of maternity care and STI/AIDS services; most support some type of pregnancy termination care, either abortion services or care for the complications of abortion. On various occasions, WHO (2000a, 2002a), has suggested a range of services that would constitute a comprehensive reproductive health package.

It is recognized that the problem with an “ideal” comprehensive package is that, in practice, programme managers and policy-makers in developing countries will always have to select a limited number of priority services, based on various criteria related to epidemiology, demand, available resources (including financial resources), political will, and other factors (see Chapter 6 for a more detailed exploration of this topic).

Often, neither the needs of men and adolescents, nor sexual violence, can be easily addressed within the most common reproductive health services (family planning and maternal and child health) provided in developing countries, as these are predominantly for women. For this reason, integration of sexual health into first-level care was also reviewed.

For the purpose of this review, reproductive health services and first-level care are understood to cover the following:

- Fertility regulation, including family planning counselling and services, emergency contraception, dual protection and the role of men.
- Maternal and newborn health care, including antenatal care, basic and comprehensive obstetric care, including emergency care, postpartum and postnatal care, nutrition and breastfeeding, newborn and infant care.
- General gynaecological services, such as for menstrual disorders and gynaecological cancers.
- Care for women during the menopause and attention to the sexual health care needs of older women and men.
- Psychosocial support related to sexual health status.

¹ Other international agreements include statements from the Fourth World Conference on Women (Beijing, 1995) and the World Summit on Social Development (Copenhagen, 1995), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979)

- RTI/STI/HIV services for men and women, including counselling, prevention, screening, diagnosis, and management (partner notification, referral, treatment and care).
- Adolescent sexual and reproductive health.
- Gender-based violence, including female genital mutilation (FGM).
- Care for women and men experiencing sexual dysfunction or infertility.

Box 2: Definitions¹ (WHO, 2002)

Sex

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

Sexuality

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

Sexual health

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and

safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Human rights related to sexuality and sexual health

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

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

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

¹ These are working definitions developed through a consultative process with international experts beginning with a Technical Consultation on Sexual Health in January 2002. They reflect an evolving understanding of the concepts and build on international consensus documents such as the ICPD Programme of Action (1994) and the Beijing Platform for Action (1995). These working definitions are offered as a contribution to advancing understanding in the field of sexual health. They do not represent an official position of WHO.

While some *vulnerable groups* are addressed in the above, specific hard-to-reach groups that may require particular interventions, such as sex workers, mobile populations and other vulnerable groups are not included in this review.

1.3.3 Integration

Integration of services can be defined as the availability of two or more services at the same facility during the same operating hours, with the aim of making those services more convenient and efficient. Integration may range from the incorporation into a vertical programme of additional activities, to a full merging of two or more programmes into a comprehensive and horizontal PHC structure. There is still debate about the meaning of integration and whether integrated family planning/STI services should replace stand-alone HIV/STI services (Foreit et al., 2002). Mayhew (1996) has proposed an “integration continuum” to accommodate varying degrees of integration of STI/HIV services with MCH/FP. Integration, furthermore, may take different shapes between policy and service levels, at different levels of care, and even for specific tasks or target groups. Although the concept of the continuum was developed for a specific aspect of integration, what can be achieved through integration can be applied across all areas (see Box 3).

Box 3: What integration can achieve (Mahew, 1996)

- Improve service accessibility
- Improve service quality
- Improve service efficiency
- Increase client satisfaction
- Address unmet need
- Improve health status

In the context of this paper, the aim of integration of services is to improve access, use, quality, efficiency, and health status, and address unmet needs. Integration of sexual health into reproductive health service delivery and first-level care is thus done by adapting or expanding the service package offered at primary care level and changing the management of services (including human resource management).¹

1.4 Methodology of the review

1.4.1 Peer-reviewed literature

Peer-reviewed English-language publications published after 1997 were searched for using Pubmed and Science Direct. Priority was given to research projects, especially in low- and middle-income countries, that included an evaluation component or lessons learned. The keywords used in the initial search were: adolescents, aging, antenatal services, counselling, couple counselling, delivery, dual protection, dual methods, elderly, female genital mutilation, gender-based violence, harmful sexual practices, health services, health care, HIV prevention, incest, integration, male, male involvement, menopause, mental health, mental health services, MTCT, partner notification, pregnant women, postnatal care, refugees, reproductive health, reproductive tract infections, RTI, safe motherhood, safe sex, sex trafficking, sexual abuse, sexual coercion, sexual dysfunction, sexual health, sexual health consequences of contraceptives, sexual health promotion, sexual violence, sexuality, sexually transmitted diseases, sexually transmitted infections, STD, STI, street children, sexual behaviour, trafficking, and VCT.

The catalogues of the following journals were also searched: African Journal of Reproductive Health; AIDS; International Family Planning Perspectives; International Journal of Gynaecology & Obstetrics; Reproductive Health

¹ Integration of sexual health into RH services could also be referred to as the strengthening of the sexual health component of SRH services. Although this concept is closer to the ideas expressed at the five-year follow-up conference to ICPD, it was considered less operational in many countries.

Matters; Social Science and Medicine; Studies in Family Planning; and Lancet.

1.4.2 Programme experiences

The following Internet sites were searched: Alan Guttmacher Institute; Engenderhealth; Family Health International; Ford Foundation; Global Reproductive Health Forum; Healthlink Worldwide; Horizons; International Centre for Research on Women; Interagency Gender Working Group; IPPF; Population Action International; Population Council; Reproductive Health Outlook; UNAIDS; UNFPA; and WHO.

The criteria for inclusion of peer-reviewed articles (listed above) served as the starting-point for fielding questions to relevant people in the field of sexual health. These questions were then posted on the e-mail discussion forums AF-AIDS, SEA-AIDS, GENDER-AIDS and INTAIDS.

This review includes only services and interventions that have been evaluated, and for which a report was published in English, either as peer-reviewed or grey literature. For projects that were the subject of recent reviews, the original reports were not consulted. When available, more recent studies were included.

E-mail questionnaire

A brief questionnaire was e-mailed to a number of key informants around the world, selected on the basis of knowledge of people working in the area of sexual health and its integration into RH services.

The following reports and reviews provided the most valuable information, insights and evidence for this review:

- *Integration into FP services:* Meyer et al., 2002; Solo et al., 2000; WHO, 2002d; FHI, 2004.
- *Integration into MCH services:* Rutenberg et al., 2002.
- *Services for men:* Collumbien & Hawkes, 2000; UNAIDS 2001.
- *Adolescent SRH services:* Dehne & Riedner, 2001b; GTZ, 2002a; IPPF, 2001; Senderowitz, 2000; Speizer et al., 2002; Bott et al., 2003.
- *Gender-based violence:* Garcia-Moreno, 2002; Guedes

et al., 2002; IPPF/WHR, 2001; UNFPA, 1999b; Guedes, 2004.

- *Female genital mutilation:* Kessler Bodiang, 2001; WHO, 2001c.
- *Health system issues:* Mayhew et al., 2000; Rutenberg et al., 2002; Waelkens et al., 2001.

In the field of HIV/AIDS and STIs, the review focused on three recent reports: Dehne & Snow, 1999; Waelkens et al., 2001; and Askew & Berer, 2003.

Limitations

The available time and resources overview did not allow for an in-depth and comprehensive exploration of all components of the integration of sexual health into reproductive health services. Subjects that are not covered in detail include medically induced harmful effects on sexual pleasure and functionality, and sexual health for vulnerable groups such as street children, sex workers, men who have sex with men, internally displaced populations and refugees, women victims of trafficking, and female migrants.

Integration of sexual health services for women

Summary

The integration of sexual health into reproductive health services for women has mainly focused on prevention and management of HIV and reproductive tract infections, including sexually transmitted infections. Both family planning and maternal and child health services have a wide experience of integrating RTI/STI/HIV prevention and management for their (female) clientele, including promotion of dual protection, sexuality counselling, and voluntary counselling and testing for HIV. Other areas of integrated sexual health services for women (such as care for women with sexual dysfunction) have received far less attention, if any.

Role of the health sector

In the prevention and management of STIs/RTIs in women, health services have generally concentrated on strategies for detection (screening) plus treatment. Effective and feasible screening programmes include: screening of pregnant women for syphilis and HIV; screening of women attending reproductive health services for HIV; and screening (older) women for cervical cancer. Screening for HIV should be provided within a framework of voluntary counselling and testing (VCT). Family planning clinics may offer one of the few opportunities to screen for cervical cancer, although the target age group needs careful consideration. Sexuality counselling, though infrequently provided, should be a component of all counselling related to sexual and reproductive health as it represents a welcome shift towards a dialogue with clients to assess their needs, including for dual protection.

Evidence and recommendations

Management strategies for RTIs/STIs in both FP and MCH services have generally concentrated on syndromic management – a low-cost, minimal-technology approach based on the recognition that several different organisms can cause similar

symptoms and signs in infected individuals, and offering treatment for groups of organisms. Syndromic management promotes management of sexual partners, either through patient-led or provider-led approaches, and provides an opportunity to discuss prevention strategies with individual clients, including promotion of dual protection and use of male and female condoms. Evidence on the effectiveness of strategies for partner notification is extremely limited for most settings, but provider-led referral may result in more partners seeking care than patient-led referrals. However, most studies have been carried out in the United States and Western Europe, and care is needed in extrapolating this finding to settings with large differentials in gender power (because of the potential risk of gender-based violence in some settings), or to low-resource settings.

Integration of syndromic management for symptomatic clients may be cost-effective for some conditions: management of genital ulcer disease in women and men; and management of urethral discharge in men. The value of the syndromic approach is that it is relatively simple to use, and can be incorporated into all levels of the health care system, in both the public and private sectors. However, management of the most common syndrome, abnormal vaginal discharge, has performed poorly in many settings, and decisions on whether to include drugs active against chlamydia and gonorrhoea should be based on the prevalence of these infections in the target population. WHO does not recommend the use of syndromic management algorithms for screening purposes.

Pregnant women should be screened for syphilis; this intervention is known to be cost-effective even in areas of low prevalence. Screening can be done in parallel with programmes for prevention of

mother-to-child transmission (PMTCT) of HIV, which should also include the following components: VCT services, anti-retroviral prophylaxis for HIV-infected pregnant women; counselling and support for safe infant feeding practices; follow-up of HIV-positive women; supply of condoms to both HIV-negative and HIV-positive women; and, for HIV-negative women, counselling to avoid risk of infection.

VCT can be introduced in a wide variety of RH settings. However, it requires additional resources in terms of staff time and physical space to ensure privacy and confidentiality; adequate training is also essential. Staff in RH services have an important role to play in ensuring that HIV-positive women are not stigmatised either by clinic staff or in the community.

There is firm evidence to show that correct and consistent use of male latex condoms is effective in preventing the transmission of HIV and some other STIs, and will also protect against pregnancy. However, evidence on the effectiveness of promoting dual protection in FP clinics is inconclusive. Training health workers to assess the protection (STI and pregnancy) needs of each individual client may be a more effective approach. Consistent use of female condoms can also protect against the transmission of HIV; however, acceptability remains an issue in many settings.

Experience with the integration of sexual health counselling (including discussion and assessment of individual risks of STIs and pregnancy, sexuality, and sexual behaviour) has shown that clients appreciate the opportunity to discuss these issues with health workers. In some settings, integration of sexuality counselling improved the quality of the family planning services, client satisfaction and staff motivation. Effectiveness is increased when health workers are both motivated and well trained. Facility-based interventions need to be complemented by advocacy and widespread work in the community to address the determinants of sexual health problems (such as gender power differentials).

Services for older women are often limited because of lack of resources and difficulty of access. In cervical cancer screening programmes with limited resources, it is

recommended that every woman in the target population should be screened at least once in her lifetime at around 40 years of age. As resources increase, women aged 35–55 years should be screened up to once every 5 years. At present, Pap smear is the only screening method recommended; however, visual inspection of the cervix with acetic acid is showing great promise for use in low-resource settings. In addition, older women attending health care services should be offered good quality clinical breast screening services if mammography (the first choice for screening programmes) is not available.

Needs

While there is a considerable experience with the integration of STI/HIV prevention and care activities into FP, MCH and other reproductive health services, there is less documented evidence or experience with the integration of other aspects of sexual health services. In addition, much of the evidence on STI/HIV interventions tends to look at issues of clinical management rather than, for example, what sustains behaviour change or how partner management should be handled. Further operational research on a wider integration agenda is now needed.

The barriers to integrated services need to be defined; in many cases, even when interventions are known to be effective, they may not be implemented or sustained (e.g. antenatal syphilis screening). A broad sexual health service that incorporates elements of counselling, screening, client management, and partner management will require additional staff training and supervision. Referral services will need to be strengthened (e.g. for women found to have abnormalities on cervical screening); and laboratory services will need additional resources to enable them to support integrated screening and management programmes for cervical cancer and STIs. Furthermore, there is little experience with taking interventions to scale and more thought needs to be devoted to the mechanisms and requirements for scaling up successful integrated services.

The integration of sexual health into reproductive health services for women has primarily focused on prevention of STI/HIV and management of STIs. In the early 1990s the importance of STIs was raised on international health care agendas for a number of reasons. First, the influential 1993 World Development Report, *Investing in health* (World Bank, 1993), calculated the burden of disease associated with these infections globally. STIs are associated with a number of (preventable) complications and sequelae, including pelvic inflammatory disease, infertility, adverse outcomes of pregnancy (including ectopic pregnancy and neonatal death), chronic pain, and genital cancers (including cervical cancer). They were found to constitute the second most important contribution to the overall burden of disease in adult women, and an important contribution to high DALY levels in men. Secondly, ICPD codified international agreements aimed at improving the sexual and reproductive health of women and men across the globe (United Nations, 1995). In developing countries integration of STI services for women into reproductive health has been shown to be effective. For example, a trial of syndromic management of STIs at the primary health care level in Mwanza district in the United Republic of Tanzania found that treatment of STIs reduced the incidence of HIV by over 40% (Grosskurth et al., 1995). As a result, integrating STI/HIV prevention and management activities into existing reproductive health services seemed a sensible option from a medical, organizational and human rights perspective (Mayhew, 1996).

From a medical point of view, all clients seeking reproductive health services are potentially exposed to health risks associated with sexual intercourse. From an organizational point of view, in many low-income countries, family planning and maternal and child health services are better run than curative services, and are sometimes the only services offered by the public sector. Taking advantage of the existing clientele and of the supply and supervision channels of these services seems an appropriate management decision. From a human rights perspective, accessibility to services that address women's needs (including sexual health needs) is important. Integrating STI/HIV interventions into health services that are relatively accessible to women – and often their only contact with the health care

system – presents a unique opportunity to reach them. Such an approach, however, is likely to miss men. As a result, many programmes are now working to become more accessible to men.

Integration interventions include, primarily, two groups of activities: diagnosis and management of STIs (screening, diagnosis, clinical management, treatment or referral for treatment, partner notification, and secondary preventive counselling) and primary STI/HIV prevention (health education and counselling, individual counselling, voluntary counselling and testing for HIV, and provision of written information and condoms).

This chapter reviews programme experience on the effectiveness of STI management and the promotion of condoms within MCH and FP services. It also addresses implications for research and service integration, quality of services, and barriers faced by the health services in providing quality care and including a sexuality approach in counselling of FP and MCH clients. The integration of infertility management is included only in so far as the reviews of STI management and primary STI/HIV prevention addressed these aspects. Services for female sexual dysfunction are not included, despite recent evidence from developed countries that such dysfunction is likely to be more common in women than men (Ragucci & Culhane, 2003). This is because no programme examples from developing countries were found that addressed the issue. Services for women who have sex with women are not addressed in this review as there is insufficient documented programme experience from developing countries on this area.

Recognizing that the most common infections of the reproductive tract are *not* sexually transmitted, this chapter focuses on the more inclusive category, reproductive tract infections, which affect both women and men. Some RTIs (such as syphilis and gonorrhoea) are sexually transmitted, but many are not. In women, overgrowth of endogenous micro organisms normally found in the vagina may cause an RTI (*Candida* sp. infection or the organisms of bacterial vaginosis). The third group of RTIs is the iatrogenic infections, which are associated with medical procedures in which infection control is poor.

2.1 Prevention and management of STIs in FP services

The integration of STI/HIV interventions into FP clinics is the component of sexual health that has received most attention in public health services and that is best documented. It is an area with some controversy: family planning services have, in the past, shown resistance to integration of STI services, often because of concerns that existing services would be stigmatised. The Indonesian Planned Parenthood Association, for example, reported resistance in its clinics when STI services were planned alongside FP services. However, with recognition of the importance of staff commitment to the principles and practice of integration, a slowly phased in integration strategy was eventually successful (http://www.rho.org/html/rtis_progexamples.htm#indonesia).

The most common approach for integrating STI prevention and management into FP settings relies on the promotion of syndromic management. This is a low-cost, minimal-technology approach to the management of individuals presenting with clinical syndromes (sets of recognized symptoms or signs) usually associated with the presence of an STI/RTI. The syndromic approach recognizes that several different organisms can cause a particular syndrome and recommends treatment for the most common group of etiological agents likely to be present.

Syndromic management has been evaluated in some settings as a screening tool to identify women with cervical infections in FP clinics (Costello Daly et al. 1994; Behets et al. 1998; Kapiga et al. 1998; Tyndall et al. 1999). These studies, however, have generally found that use of the algorithms for screening results in overdiagnosis. Research conducted by the Zimbabwe National Family Planning Council, for example, compared RTI/STI management strategies among women attending FP clinics. They reported that, while the use of syndromic management algorithms as screening tools had the lowest cost per client, 75% of women with an RTI remained undiagnosed, and 56% of those treated were misclassified as infected and received unnecessary treatment (Maggwa et al., 1999). Overdiagnosis of STIs can have an important social impact in some settings – putting women at risk of partner violence, for example. For these reasons, WHO does

not recommend the use of syndromic management algorithms for screening purposes.

Syndromic management has nevertheless worked well in some settings for some conditions – especially management of genital ulcers in men and women, and management of urethral discharge in men. However, it performs relatively poorly and is often not cost-effective for management of the most common syndrome, abnormal vaginal discharge in women (Dallabetta et al., 1998; Hawkes et al., 1999; Sloan et al., 2000; Dehne & Snow, 1999; Pettifor et al., 2000). The relatively poor performance of the management algorithms is related to the low prevalence of cervical STIs (chlamydia and gonorrhoea) in women with an abnormal vaginal discharge.

In recognition of this, WHO has recently revised its guidelines in this area, to recommend that all women presenting with vaginal discharge should receive treatment for trichomoniasis and bacterial vaginosis. It may be possible to identify women with an increased likelihood of being infected with *Neisseria gonorrhoeae* or *Chlamydia trachomatis* – for example through the use of locally relevant risk factors, or through knowledge of the prevalence of gonorrhoea and chlamydial infection in women with symptoms. The higher the overall prevalence of cervical STIs in the clinic population, the stronger the justification for treatment at first visit (WHO, 2001e). In addition, in the field providers often welcome the diagnosis of an RTI that may not be sexually transmitted, as it makes partner notification much easier.

This recommendation carries important policy implications for the integration of syndromic management into settings with low or medium prevalence of STIs, such as FP clinics. It suggests that first-line treatment should be for other RTIs, such as the endogenous infections, and that resistant or complicated cases should be referred to specialized clinics for treatment (Dehne et al., 2000). Given health workers' problems following the guidelines and carrying out the examinations in FP clinics (Dube et al., 1998; Lule & Lema, 2000; Mayhew et al., 2000; Miller et al., 1998), there is a need to strengthen the health system to ensure correct use of guidelines and tools for risk assessment and appropriate referral. In the context of STI/RTI control, strengthening of the referral system includes improving

laboratory services which are an integral component of control programmes and other primary health care services such as maternal and child health care services.

Research aimed at improving the management of women presenting with symptoms of possible STI in FP (and other RH clinic) settings is currently focused on the development of point-of-care diagnostic tests for chlamydia and gonorrhoea (often called rapid tests) (http://www.who.int/std_diagnostics/). The challenge is to develop tests that are sensitive, specific, affordable and usable in resource-poor settings. Such tests could be used for screening as well as in clinical management.

Partner notification (also termed partner management or contact tracing) has been promoted as an integral component of syndromic management. It is a well-established component of STI control programmes (WHO, 1991), which recognizes that the sexual partners of people with STIs are likely to be infected, but may be asymptomatic and may not otherwise seek care. This may be especially true for women who are more often asymptomatic than men. In treating only one partner in a sexual relationship, there is a risk that the person will be reinfected by the untreated partner. Partners can be reached through a number of different strategies: some are “patient-led” (e.g. the patient is asked to give the sexual partner a contact slip for referral to health care, or is given medicines to pass on to the sexual partner); others are “provider led” (health service personnel notify the partner); still others are a combination (termed “conditional referral”: patients are encouraged to notify the partner but health service personnel will notify the partner if the partner referred for treatment has not visited the clinic by a certain date). Of paramount concern in selecting a strategy for partner management is the need to ensure that patient confidentiality and privacy are respected.

A recent Cochrane Collaboration systematic review of the effectiveness of partner notification strategies was the first to include two randomised controlled trials conducted in low-income countries (South Africa and Zambia) (Mathews et al., 2002). The review concluded that provider-led referral (or a combination between patient-led and provider-led referral) was more likely to result in part-

ners presenting for medical care than patient-led referral, and that conditional referral for patients with gonorrhoea was more effective than patient referral.

In some settings, and especially those where sexual relationships tend to involve gender power imbalances (Blanc, 2001), a blanket approach to integrating partner notification strategies could result in women being exposed to gender-based violence when they inform their sexual partners they have an STI (Askew & Maggwa, 2002; Solo et al., 2000; Ringheim 2002).

2.1.1 Screening for STIs in FP clinics

Until recently, screening for STIs, or for the consequences of STIs, in FP clinics has been limited to cervical cancer screening. If rapid point-of-care diagnostic tests become available (as discussed above), it may be more feasible to introduce screening for other STIs in RH settings, including FP clinics. Screening for syphilis, for example, has until now been limited to pregnant women. However, newly developed syphilis diagnostic tests that work on whole-blood samples (and therefore do not require additional resources such as a rotator and serum separator) have shown promising results in laboratory-based evaluations (WHO SDI, 2003). Similar tests for chlamydia, gonorrhoea and other STIs are being developed but are currently less advanced.

2.2 Promotion of condom use for dual protection

2.2.1 Male condoms

Current policy recommendations for family planning services focus on reinforcing efforts to make condoms available and promoting condom use for dual protection, defined as protection against both pregnancy and HIV and most STIs (WHO, 2002c). This can be achieved by the consistent use of male latex condoms, alone or simultaneously with another contraceptive method, or by the avoidance of penetrative sex (IPPF, 2000). Providers should evaluate the appropriateness of each contraceptive method, with special attention to avoiding infection in

Box 4: Recommendations and suggestions

Recommendations and suggestions

- Syndromic management algorithms should not be used for screening, but as clinical management tools.
- Integration of syndromic management into FP or other RH settings may be effective and cost-effective for a number of clinical syndromes – for example, urethral discharge in men, or genital ulcer disease in men and women. However, the management of women with vaginal discharge should be based on the known prevalence of chlamydia and gonorrhoea in the population of symptomatic women presenting for care. Where prevalence is low, women should be treated for the non-STI endogenous infections in the first instance.
- The referral system for more serious or resistant cases needs to be strengthened.
- The laboratory support system for etiological diagnosis should be strengthened where appropriate.
- Integration of effective partner notification strategies alongside syndromic management needs further evaluation.

users of an intrauterine device (IUD), and integrate information and education on protection against STI/HIV.

The promotion of condoms in FP and MCH clinics presents a challenge. In the first place, over the past 30 years, providers have generally favoured more technically advanced and longer-term methods, disregarding the condom as an effective method for preventing unwanted pregnancy. Secondly, changing the practices of providers, from emphasizing prevention of pregnancy to including protection against disease, is complicated by the difficulty of providing a method that is equally effective for both. Providers need to be convinced that, when used consistently and correctly, condoms can be highly effective in preventing pregnancy (WHO, 2002c). It is still not clear whether it is preferable to promote condoms as a unique method to prevent both unwanted pregnancy and STI/HIV infection – with a possible increased risk of unwanted pregnancy – or whether use of two methods should be encouraged – with possible lower compliance and hence increased risk of STI/HIV infection (Cates & Steiner, 2000; Best, 2001). In addition, behavioural determinants, such as cultural barriers, gender-based violence, power dynamics, and practical skills, and provider attitudes towards condom use form barriers to the promotion of dual protection (WHO, 2002c; Meyer et al., 2002).

The results of promotion of dual protection are difficult to assess. In February 2001, USAID failed to assemble an overview of integration of dual protection in the family planning programmes it was funding, because great variations in submitted reports made comparison difficult (Advance Africa, 2001). Other studies confirmed the general finding of low uptake of dual protection (Meyer et al., 2002; Adeokun et al., 2002).

Box 5: Recommendations and suggestions: promoting dual protection for FP clients

Male latex condoms, when used consistently and correctly, can help to protect against HIV, some STIs and unintended pregnancy. FP providers can play a crucial role in helping clients (usually women) to assess their need for protection from pregnancy and from infection, and can provide information on prevention. In an FP setting, where infection status is not known, individual assessment of risk of STIs, including HIV, is not an appropriate way to determine method choice. Knowledge of the local prevalence of STIs and HIV and assessment of contextual factors underlying risk and vulnerability patterns may be a better basis for determining the most appropriate contraceptive methods to offer.

2.2.2 Female condoms

While male condoms are still the most widely promoted barrier method in dual protection, much attention has been given recently to female condoms. There are many reasons for promoting the female condom. It adequately protects against HIV. In addition, female condoms have the potential to give women more control, especially when they can be inserted in advance (Kaler, 2001). Some studies have shown that couples using female condoms are more likely to use male condoms as well, and tend to use protection more often than couples using only male condoms (Fontanet et al., 1998; Macaluso et al., 2000; Musaba et al., 1998). Whether female condoms indeed facilitate negotiation among partners should be evaluated in research projects where both male and female condoms are promoted as equal options (Van de Korput, 2001).

Studies have been carried out to evaluate the acceptability of female condoms among providers and clients in family planning clinics (Beksinska et al., 2001; Mantell et al., 2000; 2001). Although the results are mixed, the main obstacles described to date are related to the clients, and include partner reluctance (Beksinska et al., 2001), perceptions of reduced sexual pleasure (Van de Korput, 2001) and high costs (Adeokun et al., 2002). The high costs have also led women to reuse condoms, using inappropriate means to clean them, as they are often not aware of the risks of reuse (Irin Plus News, 2002). Various studies have evaluated the safety, acceptability and modalities of reuse (e.g. Pettifor et al., 2001; Smith et al., 2001; WHO, 2002c), but providers face a dilemma over what to recommend. While WHO does not recommend reuse of female condoms, it recognizes that reuse is common and has therefore prepared a draft protocol for their safe reuse and cleaning (WHO, 2002d).

Integrating female condoms, as an alternative to male condoms, in the promotion of dual protection seems feasible, as yet, only in situations where women are at high risk. Female condoms have been well accepted in pilot projects and study settings. Most research projects have been carried out at family planning clinics, with a follow-up period of six months or less. The acceptability

of female condoms to groups not at high risk, outside the special circumstances created by research projects, is not yet clear. Research is continuing to evaluate the efficacy of female condoms in preventing STIs and pregnancy.

Even if the costs of female condoms can be met, the acceptance of the device by the wider population remains an issue of concern. Ultimately, microbicides may have greater potential to enable women to protect themselves.

2.3 Integrated counselling for sexual health

Box 6: Recommendations and suggestions: promotion of the female condom

There are many reasons to consider promoting the use of female condoms:

- Consistent and correct use of the female condom can protect against the transmission of HIV.
- It is a female-controlled method of protection.
- They can be used in addition to other methods of protection.

However, certain barriers need to be overcome before a more widespread use of these methods is seen. For example, they have a low acceptability in many settings; they are not often promoted by providers; and, above all, they are still relatively costly compared with male condoms.

For effective prevention of both unwanted pregnancy and STI/HIV infection, providers must understand the circumstances of their clients' sexual life. To maximize the chances of continuous contraceptive use, clients should be informed of the possible effects of different methods on sexual satisfaction and sexual health. Discussing sexual behaviour also helps clients understand better their own risk of both unwanted pregnancy and STI/HIV infection (Becker & Leitman, 1998). These considerations have resulted in a shift from providing information (one-way communication) to individualized counselling (two-way communication).

Box 7: Elements of integrated sexual health counselling

- Discuss matters related to contraceptive choice: method effectiveness, side-effects and complications; advantages and disadvantages of each method from the client's point of view; proper use of the selected method; what to do if the method fails or is not used properly; emergency contraception.
- Discuss matters related to prevention of mother-to-child transmission (PMTCT) (at-risk pregnancy and child care).
- Discuss measures for protection against STI/HIV.
- Conduct STI risk assessment adapted to the local situation.
- Propose HIV testing (VCT).
- Discuss concerns, fears and values related to sexuality, sexual function, and sexual and reproductive health.

Adapted from: Murphy et al., 1999; Welsh et al., 1997.

Integrating sexuality into counselling for family planning was first a result of the concern to provide protection methods adapted to clients' personal sexual and reproductive needs. In programmes that took up the challenge, providers and programme managers were often surprised at how easily clients talked about their sexual life. Many clients had concerns about their sexual health and appreciated the opportunity to ask questions and share their problems in a safe environment (Waelkens et al., 2001). Integration of sexuality in family planning services improved the quality of the services, and increased client satisfaction and staff motivation (Murphy et al., 1999; Welsh et al., 1997).

Similar observations in various pilot programmes (Becker & Leitman, 1998; Abdel-Tawab et al., 2000) have inspired much literature on the benefits of addressing sexuality in family planning clinics. These benefits are important not only for avoiding pregnancy and infections but also to help couples to enjoy their sexuality and have a healthy and satisfying sexual relationship. The ability of partners to

discuss sexual issues is an important element in improving the sexual relationship. For example, in Nairobi, Kenya, it took the presence of a counsellor for a woman to inform her husband that, contrary to what he thought, the prolongation of sexual intercourse by condom use actually gave her pleasure. This example was related during a meeting of counsellors and led to the sharing of similar experiences. This marked a turning-point for a greater acceptance of the need to address sexual relationships in counselling in an integrated primary care centre (Waelkens et al., 2001).

Providers need intensive training if they are to introduce a sexuality focus in their discussions with clients. They need technical knowledge on the advantages and side-effects of the various contraceptive methods, STIs and safer sex. They need to know about and be comfortable with all sexual matters, and they need to clarify – and possibly change – their own values and attitudes. They also need to develop their communication skills. The commitment of all staff members, as well as of the institution, is essential if conventional family planning programmes are towards providing integrated services. Providers need support from their supervisors, not only at the outset of the programme but throughout the process of change (Becker & Leitman, 1998).

In the IPPF/WHR projects, it took months of training and follow-up before communication between providers and clients changed from one-way provision of information to individual integrated counselling (IPPF/WHR, 2000). In an Egyptian pilot project where providers were given less intensive assistance, their attitudes did not change significantly and they continued to feel embarrassed about discussing sexual matters (Abdel-Tawab et al., 2000). One idea for improvement of integrated counselling, mentioned in recent evaluations, is the provision of job aids, such as checklists or flipcharts, that can be used during counselling (Solo et al., 2000). Such written support helps ensure that all relevant topics are discussed. Health workers also find it easier to start talking about sensitive topics when clients are aware that there is a standard list, which makes the questions seem more routine.

In a pilot programme in Ibadan, Nigeria, training of providers also focused on changing attitudes and values, with practical exercises to help them to become comfortable in talking about sexual issues (Adeokun et al., 2002). There were regular staff meetings and supportive supervision to address obstacles to change. The effect on client-provider communication was modest. Discussions of the client's sexual behaviour increased from 19% to 34% of visits. Negotiation with partners on initiating condom use was brought up with 18% of clients.

In some African countries, many health workers have been trained in integration of STI/HIV interventions in family planning, but these short courses did not allow them to acquire the skills to discuss sexual matters (ICRH/GU, 2000). Promotion of dual protection has been introduced in various settings, but it is not clear whether providers include a risk assessment and discuss clients' individual circumstances, or whether they give information on dual protection in a more routine one-way communication. A report from Lusaka, Zambia, suggests that one-way counselling may still be predominant: the subject of STI/HIV infection was raised in about 50% of consultations. About half of the clients who used contraceptive methods other than condoms were told that their method did not protect against STI/HIV. But only 3% of clients were asked about the number of their partners and 12% of clients were asked if they had concerns about contracting STIs. Providers admitted to barriers to talking about sexual health issues (Chikamata et al., 2002).

An important element of Latin American examples for improving provider-client relationships is the close involvement of health workers in designing and improving their own programme (Becker & Leitman, 1998). There is growing documentation, based on observations and self-reported changes (WCHP, 2002; GTZ, 2002b), of the value of involving health workers in formative and action research for improving their ability to discuss issues pertaining to sexuality. However, sustaining these changes within the public health system will depend on continuing supervision and support.

Despite efforts to improve women's negotiation skills through individual and group counselling (e.g. group counselling in BEMFAM/Brazil (Badiani & Becker, 1996), STI/HIV prevention messages directed at women in family planning clinics did not result in behaviour change, because they could not discuss safer sex with their partners.

In order to be effective, facility-based prevention activities need to be complemented by nationwide and community-based advocacy and networking to influence the power relations between men and women. In Brazil, evaluation of successful integration of sexual health issues into health services points to the need for a multifaceted strategy, such as empowerment of women through education and counselling, and multisectoral activities, such as legal advice and social and economic networks. Community-based advocacy and networking reach men as well as women (Diniz et al., 2002), an important requirement for change which is much more difficult to achieve in traditional FP clinics. Rance¹ (2002, personal communication) reports that in Bolivia the integration of sexual health in health services is much more advanced in areas with intensive activist and NGO initiatives to promote sexual rights than in areas where integration is implemented as a top-down strategy with few advocacy activities.

Another question is how to cope with increasing demand for counselling. Integrated, individualized FP/STI counselling can place heavy demands on staff time, although some time can usually be made available through more efficient ways of working (Janowitz et al., 2002).

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Box 8: Recommendations and suggestions: sexual health counselling in FP

Integrating sexual health counselling into FP programmes can improve the quality of family planning services, and increase client satisfaction and staff motivation. In order to integrate sexual health counselling into existing services, a number of steps need to be considered:

- Providers need to know about and be comfortable with all sexual matters, and they need to clarify, and possibly change, their own values and attitudes to sexuality and sexual health care.
- Initial and follow-up training of providers should cover both communication skills and technical aspects of comprehensive sexual health care.
- Development of job aids to be used during counselling should be considered.
- Providers should be involved in designing their own training programme.
- Facility-based interventions should be complemented by community-level multisectoral activities addressing the contextual factors influencing sexual health outcomes (including gender-power imbalances, promotion of sexual rights, etc.).

2.4 Integration of STI/HIV interventions in maternal and child health services

Traditionally, maternal and child health care includes: antenatal care, immunization with tetanus toxoid, and treatment of malaria for pregnant women; advice on nutrition and micronutrient supplementation for mother and child; delivery and postpartum care; and immunization, growth monitoring, and detection and treatment of acute respiratory infections and diarrhoea for children.

The integration of sexual health issues in postpartum counselling on contraceptive use raises issues similar to those discussed in section 2.3. Integration of STI/HIV interventions expands established activities with antenatal screening for and treatment of syphilis, syndromic management of STIs, primary STI/HIV prevention, and prevention of mother-to-child transmission (PMTCT) of HIV.

Syphilis screening in antenatal services is part of national health policy in most countries, and is a cost-effective intervention in many settings (WHO, 2004a; Walker & Walker, 2002; Fonck et al., 2001). Syphilis tests should be repeated in late pregnancy, if possible, to identify women infected during the pregnancy. All women should be tested at least once during pregnancy, and all women with reactive serology should receive treatment (WHO, 2004a). The screening blood test is relatively cheap and easy to carry

out (although it does require an electricity supply for a centrifuge and rotator), the results are available on the same day and treatment (injectable penicillin) is usually affordable and readily available, and can be administered during the same visit. The impact of a functioning syphilis screening programme on the incidence of congenital syphilis can be substantial: a programme in Haiti invested in the installation of solar-powered batteries which were used in dispensaries to run a centrifuge and a rotator for carrying out rapid plasma reagin (RPR) testing. The RPR reagent was stored in a propane-powered refrigerator. As a result, the rate of congenital syphilis in the intervention area decreased by 75% over three years (Fitzgerald et al., 2003).

However, despite the existence of syphilis screening policies on national health agendas, syphilis screening programmes are rarely effectively implemented. A recent survey of 22 countries in sub-Saharan Africa found that, although 75% had a national screening policy, few antenatal clients were screened (Gloyd et al., 2001). In other countries, programmes have not been scaled up or sustained beyond pilot interventions (Fonck et al., 2001; Bekinska et al., 2002; Maggwa et al., 2001). The reasons for this are many and varied and include constraints at many levels. Lack of political will, logistic constraints within programmes, and “provider overload” may demotivate staff

and discourage them from implementing programmes. The development of point-of-care diagnostic tests that can be applied to whole-blood samples may overcome some of the current technological constraints to more widespread syphilis screening. In addition, political will to integrate syphilis screening with prevention of mother-to-child transmission of HIV should have a measurable impact on the availability of screening and treatment programmes.

Screening for cervical cancer could be integrated within MCH services, but only with consideration of the issues raised in section 2.7, the primary concern being that the women attending MCH services may not be in the target age group for cervical cancer screening.

Box 9: Recommendations and suggestions: integrating STI/HIV interventions into MCH

Screening for syphilis in antenatal programmes is a highly cost-effective intervention in many settings. However, despite its apparent feasibility, it is rarely implemented on a wide scale. Integration of syphilis screening into antenatal programmes requires the mobilization of political will, as well as the cooperation of health care providers and community-level understanding of the importance of the disease.

2.5 Prevention of mother-to-child transmission of HIV

Prevention of mother-to-child transmission of HIV has been introduced in stages in pilot programmes in many areas of high HIV prevalence. High quality antenatal, delivery and postpartum services are essential before PMTCT can be introduced. To date, sexuality counselling has seldom been part of the counselling for PMTCT. The following description can be seen as typical for programmes where no special attention is given to the sexual health of women with HIV.

Programmes for PMTCT consist of: upgrading of basic MCH services; introduction of voluntary HIV/AIDS counselling and testing services, and antiretroviral (ARV) pro-

phylaxis for HIV-infected pregnant women; counselling and support for safe infant feeding practices; follow-up of HIV-positive women; supply of condoms for both HIV-negative and HIV-positive women; and, for HIV-negative women, counselling on avoiding risk of infection (Dabis et al., 2000). Counselling of HIV-positive women who are pregnant should also include the provision of information on safe induced abortion services (where they are not against the law), so that those who decide that they do not wish to continue with the pregnancy know where and how to obtain a safe abortion. For both HIV-infected and HIV-negative women, counselling in PMTCT and VCT settings should address questions of sexuality and sexual risk taking. PMTCT draws attention to the current insufficient capacity of the public health sector to offer quality HIV/AIDS counselling beyond limited projects in some areas.

Programmes for PMTCT provide an opportunity to screen pregnant women for other infections that can be transmitted to their infants, such as syphilis, at little additional cost. As rapid diagnostic tests become available for other STIs (such as gonorrhoea and chlamydia) that can have adverse effects on pregnancy outcome, PMTCT programmes could integrate screening for these infections also.

If ARV drugs are available, counselling and support should be provided to help women take care of their own health. Lessons learned from implementing ARV treatment in Botswana, South Africa and Uganda include the importance of: “treatment literacy” through education of the community, the patients and the providers; the support of family, friends and others in maintaining adherence to treatment; addressing stigma; participation in an early phase of everyone with an interest in the programme or affected by it; empowerment of people living with AIDS to manage their own treatment programmes; networking and building on existing structures. In addition, it is essential that advocates, campaigners and other stakeholders are well informed about treatment; training should include hands-on experience as well as basic instruction during workshops (UNAIDS, 2005).

2.6 Voluntary HIV/AIDS counselling and testing

The most common model for integrating HIV/AIDS voluntary counselling and testing into existing services is its inclusion in MCH services, partly because VCT is an essential component of PMTCT. However, in at least one case, primary care services including STI management have been incorporated into stand-alone VCT centres (see the example of Haiti, below). Evaluations report that there is a great deal of interest in VCT services and in information about HIV/AIDS in MCH settings (Rutenberg et al., 2002). This high demand for VCT inevitably poses challenges for the services. High quality HIV/AIDS counselling takes time, and requires a sufficient number of trained counsellors and rooms where quiet and privacy are ensured. Counsellors need support to avoid burn-out and to discuss difficulties they encounter, and continuing education to keep up to date (UNAIDS, 1999; WHO, 2000b).

Experiences with integrating VCT in MCH services raise an important concern: the ability of services to ensure confidentiality. In PMTCT services, it is unavoidable that a number of people will know the client's HIV status. This knowledge is shared by records clerks and health workers in the antenatal and maternity clinics. Rutenberg et al. (2002) reports that these workers do maintain confidentiality in projects where its importance is emphasized.

VCT and PMTCT counselling require considerable time and effort, and carry the risk that other information and counselling needs will be neglected. In MCH services that offer PMTCT, for instance, there seems to be little attention given to the prevention needs of HIV-negative women. The counselling session during which HIV-negative women receive their results would be an ideal opportunity to discuss issues of sexuality, sexual risk-taking, vulnerability, STI/HIV prevention, and risk reduction strategies. Not to do so this seems a missed opportunity, since the risk of becoming infected after pregnancy is high: in Zambia, 10–15% of the HIV-negative women tested in the context of a PMTCT programme became infected with HIV within one year (Rutenberg et al., 2002).

Time constraints often hamper provision of quality VCT services. There should therefore be a possibility to test

alternatives to the established methods of quality counselling. As for integrated FP/STI/HIV counselling, much routine information can be given to groups or in waiting rooms, especially for pre-test counselling, but also to reinforce information on prevention after testing (UNAIDS, 1999). Questions asked in the group will benefit all the clients. In Botswana, health education with video sessions and group counselling are provided by non-medical educators and counsellors to reduce the length of individual sessions (UNAIDS, 2002). There is a need to evaluate the effects of these interventions on the quality of information received and the clients' ability to make an informed choice.

VCT programmes that counsel couples in which one person is HIV-positive have been shown to be significantly more effective than individual counselling in preventing transmission between the partners (The Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000). In pilot projects for PMTCT, male involvement was found to be important for acceptance and uptake of antiretroviral treatment (Rutenberg et al., 2002). However, couple counselling in MCH and PMTCT should go beyond the mother's HIV status and its implications for the child. In Zambia, HIV incidence postnatally was lower for couples who had attended the antenatal clinic together (Rutenberg et al., 2002). It is also important to counsel women who are HIV-positive on issues related to their sexuality, sexual and reproductive expectations, and prevention of HIV transmission.

Follow-up of HIV-positive mothers is another critical issue for MCH services. In most low-income countries, they do not continue to receive ARV therapy outside the PMTCT programme. Care is usually limited to referral to community-based care and support services. However, fear of stigmatisation may make women reluctant to disclose their status either in or outside the antenatal clinic.

In Haiti, primary health care services have been integrated into stand-alone VCT services since 1985. The centres, run by the Groupe Haitien d'Etude du Sarcome de Kaposi et des Infections Opportunistes (GHESKIO), offer treatment

of sexually transmitted infections and other reproductive health care services. A retrospective review of patient records between 1985 and 2000 found that STI management was offered to 18% of the over 8000 new clients seen for VCT in 1999, while family planning was provided to 19% of the clients (Peck et al., 2003).

Box 10: Recommendations and suggestions: VCT

When VCT is introduced into RH settings, thought needs to be given to the likely increased demands on staff time and resources. Staff will need additional training in issues relating to confidentiality. Counselling for HIV-positive women is important, and the need to counsel HIV-negative women about remaining uninfected should not be overlooked. Promotion of condom use for women who are HIV-negative as well as those who are HIV-infected is an important component of sexual health services in all RH settings. In some situations, counselling couples may be more effective than counselling individuals.

2.6.1 The role of the health services in reducing discrimination and stigmatisation of HIV-positive women

Stigmatisation of HIV-positive people limits the effectiveness of HIV/AIDS interventions. For many HIV-positive people, reluctance to disclose their HIV status is a barrier to joining post-test groups or associations for people living with HIV/AIDS, and to accepting assistance from home visitors or home care programmes.

In pilot projects where HIV/AIDS-related interventions are functioning well, stigma has diminished at the clinic level. Staff attitudes progressively change with training and growing knowledge. Pregnant women in PMTCT programmes felt that there was a trusting relationship with health workers and other pregnant women, and that a shared confidentiality within the clinic created an environment where they were accepted and where their HIV status could be discussed. Rutenberg et al. (2002)

This means that in clinics where HIV testing is routine, the stigma associated with being positive decreases. Rutenberg et al. (2002) propose wide implementation of an approach that has already been introduced in India and in private hospitals in Nairobi: to make HIV testing part of the routine antenatal procedures. Pregnant women who do not want to be tested can opt out, but have to do so explicitly. This approach goes against the prevailing opinion that only people who positively express the wish to do so should be tested for HIV. Nevertheless, it may be worth while to evaluate whether making testing a routine activity would be seen as a threat, and would increase or decrease stigmatisation, and what would be the preconditions for implementation.

This is of particular importance because the non-discriminatory attitude of health professionals towards HIV-positive women in the pilot studies mentioned above is the exception rather than the rule in MCH services. When making VCT and PMTCT available in settings where health workers do not receive the intensive support they need to work on their own values and behaviour, HIV-positive women may be discriminated against. Providers may be reluctant to touch or treat people known to be HIV-positive (although they may ignore precautions with patients whose status is unknown) and may be rude towards HIV-positive women during delivery. For these reasons, HIV-positive women in Zimbabwe did not disclose their status in antenatal and maternity clinics (Feldman et al., 2002).

Box 11: Recommendations and suggestions: reducing discrimination and Stigma

When HIV testing is part of routine activities in RH clinics, the stigma associated with having a positive test result decreases. Further research is needed on “opt out” policies (whereby those who do not wish to be tested for HIV have to explicitly opt out) as opposed to “opt in” policies (explicitly choosing to be tested), in order to measure acceptability, impact, etc.

2.7 Special needs of older women

Older women have specific sexual health care needs, including management of the menopause and screening for cancers. Despite the increasing number of older people worldwide (PAHO, 2004), many health systems are not equipped to meet the needs of older women and remained focused on women in their reproductive years. One of the biggest challenges facing older women is accessibility to services, either because services are targeted at younger women, or because of personal constraints, such as inability to travel independently. Some of the barriers can be addressed by the health system itself, for example, through the establishment of “well woman” clinics aimed at older age groups. The Federation of Family Planning Associations of Malaysia has offered services for older women (aged 45–65) since 1991. In addition to menopause management, well woman clinics (run in association with State Family Planning Associations) offer screening services (e.g. for cervical cancer) and provide a wide variety of information and educational materials. Making such materials available at the community level has been found to be a crucial element to programme success: women will come to services only if they know of their existence and understand the benefits of seeking care or being screened (http://www.rho.org/html/older_progexamples.htm#malaysia).

2.7.1 Menopause

A woman’s reproductive years usually end with the onset of natural menopause. Natural menopause is defined as the permanent cessation of menstruation that results when the body produces less oestrogen and progesterone. A woman has reached menopause when she has not menstruated for 12 months. This usually happens between the ages of 45 and 55 years (WHO, 1994). Symptoms of menopause vary widely in degree and duration. The medical definition of menopause has in recent years been criticised for not recognizing the social and cultural aspects of this transition period in women’s lives. Biomedical definitions of menopause have given way to a broader view of menopause as a syndrome characterized by a variety of signs and symptoms associated with decreased levels of oestrogens in the body (Dos Reis & Alves, 1999).

Menopause is part of the ageing process and does not in itself require therapy. Many women in developed countries, however, seek preventive treatment for the symptoms of menopause and to prevent bone loss. Hormone therapy (HT) is sometimes prescribed for short-term relief of menopausal symptoms or for long-term preventive therapy, primarily for osteoporotic fractures and cardiovascular diseases (WHO, 1994b). Recent evidence however has brought into question the safety of the use of HT over the long term. As a result, the US National Institutes of Health recommends that if a woman, in consultation with her provider, decides to use hormone therapy, it should be as the lowest dose that helps and for the shortest time needed (<http://www.4woman.gov/menopause/menopause.cfm>).

In developing countries medical treatment of menopausal symptoms is often available only through private clinics, if at all. This may be because the menopause is not considered a medical condition for which treatment is needed or because preventive treatments are considered to be beyond the resource capacity of the public health system. Women themselves may prefer traditional or herbal or other natural remedies (<http://nccam.nci.nih.gov/health/alerts/menopause>).

2.7.2 Screening for cervical cancer

Cervical cancer is the second most common cancer among women, with almost half a million new cases each year. Screening by cervical smear plus adequate follow-up therapy can achieve major reductions in both incidence and mortality rates. A recent review of screening and programme strategies for prevention of cervical cancer in developing countries (WHO and ACCP, 2003) concurred with previous recommendations about targets for screening. In summary, it recommended that, where resources are limited, every woman should be screened at least once in her lifetime at around 40 years of age. When more resources become available, women should be screened every 5 years between 35 and 55 years of age. As more resources become available, the target age group should be extended first upwards (to age 60) and then downwards (to age 25).

Screening strategies for cervical cancer are neither 100% sensitive nor 100% specific; in addition screening is unable to distinguish between cervical lesions that will progress to cancer and those that will regress naturally. Nonetheless, screening programmes have been shown to be effective in reducing mortality in women. Pap smear screening is the only approach currently recommended by WHO. PAP smears are generally used for screening only in middle- or high-income settings. Options for screening approaches that are suitable for use in low-income settings are urgently needed: visual inspection with acetic acid (VIA) is showing great potential in this regard. Screening should only be done where treatment is also available.

Family planning clinics may offer an opportunity to screen women for cervical cancer, as they are one of the few health sites where women regularly seek care. However, in order for cervical cancer screening in FP settings to be effective and efficient, there are several programme issues to be considered:

- Women in the community must be involved in programme design, implementation and evaluation. Programmes work best when they have community support.
- The age range of women attending the family planning service must be compared with the age range of women targeted for cervical cancer screening. In general, women over 35 years are the primary targets of cervical cancer screening programmes. An assessment is needed at the local level of whether these women attend FP clinics. If women over 35 are not coming to the FP services, active outreach will be needed to encourage the population to come for screening. Providers will also need to undertake screening actively and not periodically. Such efforts are currently under way in Colombia, where a national cervical cancer control programme has been operating since the 1990s. The programme's objectives include provision of Pap smears to women up to 69 years of age. One of the major challenges facing the programme is to reach these women, since most cervical cancer screening has traditionally been available to women under 35 years of age (http://www.rho.org/html/cxca_progexamples.htm#Colombia). In Thailand, women in one rural

district are being reached through a mobile screening programme, which works in collaboration with existing health services. The mobile teams target women over the age of 25 years (and especially over the age of 45 years) and in the pilot district the mobile service has become the most common source of Pap smears for women in the older age groups (http://www.rho.org/html/cxca_progexamples.htm#thailand)

- Effective follow-up mechanisms should be developed. Most cervical cancer screening programmes require women to make one or more follow-up visits (to receive the diagnosis, to initiate treatment, for post-treatment check-up, etc). Monitoring of follow-up visits is an integral component of screening programmes; at the same time, the number of follow-up visits required should be kept to a minimum.
- Regulatory barriers to screening programmes should be removed (e.g. if FP clinics are staffed by nurses, are they allowed to carry out screening?).
- Health care providers need to be trained to ensure a high skills level. Training and supervision should not be limited to screening procedures alone, but should include communication and counselling skills. In addition, in some settings, health workers can be trained in the treatment of women with precancerous lesions; in general, these women can be treated using relatively simple outpatient procedures that can be made available in some FP clinics.
- Referral systems for women requiring more specialized treatment should be strengthened.
- Supplies necessary for both diagnosis and treatment (if feasible) must be available.

2.7.3 Screening for breast cancer

Breast cancer is the most common form of cancer among women. Three types of screening are currently in use, either alone and in combination: mammography, physical examination of the breasts by a trained physician, and self-examination of the breasts. If facilities exist, screening by mammography alone, with or without physical examination of the breasts, plus follow-up of individuals

with positive or suspicious findings, will reduce mortality from breast cancer by up to one-third among women aged 50–69 years. Much of the benefit is obtained by screening once every 2–3 years. There is limited effectiveness for women aged 40–49 years. Unfortunately, mammography is an expensive test, and great care and expertise are needed both to perform it and to interpret the results. It is therefore currently not a viable option for many countries. (WHO, 2002f).

Although there is inadequate evidence that physical examination of the breasts as a single screening modality reduces mortality from breast cancer, there are indications that good clinical breast examinations by specifically trained health workers can play an important role. While some studies have found breast self-examination to be of benefit, a randomized trial of breast self-examination in China did not find a reduction in breast cancer mortality after long-term follow-up. This suggests that a programme to encourage breast self-examination alone would not reduce mortality from breast cancer. WHO does not recommend that national cancer control programmes should promote screening by breast self-examination. Rather, programmes should encourage early diagnosis of breast cancer, especially for women aged 40–69 years who are attending primary health care centres or hospitals for other reasons, by offering clinical breast examinations to those concerned about their breasts and promoting awareness in the community. If mammography is available, the top priority is to use it for diagnosis, especially for women who have detected abnormalities by self-examination. Mammography should not be introduced unless resources are available to ensure effective and reliable screening of at least 70% of women over 50 years of age (WHO, 2002f).

Attempts to strengthen breast cancer diagnosis and treatment centres in the Ukraine, through the Ukraine Breast Cancer Assistance Project, produced mixed results. The project provided training and information materials for health workers and patients on diagnosis, treatment and psychosocial support for breast cancer survivors. It also strengthened the health infrastructure and the norms, standards and protocols for breast examination, mammography and chemotherapy regimens. Despite the

significant investment in medical training and positive lessons learned regarding the feasibility and cost-effectiveness of team approaches to clinical care and the establishment of psychosocial support groups for cancer survivors, the project and its approaches were not sustainable without external support. Low-resource countries that aim to improve management of breast cancer thus need to consider which aspects of clinical care can be best addressed within the resources available (http://www.rho.org/html/older_progexamples.htm).

Services for Men

Summary

The past decade has witnessed a move away from women-only population programmes, first to involving men in family planning and other reproductive health services through a sense of solidarity and responsibility, then to programmes that aim to meet men's own sexual and reproductive health needs. More recently, programmes have emerged that attempt to address women's and men's reproductive health needs in a gender-equitable way.

Role of the health sector

There has been a proliferation of programmes that encourage men to take a more active role in services that were previously targeted at women. Many of these programmes are successfully involving men in family planning services, encouraging them to accompany their pregnant partners to antenatal care appointments and, in some cases, improving their parenting skills. Such interventions aim to improve men's understanding of women's reproductive health (e.g. to recognize danger signs in pregnancy), or to change men's behaviour (e.g. to increase male participation in contraceptive use). In some settings, emphasis is placed on counselling of couples.

In addition, some programmes have provided sexual health services and interventions for men themselves. These tend to focus on STI management or STI/HIV prevention. Because STI treatment is mainly provided in the private sector some programmes have focused their efforts on working with private providers in order to reach men. In many cases, men have been successfully reached through interventions in workplaces, sports settings, etc.

Evidence and recommendations

Health care providers have a role in helping couples discuss sexual issues. Communication between partners is associated with greater and

more consistent contraceptive use. Men currently account for only one-third of contraceptive users, but surveys often find that they would like to play a greater role. However, the involvement of men in decision-making processes should not be at the expense of women's autonomy. An understanding of power dynamics within couples may help providers to improve joint decision-making processes.

In many settings men have little understanding of women's reproductive health issues, and especially the risks associated with pregnancy and delivery. Research has shown that both maternal and child health outcomes (including mortality rates) can be improved through programmes that raise the awareness of male partners about obstetric issues and possible complications.

In many settings, men have SRH needs that extend beyond the realms of increasing their involvement in RH services for their female partners. In addition to clinical services, men's sexual and reproductive health needs include: broader sexual health services, including psychosexual counselling; interventions to address substance use and abuse; counselling and education on gender-based violence; and help with father-child relationships. Despite this wide range of expressed needs, a large number of programmes for men continue to focus exclusively on provision of STI services and STI/HIV prevention. Some services, however, aim to make men aware of gender dynamics and to influence prevailing social norms. STI services for men tend to be successful if syndromic management algorithms are applied. The effectiveness of partner notification linked to these programmes has not, in most cases, been evaluated. A systematic review of interventions to prevent STI/HIV transmission among men who have sex with women identified a number of successful strate-

gies to modify men's risk behaviour and to reduce STI incidence (e.g. skills-based motivation and training sessions, video-based education, etc.). No single consistently successful method of influencing men's sexual risk-taking behaviour can be identified. In general, however, many programmes have shown that it is possible to change men's attitudes and behaviour in a positive way, but that it often requires a long-term commitment and repeated interventions.

Needs

There are still relatively few programmes that take into account issues of gender equity when addressing men's involvement in sexual and reproductive health services. Many programmes focus on partnering with men to improve women's reproductive health outcomes; some programmes focus solely on men (usually with the aim of reducing their risk of STI/HIV transmission). Programmes that aim to improve sexual and reproductive health outcomes for both men and women in a gender-equitable way are now being designed, but few have been assessed or evaluated. There is a need to implement and evaluate more of these types of intervention.

The issue of involving men in reproductive and sexual health services has received considerably more attention over the past decade than previously. Greene (1999) described a shift away from women-only population programmes, first to involving men in family planning through a sense of solidarity and responsibility, then to programmes that aim to meet men's own sexual and reproductive health needs, and finally to an approach in which both women's and men's reproductive health needs are promoted.

Many of the programmes have the explicit aim of reaching men in order to improve health outcomes for women and children (e.g. through MCH and antenatal care), or for couples (through FP initiatives). Relatively little attention has been given to involving men as clients of sexual and reproductive health services in their own right (AGI, 2003). The following section reviews programme experience of involving men in family planning and maternal and child health, and of providing services explicitly for men.

3.1 Involving men in FP and MCH services

“Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning” (ICPD, 1994).

In the past decade, there has been a proliferation of programmes that encourage men to take a more active role in services that were previously targeted at women. Many of these programmes are successfully involving men in family planning services, encouraging them to accompany their pregnant partners to antenatal care appointments and, in some cases, improving their parenting skills.

3.1.1 Male involvement in FP

The ICPD Programme of Action highlighted the roles and responsibilities for family planning of both women and men, recognizing that male attitudes towards contraceptives are important for preventing both unwanted pregnancy and STI/HIV infection.

Studies have shown that, in some settings, both men and women see family planning as a shared responsibility. For example, in a study in Kenya, 89% of women and 87% of men interviewed said that they would like both partners to be present during family planning consultations. Providers were also in favour of partners participating in counselling (Muia et al., 2000).

Providers have a role in helping couples discuss sexual issues. Communication between partners helps them to define and meet their reproductive goals, and is associated with greater and more consistent contraceptive use (Terefe & Larson, 1993; Murphy et al., 1999; Blanc, 2001). In an ideal situation, the partners in a sexual relationship would share the responsibility for contraception (if birth spacing or limiting the number of children is desired). However, the responsibility for using a contraceptive often falls upon only one partner in the relationship (www.engenderhealth.org/wh/mhf/emkey.html). Although men account for only one-third of contraceptive users (Gallen et al, 1986), surveys often find that they would like to play a greater role. A few methods are male-controlled – condoms, withdrawal and vasectomy – but involvement of the male partner can also increase the effectiveness of female-controlled methods (www.engenderhealth.org/wh/mhf/emkey.html). However, it has to be recognized that, in many cases, family planning services are not available or attractive to men. When appropriate, providers should learn to think of the couple as their clients and take both men's and women's needs into account (Cohen & Burger, 2000).

Providers are challenged to rethink male involvement in contraceptive use (Moore & Helzner, 1996). Men, women and even health care providers may implicitly taken the attitude that preventing pregnancy is a woman's responsibility (Meyer et al., 2002; Brown et al., 2001; Ahlberg et al., 2001). Providers may even be biased against certain contraceptives that are predominantly used by men; for example, provider bias against vasectomy is relatively widespread in some settings (Ringheim, 2002; AGI, 2003). Despite this, in research undertaken by EngenderHealth in Kenya, the majority of men expressed interest in getting further information on vasectomy, even though only one-third of them had previously heard of it. One-third said they would consider having a vasectomy once they

had their desired number of children (Lynam et al., 1993). However, the study also found a high level of misconception about vasectomy, among both men in the study population (who confused the procedure with castration) and service providers themselves. Additional research carried out among men who had had vasectomy found some who reported being discouraged and sometimes humiliated by service providers. The researchers involved in this study emphasized the need to inform and educate service providers as well as the general population.

On the other hand, where men are seen as the decision-makers and tend to control women's reproduction and sexuality, providers should be careful that involving men in family planning does not threaten women's rights and autonomy. They should ensure that both partners express their views during counselling, or take time with one of the partners alone when needed. Programmes should still provide contraceptives to women who wish to use them privately or covertly (Murphy et al., 1999). It has been reported that providers give greater attention and respect to male clients, to the detriment of female clients, both individually and as couples (Ringheim, 2002). Providers have to learn about the dynamics of power within relationships in order to deal with them more effectively (Moore & Helzner, 1996; Ringheim, 2002). For example, one study has reported that use of hormonal methods or an IUD may limit women's ability to refuse to have sex, since they are protected against pregnancy at all times (Moore & Helzner, 1996). It has also been found that some men react violently to their partner's expressed wish or practice regarding the use of contraceptives. Stewart et al. (1998) argue that non-consensual sex is an important risk factor for unwanted pregnancy and STD/HIV infection.

Research is continuing regarding men's understanding of their roles as sexual partners and as fathers; their choices with regard to fertility and contraceptive use; and how partners affect each other's use of reproductive health and family planning information and services. Efforts to help sexual partners talk about sexual and reproductive health matters occur mostly at the community level. At the service level, there are not yet many examples of male

Box 12: Recommendations and suggestions: male involvement in FP

Programmes should enable, encourage and educate men to use family planning services and family planning methods. Involving men as responsible partners in family planning decision-making can lead to more consistent use of family planning. However, the involvement of men in decision-making processes should not be at the expense of women's autonomy. An understanding of power dynamics within couples (where appropriate) may help to improve joint decision-making processes.

involvement in family planning, and few have been evaluated (Best, 2002).

3.1.2 Male involvement in MCH services

The number of programmes that seek to include men in initiatives to improve the health of their female partners and their children is increasing. In many countries, however, men are not involved in MCH services and few staff members see the benefit of male involvement. Various initiatives¹ have tried to strengthen men's involvement in safe motherhood, with the aim of increasing programme effectiveness (where men are service gatekeepers) or gender equity (men supporting their partners and, to a lesser extent, strengthening their role as fathers).

In many settings men have little understanding of women's reproductive health issues, and especially the risks associated with pregnancy and delivery (Bloom et al., 2000; Ntabona, 2001). Research has shown that both maternal and child health outcomes (including mortality rates) can be improved through programmes that raise the awareness of male partners and others of obstetric issues and possible complications (Roth & Mbizvo, 2001).

¹ See, for example, reports on: the Population Council Frontiers Project (Ringheim, 2002); the Warmi project in Bolivia (Howard-Grabman, undated); India (Khanna et al., 2000); Egypt (Clark et al., 1999); and Pakistan (MotherCare, 2001)

For example, the Pati Sampark (“meeting husbands”) programme of the Deepak Charitable Trust in Baroda, Gujarat State, India, found that outreach workers who targeted the husbands of pregnant women succeeded in increasing the number of antenatal visits from an average of 2 or 3 to 6 or 7 times per pregnancy. The outreach workers spoke to the husbands about various aspects of antenatal care, safe pregnancy and motherhood (e.g. screening in pregnancy, tetanus toxoid, the need for and use of supplements, obstetric care, etc.). Husbands of women with a high-risk pregnancy were given information on management of the pregnancy and the need to seek care (http://www.rho.org/html/menrh_progexamples.htm#india-nan-desari).

Also in Gujarat, the SEWA rural programme has had success in increasing men’s involvement in their wives’ pregnancies. Health worker visits are scheduled around men’s timetables, and families are sent postcards to remind them of antenatal appointments and the expected date of delivery. The programme has been running since the mid-1990s, and SEWA reports a 40% increase in the number of men who register their wives early for ANC. In addition, husbands accompany their wives at 1 in 3 ANC visits, and there has been a noticeable increase in the number of men bringing infants for immunization (http://www.rho.org/html/menrh_progexamples.htm#india).

The Population Council’s “Men in Maternity” Programme in New Delhi, India, has several components: counselling around issues related to healthy pregnancy, danger signs in pregnancy, and postnatal family planning; improving knowledge about STIs; and syphilis screening (and treatment of those found to be infected) for both men and women. The results of this intervention are not yet available (Frontiers, 2002)

Fewer programmes and interventions are available to support men as fathers. A handful of organizations in South America and the Caribbean address this area (e.g. Fathers Inc. in Jamaica, Papai in Brazil, and CORIAC in Mexico), but it is a relatively neglected area. These programmes use a peer educator approach to encourage men to become involved with their children and to expand their notions of being a husband and father (UNFPA, 2003).

3.2 SRH services for men

Like women, men need to be encouraged to take greater care of themselves, their partners and their family, and to learn to talk about sex, sexuality and sexual health risks with their partners (UNAIDS, 2001; Mane & Aggleton, 2001). In a studies among rural and urban poor in Maharashtra, India, a substantial proportion of men reported sexual health problems. The authors argued that these adversely influenced the quality of family life, discouraged men from using contraception, and may have resulted in domestic and sexual violence (Verma et al., 2000).

Men are central to strategies for prevention and management of sexually transmitted infections, a core component of sexual health services. Increased risk of STI transmission is often due to the sexual risk-taking behaviour of men, rather than of women. STIs are generally more easily diagnosed in men than women and partner management may be easier for men than for women in some settings. Given these disparities, it could be argued that STI control strategies that do not focus at least equally on men are doomed to failure. In addition, it is clear that the sexual health needs of men extend beyond the concerns of STI control.

3.2.1 What services are men looking for?

Services for men should be designed on the basis of an adequate understanding of men’s sexual health concerns, the prevalent morbidity, and their health-care-seeking behaviour. In a survey of sexual health concerns in rural Bangladesh, about 17% of 969 men reported psychosexual problems, such as premature ejaculation, impotence, dissatisfaction with sexual intercourse, and difficulties in maintaining an erection, while just over 10% reported symptoms that could be related to an STI. The proportions were similar to the percentages of men in Europe and the USA who reported psychosexual concerns (Hawkes, 1998). When clinics were first established in Bangladesh for treatment of STIs in men, health workers observed that many men sought care for non-physical complaints, including sexual dysfunction. These findings indicate an unmet need for sexual health care for men that STI

clinics usually do not offer. Providing services that meet the expressed needs of men may offer an opportunity to integrate other sexual health interventions (Collumbien & Hawkes, 2000). For example, interventions to address aspects of some men's sexual behaviour could be integrated into clinics established to address sexual dysfunction.

There have been a number of pilot projects for organizing SRH services for men. EngenderHealth (2002b) developed a model for men's reproductive health services, which proposed three types of service:

- Screening, including a sexual and reproductive history, evaluation for cancer and substance use, assessment of mental health, and an age-appropriate routine physical examination.
- Providing information, education and counselling, including on sexuality and physiological development, contraception, STI/HIV/AIDS, genital health and hygiene, interpersonal communication, and sexual and reproductive behaviour.
- Clinical services for sexual dysfunction, STI/HIV/AIDS, fertility evaluation, and vasectomy.

For each service, possible interventions were specified that could be considered, depending on the capacity of the health service and the providers. Provider capacity is an important limiting factor in low-income countries. Except for basic information and counselling (on sexuality, fertility, contraception, STIs, hygiene, responsible sexual behaviour and sexual relationships), and treatment of STIs, most interventions need referral for advanced clinical examination and treatment or specialized therapy.

Others have proposed specific actions concerning men's needs:

- Educate men on specific sexual health topics related to their cultural environment. For example, in a number of Asian countries, many men suffer because of misconceptions about semen loss and masturbation (Collumbien & Hawkes, 2000).
- Address the concerns of men about condom use, such as the fear of losing an erection while putting the

condom on (Population Council, 2001).

- Promote correct and consistent condom use (UNAIDS, 2001).
- Address fears and concerns about vasectomy, including misconceptions about the effect the procedure may have on sexual performance (AGI, 2003).

Despite the growing information on masculinity, sexual behaviour and sexual health needs, there is still much uncertainty about how best to organize sexual health services that respond to the needs of men.

Box 13: Recommendations and suggestions: services for men

Men are key allies in programmes that aim to achieve gender equity and improved sexual and reproductive health for all. To date, many programmes have involved men as partners of women rather than as primary stakeholders in their own right. Men have their own sexual health needs. Programmes to address men's sexual health needs may be a suitable entry point to initiate interventions aimed at improving the sexual and reproductive health needs of their female partners. Evidence to support this hypothesis is still lacking and further research is needed.

3.3 Prevention and management of STIs in men

STIs are transmitted more easily from men to women than from women to men. It is estimated that women are twice as likely as men to become infected by a number of STIs, and four times more likely to become infected when exposed to HIV (Jones & Wasserheit, 1991; Harlap et al., 1991; Aral, 1993). The greater efficiency of transmission in women is mainly determined by the physical and physiological characteristics of the female genital tract. In addition, women's risk of STI/HIV transmission may be increased in settings where they have little power within their sexual relationships, and are unable to refuse sexual intercourse or protect themselves against infection (Greene & Biddlecom, 1997; Moses et al., 1994).

In many settings, it is the sexual behaviour of men that places both men and women at risk of STI/HIV. Social and cultural norms may condone or even encourage men to seek sexual relationships before or outside marriage. In addition, many men may be at increased risk of STI/HIV transmission because of their work-related mobility, e.g. if they are away from home for long periods, or are forced to migrate in search of work.

Given the central role that men play in both transmitting and preventing the spread of STIs and HIV, many programmes are now focusing on involving men, both in their own right and as sexual partners of women. A recent systematic review of interventions with heterosexual men found that several were successful in reducing the incidence of STI (Elwy et al., 2002). These interventions reached men in a number of different sites, such as the workplace, clinic settings, and the general population, through mass communications programmes.

Within clinic settings, a variety of methods have been successful in reducing men's risk behaviour and decreasing incidence of STIs, e.g. special counselling sessions on behaviour change and condom use, or video-based education. In addition, men have been reached through outreach activities in workplaces, sports settings, etc. No single consistently successful method of influencing men's sexual risk-taking behaviour can be identified. What works in one setting may not work in another setting. For example, while mixed sex group counselling sessions may be successful in some societies, they may be entirely inappropriate elsewhere. In general, however, many programmes have shown that it is possible to change men's attitudes and behaviours in a positive way, but that it often requires a long-term commitment and repeated interventions (Elwy et al., 2002).

Another strategy employed, less successfully, has been to target private sector providers and pharmacists for STI control. In Africa, training of private sector health workers and pharmacists in syndromic management of STIs has proved disappointing. In Ghana, while prescriptions improved slightly after pharmacists had been trained, fewer than half of the simulated clients who visited 96 pharmacies received correct treatment, and not one was

advised to use a condom (Adu-Sarkodie et al., 2000). Moreover, in most developing countries the number of trained pharmacists is low. Health advice is most frequently given by untrained assistants (Adu-Sarkodie et al., 2000; Goel et al., 1996).

In Hlabisa, South Africa, where half of all STI patients are seen in the private sector, initiatives for training of private providers did not improve STI care (Wilkinson, 1999). Attending training sessions and meetings is seen as a loss of time and income. Private practitioners are reluctant to meet their colleagues, with whom they are in competition. Training is also no guarantee that private providers will change their treatment practices; indeed, in one study, practitioners who received training in the public sector did not apply the same treatments in their private practice (Brugha & Zwi, 1999).

Box 14: Recommendations and suggestions: prevention and care of STIs in men

Given that, in many settings, it is the behaviour of men that places women at increased risk of STIs, including HIV, successful interventions to reduce risk for men may also reduce the burden of disease for women. Such interventions need to be carefully evaluated, including, wherever possible, measurement of the impact of the intervention on STI incidence. Interventions that target private providers may not help prevention and control strategies for STIs unless public providers are also involved. Training must be accompanied by repeated messages and monitoring to ensure compliance.

3.4 Integration of services for men

A substantial number of projects worldwide now focus on the SRH needs of men. They aim to increase men's knowledge of SRH issues, make them aware of gender relations, and influence social norms. Programmes may focus on issues such as gender-based violence, building self-esteem, responsible sexual behaviour and safe sex, helping men talk about sex and relationships, and discrimination against men who have sex with men (UNAIDS, 2001). Much work is being done to understand the influ-

ence of gender on SRH. Most of these projects are community-based, although coordination with services may be established, and many are undertaken by NGOs (Ringheim, 2002; Raju & Leonard, 2000; AVSC International & IPPF/WHR, undated).

The first UNFPA-sponsored initiatives for separate clinics for men were not very successful. Setting up separate services for men was expensive and few men attended (UNFPA, 1999a), making the clinics unsustainable in the longer term.

The success of the “On Clinics” in Israel, a private sector network of clinics that offer quality sexual health care to men of all ages, also reflects the evident need for such services (<http://www.onclinic.co.il/english/first.htm>).

The clinics advertise on radio and television, focusing on sexual dysfunction, touting the quality and experience of their health staff and therapists, and guaranteeing discretion and confidentiality. Their advertising and intervention have influenced the whole private sector approach to sexual health in the country (I Schenker, 2002, personal communication).

The Colombian NGO, Profamilia, has extensive experience with special SRH services for men, partly as separate clinics where the expected number of clients was high enough, partly in facilities shared with women’s services. Even with a broad range of services¹ and much attention to quality of care, the number of clients in the three stand-alone men’s clinics was never more than 5–10% of that in the clinics for women. The NGO found that simply offering services to men was easier than changing staff attitudes, but missed the gender perspective necessary to address prevailing gender stereotypes. In the end, Profamilia decided it was financially unsustainable to maintain stand-alone services for men, except in Bogota. Now all staff serve both men and women and are being trained to be sensitive to the specific needs of both sexes. Also, while the NGO aimed to reach low- and middle-income men,

it mainly attracted middle-class men with higher-than-average education levels. The question thus remains as to how to reach those perhaps more in need but less “ready and sensitised” to receive the services (<http://www.profamilia.org.co/>).

A study from rural Bangladesh (Hawkes, 1998) detailed the establishment of special sexual health clinics for men within the existing MCH/FP system. The study found that the clinics met a need for STI services, but also for a number of other SRH services including psychosocial health care and contraceptive services (including vasectomy). It also found that most men actually sought care in the private sector, so that provider training in that sector needs to be considered.

A number of programmes for men have the explicit aim of challenging gender norms, either alone or in combination with other interventions. Many of these programmes aim to reduce health risks associated with violence and unsafe sexual behaviour by addressing gender as a determinant of risk and morbidity. A review of many of these programmes concluded that there were few substantive evaluations, and that outcome measures tended to focus on health rather than gender norms (White et al., 2003). Nevertheless, positive examples of addressing men’s gender norms were identified. One such programme is Programme H, which aims to promote sexual and reproductive health and gender equity among young men in Bolivia, Brazil, Colombia, Jamaica, Mexico and Peru. Using a number of techniques, including actively involving men in assessing negative aspects of current gender norms, and social marketing of a gender-equitable lifestyle. The programme has reached young men (aged 15–24 years) in low-income populations in these six countries. Evaluation results show improvements in reported attitudes to gender equity and gender-based violence among others (Nascimento, 2003).

3.5 Increasing access for men

Barker (2002,) has highlighted the importance of targeting programmes to specific groups of men, characterized by, for example, age, ethnicity, sexuality, income, educational

¹ Among these services, family planning catered only to around 16% of men (compared with over 35% of women); the need for a wide range of services was evident, i.e. urology, infertility service, sex therapy, general medicine, outpatient surgery, laboratory services, STI testing and treatment, and family planning, including vasectomy (Profamilia, undated).

status, occupation, geographical location, position within the family, access to information, and ability to put information to use (Hawkes & Hart, 2003). Certain men may be particularly at risk of sexual ill-health, both because of their exposure to an environment that has high levels of risk and because of their lack of access to prevention and care programmes. For example, men who have sex with men, migrant and men with high levels of mobility (including refugees), disabled men, men in prison, men who sell sex, men who use drugs, and men living with HIV/AIDS are likely to have specific needs for sexual health services. In addition, at different times in their lives, men have very different sexual health care needs.

3.5.1 Reaching men outside the clinic

A systematic review (Elwy et al., 2002) found three interventions in the workplace that had succeeded in improving men's knowledge and attitudes, and reducing sexual risk behaviours. One such intervention was with trucking company workers in Kenya, which resulted in a significant reduction in STI incidence, and a decrease in the number of sex partners of the men. The intervention included an on-site counselling and HIV-testing centre at the trucking company. Individual sessions with the men focused on negotiation skills, demonstration and promotion of condom use, and counselling on HIV/STI risk reduction (Jackson et al., 1997).

The Healthy Highways Project in India targets truck drivers and commercial sex workers. The project operates with more than 30 NGOs and 18 transport companies, and reaches about 3.5 million men. Truck drivers appreciate the services, such as STI treatment and counselling, condom promotion and distribution, education and counselling for individual behaviour change and, especially, information and advice (UNAIDS, 2001).

UNFPA experience has shown that men can also be reached with condom programmes that rely on community-based distribution workers, social marketing programmes, and efforts to make condoms available and accessible in places frequented by men (bars, hotels, workplace, etc.) (UNFPA, 2003).

In the Dominican Republic, barbers have been trained in STI/HIV prevention, condom promotion, and referral of men with signs of STIs to health clinics (UNFPA, 2000). They received training in communication skills and demonstration of condom use. In India, more than 250 000 barbers have been trained to promote condoms (Cohen & Burger, 2000).

3.6 Services for men who have sex with men

Services for men who have sex with men (MSM) are often focused on STI and HIV prevention and care. While this is an important and central part of the health care needs of MSM and their (male and female) sexual partners, a wide range of other health issues should also be addressed in a comprehensive sexual health service. For example, in addition to the increased risks of STIs and their complications – including anal cancer linked to sexually transmitted human papilloma virus – men who have sex with other men may be more at risk of psychological stress and its associated problems (Knight, 2004). They may also be at increased risk of hepatitis virus infection (especially hepatitis A and B); in industrialized countries, immunization against these infections is routinely recommended for MSM.

Stigma, discrimination, fear and experiences of outright hostility can often prevent men who have sex with men either seeking health care, or revealing the real nature of their risks and sexual practices to health care providers. Discriminatory practices in health services may be covert rather than explicit. For example, health workers may not be trained to ask men (or women) about the sex of their sexual partners, and may assume that all clients are exclusively heterosexual. The Centers for Disease Control and Prevention in the USA have recommended that sexual risk histories in men should routinely include a question on the sex of any sexual partner (CDC, 2002).

There are examples of sexual health services being successfully established in developing countries for men who have sex with men. The Bandhu Social Welfare Society of Dhaka, Bangladesh, was established to promote sexual health among MSM and their female partners. The activi-

ties of the NGO include STI treatment and promotion of sexual-health-seeking behaviour. Much of the work of the Bandhu centres involves outreach activities to men who are vulnerable and at risk; the men contacted are encouraged to attend the clinics, which are staffed by trained health workers (<http://www.hivnet.ch:8000/asia/bangladesh/viewR?43>).

In countries where it is not possible to openly offer services for MSM, other strategies can be employed. A project in prisons in Turkmenistan was successful in reaching men who had sex with men, with condoms and health promotion messages about violence and safe sex. Run by a local NGO, Force for Change, the project characterized the intervention to local and prison authorities as a generic male sexual health project (ostensibly related to the men's conjugal visits with their wives and partners). It was implicitly understood that it was to help the prisoners and guards have safer sexual relationships among the male-only population in the prisons (UNFPA, 2004).

Addressing the needs of men who have sex with men is an area often fraught with arguments based on value judgements that make it difficult to provide non-discriminatory and non-stigmatising services. However, the risk to the health of these men and their male and female sexual partners is clear: both increased risks associated with unsafe sexual behaviours, and higher rates of psychological distress. Services for MSM, as for all population groups, need to be non-discriminatory, non-stigmatising, accessible and acceptable in order to be effective in reducing the burden of ill-health.

3.7 Special needs of older men

As men grow older they have different needs related to their sexuality and sexual health. They are more likely to need medical care, such as treatment for sexual dysfunction or diagnosis and management of cancers of the reproductive system.

International surveys of the prevalence of erectile dysfunction (ED) find that it is a surprisingly common condition among men in all societies where studies are conducted (Prins et al, 2002). The likelihood of men reporting ED

has been found to be associated with a number of characteristics of the men interviewed, most commonly with increasing age in a number of countries: Egypt (Seyam et al, 2003), Nigeria (Fatsui et al, 2003), Pakistan (Shaeer et al, 2003), Morocco (Berrada et al, 2003), Iran (Safarinejad, 2003). Population-based surveys of men in Brazil, Italy, Japan and Malaysia found an association between ED and depression, a link that increased with age (Nicolosi et al, 2003). Perhaps as a result of the association between ED and depression, men with ED in Egypt were found to report a lower quality of life compared to men without ED (Seyam et al, 2003); However, caution should be exercised in the interpretation of these findings since cross-sectional survey results do not allow for causality to be established: are men depressed because they have ED, or does depression predispose to ED?

Often, older men do not seek formal medical care, as they fear it may appear to be a sign of weakness (<http://www.menshealthforum.org.uk/>). In addition, in developing countries, men often use the non-formal health sector (traditional providers, herbal remedies) to address their sexual health care needs. There is, nevertheless, reason to believe that men might be willing to seek care for sexual health problems from the public health system, were it widely available.

3.7.1 Male sexual dysfunction

Male sexual dysfunction appears to be a widespread problem; it can affect men at any age, but usually occurs later in life. It is a complex problem and can be affected by physiological, psychological, interpersonal and behavioural factors. In community-based studies in the United Kingdom and the USA, over 35% of men reported premature ejaculation, 4–9% reported erectile dysfunction, and 4–10% reported inhibited orgasm (Spector & Carey, 1990). The Massachusetts Male Ageing Study in the USA suggested that 9.6% of men between the ages of 40 and 70 years suffered from complete erectile dysfunction and a further 25% had moderate dysfunction. (Holmes, 2000). Figures such as these highlight the demand for interventions that address these conditions, which can have a profound psychological impact on well-being (Tomlinson & Wright, 2004).

In many countries, the private health sector meets the demand of men for drugs to treat erectile dysfunction and poor or reduced sexual performance. The market success of these drugs may be the most significant evidence of a high prevalence of erectile dysfunction in older men in developing countries.

As with other services for men, lack of access remains a problem. Sexual health services, whether delivered through reproductive health services traditionally targeted towards women or through the primary health care system, must find ways to address the needs of men. The PLISSIT Counselling Model (Annon S. 1974 in Gordon G. and Gordon P, 1992) may be a useful way to integrate services for male sexual dysfunction in other service settings. It includes informed consent, some provision of information, and counselling with recommendations for interventions.

3.7.2 Screening for prostate cancer

Cancers of the reproductive tract, especially prostate cancer, become more prevalent as men age. Prostate cancer is the third most prevalent cancer in men (543 000 new cases per year) and the sixth most common in developing countries (Globocan, 2000).

Screening for prostate cancer using digital rectal examination is not sensitive for early disease. More sensitive screening tests (including measurement of serological levels of prostate-specific antigen and transrectal ultrasound) require high levels of resources and logistic support. Many obstacles to finding a widely accessible and available screening method for prostate cancer therefore remain.

Services for adolescents

Summary

The emerging emphasis on adolescent sexual and reproductive health is based on an increasing recognition of the challenges that adolescents, particularly girls, face. It is estimated that at least one-third of sexually transmitted infections occur in young people under 25 years of age, and that half of all new HIV infections are in people aged 15–24 years. Of the 19 million unsafe abortions worldwide each year, 18.5 million take place in developing countries; and 14% of these are performed on girls aged between 15 and 19 years.

Economic, social and individual factors affect the ability of adolescents to negotiate their sexual and reproductive lives. Poverty, lack of access to SRH services, vulnerability to coercion and sexual violence, and gender power relations put young women at high risk of unwanted pregnancy, unsafe abortion, and STIs, including HIV. Adults' reluctance to inform and educate adolescents on matters related to sexuality leaves girls in many parts of the world with fears and questions about menstruation, prevention of pregnancy and HIV/AIDS. Left to their own resources, adolescents often pick up misinformation that may affect the rest of their lives. Marriage does not necessarily reduce vulnerability to STI/HIV for adolescent girls, and may increase exposure. Married adolescent girls may have difficulty in negotiating intercourse and use of condoms.

The specific needs of boys and men, beyond the area of sexual health, include programmes to address violence (to self and others), substance abuse, and the wider contextual and economic expectations placed upon them.

Role of the health sector

Service providers worldwide (public sector and national and international NGOs) are evaluating different ways of improving access of young people

to SRH services, with varying degrees of integration in existing RH services. Experiments with different models of service provision for adolescents include creating youth centres, making health facilities “youth-friendly”, improving PHC services to be more responsive to adolescents' needs, and providing counselling and services in schools through community-based distributors and peer educators.

Specific strategies are necessary to expand services to hard-to-reach groups, such as out-of-school and unemployed young people, refugees, young sex workers, street children, sexually abused children, gay adolescents, and drug users. An important aspect to consider in identifying hard-to-reach adolescents is the complex nature of vulnerability. Young people in difficult circumstances often face a number of problems. The most effective programmes are holistic and multi-levelled ones that recognize the complexity and inter-relatedness of health problems

Evidence and recommendations

Programmes need to provide a range of interventions. Young people who have had access to services show clearly improved knowledge and empowerment through skills-building. There is, however, no evidence of reduced risk-taking behaviour or improved health outcomes, and the best approach to providing SRH services for adolescents is still unclear. While linking clinics to schools can be successful, educational policies often do not allow contraceptives to be provided on school premises. Few youth centres offer STI services. One factor affecting the available evidence is the complex nature of multifaceted interventions that are difficult to measure through experimental designs and the time needed to make an impact on larger scale behaviour change.

Recreational activities and computer access attract adolescents to youth centres, but use of health services in these centres for obtaining STI treatment or contraceptives is generally low. Stand-alone youth centres may be difficult to sustain and not cost-effective. On the other hand, integration of services for adolescents into existing reproductive health services may compromise confidentiality and privacy and stretch institutional capacity. In addition, adolescents tend not to use these services. Quality of care and the perception that health workers are experienced are important factors influencing use. Peer education and condom distribution can reach young people who are unlikely to attend clinics. A non-discriminatory, friendly and open attitude of service providers is key to making services acceptable to young people.

Programme evaluations indicate that the creation of SRH services for young people should always be accompanied by sensitisation of adults. Young people are more likely to use SRH services when their social environment encourages it. The participation of young people in developing the best approach and service delivery context will help to ensure that services are acceptable and effective.

Needs

The greatest challenge is to develop guidelines to assist policy-makers and programme managers to plan, implement and evaluate SRH services that are context-specific, and that take into account needs and barriers related to age, gender, and the social and cultural situation. There is a need for more operational research into: the effectiveness of various programmes; best practices that identify aspects of youth centres and clinics that most influence attitudes and behaviour; the cost-effectiveness of different approaches; strategies for scaling up programmes, with attention to reaching different groups with a range of choices for counselling, preventive care and treatment; and differences between the perceived needs of adolescent men and women.

Given the widespread double standards regarding the premarital sexual behaviour of young men and women, there is a need to address contradicting norms and values through community development strategies, and to clarify the way in which gender issues affect access to services.

Meeting the sexual and reproductive health care needs of adolescents often requires specific programme strategies and service interventions. In addition to providing adapted SRH services, there is a need to review the role the health services play in providing information and influencing behaviour in this target group.

Adolescents are a relatively new focus for health services, especially, but not exclusively, in developing countries. The new emphasis on adolescent SRH is often justified as an effective approach for reducing unintended or early pregnancy. Increased rates of STIs and HIV among adolescents have also created a need for urgent attention to their sexual health (WHO, 2002h). The consequences of sexual activity among adolescents are compelling. It is estimated that at least one-third of sexually transmitted infections occur in young people under 25 years of age (WHO, 1999c), and that half of all new HIV infections are in people aged 15–24 years (WHO, 1998b). Of the 19 million unsafe abortions worldwide each year, 18.5 million take place in developing countries; and 14% of these are performed on girls aged between 15 and 19 years (WHO, 2004b).

In adolescent services, special attention needs to be given to fostering a non-judgemental, supportive environment for healthy sexual development and maturation. Dehne & Riedner (2001a) point out that relatively little attention has been given to defining “normal” sexual development of adolescents. Perceptions of adolescent sexuality, as well as sanctioned initiation and sexual practices and behaviour, vary greatly between regions, countries and cultural groups, and between urban and rural populations. Rates of premarital sexual activity among women show similar patterns within regions, but differ widely between regions, ranging from 2% to 11% in various settings in Asia, 12% to 15% in Latin America, and 45% to 52% in sub-Saharan Africa. In some regions, lack of acceptance of premarital sexual activity has meant that data on the practice are not collected. Reported premarital sexual activity is higher among males than females, and shows more variation, both across and within regions (Brown et al., 2001).

4.1 Adolescent girls

Notwithstanding the diversity in sexual practices among adolescents, and in adult perceptions of them, a common feature across cultures is an emphasis on control of female sexuality and of the sexual behaviour of girls and women. It has been argued that, by associating sex with reproduction – put into practice through the promotion of early marriage and taboos on premarital sex – some cultures allow girls and women little control over their sexuality. The corollary, also common in most cultures, is that male adolescents are expected to have premarital sex to demonstrate their capacity as future fathers. The double standards regarding the premarital sexual behaviour of young men and women affect the access to and use of services by the two groups (Brown et al., 2001; WHO, 2001a; Dehne & Riedner, 2001a).

The factors that influence the sexual behaviour of adolescents are context-specific; however, some common trends can be identified. There is increasing evidence that, for girls, poverty is associated with poorer sexual and reproductive health outcomes and earlier sexual activity (Finger et al., 2002). This may be because they turn to transactional sex and early marriage to try to escape poverty and deprivation. In addition, urbanization and globalisation introduce them to norms, values and practices that differ from those of the adults in their community, and often contradict them. One of the most important challenges in seeking to integrate sexual health into reproductive health services is to address the difficulties that adults, including health workers, have in accepting adolescent sexuality. This applies not only to the sexuality of unmarried female adolescents but also to that of homosexual and bisexual individuals.

Both societal and individual factors affect an adolescent's ability to negotiate sexual behaviour, access to SRH services, and vulnerability to coercion and sexual violence. Gender power relations often put young girls at high risk of unwanted pregnancy, unsafe abortion and STI, including HIV (IPPF, 2001). In addition, girls are physically more vulnerable and thus at higher risk of STI transmission, in part because of the relative immaturity of their reproductive tract.

Adults' reluctance to discuss sexuality-related issues with adolescents leaves girls in many parts of the world with fears and questions about menstruation, prevention of pregnancy and HIV/AIDS (Garg et al., 2001). Left to their own resources, adolescents often pick up misinformation that may affect the rest of their lives (IPPF, 2001). Marriage does not necessarily reduce the vulnerability of adolescent girls to STI/HIV, and may increase exposure (Glynn et al., 2001). Married adolescent girls may have difficulty in negotiating sex, including timing and frequency, and use of condoms (Bruce, 2002)

Box 15: Factors that influence the sexual health of adolescents

- Poverty
- Gender relationships and identities
- Contradicting norms and values
- Social and individual factors that affect negotiation skills
- Access to SRH services
- Education on sexuality and sexual relationships
- Vulnerability to coercion and sexual violence

Where early marriage is the norm for girls, this can create additional health risks associated with early pregnancy and mental health problems related to the low status of women (Dehne & Riedner, 2001a; RHO, 2002d).

4.2 Adolescent boys and young men

Adolescent boys may have very little in common with each other except age: heterogeneity and diversity must therefore be recognized (Barker, 2003). Three publications from WHO (2000) emphasise the importance of defining the unmet needs of boys, while Barker (2000) advocated gathering information on the contextual factors that influence patterns of risk and behaviour among boys.

Dominant versions of masculinity place both boys and girls at risk of HIV/AIDS. Boys feel pressured to prove their manliness and sexual prowess. This places girls at risk of

violence and coercion, and encourages boys to take risks and to have multiple sexual partners (Rivers & Aggleton, 2002). Sexual coercion is not uncommon, especially among young women (Brown et al., 2001). However, evidence from South and East Asia suggests that boys, especially street children, are also vulnerable to coercion (Bott et al., 2003, Brown et al., 2001). The specific needs of boys and men, beyond the area of sexual health, include programmes to address violence (to self and others), substance abuse, and the wider contextual and economic expectations placed upon them (Barker, 2003).

4.3 Integration of services for adolescents

Although few adolescent health programmes have been thoroughly evaluated, some lessons are emerging. Of 41 reviewed programmes with a strong research design, 22 were interventions in schools. Of these, three involved an integrated clinic, six were accompanied by mass media support, and five included community interventions. Only four included health facilities, of which three were youth-friendly services (CEMOPLAF, Ecuador; Lomé, Togo; five cities in Zimbabwe); the fourth was a youth centre in Lusaka, Zambia (Speizer et al., 2002).

These experiences indicate that programmes need to provide a range of interventions. Young people who have had access to education and services show clearly improved knowledge and empowerment through skills building. Although many initiatives are too recent for proper evaluation, a randomised controlled trial of school-based, clinic-based and community-based interventions in the United Republic of Tanzania found a positive impact on adolescents' knowledge of STIs/HIV, but no evidence of a reduction in risk-taking behaviour in the short term. In addition, there were no significant differences in biological outcomes (rates of STIs, HIV, and unplanned pregnancy) between the intervention and control groups. The researchers concluded that even an intervention of 36 months may be too short to produce any significant impact on biological outcomes (Ross et al., 2003; Changa-lucha et al., 2003).

4.4 Increasing access to services for adolescents

Service providers worldwide (public sector, and national and international NGOs) are evaluating different ways of improving access for young people to SRH services, with varying degrees of integration in existing RH services.

Experiments with different models of service provision for adolescents include creating youth centres, making health facilities “youth-friendly”, improving PHC services to be more responsive to adolescents’ needs, and providing counselling and services in schools through community-based distributors and peer educators.

Box 16: Models for service provision

- Youth centres
- Youth-friendly services
- Improved PHC services

4.4.1 Youth centres

Youth centres are stand-alone centres that offer a mix of recreational, educational and clinical activities (GTZ, 2002a; Speizer et al., 2002). The package of services offered may be limited to SRH, or expanded to comprehensive health services, as in a proposed project in Peru (GTZ, 2002a) which intends to offer the following:

- recreation and sociocultural animation;
- workshops on self-knowledge and self-esteem, values, relationships, social skills, sexual and reproductive health, decision-making, life projects;
- individual and group counselling;
- specialized care, including obstetrics, medicine, dental care, nutrition, psychology, fertility regulation, and management of STIs and HIV/AIDS.

Services are complemented by community work and collaboration with youth organizations.

Profamilia, the IPPF affiliate in Colombia, has tested various approaches to providing SRH services for young people. Stand-alone youth centres are difficult to sustain in the long term because of the high costs (Senderowitz, 2000). Youth centres are now being attempted mainly in Africa (Speizer et al., 2002).

To attract young people, youth centres provide a range of recreational activities, such as access to computer and Internet services, cafes, clubs, video games, video and music libraries, and skills training. The youth centres evaluated in Ghana, Kenya, and Zimbabwe did indeed attract young people, but most came solely for the recreational activities and the SRH services were not much used (Population Council, 2000). In Lusaka, Zambia, clinics that were appreciated for their attractiveness were not significantly more used (Nelson, 2001). Other youth centres, however, have shown better use of sexual health services and it is too early to draw conclusions. A long-standing initiative in Bangui, Central African Republic, seems to have had a positive impact (see Box 18).

An IPPF evaluation suggested that availability of Internet and computer programs is one of the most effective ways to attract young people, and is a good entry point for discussion. They point out that the improvement of SRH should be central to all recreational activities (IPPF, 2001). Participation by girls and boys differs, but not in a consistent way.

Of the youth centres studied, most have had a positive impact on knowledge and attitudes, but less impact on sexual risk-taking and contraceptive use (Speizer et al., 2002). The cost-effectiveness of well-attended youth centres has not been sufficiently evaluated (Dehne & Riedner, 2001b).

4.4.2 Youth-friendly services

The term “youth-friendly service” usually designates a specific service adapted to young people’s needs within an existing health facility (GTZ, 2002a; PATH, 1998; Speizer et al., 2002a). Youth-friendly services can be provided in a regular health facility, in a separate area that is

Box 17

Central African Republic

The Information Centre for the Sexual Health of Young People (CISJEU) in Bangui, Central African Republic, is a youth centre that works well in attracting young people for recreational and educational activities, and that has seen a substantial increase in use of the health facilities. The centre, which was set up in 1994, offers games, and cultural and sports activities. Prevention of unwanted pregnancy, STIs and HIV/AIDS, female genital mutilation, and sexual violence are the most important subjects of education. These subjects are addressed through drama, role-plays, media activities, a magazine, and group and individual discussions. Young people and representatives of youth clubs are members of the management committee. The clinic offers advice on contraception, treatment for STIs, and other SRH services.

The centre has about 20 000 visitors per year, mostly school attenders aged between 10 and 22 years. More boys (69.4%) than girls contacted the centre in the first half of 1999, but a higher percentage of girls made use of the health facility (20.7% compared with 9% of the boys). In 1999, STI treatment was the main reason for consulting the centre (92%). One sign of the centre's success and acceptance by adults is that 30% of the young people had originally attended at the suggestion of their parents (GTZ, 2002b).

made attractive for young people and has its own specialized personnel (IPPF, 2001; Senderowitz, 2000). A different option is to reserve specific days or hours for youth consultations, as was done in IPPF projects in Guyana and Tonga (IPPF, 2001). Young people, however, often prefer their own separate space, which ensures more privacy.

Integrating youth-friendly services or youth corners in family planning clinics or primary health care facilities is a relatively low-cost approach, and can facilitate access to a wide range of services (Speizer et al., 2002). It has proven successful in various settings, but may stretch the capacity of services (IPPF, 2001).

IPPF evaluated the relationship between the perception of youth-friendliness of services and use. This evaluation confirmed that the main contributing factors to acceptability and use of services are convenient location, flexible opening hours, non-judgemental and sensitive treatment by providers, confidentiality and privacy, and an environment that is appropriate and comfortable for young people. Next to these often described components, the perception that health workers are experienced and offer quality services is an important determinant. Confidentiality, a non-judgemental attitude, and quality of care were also important factors listed by users of a Marie Stopes

youth clinic in Hanoi, Viet Nam (Huong & Kelly, 2002).

These observations suggest that improving quality of care is a strategy to improve utilization as much for young people as for adults.

4.4.3 Improved PHC services

Another approach is to ensure more friendly treatment of adolescents within the general RH services (Senderowitz, 2000). This option requires complete acceptance by all health staff, adult clients and the society as a whole.

In South Africa, the National Adolescent-Friendly Clinic Initiative (NAFCI), a nationwide initiative to improve the response of public health centres to adolescents' health needs, chose not to create separate services for young people, but to take measures to increase their attendance at the regular primary health care services (Dickson-Tetteh et al., 2001). This choice was underpinned by the assumption that stand-alone youth centres would not be cost-effective or sustainable. Moreover, such centres can be set up only in large cities, whereas adapting primary health care centres to the needs of young people may be the only acceptable option in rural areas.

NAFCI defined a package of essential services (see Box 19) that should be accessible to young people, together with standards that each health centre should achieve. An accreditation system was developed to reward the centres that achieved the established standards. Health centre managers are given a self-audit tool to improve the response of their centres to adolescents' needs. During the assessment of the pilot clinics, however, it was found that they needed assistance to improve the quality of care in order to achieve accreditation. Few adolescents attended the services, but it is not clear why.

Box 18

NAFCI package

- Information, education and counselling on SRH.
- Information, education and referral for sexual violence, abuse and mental health problems.
- Contraceptive information and counselling, provision of methods including oral and injectable contraceptives, condoms, and emergency contraception.
- Pregnancy testing and post-abortion counselling and referral.
- Information on STIs, and on dual protection strategies.
- Syndromic management of STIs.
- HIV/AIDS information, pre- and post-test counselling, and referral for VCT if services are not available.
- Partnerships with organizations for outreach activities.

Dickson-Tetteh et al., 2001

Although evidence so far suggests that integration of youth services in health centres and hospitals often fails to attract young people (WHO, 2002g; Poonkhum, 2003), it is too early to draw firm conclusions; more operational research is needed to find ways to make these services more acceptable to young people.

4.4.4 Youth participation

The range of services provided should be based on client needs (Dehne & Riedner, 2001b). Programmes with a strong community-based component tend to be more diverse and to focus on specific local needs, such as providing VCT in Malawi, empowering young women to avoid female genital mutilation in Ethiopia and Guinea, reducing abortion in Mongolia, addressing double standards in Nepal, and promoting sexual rights and combating violence in Bolivia (GTZ, 2002a). Evaluations point to the paramount importance of involving young people in all stages of programme design, development, implementation, decision-making and evaluation. Such involvement increases the responsiveness of services to their needs, creates a sense of ownership and active participation, and improves attendance (GTZ 2002a; Finger et al., 2002; Reproductive Health Outlook, 2004).

For most young people, the cost of transport and consultation fees is an important barrier to access. To keep fees low, youth programmes may need external funding. (IPPF, 2001). Sustaining the involvement of young people in programme management and peer education requires important investments of time and resources.

4.4.5 Sensitisation

Programme evaluations have indicated that creation of SRH services for young people should always be accompanied by sensitisation of adults – from national policymakers to community opinion leaders and parents – to the reality of young people's sexuality (Dickson-Tetteh et al., 2001; GTZ, 2002a; IPPF, 2001; Senderowitz, 2000). In communities that accepted adolescent SRH services, young people were more likely to use them (WHO, 2001a; Nelson, 2001). In Brazil, young people use the regular public health services for contraception, and this is accepted as normal. In the Netherlands, distribution of contraceptives was greatly improved and teenage pregnancy rates were reduced when it became socially acceptable for adolescents to have easy access to confidential SRH services (Berne & Huberman, 1999).

If access of adolescents to SRH services is strongly limited by the adult society, partnerships should be developed with schools and other institutions to promote acceptance (IPPF, 2001; GTZ, 2002a). Where laws and policies prohibit the provision of certain services to unmarried people or to those under a certain age, it may be necessary to lobby for change (Speizer et al., 2002).

4.5 Other interventions to reach adolescents

Although the effectiveness of peer educators in changing behaviour is unclear, many programmes include them as an integral part of strategies for service provision. Active outreach is necessary to create awareness of the existence of services, and to increase acceptance and utilization (IPPF, 2001). In various projects, existing community-based distributors have been trained to reach young people who are not likely to visit health facilities. CBDs provide adolescents with condoms and education, and refer them for clinical care or advice. If the attitudes of health care providers discourage attendance at facilities, adolescents are more likely to purchase condoms from retail outlets (IPPF, 2001; Senderowitz, 2000).

Examples of peer outreach programmes can be found in many diverse settings; for example, in El Salvador, a peer outreach programme with gang members has successfully raised awareness of STIs, HIV and other sexual health issues in this at-risk group. The programme relies on identifying leaders within the gangs themselves (http://www.rho.org/html/adol_progexamples.htm#elsalvador).

Building on young people's existing social networks has also been successful in redefining peer behaviour. A programme in Chiang Mai, Thailand, aims to reach young people in entertainment venues as well as in selected work environments (such as the construction industry). The information offered to the young people is based on an understanding of their needs, fears, knowledge, and risk-taking behaviour, and is provided through their extensive social networks. These networks have been mapped and the relationships between young people in different social settings have been described. This extensive background work has helped in the design of a programme which is reducing risk-taking and promoting protective

behaviour (http://www.rho.org/html/adol_progexamples.htm#thailand).

Individual information can be offered over a telephone hotline, to overcome the problems of face-to-face contact. A national free helpline service of the Planned Parenthood Association of South Africa received 699 952 calls during the first 12 months of its existence. Calls related to boy-girl relationships, family relationships, HIV/AIDS and contraception (Dickson-Tetteh, 2001).

The private sector has so far been neglected in attempts to bring services closer to adolescents (Dehne & Riedner, 2001b). Cooperation with private providers and pharmacists could be useful in increasing access to condoms and in managing STIs.

The impact of the initiatives described above is not yet clear. In the high-prevalence countries of southern Africa, voluntary HIV/AIDS counselling and testing services are becoming progressively more available at affordable prices in the large cities. Research by the Horizons Project in Kenya and Uganda confirmed the interest of young people in VCT. VCT drop-in centres could be used to get information to more young people (Senderowitz, 2000).

4.6 Reaching the most vulnerable

Specific strategies are necessary to expand services to hard-to-reach groups, such as out-of-school and unemployed young people, refugees, domestic workers, young sex workers, street children, sexually abused children, gay adolescents, and drug users (Dehne & Riedner, 2001a; IPPF, 2001; RHO, 2002d). An important aspect to consider in identifying hard-to-reach adolescents is the complex nature of vulnerability. Young people in difficult circumstances often face a number of problems simultaneously, such as economic hardship, or drug use or mental illness in the family. The most effective programmes are holistic and multileveled ones that recognize the complexity and inter-relatedness of health problems (Shaw & Aggleton, 2002).

Health services should try to reach young people who rarely seek health care and advice of their own accord.

Special attention should also be paid to the growing group of AIDS orphans who are particularly at risk of sexual abuse and sex work. The group most difficult to reach is children sold or taken away for trafficking.

Various projects reflect the differences between the needs of young women and those of young men. In Jamaica, for example, the Women's Centre of Jamaica Foundation supports young women who have given birth while still at school. These young women are provided with support to return to school and are counselled on how to delay a second pregnancy (http://www.rho.org/html/adol_progexamples.htm#jamaica). Specific strategies are needed to influence the health-seeking and sexual risk behaviour of young men. Much research is being done to identify ways to attract more young men to SRH services. Programmes need to design suitable approaches to involve them, meet their needs, and encourage gender equity (Senderowitz, 2000; Shaw & Aggleton, 2002). Moreover, programmes should be tailored to the sexuality of young people: an intervention using street outreach workers has reached young gay men in one area of Indonesia, and has provided condoms, IEC and weekend retreats offering a supportive environment for this marginalized group (http://www.rho.org/html/adol_progexamples.htm#indonesia).

It is not clear from programme descriptions which specific age groups attend services. A stand-alone clinic in Hanoi seemed to attract mainly young adults who had the means to pay for the services. In the youth centres in Ghana, Kenya, and Zimbabwe, the few young people who used the health services were mostly over 20 years of age (Population Council, 2000). Health workers who are sensitised to the sexual health needs of adolescents may still be reluctant to provide dual protection and treatment for STIs, or to discuss sexual health issues with the youngest teenagers (RHO, 2002d). The fees asked for services may specifically reduce access for the youngest adolescents.

Different age groups may have different needs for information, counselling, contraception and treatment for STIs (Dehne & Riedner, 2001b). Providing information and developing the life skills of the youngest adolescents, who are not yet sexually active, are important for their future sexual health; unfortunately, it is not clear whether youth programmes, other than school-based ones, reach them.

Box 19: Hard-to-reach adolescents

- Out-of-school young people
- Unemployed young people
- Refugees
- Domestic workers
- Young sex workers
- Street children
- Sexually abused children
- Men who have sex with men
- Women who have sex with women
- Drug users

4.7 Role of the health sector in education

In addition to sex education programmes in schools, a variety of approaches are being used to disseminate SRH messages. Many programmes provide individual counselling, and respond to individual questions through a hotline. However, adolescents generally express a desire to be better informed about sexuality, and most prefer to receive information from health workers rather than parents and teachers (Brown et al., 2001). The socialization processes of young boys are key areas for interventions aimed at improving reproductive and sexual health outcomes for both men and women, and at constructing positive attitudes to sexual health (IPPF/WHR, 2001b).

In the USA, linking clinics with sex education in schools reduced levels of sexual activity among students, increased contraceptive use, and lowered pregnancy rates (WHO, 2001a). However, provision of contraceptives in schools is still problematic, because of restrictive school and educational policies (Peak & McKinney, 1996; Fothergill & Feijoo, 2000).

Research on adolescents' sexual health tends to be related to risks and problems. Consistent with these research priorities, information and counselling given in the health sector tend to focus on the negative aspects of young people's sexuality. However, the role of sex

education and counselling is not only to prevent health problems, but also to promote the positive aspects of sexuality and sexual relationships as a fundamental part of life (Berer, 2001; Muñoz, 2001). Many studies have documented the influence of gender norms on the sexual behaviour of young people, and have stressed the need for a gender component in education for a healthy sex life (Ahlberg et al., 2001; Ajuwon et al., 2001; Ampofu, 2001; Harrison et al., 2001; Machel, 2001; Nkioza, 2001; Varga, 2001). Schoolteachers often lack the skills to introduce the subjects of relationships, gender dynamics and social norms, and cannot help adolescents acquire the skills to negotiate safer sex and engage in healthy and enjoyable sexual relations (Ahlberg et al., 2001). It may not be possible for health professionals who are also involved in other activities in the health facilities to acquire the skills needed for sexuality counselling and education; in addition, the number of health professionals is decreasing in many countries. Working with specialized social workers or psychologists may be a better option.

In 1975, the Family Planning Association of India (FPAI) started an NGO that has a countrywide network of sexual counselling centres, staffed by trained, qualified and experienced counsellors who provide education, counselling, training and therapy in the area of sexuality. It soon became obvious that these centres needed to develop their own sex education strategy, rather than using American or European educational material. The teaching covers knowledge of the reproductive system, personal hygiene, nutrition, contraception, sexual health and safe sex, with an emphasis on values (i.e., respect, trust), relationships, decision-making, responsible sexual behaviour, gender, and marital and parental responsibility. Specifically, the centres correct widespread misunderstandings about menstruation and masturbation (a cause of great anxiety in India). Separate educational programmes have been developed for those with visual, auditory or mental impairments (Mahinder, 1999).

The greatest challenge at the moment is to develop guidelines to assist policy-makers and programme managers to plan, implement and evaluate SRH services in specific situations, taking into account needs and barriers related to age, gender, and social and cultural context.

The following issues need to be considered:

- the importance of sensitising of adults to the reality of young people's sexuality;
- the relative importance of various barriers to health-care-seeking behaviour (Dehne & Riedner, 2001b);
- the aspects of youth centres and clinics that most influence attitudes and behaviour (Speizer et al., 2002);
- the cost-effectiveness of different approaches (Speizer et al., 2002);
- the ways in which programmes can be expanded and scaled up (Senderowitz, 2000), with attention to designing programmes to reach different groups with a variety of choices for counselling, preventive care and treatment (Finger et al., 2002);
- the need for more operational research into the effectiveness of various programmes and descriptions of best practices;
- the selection of the most appropriate model of service delivery in relation to available resources, provider characteristics, sociodemographic and epidemiological circumstances, specific risks and needs (Dehne & Riedner, 2001b);
- the need to address contradicting norms and values regarding premarital sexual behaviour, through community development strategies, and to clarify the way in which gender issues affect access to services;
- the need for specific strategies to expand services to hard-to-reach groups.

Box 20: Recommendations and suggestions: challenges and needs

- Address contradicting norms and values in society towards adolescent sexual health.
- Extend operational research on the effectiveness of various programmes.
- Implement or expand services for adolescents, accompanied by sensitization of adults.
- Develop specific strategies to tackle the hard-to-reach groups.

Violence related to gender and sexuality

Summary

Gender-based violence (GBV) is violence directed against women or girls, on the basis of their sex. It includes acts that inflict physical, mental or sexual harm and suffering, threats of such acts, coercion and other deprivations of liberty. GBV is a major public health problem and human rights violation throughout the world. Many forms of violence against women and girls are related to gender and sexuality. Intimate partner violence (IPV) – also known as domestic violence or spouse/partner abuse – is violence by an intimate partner or ex-partner and can include acts of physical, sexual and emotional abuse, as well as a range of coercive or controlling behaviours. Sexual violence includes rape and other forms of sexual abuse and coercion, –and may be perpetrated by partners, strangers, acquaintances or family members.

Female genital mutilation (FGM) – sometimes called female circumcision or female genital cutting – is any procedure that involves the partial or total removal of the external female genitalia or other injury to the female organs for non-therapeutic or cultural reasons.

Role of health sector

The numerous health consequences of sexual abuse highlight the need for the health sector to provide appropriate care. The role of health care providers is crucial in identifying, supporting, caring for, and referring women who have been subjected to violence, including sexual abuse. RH services may offer an entry point for work against violence, because many women are likely to use such services, even in poor areas. service response to violence should include care for physical injuries, and assistance in the initial healing process, through referral to community services for psychological and social support and legal The health assistance.

Studies are needed to determine the most effective, safe and reliable way to identify and support women who suffer from violence and its consequences. There is no consensus on whether, when or how women should be systematically screened for gender-based violence. It is, however, agreed that the screening process should not put women at additional risk. To help overcome some of the barriers to screening, training, continuous, sustained support and supervision of providers should be put in place. Health services should develop approaches based on their capacities, and the availability of appropriate referral services, in both the formal and the informal sectors, and should create a network of available services to facilitate follow-up.

FGM is a harmful practice, which violates women's and girls' human rights. Health workers can help eradicate FGM only if they are not in any way involved in the practice. Health workers who need to deal with FGM should be trained to provide education and prevention messages, to manage complications, and to provide counselling for women and couples with psychological and sexual-health-related problems as a result of FGM.

Evidence and recommendations

The health sector has only recently started to respond to sexual violence. In many countries, interventions to prevent or respond to sexual violence are limited and few have been properly evaluated. Recent reviews have highlighted several service models for provision of care to victims of sexual assault, ranging from “sexual assault examiner” programmes to crisis centres and more integrated multisectoral responses that include the legal and social services. A multisectoral approach is needed when dealing with violence against women, because the consequences have implications in many spheres.

WHO unequivocally opposes any medicalization of the procedure, advising that under no circumstance should it be performed by health professionals or in health establishments.

FGM is best combated through community-based interventions supported by the health sector. The most successful programmes have been community projects that emanated from local organizations or women's groups. Not all these programmes included a health services component.

Needs

There is a need to develop guidelines for health workers on how to address GBV and FGM. Health workers need training on how to detect and discuss these sensitive issues, and to care for and refer women suffering from GBV. They should be trained to work towards the abandonment of FGM by providing counselling and care whenever the opportunity arises. Operational research is needed to identify best practices. There is, as yet, little precise information on the prevalence of GBV and FGM. Operational research is needed to determine the costs associated with them, in terms of burden of disease, as well as the cost-effectiveness of integrated programmes.

There is a continued need to understand the norms, values and attitudes of the health workers themselves. More operations research on the efficacy of sensitisation programmes could provide important guidance on how best to provide training for health care providers.

Gender-based violence (GBV) is violence directed against women or girls on the basis of their sex. It includes acts that inflict physical, mental or sexual harm and suffering, threats of such acts, coercion and other deprivations of liberty (WHO, 2002g). GBV is a major public health problem and human rights violation throughout the world. Most forms of violence against women and girls are related to gender inequality and to the desire to control women's sexuality. For instance, intimate partner violence (IPV) – also known as domestic violence or spouse/partner abuse – is perpetrated by an intimate partner or ex-partner and can include acts of physical, sexual and emotional abuse, as well as a range of coercive or controlling behaviours. Sexual violence includes rape and other forms of sexual abuse and coercion, and may be perpetrated by partners, strangers, acquaintances or family members (WHO, 2002g).

It is difficult to know precisely the extent of sexual violence, but available data suggest that:

- in some countries, nearly one in four women is sexually coerced by her partner;
- both boys and girls may be exposed to sexual violence in childhood;
- in some countries, up to one-third of adolescent girls report forced sexual initiation;
- each year hundreds of thousands of women and girls are bought and sold into prostitution.

Although both men and women can be the targets of sexual violence, women and girls are more likely to be subjected to sexual and IPV abuse than men. In studies in developed countries, 5–10% of men reported being sexually abused as children; this figure, while significant, is considerably lower than that for women. Studies from both industrialized and developing countries also reveal that forced first intercourse for boys is not uncommon (WHO, 2002g).

5.1 Health consequences of GBV

Women and girls who experience abuse may suffer severe physical and mental consequences, in both the short and

Box 21: Prevalence of sexual violence

- Studies in different parts of the world have found that 7–36% of girls and 3–29% of boys are sexually abused in childhood; most studies report 1.5–3 times more sexual violence against girls than against boys.
- The proportion of adolescents who have been coerced into sex can range from 7% to 46% of females and 3% to 20% of males, depending on the country.
- Population-based studies report that between 6% and 46% of women have experienced attempted or completed forced sex by an intimate partner or ex-partner at some time in their life.
- Rape and domestic violence account for an estimated 5–16% of healthy years of life lost in women of reproductive age.

WHO, 2002g.

the long term. In addition to the common physical consequences, including external and internal injuries, a number of acute and chronic sexual and reproductive health problems are associated with sexual assault, such as STIs, HIV, pelvic inflammatory disease, infertility, unwanted pregnancy, and sexual dysfunction.

In the medium and long term, psychological trauma may include persistent post-traumatic stress disorder, sleeping and eating disorders, anxiety, obsessive-compulsive disorder, depression, alcohol dependence, self-injuring behaviour, and suicidal thoughts. Psychological distress may also be expressed in physical problems related to sexual and reproductive health, such as menstrual pain, chronic pelvic pain, and sexual dysfunction, including fear of sexual intercourse and lack of libido (WHO, 2003).

In some cultures, girls who have been raped may suffer further violence, including being beaten, or even murdered or driven to suicide because of the stigma attached to the sexual abuse (WHO, 2003; UNFPA, 1999b; RHO, 2002a; IPPF, 2000; Guedes et al., 2002).

5.2 The role of the health sector

The numerous health consequences of sexual abuse highlight the need for the health sector to provide appropriate treatment and care. The role of health care providers is crucial in identifying, supporting, caring for, and referring women who have been subjected to violence (WHO/PAHO, 2003; Garcia-Moreno, 2002; WHO, forthcoming). Women are often reluctant to disclose a history of abuse for a variety of reasons, including shame, embarrassment, stigma, fear, uncertainty about housing or financial options, or because past attempts at disclosure were met with disbelief or denial. However, many of these women tend to use health services, even if they do not reveal their experience of violence (Garcia-Moreno, 2002). Reproductive health services may offer a potential entry point for identifying and addressing violence, because many women are likely to use these services at least once during their lifetime (Guedes, 2004; Mayhew & Watts, 2002).

Health services should be prepared and health providers trained to respond appropriately to women who report being abused and, where appropriate, to recognize signs of intimate partner violence and other forms of sexual violence. As a minimum, health services should offer the necessary health care and assist in the initial healing process, by referring women to appropriate community services for psychological and social support and legal assistance (Butchart et al., 2004).

In some cases, women who use health services may be at further risk of partner violence, for example if they use contraceptives covertly or come for STI/HIV testing. Violence is not only a risk factor for HIV, but may also be a response to a positive diagnosis (Bawah et al., 1999, and Maman et al., 2001) Violence can also be a barrier to women using services, for example violence and fear of violence and stigma are important barriers to HIV testing (WHO, 2003). Studies have shown that some HIV-positive women may be at risk of abuse when they disclose their HIV status (Maman et al., 2000).

Studies are needed to determine the most effective, safe and reliable way to identify and support women who suffer from violence and its consequences. There is, as yet,

no consensus on whether, when and how women should be systematically screened for gender-based violence, particularly for intimate partner violence. Some professional organizations support routine screening to improve health care response and to help women access available services, but the effectiveness of such screening has not been rigorously evaluated. More work is needed to determine when and how screening should be done, what changes are required in the health system, and what level of training, support and supervision is needed.

It is, however, agreed that the screening process should not put women at additional risk (Nelson et al., 2004), that it must ensure their privacy and confidentiality, and that it should be conducted in a safe and non-judgemental way. To help overcome some of the barriers to screening, training, continuous, sustained support, and supervision of providers should be put in place. Health services should develop approaches based on their capacities, and the availability of appropriate referral services (e.g. emergency housing, legal support, counselling, and possibly risk assessment and safety planning), in both the formal and the informal sectors, and should create a network of available services to facilitate follow-up (Butchart et al., 2004).

Health services can also play an important role by collecting systematic data about violence against women and by documenting the evidence of violence, not only for the purpose of managing physical and psychological consequences, but also for eventual legal action, if desired (UNFPA, 1999b). However, all documentation and record-keeping should respect the privacy and confidentiality of the woman. Consistently recorded data may also provide a basis for monitoring how countries respond to the international conventions to which they subscribe (Garcia-Moreno, 2002).

Comprehensive health services can only be provided in a setting with immediate access to medical expertise, such as a hospital or a medical clinic (WHO, 2003). At the primary care level, initial screening, counselling and documentation of injuries should be possible, with referral if appropriate to higher-level services. Interventions in the health service setting should ideally be accompanied and supported by community-based interventions (WHO/PAHO, 2003).

5.3 Integrating care of abused women into services

The health sector has only recently to respond to sexual violence. In many countries, interventions to prevent or respond to sexual violence are limited and few have been properly evaluated. A recent review of health service models for provision of comprehensive care to victims of sexual assault found that services were diverse (Kelly, 2004). A number of countries have adopted “sexual assault examiner”. This is primarily a medico legal model, which has been developed to ensure that forensic examiners are trained and available to respond promptly when rape is reported to the police or to a hospital facility.

Other models include the establishment of centres, sometimes called One-Stop Crisis Centres, which are often located in health facilities. In these centres, which are common across Malaysia, services are provided through a partnership between the health sector and a women’s NGO, and include counselling, support, and temporary shelter. A similar service is found in Thailand, where one-stop crisis centres for survivors of physical or sexual assault have been integrated into hospitals. Training of staff and creation of referral networks have improved responses to survivors’ needs.

Thuthuzela Centres, established in South Africa through the Department of Justice, respond to domestic and sexual violence, recognizing that the needs of survivors extend beyond physical treatment; they can be accessed via hospital emergency rooms (Guedes, 2004).

The women’s resource centre in Rajasthan, India, trains public health care providers in gender issues, reproductive health and responding to gender-based violence. The inputs provided included training, gender sensitisation, communication, more female doctors, separate female toilets, safety of the auxiliary nurse-midwife, and improved mobility for women to reach more women. In South Africa, an SRH network called the Gender and Health Group incorporates care for women exposed to GBV in RH interventions through a programme called “Stepping Stones”, which includes peer education (Guedes, 2004).

In Nicaragua and the Philippines, integrated centres provide services for victims of different forms of violence, including child abuse and domestic violence. In a project in the Philippines, a Volunteer Advocate Group has been established to improve services to survivors. A flowchart for case-handling was also developed, setting out a holistic approach to ensure that the physical, mental and legal aspects of violence are all addressed, with appropriate medical and psychosocial follow up (WHO, unpublished).

Most of the services described are located in dedicated facilities within hospital emergency departments. In a few programmes, services for sexually abused women are integrated into existing sexual and reproductive health services. In Brazil, the Brazilian Civil Society for Family and Well-being (BEMFAM), started including services for victims of gender-based violence in its sexual and reproductive health services in January 2000 (IPPF/WHR, 2002a). The first phase concentrated on improving the knowledge and attitudes of health staff. In several workshops, methods of sensitising staff to the problem of gender-based violence were tested, and a service protocol was developed. Systematic screening was started in six clinics to collect data on the prevalence of gender-based violence, and the different types. The need for a referral network quickly became apparent, since health workers were reluctant to screen if they could not offer services. BEMFAM has compiled a directory of existing services for victims of gender-based violence.

In 1999, IPPF/WHR started a project to combat gender-based violence in the Dominican Republic, Peru and Venezuela. The goals were to increase awareness of gender-based violence as a public health problem, to identify victims, to provide services, and to contribute to changing social norms. IPPF affiliates in the three countries have sensitised their staff, elaborated protocols, and started systematic screening in 11 clinics. They have developed and distributed a screening tool that can be used in services throughout the three countries, as well as systems for data collection, monitoring and evaluation. Only a few women could be referred, however, because social and legal services are not widely available. While a number of organizations conduct advocacy and training, few offer actual assistance to victims (IPPF/WHR, 2002b).

A multidisciplinary approach is needed when dealing with violence against women, because the consequences have implications in many spheres, e.g. medical, psychological, social and legal. One example of a comprehensive response is found in Brazil. In 1988, hospitals in Rio de Janeiro and São Paulo were authorized to terminate pregnancies resulting from rape. From 1996 onwards, services were created in a number of hospitals to address the consequences of sexual violence. The programmes offered emergency contraception, prophylactic antibiotics against syphilis, gonorrhoea and chlamydial infection, immunization against hepatitis B, antiretroviral drugs to prevent HIV transmission, pregnancy termination, and psychological counselling. Women were also advised to report assaults to the police. On the basis of these experiences, the Ministry of Health in 1998 published standards for the prevention and treatment of the consequences of rape in adult and adolescent women. The number of hospitals offering such services increased from three in 1997 to 71 by the end of 2001 (Andalaft & Faundes, 2001; Faundes & Andalaft, 2002).

Another example is in Armenia, where a pilot programme launched in 2002 demonstrated how reproductive health care providers could effectively screen, educate and refer women who experience violence. Providers refer women for appropriate services, including psychological support, legal counselling, social support, hotline services, and shelter. The programme has influenced national health policy towards GBV as a public health concern, and has helped providers collaborate with others working in the community against GBV (Guedes, 2004; PRIME II, 2004).

Research on gender-based violence is important for a greater understanding of the problem and to facilitate the design of cost-effective and appropriate prevention, intervention and treatment programmes. In particular, there is a need for more systematic documentation of the range of health sector interventions being tried in different settings, together with assessment of their effectiveness and costs, in order to develop good practices that can be replicated in other countries.

5.3.1 Health system considerations

Issues of violence should not be addressed using a vertical approach, but rather integrated into different health services. However, there are many obstacles to the integration of activities directed towards the prevention of gender-based violence and management of its consequences. Funding is often a constraint, especially in rural areas. In addition, protocols and guidelines need to be developed for the detection and treatment of cases, a referral system for counselling and legal assistance developed, a data collection system created, and staff trained.

5.3.2 Gaps in clinical care

Specific protocols for dealing with the health consequences of GBV should be developed. These should cover: the need for personnel to be sympathetic and sensitive towards the victim; how to conduct a physical examination and document the findings; how to collect forensic evidence; counselling, including the options for HIV testing, pregnancy testing, emergency contraception, and termination of pregnancy; prophylaxis for STIs, including HIV and hepatitis B; referral to police; referral for psychosocial support; and testifying in court as an expert witness (WHO/PAHO, 2003) (see also Box 23).

5.3.3 Training

Health personnel often do not have the knowledge, tools or skills to deal with women who have been sexually abused. They may be judgemental and unsympathetic. It is thus crucial to provide gender-sensitive training for staff, as well as developing tools and guidelines to improve the services' response to violence and to change the attitudes and practices of health providers (Heise et al., 2002). Pre- and in-service training, during which staff learn to ask the right questions in a non-judgemental way, is a prerequisite for integration of gender-based violence into reproductive health services. A project in the Philippines, supported by the Department of Health, has produced training modules on GBV to be included in the curricula of nursing and medical students (Ramos-Jimenez, 1996). Training and

awareness-raising also help health professionals advocate for violence prevention.

As with other sensitive matters, the training should address the health workers' own prejudices and experience of violence. Trainees need to recognize their own values and deal with their own situation of violence.

Training is even more important in countries where domestic violence is the social norm. In these societies, health staff may accept such violence or may have experienced intimate partner violence themselves (Kim & Motsei, 2002; UNFPA, 1999b). In a study in South Africa, more than one-third of female nurses had been physically abused and an equal number had been sexually abused (Garcia-Moreno, 2002). Other PHC nurses in South Africa did not intend to refer abused patients to the police or judicial system. Only some female nurses would "hear [the woman's] side of the story", and most of them would try to resolve the issue within the family (Kim & Motsei, 2002).

Training should address the notion that there are no quick answers, as well as the need for a rights-based approach to RH (i.e. private spaces for consultation, respect of patients' confidentiality) (Garcia-Moreno, 2002).

5.3.4 Referral

In some cases women will need to be referred for additional services; whenever possible referral to existing counselling systems and available local community support systems should be encouraged.

5.4 Female genital mutilation

Female genital mutilation (FGM) – sometimes called female circumcision or female genital cutting – is any procedure that involves the partial or total removal of the external female genitalia or other injury to the female organs for non-therapeutic or cultural reasons (WHO, 1999a).

Worldwide, between 100 and 140 million women are currently affected. Every year, around 2 million girls and women are at risk of undergoing FGM (WHO, 2001c). Demographic and health survey estimates of the prevalence of FGM are available only for a small number of countries, and data on whether the practice is declining or spreading are not generally available. There are some reports that, where FGM was previously universally practised, the rates are now declining. However, among other

Box 22: Recommendation and suggestions: integrated services for patients who have experienced sexual violence

Facilities and staff should be assessed for their suitability to provide an integrated response to violence.

The following services should be available, on site or through referral, for patients who have experienced sexual violence:

- essential medical care for any injuries and health problems;
- collection of forensic evidence;
- evaluation for STI and preventive care;
- evaluation of pregnancy risk and prevention, if necessary;
- psychosocial support (both at time of crisis and in the long term);
- follow-up services for all of the above.

In order to provide such services, additional resources will need to be provided, referral mechanisms will need to be strengthened, and health workers will require additional training.

Adapted from WHO, 2003

groups, it has reportedly been introduced or revived (Shell-Duncan & Hernlund, 2000; WHO, 1998a; Hammond, 2002).

The procedure can cause immediate and long-term physical health consequences, and chronic disabilities may be associated with the more severe types of FGM (WHO, 1999a, 2001c; Slinger et al., 2002). Despite documentation of the immediate and long-term health consequences of FGM, there are few data on the frequency of such complications (Obermeyer 1999, 2003).

Female genital mutilation is not only a threat to the health of women, but is also a recognized human rights violation (WHO, 1999a); several countries where it is practised have made it illegal. However, the practice will not necessarily be changed by legislation alone: in Sudan, making FGM illegal does not seem to have influenced practice to a large degree. Likewise, despite the fact that the Kenyan government has banned FGM, it is still practised in 50% of districts in the country (RHO, 2002c). Most governments therefore aim for gradual abandonment of the practice through a combination of political and legal action, with promotion of behaviour change at the grass-roots level.

5.4.1 Role of health services

The health sector has an important role in monitoring the prevalence of FGM and its complications. Health professionals are key persons in general prevention efforts (WHO, 2001c); they are often leaders in their community and are in the best position to inform people about the risks of FGM.

5.4.2 Medicalization

Awareness of the adverse health consequences of FGM has led to its increased medicalization. Health professionals perform a variety of forms of FGM in Djibouti, Mali, Kenya, Nigeria, Somalia, Sudan and other African countries (Shell-Duncan, 2001). In Egypt, FGM is now carried out much more frequently than before by physicians (Kessler Bodiang, 2001). In Nyamira district in Kenya, 11% of health workers interviewed admitted that they had performed FGM (RHO, 2002c). Medicalization has proliferated

based on arguments that if FGM is performed by doctors then at least the intervention will be done under hygienic conditions, HIV infection during cutting can be prevented, complications such as excessive bleeding and organ injuries can be avoided, and anaesthesia, painkillers and antitetanus vaccine can be given (Kessler Bodiang, 2001). Medicalization has also been promoted as a way to introduce less extreme forms of FGM (Kessler Bodiang, 2001); in Somalia, pricking of the clitoris is done by midwives in clinics as an alternative to infibulation (Shell-Duncan, 2001). However, health workers can only be effective in advocating the abandonment of FGM if they are not in any way involved in the practice.

Health professionals are often part of the community where FGM is practised and may be under pressure to comply with traditions. Many still endorse FGM as an important tradition that should be preserved as part of cultural identity (Kessler Bodiang, 2001). This means that, in addition to providing an evidence base and biomedical training programmes for health workers, there is a need to implement culturally sensitive programmes addressing the values of the health workers themselves.

Box 23: WHO statement on FGM

In August 1982, WHO made a formal statement of its position towards FGM to the UN Commission on Human Rights, expressing “its unequivocal opposition to any medicalization of the operation, advising that under no circumstance should it be performed by health professionals or in health establishments” (WHO, 1998a).

5.4.3 Managing complications

Health professionals have to manage the direct and indirect physical and psychological complications of FGM (Kessler Bodiang, 2001). When women come for antenatal, delivery or postpartum care, or for treatment for the physical health consequences of FGM, the opportunity can be taken to manage sexual and mental health problems and to discuss prevention of FGM (Kessler Bodiang, 2001). Appropriate rehabilitation and treatment are needed for women and girls who have suffered consequences of FGM, as is counselling, to allow them to express their fears and concerns about their sexuality. Midwives, gynaecologists and birth attendants should not only be aware of FGM and its consequences, but should also be able to discuss the topic with clients and their husbands. Through counselling, health care providers can address sexual problems and their relation to FGM; they can also use the opportunity to counsel against re-infibulation after delivery and against the performance of FGM on any daughters (Derksen & Van Roosmalen, 2001).

5.4.4 Training

WHO promotes the training of health workers at all levels in the prevention of FGM (WHO, 1999a). The Organization has developed a manual for nurses and midwives on the prevention and management of the health complications of FGM (WHO, 2001f); this is currently being pilot-tested in several countries in the African region. Health workers should be trained to manage complications, provide care and counselling for psychological and sexual-health-related problems of women and couples affected by FGM, and provide education about FGM. The training should aim to convince health professionals that FGM is a public health issue (WHO, 2001c). The health sector can also organize training of community health workers, traditional birth attendants, and people involved in community-based prevention projects (Kessler Bodiang, 2001).

5.4.5 Health education

The elimination of FGM and other harmful practices requires both health education and child protection efforts.

Health messages should relate not only to physical health problems, but also to mental and sexual complications (Kessler Bodiang, 2001).

5.4.6 Integrated programmes to eradicate FGM

The most successful programmes aim at the elimination of FGM are community projects that emanate from local organizations or women's groups; examples include the Coptic Evangelical Organisation for Social Services (CEOSS) and the Centre for Development and Population Activities (CEDPA) in Egypt, the Malian Association for the Follow-up and Orientation of Traditional Practices (AMSOPT) and Centre Djoliba in Mali, the Fight Against Female Genital Cutting (CNPLE) in Burkina Faso, the Coordinating Committee on Traditional Practices Affecting Women's and Children's Health (CPTAFE) in Guinea, the (Reproductive and Community Health) REACH programme in Uganda, Mandaleo Ya Wanawake Organisation (MYWO) in Kenya and the TOSTAN experience in Senegal (WHO, 1999b; RHO, 2002c).

Some of these programmes include a health services component. The REACH project in Uganda was set up by UNFPA with the involvement of community members, political, religious and local leaders, and representatives of women and young people. The programme aims to discourage the practice of excision and to provide accessible and affordable quality RH services in the maternity ward of the district hospital and in four health units. Health workers and traditional birth attendants were involved in the sensitization campaigns. A 36% decrease in excision of girls is reported, but it is not clear whether the RH services have indeed improved. One of the most important elements of success in reducing FGM seemed to be the creation of community awareness of the health consequences through peer education; also, the idea of alternative rites was launched through discussions involving the whole community (WHO 2000c).

In Ghana, an agriculture and nutrition programme included an RH component that addressed both the high fertility rate and FGM. As a result of the programme, men and women now openly discuss the practice of FGM, and the

circumcisers or *wanzams* no longer perform it. Although some girls still travel to other areas for circumcision, there is clear evidence of change (Retzlaff, 1999).

In the United Kingdom, the African Well Woman clinic was set up in 1997, to provide counselling, information and support to women who have undergone FGM, as well as surgical defibulation, where appropriate, to both pregnant and non-pregnant women. It is staffed by a full-time specialist midwife and a female consultant. Women can attend the clinic on their own initiative, or may be referred by health professionals or women's groups. The clinic provides for flexible appointments and also gives educational support and outreach activities to the communities involved (Momoh, 2002).

The topic of FGM was included at various points in an Egyptian training course on introducing sexual health into a family planning programme. The approach was, first, to discuss with participants the potential negative effects of FGM on the female sexual response and husband-wife relations and, second, to discuss strategies for helping circumcised women to have better sexual relations with their husband. FGM was used as a topic to engage the trainees in practice counselling situations. However, health staff remained embarrassed about discussing sexual matters after this training course. (Abdel-Tawab et al., 2000).

5.4.7 Research needs

Research on FGM has so far concentrated on how it is done, its prevalence, and attitudes towards the practice. Gender relations and the social environment within which women's sexuality and reproduction are being controlled have rarely been addressed. Examination of male involvement in stopping the practice started only a few years ago. Additional qualitative research is needed on the relationship between sexuality and FGM, the mental and psychological effects of the practice, and the social construction of practising communities. Greater understanding is needed of the forces driving the continuation of FGM and possible ways of intervening to weaken or counteract these forces. Operations research could support the design of appropriate interventions for eliminating FGM

and for developing methods to evaluate such interventions (Obermeyer, 1999, 2003; Shell-Duncan, 2001; WHO, 2001c).

Box 24

Recommendation

Female genital mutilation is a human rights violation. Health workers should not be involved in the medicalization of FGM, since this is not only contrary to the ethics of health care, but also legitimises a harmful practice. Health workers at all levels should be trained in the prevention of FGM, including community-based interventions. Health workers need training in managing the many physical, psychological and sexual complications associated with the practice.

Health system issues and challenges

Summary

Examples of successful integration of sexual health into reproductive health services tend to be small-scale; problems are often faced in replication and scaling up. Inadequate support to programme implementation and weaknesses in the health system in general are among the most important reasons why integration is not successful.

Role of the health sector

A fragmented, poorly functioning health system can impede progress on integration of sexual health interventions. This situation may be compounded by uncoordinated external assistance to the sector, resulting in donor-led priorities taking precedence over the goals of integration. It is essential to ensure adequate support to the public sector health system as a whole if integration is to be successful. The role of the public sector in coordinating inputs from service providers in the NGO sector needs to be clarified and agreed upon. NGOs have a long history of providing innovative and creative services in sexual health, often reaching sections of the population that are hard for the public sector to reach (e.g. groups high risk of STI/HIV transmission).

Evidence and recommendations

In many resource-poor settings, integration efforts are hampered by a host of problems related to the shortcomings of the health system. Underfunding and poor management of public sector services are compounded by poorly adapted infrastructure of health facilities. For example, there may be a lack of space for confidential interviews and examination of patients; shortages of personnel and medical supplies may hamper the delivery of high quality services; and there may be insufficient service capacity for delivery of an integrated service. The first priority should be to improve the performance of public health services and the health system as a whole, if integration is to succeed.

It is not clear that coordinated priority setting and resource allocation at higher levels of the health system, such as in sectorwide approaches, is necessary for provision of integrated services to clients. However, such high-level integration may encourage donors to fund nationally set priorities for integrated services rather than single-issue vertical programmes.

Needs

There is scant evidence on the costs or cost-effectiveness of integrated services. In the absence of an evidence base on costs, programme managers and other key stakeholders are likely to set programme priorities for integrated services on the basis of other factors (e.g. perceived burden of disease, associated complications, costs of non-intervention). Further evidence on the costs and benefits of providing integrated sexual health services in a variety of different contexts is needed.

Integration of sexual and reproductive health services has been a health sector priority since 1994, when the ICPD Programme of Action made recommendations to that effect. The rationale for integration is increased accessibility and efficiency of services (O'Reilly et al., 1999; Hardee & Yount, 1995). However, although there is broad agreement in many settings on the need for integration, the findings of this review suggest that, in practice, integration of sexual health interventions into RH services is problematic and, with the exception of some small-scale NGO projects, has not yielded the desired results.

Various reasons have been advanced to explain this situation, of which the most important seem to be inadequate support to programme implementation and weaknesses in the health system in general. In addition, the impact of wider health sector issues cannot be overlooked: health sector reform, for example, may have an important influence on the ability of sexual and reproductive health programmes to provide an integrated service; in addition, systems that are heavily reliant on external funds may find that the contents of services are dictated by externally set (donor) priorities (Buse, 1998; Reichenbach, 2002).

Evaluations have mostly concentrated on integration of sexual health in FP and MCH programmes. As outlined in previous chapters, the provision of comprehensive sexual health packages for women, men and adolescents puts considerable demands on the knowledge, attitudes and skills of health providers. The question needs to be raised as to what can reasonably be asked of health providers, even in well-functioning health systems. In this chapter we look at the organizational, structural and human resource development issues related to integration of sexual health in existing services.

6.1 Organisational issues

In many resource-poor settings, integration efforts are hampered by a host of problems related to the shortcomings of the health system. Underfunding and poor management of public sector services in much of the developing world causes many of these problems. The infrastructure of health facilities often does not ensure privacy for

confidential interviews and examination of patients. Shortages of personnel and medical supplies hamper the delivery of quality services. Even where integration is a priority and the necessary resources have been made available, results suggest that service capacity and quality of care are not sufficient (Mayhew et al., 2000). Often, supply channels are not well organized, and drugs and materials made available through international funding do not reach the services. Monitoring and supervision systems may be inadequate and trained health professionals may not get the support they need to put their new knowledge into practice. In addition, many health workers are not motivated because of, for example, lack of support, poor training and low salaries. The first priority, therefore, should be to improve the performance of public health services and the functioning of the health system as a whole (ICRH/GU, 2000; Mayhew et al., 2000; Lush, 2002).

Integration planning is further complicated by the hybrid structure of health systems (Mayhew et al., 2000; Rutenberg et al., 2002). Several departments or administrative entities may be involved in planning and organizing integrated services, and collaboration between these different actors is often inadequate.

6.1.1 Integration and the structure of health services

The history of health systems in most developing countries is characterized by an oscillation between horizontal and vertical approaches (Waelkens et al., 2001). Efforts to prioritize comprehensive PHC systems are counterbalanced by the concerns around the quality of interventions. In some cases vertical programmes are better suited to reach vulnerable groups, for example sexual health services for adolescents, than regular PHC programmes. Such programmes must offer comprehensive care and combine treatment of STIs, health education, counselling, and community interventions adapted to specific needs (Waelkens et al., 2001).

Donor agencies may concentrate resources on vertical programmes to achieve their priority health targets, and do not necessarily include resources to improve existing services. This is despite the observation that well-func-

tioning services are a condition for successful integration of any programme component. Funding that is too selective is encountered in many programme settings, and can prevent integration of services. For example, a donor focus on HIV and STI control programmes may result in their not being integrated into wider reproductive and sexual health services (Oliff et al., 2003). The Zambian MTCT Working Group has solved a similar problem by requiring PMTCT donors to support all elements of antenatal care (Rutenberg et al., 2002).

It is not clear that integration at higher levels, as in sector-wide approaches (SWAps) or other mechanisms, is necessary for provision of integrated services to clients (Lush, 2002). Moreover, it is not clear that SWAps will necessarily lead to a higher priority being placed on sexual and reproductive health services. On the other hand, greater collaboration between the different departments and programmes is essential for delivery of integrated services. It could also avoid unnecessary waste of resources caused by duplication. In several African countries, separate institutions dealing with RH, such as the AIDS Control Programme and the MCH programme, may have developed policies, drug lists, training manuals and technical guidelines that cover FP, MCH and STI-HIV/AIDS with little inter-departmental consultation (Mayhew et al., 2000). This lack of collaboration may even be encouraged by international funding agencies that support different departments. In Malawi, for example, both the Safe Motherhood Initiative, funded by DFID, and the Reproductive Health programme, funded by USAID, independently revised the curricula of all training institutions in the country (ICRH/GU, 2000). In Nepal, where external donors fund about 58% of primary health care activities, the Ministry of Health does not have the power to impose one strategy, and different donors and NGOs prioritise their own model (Hardee et al., 1999).

The district level should not be overlooked in the integration process, especially when pilot projects are being upgraded to national programmes, and district managers have to lead the integration process in the health facilities. Districts are often squeezed between conflicting vertical and horizontal strategies. Vertical programmes do not involve district managers in decision-making, priority setting and budgeting, yet the district has an important

role in implementing policies. District officials are rarely trained to carry out the tasks they are requested to perform; indeed, what is required of them may conflict with their role in the horizontal structures (Criel et al., 1997). Programme funding usually does not include financial resources to increase district capacity to meet the increased workload.

This makes it difficult to improve motivation, supervision and quality of care, which in general are the weakest points in health systems in low-income countries. Addressing sexual health can challenge health workers' norms and values more than dealing with RH, and may require them to change their attitudes towards sexual practices often considered taboo. It needs special skills that go beyond the straightforward provision of information, diagnosis and treatment. This means that integration of sexual health requires careful "management of change".

The exact place of integrated services within the health system is context- and country-specific. In Western Europe, for example, services are provided at the primary care level, usually free of charge and, in the United Kingdom, by STI physicians (Bingham, 2002). In newly independent states (NIS), STI services are provided mainly by dedicated clinics and, in several of these countries, only public health specialists are licensed to treat STI (Dehne et al., 2002). STI management by individual practitioners or dedicated clinics is not entirely effective. Surveillance data indicate that the prevalence of STI and HIV has been increasing in Western and especially Eastern Europe (Bingham, 2002; WHO, 2001d). The main problem in the NIS is lack of affordable high quality STI services, including STI treatment and condoms (Dehne et al., 2002).

6.1.2 Integration and health sector reform

While policies for health sector reform may have predated those for integration in many countries, they have at least one aim in common: to improve service organization by reducing duplication and enhancing effectiveness (Gilson & Mills, 1995). Health sector reform takes many forms, but common strategies include the introduction of user fees,

community financing and decentralization of services (Gilson & Mills, 1995). The impact of health sector reform on the integration of sexual and reproductive health services was explored by Oliff et al. (2003) in the United Republic of Tanzania. They found that integration was hampered by a perception among district-level staff that national programme managers feared losing their resources and power if they followed the reform agenda and moved from vertical to integrated programmes. Overshadowing the need for integration in the reproductive and sexual health services was a genuine concern over loss of donor support in the absence of vertical programmes. Oliff identified several preconditions for successfully integrating sexual and reproductive health services in the context of health sector reform, including better coordination of external support, and support for country-level decision-making.

6.2 Quality

The strategy most often proposed to improve staff attitudes and quality of care is training and supervision (Van Lerberghe & De Béthune, 1998). To be effective, initial training should be followed by continuing in-service training and support, the creation of an environment favourable to change, and availability of regular supplies. Without such support, health workers will be unable to do their work well, and their motivation and quality of work will suffer.

Front-line workers are rarely in a position to influence these factors. Several projects now concentrate on the elements of quality care that health workers can themselves improve (e.g. Bradley, 1999). In their programmes for young people, both GTZ and IPPF use a bottom-up approach to improve quality of care, providing local health workers with tools to evaluate and improve their own work. GTZ (2002a) organized a course in action research, which aimed to provide local health workers with the skills to investigate what people want and need, and to improve the response of the health services. IPPF (2001) assessed the factors that influenced quality and perceived quality in existing programmes. Health workers who participated in the evaluation were interested in using the method to adjust programme interventions. The National Adolescent-Friendly Clinic Initiative (NAFCI) in South Africa provides health managers with a self-assessment tool in the context of a national accreditation system (Dickson-Tetteh et al., 2001).

These strategies may not by themselves change any of the shortcomings inherent in the health system. But they will sensitise providers to the needs and demands of patients and help them understand why and how they should change their attitudes. When clinic staff participate in evaluation and decision-making, and see the results of their changed attitudes and methods, they become more satisfied with their job and understand that their new

Box 25

Recommendations and suggestions

An international agreement was reached a decade ago that integrated health services would ensure better sexual and reproductive health care. However, the implementation of integrated services has proved problematic in many settings. In part the lack of progress arises from fragmented, poorly functioning health systems. This situation can be compounded by uncoordinated external assistance, which results in donor-led priorities taking precedence over integration. In addition, health sector reform can impede progress. The goals of integration will be better met when:

- Health services in general function more effectively and efficiently. The first priority should be to improve the performance of public health services and the health system as a whole.
- External assistance to the health sector is coordinated and in line with national strategic priorities.

ways can make a difference (e.g. Rutenberg et al., 2002). In the IPPF projects, the operations research created the conditions for change that training programmes without follow-up and supportive supervision could not provide (IPPF, 2001).

6.3 Collaboration between the public sector and NGOs

Through their lobbying and networking, NGOs have had an essential role in operationalizing the concept of sexual health and putting it on the health development and rights agenda. NGOs are often able to be flexible and creative, and to reach vulnerable groups; they were among the first to pilot-test community-based education strategies on issues such as adolescent sexual health, preventing sexual violence, reducing FGM, and addressing gender issues. NGOs can bring to the forefront taboo subjects, such as abortion, child trafficking and child abuse. Currently, an impressive number of NGOs are active in work to influence gender relations and to make sexual health a subject of discussion. Their community-based education activities are an important component of behaviour change programmes (Welbourn, 2002; Gordon, 1995; Klugman, 2000). But they are also a precondition for (1) promoting acceptance of sexual and RH services for special groups such as adolescents, and (2) reducing stigma and stimulating discussion of sexual health issues between partners, and between parents and adolescent children (GTZ, 2002a; IPPF, 2001)

6.3.1 Service delivery

Many NGOs are also involved in service delivery. NGOs often complement the public sector, address unmet needs, and are active where public services do not reach. Because of their creativity and flexibility, NGOs are well placed to make services accessible to underserved and hard-to-reach groups, such as people living with HIV/AIDS, sex workers, street children and refugees. Such work offers the opportunity to address specific concerns that have not previously been brought to the attention of the general public, and to try out innovative approaches

(UNAIDS, 2002). However, scaling up pilot activities to reach broader target groups with comprehensive services remains problematic in many cases.

6.3.2 NGO support to the health sector

Community-based NGOs have been the first to respond to the growing demand for HIV/AIDS prevention and care. Active collaboration with NGOs specialized in specific areas (such as health education or reaching vulnerable groups) could be beneficial for the public health sector and for the health services in general. For such collaboration to be effective, NGOs and their donors must guarantee a long-term engagement. Governments should define the conditions for collaboration, e.g. a legal framework at the national level, official structures that promote collaboration among NGOs and between NGOs and public services, improved communication channels between NGOs and the Ministry of Health. The Ministry of Health should define the priorities for collaboration (Nwankwo & Takele, 1996).

Another option is to integrate NGO activities within the public sector itself. This would help deal with the lack of financial and human resources in the public sector. There are various examples of good collaborations. Médecins Sans Frontières of Belgium assisted health centres of the Nairobi City Council to integrate HIV/AIDS interventions (education, VCT, treatment of opportunistic infections, home-based care, referral to hospital, social support) within existing activities (Waelkens et al., 2001). The Malian Family Planning Association collaborated with the public sector in Mopti, Mali, to improve the quality of maternal care (Tautz, 1999). Both NGOs used similar strategies. The roles and responsibilities of both the public sector and the NGO were stipulated in a written agreement. Quality of care at the health facilities and the needs in the community were assessed. The NGOs provided equipment, tools and drugs, organized training for all health workers, and assisted health workers to progressively integrate the new programme components and changes in attitude. They had an important role in helping providers listen to the needs and expectations of clients, and introduced them to the process of improving their response through operations research.

Other examples of collaboration were given by participants in a meeting in Kenya on integration of HIV/AIDS prevention and care into MCH settings (Rutenberg et al., 2002). In Indian programmes, NGOs provide HIV/AIDS counselling in urban antenatal clinics, and midwives go door-to-door in rural areas. In Kemba, Zambia, traditional birth attendants selected by the community are trained and offer supportive counselling. The District Health Management Team in Ndola, Zambia, has incorporated community health workers into their PMTCT programmes.

Box 26

Working with NGOs

NGOs have a long history of providing sexual health services, and have played a key role in promoting the concept of integrated sexual health services, even in the most difficult of circumstances. Rather than being seen as rivals, NGOs can be complementary to the public sector and can provide services in circumstances where the public sector may be constrained (e.g. by reaching vulnerable and high-risk populations). Collaboration with NGOs should be seen as a long-term strategy rather than a short-term solution to individual issues. Governments should define the conditions for collaboration and the Ministry of Health should define.

6.4 The private for-profit sector

The private sector plays an important role in SRH service delivery. The review by Waelkens et al. (2001) found similar health-seeking behaviour for treatment of STI in various developing countries: most people, especially men, sought care in the private sector. However, as has been outlined, the quality of treatment for STIs in the private sector is usually poor, whether by informal or by trained providers, and clients rarely receive counselling or advice about safer sex. Therefore, improving the quality of STI

management by private providers is a priority. However, training of private sector health workers and pharmacists, for instance in syndromic management, has generally not improved treatment (Waelkens et al., 2001).

On the other hand, integration of STI/HIV/AIDS activities into the public sector, and particularly into FP services, has not improved coverage and is not likely to do so given the organizational and financial difficulties the public sector faces. There is also the common observation that reaching men, who tend to use the private sector services, may have more effect on treatment outcomes than reaching women (Waelkens et al., 2001).

6.5 The cost of providing integrated sexual health services

The policy-level decision to integrate sexual health services into existing health services may receive support from key stakeholders. However, decisions about the exact content of an integrated service may have to be based on pragmatic considerations of cost, cost-benefit, cost-effectiveness and resource availability. Evidence on the costs of sexual and reproductive health interventions has been gathered by the POLICY project (2000) and the Alan Guttmacher Institute (Singh et al., 2004), and these studies are reviewed below.

The burden of disease associated with sexual and reproductive morbidities provides compelling evidence of the need for services in these areas. Among women of reproductive age (15-44 years), for example, maternal conditions globally contribute 13% of all DALYs lost, and HIV/AIDS accounts for a further 14% (WHO, 2001d). The urgency of addressing the spectrum of reproductive and sexual ill-health is clear, and a number of interventions to address these issues are recommended in even the most resource-constrained settings. For more than a decade, the “essential health package” promoted by the World Bank has included a number of sexual and reproductive health services among priority interventions: prevention and care of STIs (including HIV); maternal health care; and family planning (World Bank, 1993).

UNFPA and others have estimated that the total cost of meeting the pledged provision of universal sexual and reproductive health care, as outlined in the ICPD Programme of Action in 1994 was around US\$10 billion in 2000. UNAIDS, meanwhile, estimated (albeit the debate is still going) that by 2006 US\$2.6 billion would be needed additional to currently predicted pledges and commitment of US \$ 9 billion for a rapid acceleration in the response to AIDS (UNAIDS, 2005).

While the direct and indirect costs of services can be calculated, the benefits of those services, and especially integrated services, may be more difficult to quantify. Benefits may be accrued at several levels: improved medical outcomes for the individual seeking care; reduced health expenditures on complications and sequelae of untreated conditions; and secondary outcomes, such as social benefits for individuals, families and communities (for example, the contribution of family planning services to women's empowerment).

Viewing sexual health services from these multiple economic perspectives, it can be seen that the measurement of benefits is a complicated process. For example, if an integrated family planning service offers cervical cancer screening, should the benefits of the cervical cancer deaths averted be attributed directly to the integrated FP service? The benefits to society of providing sexual health services may be even more difficult to quantify. However, there have been attempts to quantify benefits: studies in Egypt, Thailand, and Viet Nam estimated that every \$1 invested in FP yields a government saving in the social and allied sectors (education, food, health, etc.) of between \$8 and \$31.

The Alan Guttmacher Institute, and others, have reviewed the evidence on the costs and benefits of investing in sexual and reproductive health care (Singh et al, 2004). A brief summary of the main review findings highlights the following:

- Primary prevention (preventing infection) is more cost-effective than secondary or tertiary prevention (providing services for diagnosis, management or long-term care). In the case of HIV, while both prevention and

treatment are necessary, it is more cost-effective to prevent infection in the first place than to treat those who are infected. In the case of cervical cancer, prevention costs US\$100 per DALY saved while treatment costs US\$2500 per DALY saved (World Health Report 1993 in: Singh et al., 2004).

- Information, education and communication programmes that focus on risk reduction, along with increased access to condoms, are generally recommended from a cost perspective. Improved health-care seeking (reducing the time taken to seek care from a trained provider) is also worth while from a public health perspective.
- Some interventions to prevent transmission of HIV, e.g. use of nevirapine for PMTCT, and screening of blood and blood products are very cost effective.
- Prevention and diagnosis of STIs are generally more cost-effective when focused on groups at known or perceived high risk of infection rather than on the general population (World Bank, 1993).
- Antenatal syphilis screening is a cost-effective intervention even when levels of active syphilis in pregnant women are relatively low. Screening is health policy in many countries but is rarely fully implemented (Gloyd et al, 2001) . New diagnostic techniques, combined with a full-scale effort to implement PMTCT of HIV, provide a unique opportunity to implement this highly cost-effective intervention against an entirely preventable condition (Schmid G, 2004).
- Family planning services are a highly cost-effective way of preventing adverse events (which carry additional costs), such as maternal deaths, perinatal deaths, maternal morbidity, and low birth weight.

At present, the evidence base for the costs and cost-effectiveness of many sexual health interventions is lacking and policy-makers and programme managers will have to base their decisions on a number of other criteria, including ensuring equitable access to sexual health care (which may mean a critical evaluation of funding mechanisms to ensure that the poor are benefiting from public sector subsidies). In addition, given that many sexual health

services are already provided by the private sector (e.g. STI services), there is a strong argument that one role of the public sector is to ensure that these services are of high quality.

Box 27

Recommendations and suggestions

Primary prevention remains the most cost-effective intervention in the field of STI/HIV. There is little evidence on the costs and cost-effectiveness of other components of integrated services for sexual health care. It is essential to define these costs to allow evidence-based decision-making by programme managers and other key stakeholders in sexual health.

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Annex 1: PAHO/WHO/WAS 2000 List of sexual health concerns and problems

During a meeting held in Antigua, Guatemala, in May 2000, an expert group of PAHO, WHO and the World Association for Sexology (WAS) made an overview of sexual concerns and problems that should be addressed to advance towards sexual health (PAHO/WHO 2000).

Sexual health concerns are life situations that can be addressed through sexuality education and society actions for the promotion of sexual health of individuals. The health sector has a role to play in the assessment, in providing counselling and care.

Sexual health concerns

Sexual health concerns related to body integrity and to sexual safety:

- Need for health-promoting behaviours for early identification of sexual problems (e.g. regular check-ups and health screening, breast and testicular self-scan).
- Need for freedom from all forms of sexual coercion such as sexual violence (including sexual abuse and harassment).
- Need for freedom from body mutilations (i.e. female genital mutilation).
- Need for freedom from contracting or transmitting STIs (including HIV/AIDS).
- Need for reduction of sexual consequences of physical or mental disabilities.
- Need for reduction of impact on sexual life of medical and surgical conditions or treatments.

Sexual health concerns related to eroticism:

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

Sexual health concerns related to gender:

- Need for gender equity.
- Need for freedom from all forms of discrimination based on gender.
- Need for respect and acceptance of gender differences.

Sexual health concerns related to sexual orientation:

- Need for freedom from discrimination based on sexual orientation.
- Need for freedom to express sexual orientation in safe and responsible manners within a values framework respectful of the right of others.

Sexual health concerns related to emotional attachment

- Need for freedom from exploitative, coercive, violent or manipulative relationships.
- Need for information regarding choices or family options and lifestyles.
- Need of skills, such as decision-making, communication, assertiveness and negotiation, that enhance personal relationships.
- Need for respectful and responsible expression of love and divorce.

Sexual health concerns related to reproduction

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

Sexual health problems

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

The expert working group of PAHP/WHO/WAS (2000) proposed a syndromic approach to classification that makes them easier to identify for both health workers and the general public, and easier to report for epidemiological considerations.

All of these sexual health problems can be identified by primary health workers. Some can be addressed by trained health workers at primary level, for others, referral to a specialist is necessary.

- Clinical syndromes that impair sexual functioning (Sexual dysfunction) such as sexual aversion, female sexual arousal dysfunction, male erectile dysfunction, vaginismus, premature ejaculation.
- Clinical syndromes related to impairment of emotional attachment/love (Paraphilias) such as exhibitionism, paedophilia, sexual sadism, voyeurism.
- Clinical syndromes related to compulsive sexual behaviour such as compulsive sexual behaviour in a relationship.
- Clinical syndromes involving gender identity conflict such as adolescent gender dysphoria.
- Clinical syndromes related to violence and victimisation such as clinical syndromes following being sexually abused as a child (including post-traumatic stress disorder); clinical syndromes following being sexually harassed; following being violated or raped; clinical phobia focussed on sexuality; patterns of unsafe sexual behaviour placing self and/or others at risk for HIV infection or/and other STIs.
- Clinical syndromes related to reproduction such as sterility, infertility, unwanted pregnancy, abortion complications.
- Clinical syndromes related to sexually transmitted infections such as genital ulcer, urethral, vaginal or rectal discharge; lower abdominal pain in women, asymptomatic STIs.
- Clinical syndromes related to other conditions such as clinical syndromes secondary to disability or infirmity; secondary to mental or physical illness; secondary to medication.

Annex 2: Resources

Google and Reproductive Health Gateway were the main entry points for searches on the Internet. The following sites were consulted:

Alan Guttmacher Institute, <http://www.guttmacher.org>

EngenderHealth, <http://www.engenderhealth.org/>

Family Health International, <http://www.fhi.org/en/index.htm>

Ford Foundation, <http://www.eeford.org>

Global Reproductive Health Forum, <http://www.hsph.harvard.edu/grhf/index.html>

Healthlink Worldwide, <http://www.healthlink.org.uk/>

Horizons, <http://www.popcouncil.org/horizons/horizons.html>

International Centre for Research on Women, <http://www.icrw.org/>

Interagency Gender Working Group, http://www.prb.org/Content/NavigationMenu/Measure_Communication/Gender3/Gender.htm

International Planned Parenthood Federation, <http://www.ippf.org/>

Joint United Nations Programme on HIV/AIDS, <http://www.unaids.org>

Population Action International, <http://www.population-action.org/>

Population Council, <http://www.popcouncil.org/>

Reproductive Health Outlook, <http://www.rho.org/>

UNIFEM South East Asia: <http://www.unifem-eseasia.org/projects/evaw/vawngo/vamphil.htm>

United Nations Population Fund, <http://www.unfpa.org/>

World Health Organization, <http://www.who.int>

AF-AIDS, af-aids@healthdev.net

AF-AIDS is the regional forum on HIV/AIDS in Africa, coordinated by the Health & Development Networks (HDN, www.hdnet.org).

SEA-AIDS, sea-aids@healthdev.net

SEA-AIDS is the regional forum on HIV/AIDS in Asia and the Pacific. Coordinated by Health & Development Networks (HDN).

GENDER-AIDS gender-aids@healthdev.net

GENDER-AIDS is an international forum on issues around gender and HIV/AIDS. Coordinated by Health & Development Networks (HDN).

INTAIDS intaids@hivnet.ch

INTAIDS is an international forum on issues around Global advocacy and information. Coordinated by Health & Development Networks (HDN).

