Module 2

Key issues related to sexual health (STI, Sexual dysfunction, Gender, sexuality-based violence)

Upon completion of this module you should have acquired basic information on:

- Sexually transmitted infections (STIs)
- Sexual dysfunctions
- Unintended pregnancy
- Unsafe abortion
- Gender, sex & sexual orientation
- Sexual health throughout the lifespan
- Sexuality-based violence

1. Sexually Transmitted Infections (STIs)

•STIs are infections that are spread primarily through human sexual contact. There are more than 30 different sexually transmissible bacteria, viruses and parasites.

•The most common infections are gonorrhoea, chlamydia, syphilis, trichomoniasis, chancroid, genital herpes, genital warts, human immunodeficiency virus (HIV), human papillomavirus (HPV) and hepatitis B.

•Sexual contact includes vaginal, anal and oral sex. Some STIs can also be spread via blood or blood products. Many STIs —including chlamydia, gonorrhoea, hepatitis B, HIV, and syphilis — can also be transmitted from mother to child during pregnancy, childbirth and breastfeeding.

•The majority of STIs have no symptoms or only mild symptoms that may not be recognized as an STI.

World Health Organization. Sexually transmitted infections (STIs): Fact sheet N110. WHO; 2015.

Sexually transmitted infections (Continued)

A person with an STI may not present with any obvious symptoms of disease, which delays the timely diagnosis and treatment of the infections. This is a serious public health issue. Moreover, an untreated infected person can continue to transmit the infection. The STIs of the most important public health concerns are HIV, syphilis, gonorrhea, hepatitis B, human papillomavirus (HPV), chlamydia and trichomoniasis.

Some STIs like herpes and syphilis can increase the risk of HIV. HPV infections cause 528,000 cases of cancer and 260,000 deaths due to cancer each year. Gonorrhea and chlamydia are the main causes of pelvic inflammatory diseases and infertility. Moreover, mother-to-child transmission of STIs can result in stillbirth, neonatal death, low birth weight, intrauterine growth restriction and congenital malformations. The impact of STIs, including HIV, on individuals, families and communities and health services is enormous in many parts of the world.

World Health Organization. Sexually transmitted infections (STIs): Fact sheet N110. WHO; 2015.

Sexually transmitted infections (Continued)

Control of STIs requires a variety of approaches tailored to the prevalence of the population, social and cultural context, and availability of resources. Some subgroups face an increased risk and vulnerability to STIs, such as young people, MSM, transgender persons, sex workers and people at increased risk of sexual violence in their sexual relationships. The sexual needs of these people go beyond clinical care and require multifaceted interventions and care provision.

Counselling and behavioural change and communication are the primary preventive measures against STIs (including HIV), as well as against unintended pregnancies. These include sexuality education, safer sex counselling, and specific interventions for vulnerable populations. The implementation of these interventions are challenging due to many barriers such as lack of public awareness, lack of health workforce knowledge and above all stigma around STIs, particularly HIV.

World Health Organization. Sexually transmitted infections (STIs): Fact sheet N110. WHO; 2015.

2. Sexual dysfunctions: Definition

Sexual Dysfunctions are syndromes that comprise the various ways in which adult people may have difficulty experiencing personally satisfying, non-coercive sexual activities. Sexual response is a complex interaction of psychological, interpersonal, social, cultural and physiological processes and one or more of these factors may affect any stage of the sexual response. In order to be considered a sexual dysfunction, the dysfunction must: 1) occur frequently, although it may be absent on some occasions; 2) have been present for at least several months; and 3) be associated with clinically significant distress.

An individual may have several sexual dysfunctions at the same time. In such cases, all of the dysfunctions should be diagnosed.

The public health impact of sexual dysfunctions has received very little attention. This may in part be attributed to the difficulty of accurately assessing the burden of disease. Measurement is challenging because of the difficulty of identifying universally applicable principles.

Sexual dysfunctions can take a heavy psychological toll, bringing on depression, anxiety, and debilitating feelings of inadequacy. Several studies highlight the fact that sexual dysfunction is associated with quality of life.

D Chou et al. Sexual health in the International Classification of Diseases (ICD): implications for measurement and beyond. Reproductive Health Matters 2015;23(46):185–192.

Ning L, Yang L. Hypertension might be a risk factor for erectile dysfunction: a meta-analysis. Andrologia. 2016 Aug 5. doi: 10.1111/and.12644

Reed GM, Drescher J, Krueger RB, et al. Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatry*. 2016;15(3):205-221. doi:10.1002/wps.20354.

World Health Organization. Developing sexual health programmes: A framework for action. WHO; 2010.

Sexual dysfunctions (Continued)

Current estimates are that between 8% and 33 % of the population in developed countries experience some kind of sexual dysfunction in their lifetime. There is a serious lack of data and information on the magnitude of this problem at global level. Thus any estimate of the public health burden is likely to be an underestimate.

Despite being a common problem, sexual dysfunctions have seldom been a public health concern. Studies on the aetiology and epidemiology of sexual dysfunctions are few in number and are quite recent, mostly focusing on male erectile dysfunction.

Expectations and priorities vary by age and gender, as well as across cultures. In societies where female pleasure is not viewed as a legitimate concern, for instance, women may accept lack of orgasm or painful sex as 'normal'. Another issue is that even in countries where services do exist, few of those reporting problems to surveys actually seek professional help.

D Chou et al. Sexual health in the International Classification of Diseases (ICD): implications for measurement and beyond. Reproductive Health Matters 2015;23(46):185–192. doi:10.1002/wps.20354.

Ning L, Yang L. Hypertension might be a risk factor for erectile dysfunction: a meta-analysis. Andrologia. 2016 Aug 5. doi: 10.1111/and.12644

Reed GM, Drescher J, Krueger RB, et al. Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatry*. 2016;15(3):205-221.

World Health Organization. Developing sexual health programmes: A framework for action. WHO; 2010.

Sexual dysfunctions: Classification

Sexual desire dysfunctions

Hypoactive sexual desire dysfunction: characterized by absence or marked reduction in desire or motivation to engage in sexual activity as manifested by any of the following:

1) reduced or absent spontaneous desire (sexual thoughts or fantasies);
2) reduced or absent responsive desire to erotic cues and stimulation; or
3) inability to sustain desire or interest in sexual activity.

D Chou et al. Sexual health in the International Classification of Diseases (ICD): implications for measurement and beyond. Reproductive Health Matters 2015;23(46):185–192.
Reed GM, Drescher J, Krueger RB, et al. Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatry*. 2016;15(3):205-221.

Sexual dysfunctions: Classification

Sexual arousal dysfunctions

Female sexual arousal dysfunction: characterized by absence or marked reduction in response to sexual stimulation in adult women, despite adequate stimulation including the desire for sexual activity. It is manifested by absence or marked reduction in any of the following, as reported by the woman:

1) genital response, including vulvovaginal lubrication, engorgement of the genitalia, and sensitivity of the genitalia;
2) non-genital responses such as hardening of the nipples, flushing of the skin, increased heart rate, increased blood pressure, and increased respiration rate;
3) feelings of sexual arousal (sexual excitement and sexual pleasure) from any type of sexual stimulation.

Male erectile dysfunction: characterized by an inability on the part of an adult male to attain or sustain a penile erection of sufficient duration or rigidity to allow for sexual activity, despite adequate sexual stimulation including the desire for sexual activity.

D Chou et al. Sexual health in the International Classification of Diseases (ICD): implications for measurement and beyond. Reproductive Health Matters 2015;23(46):185–192.
Reed GM, Drescher J, Krueger RB, et al. Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatry*. 2016;15(3):205-221.

Sexual dysfunctions: Classification

Orgasmic dysfunctions

Anorgasmia: characterized by the absence or marked infrequency of the orgasm experience or markedly diminished intensity of orgasmic sensations, despite adequate sexual stimulation including the desire for sexual activity and orgasm.

Ejaculatory dysfunctions

Male early ejaculation: characterized by ejaculation that occurs prior to or within a very short duration (e.g. less than 1 – 3 minutes) of the initiation of vaginal penetration or other relevant sexual stimulation, with no or little perceived control over ejaculation.

Male delayed ejaculation: Male delayed ejaculation is characterized by an inability to achieve ejaculation or an excessive or increased latency of ejaculation, despite adequate sexual stimulation and the desire to ejaculate.

D Chou et al. Sexual health in the International Classification of Diseases (ICD): implications for measurement and beyond. Reproductive Health Matters 2015;23(46):185–192.
Reed GM, Drescher J, Krueger RB, et al. Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatry*. 2016;15(3):205-221.

Sexual Pain Disorder: Classification

Sexual Pain-Penetration Disorder (SPPD): characterized by at least one of the following:

1) marked and persistent or recurrent difficulties with penetration, including due to involuntary tightening or tautness of the pelvic floor muscles during attempted penetration;
2) marked and persistent or recurrent vulvovaginal or pelvic pain during penetration;
3) marked and persistent or recurrent fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of penetration.

The symptoms are recurrent during sexual interactions involving or potentially involving penetration, despite adequate sexual desire and stimulation. The symptoms are not entirely attributable to another health condition, including Mental and Behavioural Disorders, to insufficient vaginal lubrication or to age-related changes. The symptoms are associated with clinically significant distress.

D Chou et al. Sexual health in the International Classification of Diseases (ICD): implications for measurement and beyond. Reproductive Health Matters 2015;23(46):185–192.
Reed GM, Drescher J, Krueger RB, et al. Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatry*. 2016;15(3):205-221.

3. Unintended pregnancy

As of 2014, more than half of all women of reproductive age in developing regions want to avoid pregnancy. However, one-fourth of these women— 225 million—are not using an effective contraceptive method.

These women, who are defined as having an unmet need for modern contraception, account for 81% of all unintended pregnancies in developing regions. Reasons for their unmet need for contraception include:

- limited choice of methods;
- limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people;
- fear or experience of side-effects;
- cultural or religious opposition;
- poor quality of available services;
- user and provider bias; and
- gender-based barriers.

If all unmet need for modern contraception were satisfied, unintended pregnancies would drop by 70%, from 74 million to 22 million per year; and unsafe abortions would decline by 74%, from 20 million to 5.1 million.

Singh S, Darroch JE and Ashford LS, Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health: UNFPA Fact Sheet—2014, New York: Guttmacher Institute, 2014.
World Health Organization.Family Planning/Contraception Fact Sheet. WHO. 2016.

4. Unsafe Abortion

According to WHO, unsafe abortion occurs when a pregnancy is terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

Based on 2008 estimates, worldwide 22 million unsafe abortions occur each year, which results in 47,000 deaths and more than 500 million complications. Unsafe abortion can also have a negative impact on the social and financial status of women, families, communities and on the health system.

Women, including adolescents, with unwanted pregnancies resort to unsafe abortion when they cannot access safe abortion. Barriers to accessing safe abortion include:

- restrictive laws
- poor availability of services
- high cost
- stigma
- conscientious objection of health-care providers
- unnecessary requirements such as mandatory waiting periods, mandatory counseling, third-party authorization, medically unnecessary tests

World Health Organization. Preventing unsafe abortion: Fact sheet N° 388. WHO; 2015.

5. Gender & Sex

Gender refers to the socially constructed characteristics of women and men – such as the norms, roles and relationships that exist between them. Constructions of gender vary across and between cultures and can change over time. It is also important to recognize identities that do not fit into the binary male or female sex categories. In many cultures, there are established genders beyond the binary (e.g. hijras in India).

"Sex" vs. "Gender"

While most people are born either male or female (biological sex), they are taught appropriate behaviours for males and females (gender norms) – including how they should interact with others of the same or opposite sex within households, communities and workplaces (gender relations) and which functions or responsibilities they should assume in society (gender roles).

Smith KC. Sex, gender, and health. Johns Hopkins School of Public Health. 2006.
World Health Organization & United Nations Population Fund. Measuring sexual health: Conceptual and practical considerations and related indicators. World Health Organization; 2010.
World Health Organization. FAQ on Health and Sexual Diversity: An Introduction to Key Concepts. WHO. 2016.

Gender & Sex (Continued)

Gender norms, relations and roles also impact the health outcomes of people with transgender or intersex identities.

Transgender (sometimes shortened to “trans”) is an umbrella term used to describe people with a wide range of identities —including transsexual people, people who identify as third gender, and others whose appearance and characteristics are perceived as gender atypical and whose sense of their own gender is different to the sex that they were assigned at birth. For example, trans women identify as women but were assigned as males when they were born. Trans men identify as men but were assigned female when they were born. Some transgender people seek surgery or take hormones to bring their body into alignment with their gender identity; others do not.

Intersex people are born with physical or biological sex characteristics (including sexual anatomy, reproductive organs and/ or chromosomal patterns) that do not fit the traditional definitions of male or female. These characteristics may be apparent at birth or emerge later in life, often at puberty. Intersex people may be subjected to gender assignment interventions at birth or in early life with the consent of parents though this practice is largely contested by intersex persons and has been the subject of a number of recommendations by human rights experts and bodies

Smith KC. Sex, gender, and health. Johns Hopkins School of Public Health. 2006.
World Health Organization & United Nations Population Fund. Measuring sexual health: Conceptual and practical considerations and related indicators. World Health Organization; 2010.
World Health Organization. FAQ on Health and Sexual Diversity: An Introduction to Key Concepts. WHO. 2016.

Sexual Orientation

Sexual orientation refers to an individual's physical, romantic, and/or emotional attraction towards others. Sexual orientation is distinct from gender identity. The term sexual orientation can be applied to sexual attraction, sexual behaviour, and/or sexual identity.

Sexual orientation is not always fixed and constant, but may be fluid and changing. Individuals may fall on the continuum rather than fit into dichotomous categories of exclusively heterosexual or homosexual categories. Also, an individual's orientation may vary during their life course. Same-sex attraction may be a singular event in a person's life, or may occur fleetingly.

Not all individuals who have experienced same-sex sex identify as "homosexual" or "gay". For this reason, it is sometimes useful in a public health context to use the term "men who have sex with men" or "MSM" to describe an epidemiological group of men with behaviours that potentially put them at higher risk for acquiring HIV or STIs.

Smith KC. Sex, gender, and health. Johns Hopkins School of Public Health. 2006.
World Health Organization & United Nations Population Fund. Measuring sexual health: Conceptual and practical considerations and related indicators. World Health Organization; 2010.
World Health Organization. FAQ on Health and Sexual Diversity: An Introduction to Key Concepts. WHO. 2016.

Sexual diversity and sexual health

Sexual and gender minorities such as lesbian, gay, bisexual, transgender and intersex people face both similar and different challenges in accessing health care services and ensuring their health needs are met, but as a community, are more likely to experience human rights violations including violence, torture, criminalization, forced sterilization (often in the case of intersex persons), discrimination and stigma because they are perceived to fall outside of socially constructed sex and gender norms.

Sexual orientation greatly influences sexual health needs. Marginalized sexual orientations are often accidentally or purposely ignored in sexual health education or services, and are therefore at greater risk of negative health outcomes.

Smith KC. Sex, gender, and health. Johns Hopkins School of Public Health. 2006.
World Health Organization & United Nations Population Fund. Measuring sexual health: Conceptual and practical considerations and related indicators. World Health Organization; 2010.
World Health Organization. FAQ on Health and Sexual Diversity: An Introduction to Key Concepts. WHO. 2016.

Gender related issues and relationships

Traditional gender roles serve to inform sexual behaviours and power dynamics in relationships. Such power dynamics can limit an individual's ability to advocate for themselves and their health, most notably condom or other contraceptive use in the context of sexual health. Gender inequalities arise when there are differences in power dynamics in which one group is advantaged at the cost of the other.

Consensual sexual relationships do not include coercion or violence. In certain countries, one in five women experiences sexual violence perpetrated by an intimate partner (WHO 2006).

The ability of individuals to make choices about their sexuality freely is a critical element of good health and sexual well-being. Within a sexual relationship, many choices are shared and must be negotiated between partners.

World Health Organization. Defining sexual health: Report of a technical consultation on sexual health, 2002. WHO; 2006.
World Health Organization. Sexual health, human rights, and the law. World Health Organization; 2015.

6. Sexual health throughout the lifespan

Age also serves to determine the unique sexual health needs, education and resources required to make informed choices about sexual health.

Young People's Sexual Health

There are over 1.8 billion young people between the ages of 10 and 24 years in the world today, 90% of whom live in developing countries. Comprising one quarter of the world's total population, youth are faced with a number of challenges to their sexual and reproductive health (SRH) and well-being.

Young people, in particular, are at the critical age of development.
The sexual health needs of young people require a tailored and unique approach to guidance, education, and resources in order to make well-informed decisions regarding their individual sexual health.

The way young people are defined varies between cultures and over time. It also acknowledges that young people may continue to be at heightened risk of adverse sexual health outcomes into their twenties.

UNFPA. Adolescent and youth demographics: a brief overview. UNFPA; 2012.
UNFPA.UNFPA strategy on adolescents and youth: towards reaching the full potential of adolescents and youth. UNFPA: New York, NY; 2013.
World Health Organization & United Nations Population Fund. Measuring sexual health: Conceptual and practical considerations and related indicators. World Health Organization; 2010.

Sexual health throughout the lifespan (Continued)

Being young is a risk factor for a range of sexual health outcomes, including coercive sex, unplanned pregnancy, and sexually transmitted infections (STIs). This period of life is characterized by experimentation and risk-taking.

Young people are vulnerable to the adverse consequences of sex as a result of their relative lack of experience, power and autonomy, and access to knowledge and resources.

It is not uncommon for cultures to aim to control and regulate the sexual behaviours of young people. This desire to control often limits young people's access to education and resources, resulting in risky or uninformed sexual behaviours. Even if resources are available to young people, they may avoid seeking care if confidentiality cannot be guaranteed, or if parental permission is required.

UNFPA. Adolescent and youth demographics: a brief overview. UNFPA; 2012.
UNFPA.UNFPA strategy on adolescents and youth: towards reaching the full potential of adolescents and youth. UNFPA: New York, NY; 2013.
World Health Organization & United Nations Population Fund. Measuring sexual health: Conceptual and practical considerations and related indicators. World Health Organization; 2010.

Sexual health throughout the lifespan (Continued)

Sexual Health of the Elderly

The sexual health of the older people demands attention because there is increasingly ageing population in many parts of the world.

Older people experience and express sexuality differently from the younger age groups. Their sexual health problems also differ. These include the adverse effect of hormonal changes on their sexual function, sexual dysfunction and life-threatening conditions like reproductive cancers. In addition, there is insufficient data to demonstrate the extent and patterns of intimate partner violence against older women, especially in in low- and middle-income countries.

It is therefore necessary to respond to the sexual health needs of the elderly.

World Health Organization. Defining sexual health: Report of a technical consultation on sexual health, 2002. WHO; 2006.
World Health Organization. Developing sexual health programmes: A framework for action. WHO; 2010.
Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and nonpartner sexual violence. WHO 2013.

7. Sexual violence

•**Sexual violence** is defined as any act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.

•**Sexuality-related violence** includes violence of both sexual and non sexual nature committed against a person because of his or her sexual characteristics or behaviour, or violence which has an impact on a person's sexual health.

•Intimate partner violence is not only dangerous and damaging to the survivor, but also increases the likelihood of negative outcomes in his or her reproductive health. Relationships can also contribute positively to sexual health, creating a supportive environment in which preferences and health needs can be negotiated.

World Health Organization. Sexual health, human rights, and the law. World Health Organization; 2015.

Global figures on sexual violence

- Worldwide, 35% of women have experienced some form of sexual violence in either intimate or non-partner relationships (WHO 2013).
- On average, 30% of women who have been in relationships have experienced some form of physical or sexual violence by their partners (WHO 2013).
- 38% of global figures of murder of women were carried out by their partners (WHO 2013).
- Although everyone is at risk of being violated sexually, women and girls are at the highest risk; the more vulnerable groups of persons include people engaged in sex work, migrants, internally displaced persons and refugees, and people with disabilities (WHO 2002, WHO 2015).
- According to global data from 25 armed conflict areas, there is also an increasing incidence of sexual violence against men in conflict situations - including rape, sexual torture, mutilation of the genitals, sexual humiliation, sexual enslavement, forced incest and forced rape (WHO 2002, WHO 2015).
- 20% of women and 5-10% of men have reported having been sexually abused when they were children (WHO 2002, WHO 2015).

World Health Organization. Defining sexual health: Report of a technical consultation on sexual health, 2002. WHO; 2006.
World Health Organization. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. WHO; 2013.
World Health Organization. Sexual health, human rights, and the law. World Health Organization; 2015.

Consequences of sexual violence

- Sexual violence is a serious public health threat (PAHO,WHO 2000).
- It affects an individual's physical and mental health presenting a range of sexual and reproductive health problems in the short term and in some instances with long term consequences.
- People living in constant sexual abusive relationships lose the courage to make self choices with their sexuality which may lead to dire consequences such as sexually transmitted infections and other reproductive and or gynaecological morbidities. Sexual violence which lead to pregnancies increases the risk of abortions, miscarriage, stillbirth, preterm delivery and low birth weight.
- Other consequences of sexual violence include increased risk of depression, post-traumatic stress disorder, sleep difficulties, eating disorders and emotional distress.

World Health Organization. Sexual health, human rights, and the law. World Health Organization; 2015.

Forms of sexuality-related violence

- Rape and coerced sex
- Sexual harassment
- Trafficking and forced prostitution
- Child sexual abuse
- Neglect of girls
- Sexual war crimes
- Female genital mutilation
- Forced pregnancy
- Forced abortion
- “Honour” crimes
- Violence stemming from real or imagined sexual characteristics (e.g. LGBT status, lack of virginity, extramarital partnerships and sexual contact, and sexual “disobedience”).
- Cyber violence or Virtual violence

World Health Organization & United Nations Population Fund. Measuring sexual health: Conceptual and practical considerations and related indicators. World Health Organization; 2010.

World Health Organization. Developing sexual health programmes: A framework for action. WHO; 2010.

Addressing gender inequality and sexual-based violence

Gender inequality and sexual-based violence seriously hinder efforts and progress towards a more healthy and equitable society. States can tackle inequality and violence through empowerment and education of all individuals, regardless of gender or sexual identity.

All individuals have a role and responsibility to end inequality and violence. Change can be brought on through collaboration between individuals and societies' willingness to tackle these issues head-on.

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