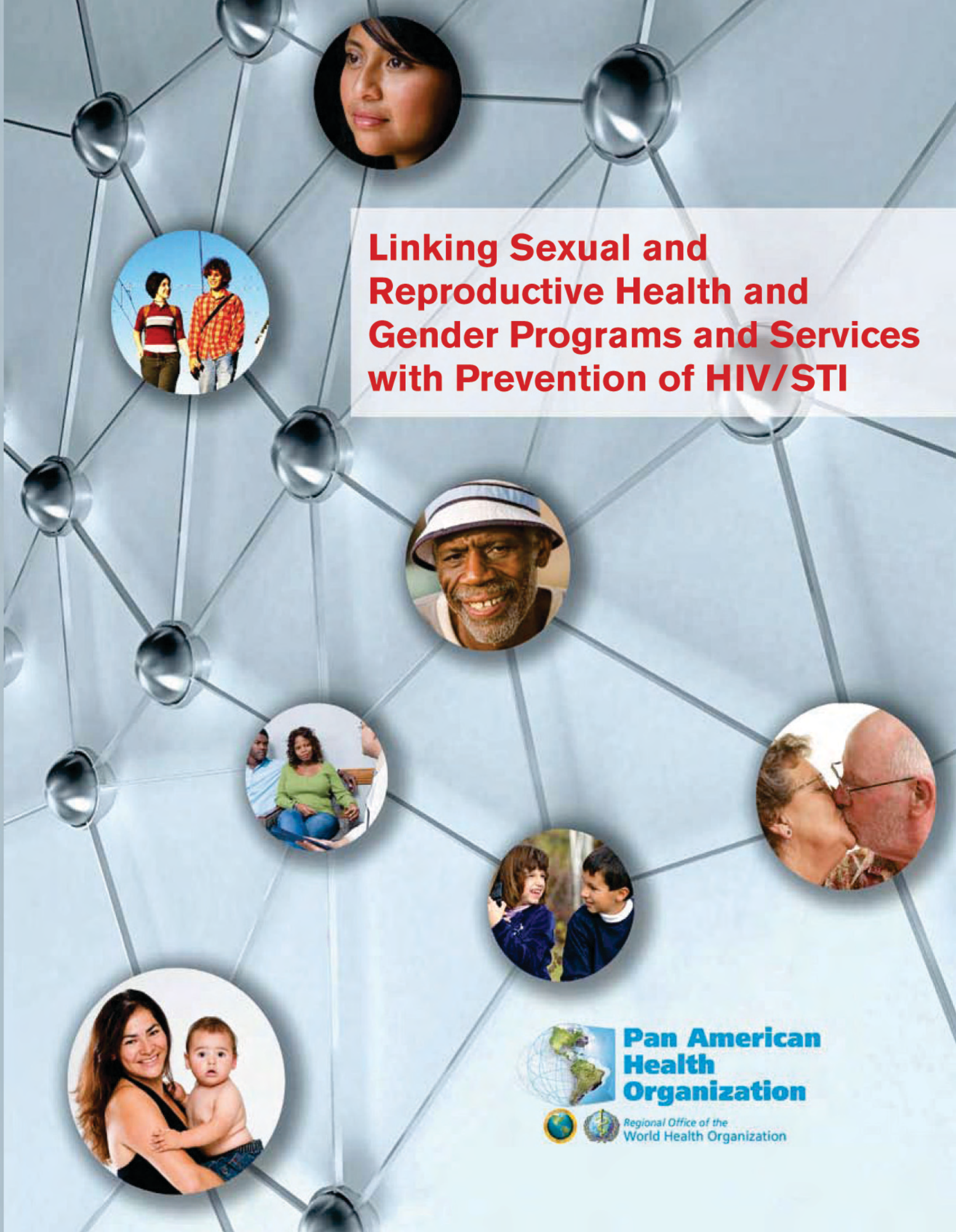

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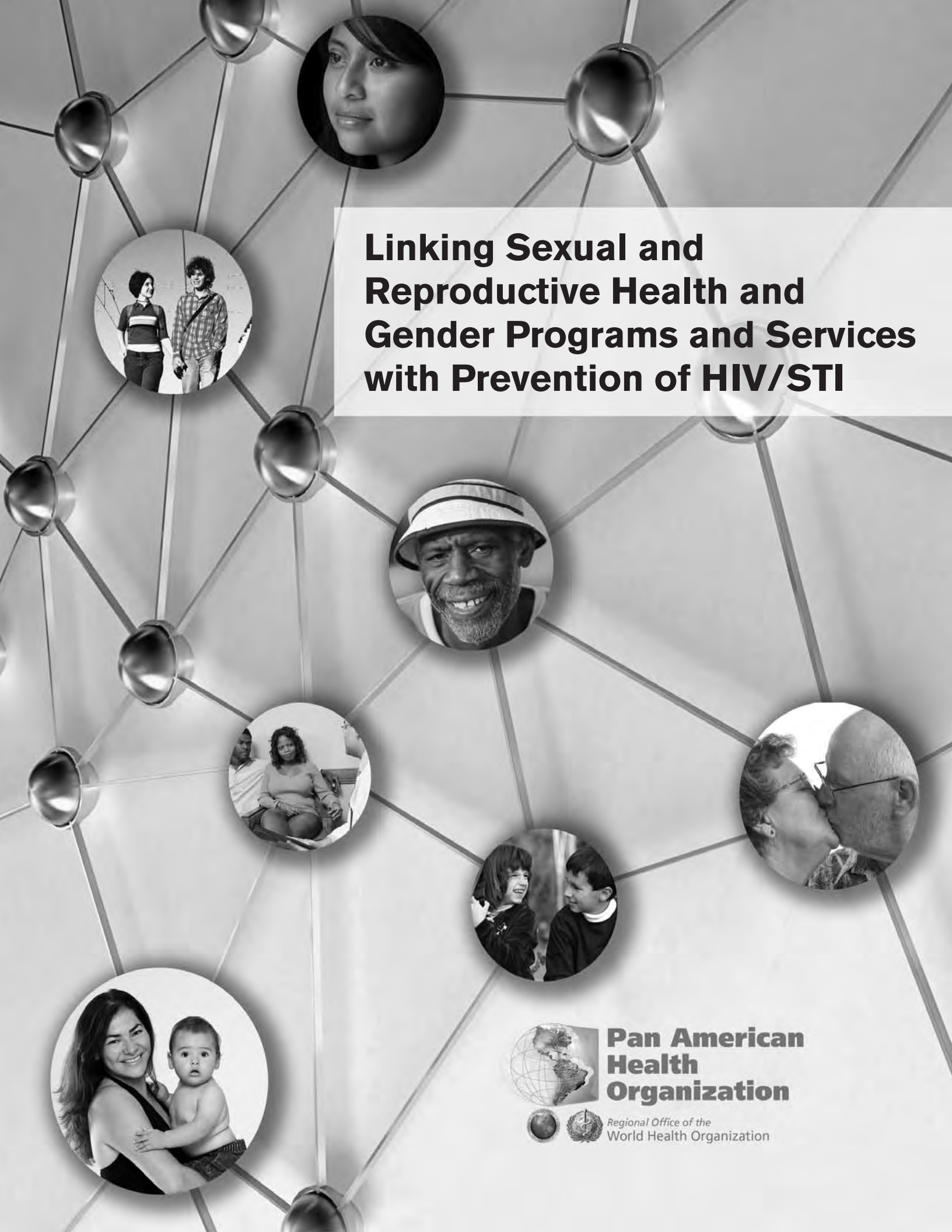

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PAHO HQ Library Catalog-in-Publication

Pan American Health Organization

"Linking Sexual and Reproductive Health and Gender Programs and Services with Prevention of HIV/STI"

Washington, D.C.: OPS, © 2010

ISBN: 978-92-75-13077-3

I. Title

1. HIV INFECTIONS – prevention & control

2. SEXUALLY TRANSMITED DISEASES – prevention & control

3. REPRODUCTIVE HEALTH SERVICES – organization & administration

4. PREVENTIVE HEALTH SERVICES – methods

5. HEALTH PROMOTION

6. SEX EDUCATION – manpower

7. SEXUALLITY

NLM WC503.6

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This document, targeted at health sector decision makers and sexual and reproductive health (SRH) and HIV/STI program and service managers, is the fruit of a series of intensive expert consultations organized by PAHO over the course of several months, with the participation of other United Nations agencies.

This process has been geared to developing a work approach that not only increases the coverage of these programs and services but makes them more accessible to the segments of the population that need them the most. At the same time, greater use of these programs and services should result in a substantial reduction in problems associated with sexual activity and reproduction.

HIV and other sexually transmitted infections are so important that the actions necessary to deal with them cannot be postponed. It is therefore essential to integrate them into the work of SRH programs and services. The gender dimension, which intersects with all facets of human life, is especially visible in the area of sexuality and reproduction. Thus, it has been regarded from the outset as an underlying aspect of the linkage between programs and services. It serves as the foundation for building connections and linkages that should result not only in fewer cases of HIV and other STIs but also in marked improvements in a variety of sexual and reproductive health indicators as well as indicators of the general sexual well-being of individuals, families, and communities.

Rafael Mazín, of the Family and Community Health Area, was responsible for coordinating and managing the expert consultations and for the preparation, review, and editing of the different versions of this document. The first two expert consultations were held in Montevideo in June and August 2007. The following individuals participated: Betzabé Butrón, Virginia Camacho, Luis Codina, Catharina Cuéllar, Bremen De Mucio, Ricardo Fescina, Matilde Maddaleno, Gerardo Martínez, Patricio Rojas, Maritza Romero, Gina Tambini, Horacio Toro, and Luis Toro (PAHO); and Raquel Child (UNFPA).

The third consultation in October 2007 was also held in Montevideo and was attended by the following individuals: Fernando Amado, Virginia Camacho, Catharina Cuéllar, Bremen De Mucio, Ricardo Fescina, Matilde Maddaleno, Gerardo Martínez, Patricio Rojas, Gina Tambini, and Luis Toro (PAHO); Maria Inês Barbosa (UNIFEM); Raquel Child (UNFPA); Mark Connolly (UNICEF); Esther Corona (World Association for Sexual Health [WAS]); Barbara De Zalduondo (UNAIDS); Jane Galvão (IPPF); Wolfgang Munar (Inter-American Development Bank); and Carlos Cáceres and Marisela Padrón, who attended as expert consultants in sexual and reproductive health.

An additional meeting was held in Washington, D.C., in April 2008 to review the architecture of integrated programs and services. During that meeting, the working document was thoroughly reviewed and additional recommendations were made.

The participants at that meeting were Christopher Bates, Tom Broker, Carlos Cáceres, Xóchitl Castañeda, Arachu Castro, Barbara Clarke, Eli Coleman, Lynn Collins, Esther Corona, Maryanne Doherty, Layla Esposito, Jane Galvao, Julia Heiman, Rubén Hernández Serrano, Rhonda Kropp, Danuta Krotski, Marilyn Lauglo, Scott Long, Eleanor Maticka-Tyndale, Susan Newcomer, Luis Perelman, Michael Ross, Sonia Ruiz, William Smith, Mitchell Tepper, and Priscila Vera. PAHO was represented by Mónica Alonso, Cristina Beato, Christopher Drasbek, Gottfried Hirnschall, Hernan Montenegro, Sofialeticia Morales, Luis Fernando Padilla, Ewa Nunes Sorensen, Gina Tambini, José Romero Teruel, Marijke Velzeboer-Salcedo, and Fernando Zacarías.

The initial drafts of the document were prepared by Carlos Cáceres and Esther Corona. Finalization of the document was a long process involving the review of countless drafts, the translation of entire sections, and wide circulation of the versions that emerged during the course of the process.

Input from Suzanne Serruya, Marijke Velzeboer-Salcedo, and Maritza Romero (PAHO) and from Esther Corona (WAS) was particularly useful and facilitated a more accessible format for this document, making it more easily applicable in the field.

The well-being and fulfillment associated with gratifying, responsible, and risk-free sex are essential to overall health.

Introduction

A. Sexuality and health

Sexuality is a fundamental dimension of the quality of life of individuals (men and women alike), families, and communities. In addition to its obvious link with reproduction, it is a basic source of gratification, well-being, and intimacy that, by making it possible to express affection and commitment, helps to forge enjoyable and constructive affective-emotional bonds. *(1)*

The well-being and fulfillment associated with gratifying, responsible, and risk-free sex are essential to overall health. Sexual activity, however, can also be associated with emotional/interpersonal conflicts and situations that jeopardize the health and quality of life of individuals, families, and communities.

The spread of the human immunodeficiency virus (HIV)—a pathogen transmitted in most cases by sexual activity—is a clear example of the urgency of tackling the issue of sexuality head on and understanding how it relates to the health and well-being of men and women and the population as a whole.

Sexuality is a fundamental dimension of the quality of life of individuals, families, and communities. It is profoundly influenced by social interaction, culture, and personal experiences. Thus, getting the issue on the public health agenda calls for a deep and clear understanding of the expressions and dynamic of sexuality in everyday life and throughout the life cycle—not only during the reproductive phase. Nor should sexuality be reduced simply to events associated with reproduction, because in a substantial proportion of human sexual activity the primary purpose and outcome are not procreation.

Since the first AIDS cases came to the attention of the public, the resources invested in confronting the many challenges that HIV infection poses have exceeded those invested in other health areas or problems. This extraordinary investment has not been in vain, since it has led to scientific discoveries and rapid progress. Nevertheless, the epidemic has not been contained, and HIV continues to infect a growing number of people.

However, on analyzing this investment of resources to combat HIV, the insufficiency of the funding currently allocated to promotion and prevention is evident. This may explain why for every two infected people with access to treatment, an estimated five new infections occur. According to the UNAIDS report of July 2008 on the global epidemic, every day some 7,600 new infections occur, meaning that five people are infected every minute. It is also estimated that nearly half of those new infections occur in young people aged 15–24. This fact alone poses an unavoidable challenge that cannot be put off: to search for different, innova-

tive ways of preventing new infections, especially in young people, while preserving and maintaining the gains made with respect to improving the conditions of people with HIV and AIDS, including access to treatment, which has without a doubt contributed to a significant reduction in mortality from AIDS.

Adolescents and young adults of both sexes are a very important segment of the Region's population, since they account for some 30% of the total population of Latin America and the Caribbean. They are considered a relatively "healthy" sector of the population and, as a result, their health needs are often overlooked. Nevertheless, since young people are particularly impacted by the HIV/AIDS pandemic, their sexual and reproductive health (SRH) merits special attention. Many of the sexual behaviors acquired during adolescence can have persistent effects into adulthood. Improving the sexual and reproductive health of adolescents requires forceful action, including provision of comprehensive sex education and promotion of sexual health. Moreover, matters that significantly impact the young population, such as early motherhood, prevention of HIV and other sexually transmitted infections (STIs), care seeking, violence, and risk behaviors, must be addressed. *(2)*

In 2000, a PAHO consultation held in Antigua Guatemala, Guatemala, and the publication that emerged from it, Sexual Health Promotion: Recommendations for Action, recognized the importance of adopting a holistic approach to sexual health that differs from the more traditional one that focuses basically on reproduction. *(3)* The Conceptual Framework for Adolescent Sexual and Reproductive Health was developed in 2003 and described in a subsequent publication. *(4)* In 2005, another PAHO publication, Youth: Choices and Changes, *(5)* delved even more deeply into the subject and offered an extensive overview of theoretical frameworks for the promotion of adolescent health and development.

According to the July 2008 UNAIDS report mentioned earlier, surveys conducted in 64 countries showed that only 40% of young people and 38% of young women have sufficient knowledge about HIV and how to prevent its transmission (United Nations General Assembly Special Session [UNGASS] Indicator 13). It can be inferred from this finding that there is widespread unawareness of the importance of low-risk sex and protected sex. Such lack of knowledge is associated with unprotected sex that results in unwanted pregnancies, as well as the risk of infection with HIV and other pathogens that cause inflammation and lesions in the uro-genital tract. Recent studies conducted by the Guttmacher Institute indicate that rates of adolescent motherhood in Honduras, Nicaragua, and Guatemala are higher than rates reported in other studies. *(6)*

Adolescent motherhood, the disproprtionate number of new HIV infections in this population, and the high incidence of STIs among young people are indicators of unprotected sex stemming from lack of access to comprehensive sex education and high-quality sexual and reproductive health promotion services.

In August 2008, on the eve of the XVII International AIDS Conference in Mexico, that country's government convened a ministerial meeting in which the health and education ministers of Latin America and the Caribbean made a commitment to revitalizing HIV prevention activities, especially among youth. As a result of that meeting, a declaration was issued that proposed concrete actions, especially comprehensive sex education, closely linked with sexual and reproductive health promotion services. *(7)*

For PAHO, creating dynamic links between programs and services designed to improve the sexual and reproductive health of the most vulnerable population is an ethical imperative, a technical challenge, and a mandate from its Member States.

The challenges inherent to this process are clearly reflected in regional and global initiatives such as the Millennium Development Goals (MDGs), the Strategic Plan for PAHO 2008–2012, the Regional HIV/STI Plan for the Health Sector, PAHO's gender equality policy, the universal access goals for 2010, the initiatives for a generation of children free of HIV and congenital syphilis, the regional strategy to improve adolescent and youth health, and the other interagency and interinstitutional commitments to equitable health and development. Thus, integration of sexual health, reproductive health, gender, and prevention of HIV/AIDS and other STIs is a critical strategy for ensuring that adolescents and adults, both male and female, can enjoy healthy, satisfying, and safe sex free of violence and coercion and without inequities associated with gender or sexual orientation.

The purpose of this document is to offer readers a strategic proposal developed by experts from the Region. This proposal seeks to make a significant contribution to the efforts already under way in several locations to optimize health care, including sexual and reproductive health promotion and care with a gender perspective that explicitly approaches HIV and other STIs as problems requiring immediate attention. The proposal not only stresses the importance of collaboration among programs, services, providers, and community members to better tackle the challenges posed by these issues but proposes actions that can lead to a better quality of life for the individual, the family, and the community.

B. Linkage, articulation, or integration?

The existence of multiple points of intersection among the underlying causes of HIV/STI infection, such as gender inequities and other power asymmetries that prevent people and groups from exercising their rights, as well as a variety of conditions associated with SRH in general, has led to a call for convergence in the responses to such problems. The search for this functional link has been impeded by factors related to the internal structure of health systems (for example, the existence of predominantly vertical programs with little interconnection) and the express or tacit assignment of the different fields of health to assorted professional networks (infectious disease specialists and epidemiologists have traditionally been in charge of HIV/AIDS services, STIs have been the focus of dermatologists, and obstetricians, gynecologists, and health professionals specializing in adolescents frequently dominate the field of SRH). Inadequate integration of gender issues into health programs, the lack of an intercultural perspective, and failure to recognize the existence of sexual diversity or the specific needs of groups such as indigenous populations or persons with disabilities—not to mention funding trends (political agendas, donor priorities)—have also played a major role by hindering the creation and activation of the desired linkages.

As mentioned earlier, the main purpose of this document is to offer a strategic proposal to guide coordination, collaboration, and effective participation that transcends the mere recognition and mutual endorsement of programs and services to which people can be referred "for treatment." In this regard, instead of viewing services devoted to sexual health and reproductive health, gender and HIV prevention, and STIs in isolation, the idea is to create synergies among them—with a gender perspective and broad community participation—that will produce the following:

C
A
R
I
B
E

a) EXPANDED **COVERAGE**: care for a growing number of infants, boys and girls, and women and men who, as citizens with rights, should have the highest attainable access to care

b) **ADAPTATION** FOR GREATER USE: adjustment of responses to specific needs and demands instead of rigidly standardized processes, bearing in mind the existence of groups with disabilities and special needs and that the people in those groups are citizens, too, not sick or potentially sick organs or bodily systems

c) GREATER **RESILIENCY** IN THE POPULATION: the contribution of an emphasis on prevention, instead of merely clinical care, to developing the capacity for self-care and reducing adverse events requiring curative interventions

d) **INTEGRATED** SERVICES: delivery of full and exhaustive services instead of fragmented ones

e) GENERAL WELL-**BEING**: care for the entire population as opposed to just certain segments

f) **EQUITY**: reduction of inequities in access to health promotion, health care, and prevention programs and services

We propose that the interaction of such programs and services be considered synergistic if these elements are achieved (the acronym **CARIBE** can be used as a mnemonic to keep them in mind during the later discussions on linkage/coordination/integration).

The use of certain terms helps to determine the nature of the strategic options proposed. However, such usage can also lead to confusion; because certain words sometimes used to express similar ideas at a particular time and place perhaps express rather different concepts in another context.

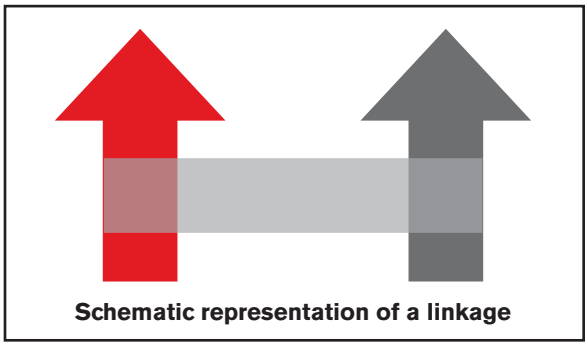
In this document, we indicate how the terms *linkage, articulation,* and *integration* are defined to maintain conceptual uniformity. The usage suggested is an adaptation of terms proposed in initiatives to secure the necessary interprogrammatic convergence between SRH and HIV/STIs. *(8).*

Interprogrammatic linking modalities

Many modalities can be adopted for collaboration between programs and services. The simplest of them focus on communication and referral mechanisms, and the more complex entail total fusion. Between these extremes lie multiple intermediate points.

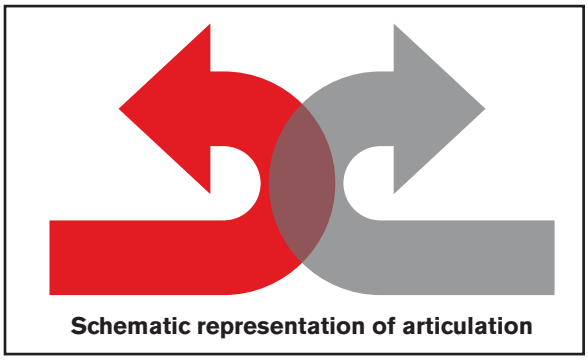
For the purposes of this publication, there will be three basic modalities: linkage, articulation, and integration. It is important to mention that, in some populations, terms such as "no integration," "partial integration," and "full integration'" are used.

Linkage refers to the connection of programs and services that use different methods or even different approaches but that, when linked together, are complementary and generate the synergies sought. An example of this would be preventing vertical transmission of HIV through primary prevention and counseling and screening of the reproductive-age population via HIV programs, in addition to programs that provide family planning services, prophylactic treatment, and skilled childbirth care for HIV-positive women, with the involvement of the male partner and the referral of both parents by reproductive health workers. Here, the synergy obtained would be a reduction in vertical HIV transmission and pediatric AIDS cases together with timely, adequate clinical, psychological, and social assistance for the infected parents.



Schematic representation of a linkage

Articulation refers to an understanding, at the conceptual and strategic levels, of the synergies that can be created through the use of standardized methodologies to confront specific health issues. For example, HIV prevention is addressed in SRH and HIV/STI services using a standardized methodology: educating patients in the use of condoms and providing condoms and lubricants. In both contexts, the effect obtained is synergistic, since condoms offer "dual protection" (pregnancy prevention and prevention of STIs, including HIV).



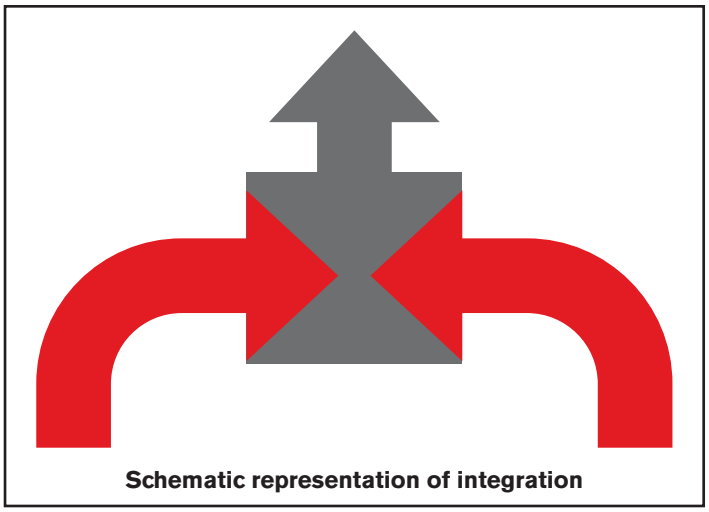
Schematic representation of articulation

Integration refers to clearly defined, joint implementation processes in different programs and services that converge at different levels acting as a whole. Some examples of integration would be:

a) comprehensive care for women who are raped, which should include psychological care and support; pregnancy, HIV, and STI prevention; treatment for injuries; and articulation with legal and social support services

b) sexual health care for men who have sex with men, which should include HIV counseling and testing, education, and psychological support for risk reduction; vaccination against hepatitis A and B; detection of STIs in the genital tract, pharynx, and anus; and protection against stigma, homophobia, and abuse

c) care for the sexual and reproductive health needs of people with hearing impairments or deafness at health centers that provide education as well as confidential and reliable interpreting for HIV and STI prevention through appropriate media and methodologies *(9)*



Schematic representation of integration

All of these approaches have a common purpose: to ensure that individuals, families, and communities benefit from interventions that are mutually reinforcing. All of them have beneficial, provided that opportunities for linkage, articulation, and integration have been considered and conscientiously programmed. It is also critically important that joint and complementary action be taken in a timely manner to properly define each of these approaches.

In any case, it is important to recall a basic principle of the family and community health strategy: *the principle of timeliness*. According to this principle, the best approach is the one that can be taken when the interaction between programs, services, families, and individuals allows for timely, simultaneous, and harmonized health interventions.

1 Background and Justification

A. Importance of harmonizing efforts in sexual and reproductive health, the gender perspective, and program responses to HIV/AIDS and other sexually transmitted infections

Several key meetings on gender and reproductive issues in the past two decades have acknowledged the pressing need for close coordination in these fields of endeavor, suggesting mechanisms for creating connections and synergies. Annex 1 describes some of the most important documents and meetings on the justification and initiatives for creating such links.

B. Progress in and impediments to linking sexual and reproductive health interventions, the gender perspective, and program responses to HIV/AIDS and other sexually transmitted infections

Several experiences have recently been documented that reflect major efforts to integrate SRH services with activities to prevent HIV and other STIs. For readers interested in learning more about them, Annex 2 contains a description of these experiences and efforts.

Although no explicit reference is made to sexual health, it has been argued that this definition (of reproductive health in: ICPD, Program of Action 1994, Paragraph 7.2) recognizes that sexual health is inextricably interwoven with reproductive health.

2

Rationale for linking sexual and reproductive health and gender programs and services with HIV/STI prevention

A. Integrating sexual and reproductive health

The contemporary definition of reproductive health (which implies a radical shift from a demographic paradigm limited to fertility control to a holistic approach that addresses human rights, the gender perspective, and cultural diversity) had already been in use for several years prior to the International Conference on Population and Development (ICPD, 1994). However, it was the international consensus forged at that meeting that contributed to the development of the current concept of reproductive health:

> ***Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.***
>
> —ICPD Program of Action, 1994, paragraph 7.2

Although no explicit reference is made to sexual health, it has been argued that this definition recognizes that sexual health is inextricably interwoven with reproductive health. *(10)* However, and probably because of the very delicate political climate that prevailed during the ICPD, sexual health was lumped together with (and masked by) reproductive health.

The Program of Action also emphasizes that sexual health is part of reproductive health in the following: "Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." *(11)*

Although sexual health remains embedded in reproductive health, it should be recognized that the definition takes a positive view of sexuality and clearly spells out reproductive rights. However, several authors,

such as Miller, argue that treating sexuality as a component of reproduction renders non-reproductive sexual activity invisible. (*12)* This has resulted in the not uncommon suggestion that sexual health and reproductive health be considered two distinct concepts, each with its own program implications. Far from assigning greater importance to sexual health, this separation can lead to an unnecessary dichotomy that is detrimental to delivery of services. Fortunately, over the years the ICPD's definition of reproductive health has contributed to the development of an integrated concept in which a multiplicity of approaches (and, hence, services) can coexist and the various programs and services can eventually generate synergies among themselves.

Thus, the field of "reproductive health" has gradually morphed into "sexual and reproductive health." It should be noted, however, that the emphasis is still primarily on reproductive health, with much less attention focused on sexual aspects. Nevertheless, interest in non-reproductive sexuality is gaining ground in technical discussions, and the issues of gender and rights have also become an irreplaceable part of the discourse on sexual and reproductive health.

Side by side with the development of the broader concept of sexual and reproductive health was growing concern about the implications of the HIV epidemic. Many authors are coming to recognize that the traditional view of sexual activity and sexual practices held in the field of family planning and the sexual transmission models for HIV do not easily correspond to public norms of sexual activity or standard socio-sexual categories. *(13)*

As mentioned earlier, the call to integrate sexual and reproductive health with programs and services for the prevention and treatment of HIV has become louder over the years, thanks in part to the abundant evidence of the benefits of this linkage; however, criticism and reservations about the importance of creating that linkage are still voiced. *(14)* It should be noted that in the majority of references in the growing and already abundant literature on the subject, sexuality continues to be considered a component of reproductive health.

There are many reasons to support the integration of reproductive health, gender, and HIV/STIs, particularly in the services. Among them:

- To be able to systematically tackle two of the most important challenges in public health, which are improving women's and men's health and halting the spread of the HIV epidemic
- To recognize and therefore respond to the fact that the majority of HIV infections in Latin America and the Caribbean are sexually transmitted or associated with vertical transmission during pregnancy, childbirth, and breast-feeding
- To produce synergistic activities for an effective response to problems that would be extraordinarily difficult to eliminate with a single program, such as poverty, gender inequality, and the social marginalization of the most vulnerable populations

B. Sexuality and HIV prevention

Even before the ICPD, in a much-cited 1993 article (and, subsequently, a book chapter), Dixon-Mueller called attention to the need to establish the "sexuality connection in reproductive health." *(15)* In the final analysis, sexuality and power relations underlie all of the behaviors and conditions addressed in reproductive health programs. The ICPD and the subsequent Fourth World Conference on Women included language legitimizing the inclusion of sexuality in health and development agendas. *(16)*

The HIV pandemic has undoubtedly been one of the driving forces in bringing the need for greater

study and a better understanding of sexuality to the attention of scientific discussion forums. The HIV epidemic has been closely linked with important efforts to conceptualize sexuality and explore it from an anthropological-ethnographic, psychological, and social perspective, which has helped to increase knowledge about this major dimension of human existence.

Nevertheless, despite this recognition, many of the approaches in HIV prevention and treatment have succeeded in evading some of the complexities of sex. *(17)* The dimension of eroticism and pleasure in particular has often been overlooked. *(18)*

Boyce has suggested that a limited concept of human sexuality in HIV and AIDS efforts is the main barrier to effective prevention of HIV infection at the global level (see reference 13). Reproductive health would also benefit from an acknowledgment of the centrality of sexuality, which could not only open the door to a more effective approach to resolving urgent health concerns but respond to the ethical imperative and the technical challenge implied in efficiently performing the tasks necessary for achieving the MDGs.

C. Approach based on human rights

The international system of human rights, much like the regional systems, has an important body of legal instruments that can be used to protect the human rights and basic freedom of people who live with HIV and other vulnerable groups. Some of these instruments have arisen from conventions or treaties and are of a compulsory legal nature for the States that have ratified them. Other instruments such as the declarations or standards of international human rights, although they are not legally binding, are considered useful instruments to interpret the requirements of the international conventions that have been developed from the consensus of the States and are based on the principles of social justice, many of which are directly pertinent for reproductive health care *(19).* This assertion can be equally valid for HIV.

The Preamble of the Constitution of the World Health Organization (WHO) establishes that "the enjoyment of the maximum level of health that can be achieved is one of the basic rights of every human being, without distinction of race, religion, political ideology, or condition which is economic or social" *(20).* The enjoyment of the highest possible level of health that can be achieved as a fundamental human right is also protected by several declarations, treaties and international conventions of human rights such as the Universal Declaration of Human Rights, the Pact of Economic, Social, and Cultural Rights, the Convention on the Rights of the Child, the Convention on the rights of persons with disabilities and the Protocol in Addition to the American Convention with regard to economic, social, and cultural rights (Protocol of San Salvador), among others. At the same time, there is a growing recognition at the international level that a certain level of physical and mental health is necessary to be able to exercise the rights and fundamental freedoms and thus participate in civil, social, political, and economic life of a State; and that the exercise of human rights and aforementioned freedoms is essential so that the most vulnerable people can enjoy true physical and mental well-being *(21).*

The reproductive rights that serve to support reproductive health were identified and recognized in the International Conference on Population and Development (ICPD, Cairo), while the Fourth World Conference on Women (Beijing) established that human rights include the right to have control over issues related to sexuality, including sexual and reproductive health. In the two aforementioned conferences, the Member States of the United Nations confirmed that human rights have a direct influence

on sexual and reproductive health, that there exists the right to reach the maximum level of sexual health and that sexual health is different from a human's well-being *(22).*

The Secretariat of WHO does not define sexual rights as such but instead as ***"human rights related to sexual health"*** *(23).* In spite of this, in the technical documents that are found in discussion, the Secretariat not only identifies several "sexual rights", but also succeeds in explaining them in some detail:

The sexual rights are included within the human rights that are already recognized in the national laws, international human right documents, and other declarations of consensus. They include the rights of all people, free from coercion, discrimination, and violence, to:

- Reach the highest standard of sexual health, including access to sexual and reproductive health care;
- Seek, receive, and issue information related to sexuality;
- Receive education on sexuality;
- Have protected and respected their physical integrity;
- Elect freely their partners;
- Decide to be sexually active or not;
- Engage in consensual sexual relations;
- Establish marriage ties consensually;
- Make decisions concerning having children and when to do it; and
- Try to have satisfactory, safe, and pleasant sexual activity.

At the level of civil society, other organizations propose a group of specific sexual rights. This is the case of the World Association for the Sexual Health (previously known as 'World Association for Sexual Health') *(24).*

The "right to enjoy the highest possible level of sexual health" (Beijing and Cairo Conferences) and the "sexual rights" that are proposed by the technical documents under review of WHO can be included as a basic component of the MDG (v. ref. 8). It is important to mention that in accordance with the States of PAHO, the international law of human rights firmly established in agreements, and international and regional standards in regards to human rights, it offers a conceptual and legal unifying framework of strategies for the reduction of poverty, gender-based inequalities, vulnerability to HIV infection and STIs, and domestic and gender violence and that is closely interrelated. Similarly, the international human rights law also offers measures to evaluate the progress of the States and clarify accountability and responsibilities of the different stakeholders *(25).*

D. Creating a culture of prevention

An estimated 450 to 500 new HIV infections occur every day in Latin America and the Caribbean, and these figures could rise even higher if the multiple factors that influence HIV transmission, such as cultural and community norms, economic factors, and gender differences, are not duly addressed. However, as mentioned earlier, most HIV infections are the direct or indirect result of sexual behavior, even in the case of vertical transmission. Thus, an approach aimed at reducing the risk of exposure to the virus (i.e., reducing the number of sex partners, using mechanical barriers, or adopting mutual sexual exclusivity) and/or the efficiency of transmission (through the use of microbicides or antiretrovirals, methods still in the testing phase, and the treatment of other sexually transmitted infections) constitutes a response that, while not eliminating many of the aspects of vulnerability, does lower the risk of contracting the infection.

The Declaration of UNGASS 2001 stresses the need for using an approach based on rights and to promote legal reforms

In the field of HIV/AIDS a transition of an approach based on needs has occurred to one based on rights. The advantages that the latter encompasses are, among others:

- Emphasizes the obligation of the state to carry out the inalienable rights of its citizens and includes the beneficiaries as subjects of development, not objects of the "charity" or "paternalism" of the authorities
- Recognizes that is essential the full development of the abilities of people to exert their powers as citizens in actions of participation and involvement in decision-making
- It focuses on the underlying causes of the problems, including the social, political, economic, religious, and cultural context, together with the manifestations of those problems.
- Visions and holistic attitudes are guided in development of policies and promoted in order to provide sustainable and lasting solutions (adapted from Patterson, D., http:// icad-cisd.com/pdf//David _ Patterson _EN. ppt)

An example of this integrated approach can be seen in programs that prioritize strategies for outreach to women, especially young women, to prevent them from contracting the infection in the first place. The goal is to make this happen through comprehensive education and communication programs that help to develop attitudes and skills leading to a safe and healthy sexual and reproductive life. At the same time, efforts are under way to offer services to uninfected women that will guarantee their access to contraceptives (including condoms) to prevent HIV and other STIs, unintended pregnancies, and reinfection and coinfection among women who are already infected. Because these actions can also lead to a reduction in vertical transmission, they have a major impact on children's health.

A culture of prevention instilled at all levels—social and structural, in the community, the family, and the individual—coupled with the integration of sectors and services and an understanding of the basic determinants of sexual and reproductive health, would surely contribute to achievement of the MDGs related to HIV, maternal and child mortality, and the empowerment of women.

Prevention activities must be inclusive and must never be based on the assumption (usually based on prejudices) that individuals in certain groups (such as persons with disabilities and the elderly) are not sexually active and are therefore not at risk of becoming infected *(26)*.

A new paradigm is taking shape through the concept of "sexual citizenship," which is used to support and promote a rights-based approach and create the necessary mechanism for articulating and reporting inequalities, inequities, and injustices based on sexuality and its expressions. The concept of sexual citizenship links private matters with public matters and emphasizes the cultural and political dimensions of sexual expression and its multiple repercussions, important among which are reproduction, HIV, and other STIs.

The debate over the supremacy of sexuality, reproduction, or the components of HIV/STIs in an integrated approach is artificial. Clearly, the path should be smoothed so that social and health problems can be tackled in an integrated, coherent, and comprehensive fashion and strategic decisions about where to place the emphasis at the local level can be made.

Risk, Vulnerability, and Prevention

The terms "risk" and "vulnerability" are often used inconsistently when undertaking prevention activities. Actually, they describe different phenomena that are closely linked but not equivalent.

Risk is a concept that describes the probability that a specific undesirable event will occur in a particular period or under certain specific circumstances. For example, the risk of contracting HIV infection through unprotected sex between the members of serodiscordant couples (that is, only one member is infected) can be expressed by the number of infections occurring in a certain population of serodiscordant couples engaging in such practices in an observed period of time (for example, one year). The concept of risk presupposes exposure to an agent or factor (in this case, the virus) that causes, fosters, or precipitates the appearance of the undesirable effect.

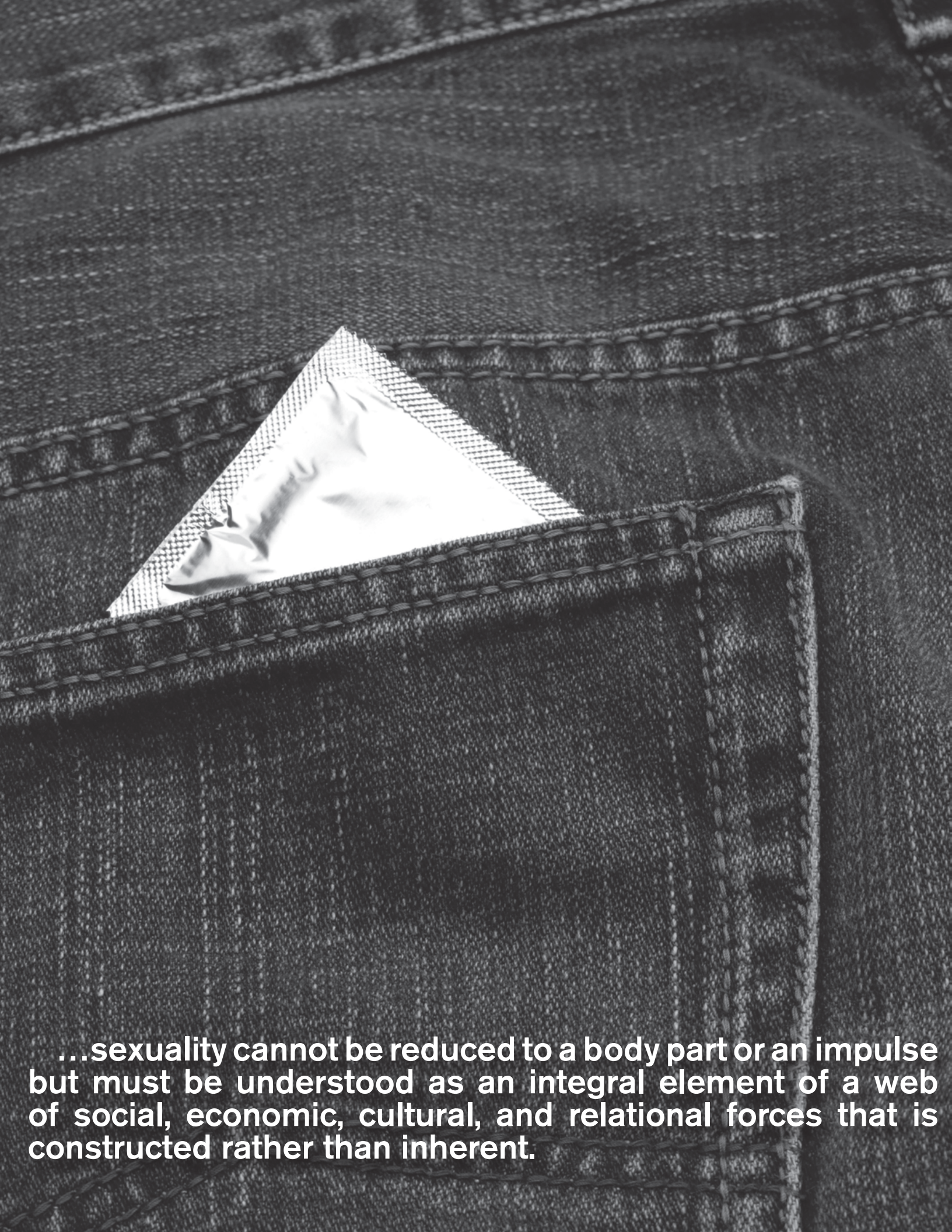
Vulnerability is a concept that describes the level of control that people have over internal or external hazards. At the individual level, these hazards can be genetic (sex and other genotypical attributes), acquired (the presence of a sexually transmitted infection or its sequelae), or developmental (age and physical maturity, emotional development, individual experience, education, beliefs, abilities, perceptions). At the social level, they are associated with culture and ideology, systems of gender relations, official norms governing sexuality, and public attitudes that lead to stigma and discrimination, heterosexism, and homophobia. Some authors also describe another level of vulnerability, the programmatic level, which they use to refer to the limitations on control, imposed by official programs whose policies, objectives, and resource distributions do not help to reduce the lack of control of individuals or groups over dangerous situations, agents, or causative factors of disease and their impact.

All action taken to prevent a health problem from occurring in a particular population, suppressing insofar as possible the emergence of cases of an undesirable event (disease, injuries, deaths), falls within the concept of **primary prevention**. The tasks involved in primary prevention are the reduction or elimination of exposure to harmful agents or determinants (i.e., risk reduction) and the removal of obstacles that limit the control that populations should have over their health, their environment, and their lives (i.e., reduction of vulnerabilities through protective action, individual and community empowerment, and appropriate programs). **Secondary prevention** consists of efforts to ensure that even though there has been exposure to a harmful agent, the harm that it may cause can be contained (e.g., early detection of HIV infection so that treatment can be initiated to prevent replication of the virus and the progression of the disease, treatment of pregnant women who test positive for syphilis to prevent cases of congenital syphilis). **Tertiary prevention** is designed to prevent the damage caused by harmful agents from resulting in incapacitating injuries and disorders or causes of illness, suffering, or threats to life (e.g., detection of unapparent infections of the female genital tract that can lead to chronic inflammation and tubal injury with secondary infertility).

Despite widespread recognition of prevention's importance in maintaining individual and community health, there are several factors that contribute to the perpetuation of a culture centered on remedial responses, curative action, and compensation for harm. For example, the recovery of lost health through medical treatment and surgery has a more dramatic impact than health promotion and preservation through healthy lifestyles, taking precautions, and avoiding exposure to risk and harmful agents. Knowing that recovery is possible if a certain procedure is done or a certain substance is ingested can lead to a loss of the inhibition that helps keep people at a reasonable distance from dangerous situations or substances. This reaction is known as "preventive behavioral disinhibition" and is manifested through behaviors and attitudes marked by overconfidence and recklessness. For instance, the introduction of antibiotics may have had a disinhibitory effect on behaviors that contribute to preventing sexually transmitted diseases. There are those who suggest that the existence of antiretroviral therapy (ART) may be having a similar effect when it comes to practices aimed at preventing HIV transmission. *(27)*

Other factors that may be part of a culture in which a paradigm centered on curative responses and compensation for harm prevails are those related to the commercial interest in putting remedies for health problems in a bottle. The profit motive can lead business interests to convince the public that the inconveniences of prevention can be eliminated with effective cures. Some factors and situations, however, limit the ability of individuals and groups to adopt preventive measures—that is, there are circumstances that make them vulnerable and powerless to take preventive action. Therefore, they often have no other recourse than to seek drastic remedial solutions. An example is women who have unwanted pregnancies because of their lack of access to sex education or family planning services. The only option for many is to resign themselves to not having any control over their fertility or their lives. For others, there is a drastic remedial solution: interruption of the pregnancy. This intervention is often done clandestinely and in unsanitary conditions that involve a high risk of health complications, including death. In areas with a culture of promotion and prevention, the scenarios of fatalism and clandestine abortion are modified by a high level of access to sex education for young people, especially women; widespread access to family planning services; and adequate protection of people's rights.

In linking sexual and reproductive health, gender, and HIV/STI prevention, the goals are to ensure that the preventive approach is preferable to the curative one and to promote a culture of prevention (the "R" in the mnemonic "CARIBE" mentioned earlier).



…sexuality cannot be reduced to a body part or an impulse but must be understood as an integral element of a web of social, economic, cultural, and relational forces that is constructed rather than inherent.

3

Social determinants of HIV/AIDS and the key role of sexuality

The social determinants associated with the HIV epidemic have become increasingly clear over the past two decades. While at the beginning, HIV was considered essentially an individual problem that was approached from the biomedical-behavioral perspective, the growing attention paid to its social and cultural dimensions has led to a broader understanding of the diverse and complex factors related to the dynamics of the epidemic, such as sexuality, gender, ethnicity, social class, ability and disability, and control over one's own life (power). This expanded vision, moreover, has made it possible to grasp the importance of a human rights perspective, as well as the key role of different actors in the epidemic response. *(28)*

Introduction of the concept of vulnerability was intended to make it clear that the risk of HIV infection is strongly associated with social structures and constructs that increase or reduce an individual's control (power) over her or his life and health and does not depend solely on individual behavioral or physical (phenotypical) characteristics. *(29)*

Social vulnerability is usually associated with increased susceptibility to HIV infection, as a result of not only limited access to health services but also the role that sexuality plays among the socially vulnerable: HIV is transmitted primarily through sexual contact, and vulnerable groups are often affected by social dynamics in which sex ends up as a resource for barter (e.g., transactional sex) among those who have little control over the terms of the transaction. There are also groups that have less control over their sexual activity, for both individual reasons (e.g., sex under the influence of alcohol or other substances) and social reasons (stigma, discrimination, ostracism, and abuse of drug users). *(30)*

Their search for an understanding of the connection between sexuality and HIV infection has led experts in the field to study the epidemic from different perspectives, which has resulted in more thorough analyses of the processes associated with the history, culture, and politics of sexuality. A report by the Sexuality Policy Watch, a global forum of researchers and activists in the area of health and sexual rights, provides a theoretical framework for understanding the relationship between sexuality and social policy. *(31)* The authors use assessments from at least the past two decades of intellectual output on the history, culture, and politics of sexuality. Their theory contains three propositions:

First, sexuality cannot be reduced to a body part or an impulse but must be understood as an integral element of a web of social, economic, cultural, and relational forces that is constructed rather than inherent.

Second, sexuality, sex, and gender are independent yet also interdependent concepts. Social historians and ethnographers of sexuality have produced a wealth of information and convincing qualita-

tive data indicating that sexuality and gender are extraordinarily complex and layered phenomena. This means that sexual behavior is different from sexual orientation, identity, and desire.

Third, sexuality is not a secondary characteristic but a primary one that is part of the essence of the HIV/AIDS pandemic as well as a component of the realities and debates surrounding the family, women's place in society, reproductive self-determination, the meaning of masculinity, and the expression and corruption of political power.

Another key element in the dynamic of the HIV epidemic is gender inequality, which heightens the vulnerability of men and women to HIV infection. For example, violence or the threat of violence against women creates situations that increase women's vulnerability to infection with HIV and other agents. Socioeconomic status and the cultural expectations and social demands that weigh on both women and men can heighten the risk of HIV infection. The subordinate role imposed on women is associated with a greater risk of involuntary exposure to the infection, while men can consciously take the risk. This is because the prevalent notions of masculinity in Western society are associated with wholesale sexual conquests and reckless risk behaviors.

An analysis of the impact of gender on HIV infection reveals the importance of integrating a gender perspective into the programming of activities to contain the growth of the HIV epidemic and find ways of empowering women through policies and programs that increase their access to education and information. *(32)*

Discussions of stigma and discrimination have been vital to fighting the epidemic, in terms of both comprehensive care and prevention. In a 2003 article on this issue, Aggleton, Parker, and Maluwa explored the association between stigma and discrimination and its impact on the effectiveness of HIV/AIDS programs. These authors provided a conceptual framework describing the interaction between stigma, discrimination, and human rights. They also offered guidelines for programming activities that consider the stigma and discrimination associated with HIV and AIDS as manifestations of other varied sources of stigma in a broader social context. From this perspective, stigma is a result of the compulsive need of human groups to classify, group, and include (or exclude) others (the exogroup) on the basis of race, sex, ethnicity, and other characteristics. This framework can be very useful to those working to halt the spread of HIV as well as those fighting to eliminate exclusion and inequality in other contexts. *(33)*

A very important document in this area is the United Nations Declaration of Commitment on HIV/AIDS, adopted at the conclusion of the 2001 UNGASS. This declaration underscores that the realization of human rights is an essential element in the global response to the HIV/AIDS pandemic. Protecting and promoting human rights reduces vulnerability to the infection and prevents stigma and discrimination against people infected with HIV or at risk of contracting the infection. The declaration calls on governments to prepare strategies to confront stigma, discrimination, and social exclusion and to develop legislative and policy frameworks that protect the rights and dignity of people living with HIV/AIDS. *(34)*

Principles to consider in integrating gender and sexuality into sexual and reproductive health and HIV/STI prevention and treatment services

INCLUSION: Service planning processes should recognize that people, regardless of their sex, gender identity, marital status, sexual orientation, work, health status, and other aspects that individually define them in the social context, have the right to equitable, egalitarian treatment. Service delivery should be guided by humanistic principles in a nondiscriminatory setting.

ADAPTATION: All groups and populations in a society have sexual and reproductive health care needs. However, some needs are highly specific (for example, those of pregnant women and women in the climacteric, sex workers, persons with disabilities, men who have sex with other men [MSM], transgender people, sexually active adolescents). These different needs should be considered when developing guidelines and algorithms for the delivery of care to different groups and populations.

AVAILABILITY: Services should be accessible to people in these populations and groups and be provided under conditions that permit their most efficient use. Location near public transportation is one of those conditions. The hours in which the service is open to the public is an important factor, since there are differences in the availability to different population groups. Service programming should be compatible with that availability (for example, sex workers whose activities take place at night have problems making health service visits in the morning, and people who work during the day probably prefer to visit health services in the evening). Facilities should also have comfortable waiting rooms and child-care centers so that children are protected while their fathers, mothers, or other adults use the services.

PROTECTION: Services should identify mechanisms to keep their specificity (in terms of services offered) from being used as a pretext for creating social stigma (for example, clinics for HIV-positive people, services that provide check-ups for female sex workers, centers for gay adolescents, clinics treating sexually transmitted infections).

EXPANSION: Access to care for sex partners should be promoted through linkage or articulation of services (prenatal care services that detect HIV-positive women or women who test positive for syphilis should be able to reach out to male partners and offer them access to testing and treatment, STI treatment services should have mechanisms for contacting sex partners, and women's clinics should be able to reach partners who have asymptomatic trichomoniasis or Chlamydia).

CAPACITY/SENSITIVITY: Service providers should not only be familiar with the guidelines and treatment protocols for members of particular groups and populations but knowledgeable enough about sexuality and gender to interact with users in an absolutely professional and informed manner.

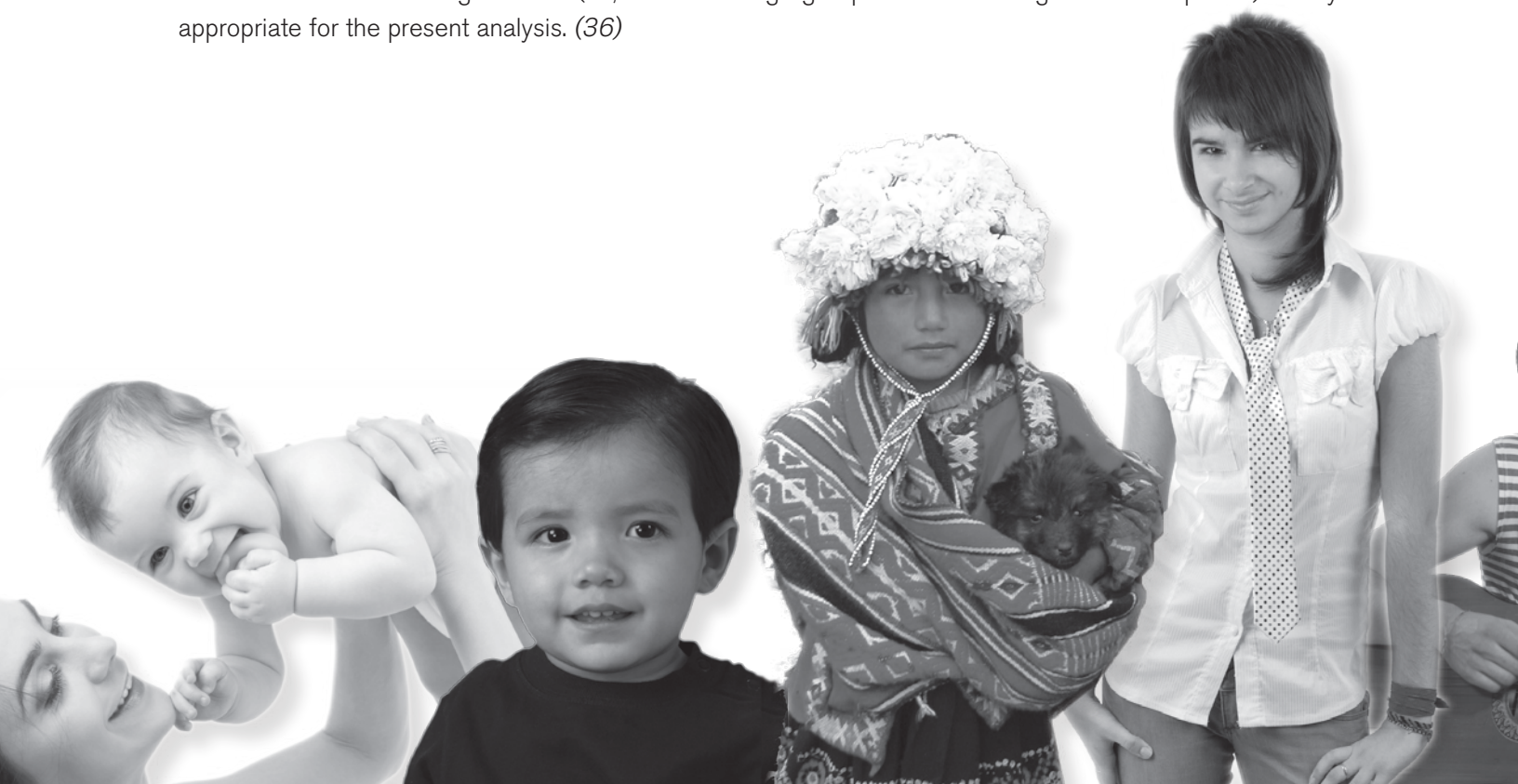
RESPECT: Other service employees, including administrative personnel and janitorial staff, should be duly sensitized and educated about sexuality and gender in order to treat users with respect, consideration, and a sense of solidarity.

CONFIDENTIALITY: All files and information about users should be safeguarded. Communication to health authorities for the purpose of reporting and surveillance should be made in a way that protects the patient's identity.

4 Goals, strategies, and settings for addressing sexual and reproductive health throughout the life cycle

We have selected a life-cycle approach to examine strategies for linkage, articulation, and integration, since this approach has been proven to be useful for the adoption of interdisciplinary and gender perspectives. *(35)* Integrating SRH and HIV and other STIs has the additional advantage of recognizing that SRH is vitally important to both sexes from infancy through old age. However, this approach does not permit full recognition of the wide range of ways in which the stages of life are experienced in different social, economic, and ethnic contexts in the Americas. If suggestions for strategies are to be derived from this examination, it will be necessary to consider the local conditions in which programs and interventions are going to be carried out, as well as the existing services. In this regard, it is essential to recall that the life cycle of an individual occurs not in a vacuum but in the context of a family and community setting shaped by the predominant culture.

Although there is no universal criterion for disaggregating the stages of the life cycle, in some cases the categories used are compatible with census data in specific countries. An approach that examines people's needs at the different stages of life (i.e., in different age groups as well as stages of development) is very appropriate for the present analysis. *(36)*



A. First year of life

SRH and HIV/STI prevention goals:

In humans, the first year of life is critical for future development in all aspects, from growth and development determined by nutritional status to the emotional aspects of life. Most health systems provide for this stage as part of reproductive health care. For example, under Cuban law, working mothers have the right to time off with pay for regular pediatric care during the baby's first year. *(37)*

It is very difficult during this stage to separate the health goals and needs of the child from factors associated with maternal behavior, health, and well-being. In other words, educating future mothers and preventing maternal morbidity and mortality help prevent the dire consequences for health and development that could occur if children are improperly cared for or orphaned. SRH is threatened in many ways; for example, infants are at risk of HIV infection at the moment of the birth and through breastfeeding if the mother is HIV-positive and is unaware of it or is not receiving treatment to reduce her viral load. Intrauterine infection with the causative agent of syphilis (congenital syphilis) is associated with blindness, deafness, neurological damage, and bone deformities in infants. Congenital syphilis is preventable if active syphilis in pregnant women is detected and effectively treated.

Gender considerations: Social gender constructs, which play a part in the life of the infant through the gender assigned to it on the basis of its apparent biological sex, begin to define sexual and reproductive activity even at this initial stage of life. Identity as a girl or a boy determines how the family and general environment meet the baby's basic needs. Thus, depending on their biological sex, children may receive different stimulation, different overall care, and different food and medical care, with implications for morbidity and infant mortality

Setting for addressing needs: The ideal setting for protecting health, providing health care, and promoting sexual and reproductive health in this initial phase is the home. In order to take the necessary action, families need government support, which is crystallized through the policies of different government sectors.

The health sector can intervene through specific efforts of proven efficacy. For example, early detection of active syphilis in pregnant women makes it possible to provide relatively simple, very inexpensive treatment to prevent congenital syphilis in newborns. It is also possible to substantially reduce mother-to-child transmission of HIV through a

series of measures that include the use of antiretrovirals in a prophylactic treatment regimen. Mother-to-child transmission of HIV is known to be almost entirely preventable with the use of these measures. Among the goals of the 2001 UNGASS Declaration were a 20% reduction in the proportion of HIV-positive infants by 2005 and a 50% reduction by 2010. *(38)*

It is suggested that to achieve broad coverage, programs for the prevention of mother-to-child transmission of HIV should be adopted by current public health systems as part of the interventions performed in all prenatal clinics and clinical care facilities and hospitals that provide care in childbirth. *(39)*

Ideally, there should be universal monitoring and detection of preventable vertically transmitted infections, with treatment provided if necessary. Thus, it is recommended that treatment protocols for pregnant woman include detection and management of active syphilis and HIV infection.

Access to family planning services also enables mothers and fathers to postpone a subsequent pregnancy, giving them sufficient time to provide all of the attention, care, and stimulation that their newborn needs. *(40)*

To circumcise or not to circumcise?

In many countries and cultures circumcision of male infants is a widespread practice, with the procedure performed several few days after birth. The reasons range from religion and family custom ("so he looks like Daddy") to hygiene ("it's easier to keep clean"), prevention (fewer urinary tract infections), and medical concerns (phimosis, balanoposthitis). There are detractors who consider circumcision a form of mutilation and argue that removal of the prepuce and keratinization of the glans lead to a "loss of pleasurable sensation" (actually, the ejaculatory response is triggered by the stimulation of deep touch receptors that are not affected by the intervention).

Other detractors argue that the procedure, performed without anesthesia under the assumption that infants' nervous conduction is still poor and their perception of pain is very vague, is a form of torture that could inflict permanent trauma. There is no impressive evidence, however, either of the absence of pain or that the experience leaves "indelible imprints." Many adult men who were circumcised as infants claim to be satisfied with the procedure and the results, although others say that they would have preferred to be left "intact." There are also many adult men who were not circumcised and say that they would have preferred to have had the procedure as infants.

In some parts of the world, circumcision has long been a common practice (an estimated 30% of the world's male population is circumcised, with a considerable proportion of the procedures occurring in early infancy) and one that is even routine (nearly 90% of white males born in the United States in the 1940s, 1950s, and 1960s were circumcised shortly after birth). In recent years, however, reductions in the practice have been observed because health insurance companies have stopped covering it, pediatricians do not recommend it as a "routine procedure," and pressure by anti-circumcision groups seems to have left its mark (with the use of terms such as "mutilation," "barbaric custom," "torture," and the like). Since the 1970s, routine circumcision of male infants has declined in frequency, and for a time it seemed that it would remain exclusively a religious practice or a medical procedure performed to treat particular conditions such as phimosis or paraphimosis.

(continued)

To circumcise or not to circumcise? (continued)

In 2007, however, the findings of a series of studies *(41,42,43)* showed conclusively that circumcision protects against HIV, reducing the risk for men by up to 60% (a percentage higher than that attributed to some vaccines on the market). Evidence of the intervention's protective value has continued to mount. Furthermore, empirical evidence indicating a lower prevalence of cervical cancer in the female partners of circumcised men seems to have been confirmed in a prevalence study of human papillomavirus (HPV) infection in a male population. In that study, infection prevalence rates were significantly higher among uncircumcised (22.3%) than circumcised (14.8%) men, which may explain the aforementioned empirical observation. *(44)* In light of these findings, circumcision is attracting the interest of the scientific community, and some countries in southern Africa are beginning to launch mass circumcision programs for adults and youth. Since the intervention is relatively easier and less expensive with infants and complete healing occurs earlier, it is worth considering whether it would be justified to begin reintroducing circumcision as a routine practice. As a public health measure, it could have preventive value in stemming the eventual generalization of the HIV epidemic and reducing the number of cervical cancer cases.

B. Infancy (1–5 years)

SRH and HIV/STI prevention goals:

The procurement and consolidation of a gender identity, the development of a positive body image, and the internalization of social gender roles are the building blocks of an individual's sexual development at this stage. Given that these processes are determined by social and cultural structures and dynamics, it is impossible to conceive of them outside of that context.

Body image, an extremely important element in the development of self-care, protective, and preventive behaviors in the later stages of life, is initially developed through stimulation and sensory exploration (visual, tactile, olfactory). Observation of one's own body (directly, in the mirror) and that of other children and adults contributes to the recognition of differences and similarities. In most cultures in the Region, observation and exploration of the genitals is proscribed. Even health professionals often find it difficult to ask questions about the genitalia during a general physical performed on children, and as a result they have difficulty informing parents and families about the healthy development of sexuality in their children.

Gender considerations: During this stage, the basic gender identity is consolidated, and generic roles (based on the child's biological sex) are learned. The latter process depends largely on the specific culture in which this occurs. Unfortunately, there are major sectors in Latin America and the Caribbean that promote the development of gender stereotypes that keep people from fully developing; for example, such stereotypes inhibit women's ability to learn how to negotiate preventive measures related to their SRH. Health professionals and community workers can perhaps offer support to families in developing more flexible and equitable gender roles.

A major prevention effort must be made by all sectors of society to achieve gender equality, and health systems should train health care providers to identify the signs of domestic and gender violence and protect children from all types of violence.

Setting for addressing needs: Again, the family should be the main setting for meeting sexual health needs, but unfortunately many families are uncomfortable discussing sex and thus evade, avoid,

and even conceal such issues. Some authors have described the skirting of these issues as a family and societal conspiracy of silence about sexuality. However, even in poorer settings, families are concerned about the general health of their children and sooner or later will visit a health center if one is accessible. In many cases, women will go in search of assistance with family planning and contraception. These situations are excellent opportunities for primary health care providers to offer sexual health care, not only for the child but for the family as a whole, through integrated educational and preventive activities that include objective discussions based on scientific evidence about children's sexuality, voluntary testing and counseling for parents, the addressing of questions and concerns, and discussions of widespread beliefs and myths. Parents will also benefit from discussions about the use of condoms, information on STIs, and general counseling on family planning.

This is the stage when children may begin to attend preschool in a formal or community setting. HIV-positive children should be admitted in any care, recreational, or educational facility (e.g., day-care center, community center, kindergarten, recreational club) if their health does not require them to be hospitalized or stay at home in bed.

C. Childhood (5–9 years)

SRH and HIV/STI prevention goals:

Although not as critical to psychosexual development as the first five years of life, this stage is very important. In most countries, childhood is the period when schooling begins, even in very poor areas. The impact of school attendance on the reproductive health of women is well documented. The more schooling a woman has, the better her reproductive health in-

Sexual abuse of children

If children are to develop self-confidence, parents and other health care providers must appropriately, consistently, and affectionately meet their needs. This includes expressions of affection, which are absolutely necessary for children's emotional and affective development (in contrast to the widely held belief that "boys who receive affection become crude, ill mannered, and demanding"). Affection contributes to emotional and affective development if it is perceived as comforting, protective, and gratifying. Physical affection should not make a child uneasy, uncomfortable, insecure, anxious, or fearful.

One of the basic functions of the relationship between children and adult health care providers, including parents, is to instill basic confidence in children rooted in the certainty that they are being protected. This confidence is an important element that will help facilitate all of their future relationships, including the couple relationship. If the provider systematically fails to offer protection accompanied by comforting expressions of affection or does so in a manner that makes the child physically and emotionally uncomfortable (tickling or touching that produces uncomfortable or even painful sensations, playing games that frighten the child, dressing children in a way that embarrasses them, or subjecting them to humiliating practical jokes), the child is likely to develop social problems. These problems will be more serious if there is clear sexual abuse, since abuse causes confusion, pain, discomfort, suffering, emotional problems, and, later in life, rage and lasting resentment. For a child, sexual abuse, especially if it is repeated, is a traumatic experience associated ultimately with impaired neurological functioning. For example, sensations of intense fear and anxiety can be created by touching the child's genital area, which can affect sexual response in adulthood.

(continued)

Sexual abuse of children (continued)

Depending on the nature, duration, and frequency of the abuse and at what point in the stage of development it occurred, a range of problems can emerge. The vast majority of them stem from evocation of the emotions experienced during the event. Children may become anxious and agitated in situations they associate with the traumatic experience. In many cases, sleep alterations can occur, with frequent nightmares. Moreover, situations in adolescence and young adulthood that would typically constitute normal events in an individual's psychosexual development (e.g., petting) can take on negative overtones and become experiences that produce aversion. Incestuous child abuse is more harmful, and those who have experienced it will very likely suffer from future problems in the areas of intimacy, self-confidence, trust, and bonding.

A sexually abused child should be medically evaluated to determine whether there are any injuries and whether there is a potential risk of HIV or other STIs. Genital or anal lacerations should be treated, and the child should be given post-exposure prophylactic treatment in which the antiretroviral and antibiotic dosage is adjusted to his or her age and condition. *(45,46)*

In a suspected case of child sexual abuse, the following guidelines are important:

- It may be necessary to keep the child under protection, especially when incest is suspected.
- Ensure that the child is assessed by a professional knowledgeable about child sexual abuse.
- Determine the condition of other children in the home.
- Identify the perpetrator and confirm his/her serological status, the presence of active STIs, and risk factors for HIV, hepatitis B virus, and other STIs.
- Report the case to competent authorities.
- Refer the child to psychotherapy services for appropriate management of the traumatic experience and resulting stress.

dicators will be. During these years, comprehensive sex education, especially within the school system, should begin to answer any questions that the child may have about sexuality and reproduction. This education should also help create positive attitudes about the body and sexuality. Many Latin American countries now provide comprehensive sex education, and it is important to ensure that the quality of that education is maintained and continually improved and that it is provided in all locations.

It should also be noted that in some cases an early onset of puberty may occur, and its manifestations may make the child uneasy, anxious, and overly concerned if appropriate information is not provided. Health workers should become involved in the education process, taking advantage of opportunities such as individual consultations, school physicals, vaccination campaigns, and school talks to counsel both the family and the child.

It is also important to address the problem of child sexual abuse [see box above] and its prevention. To do so, it will be necessary, first and foremost, to duly educate adult health care providers (parents and teachers, primarily) about the issue, reminding them that preventing abuse is the responsibility of adults and by no means the children. Next, it will be necessary to work with adults to develop a strategy for informing children clearly, objectively, and appropriately, without alarming them, about the existence of sexual abuse, offering general recommendations

that should include setting boundaries and the importance of reporting disagreeable or uncomfortable experiences without yielding to pressure or threats that they make promises to "keep it a secret." In areas where prevalence rates of HIV and other STIs are high, it is important to consider this factor when dealing with a case of child sexual abuse.

Some children at this stage may begin to exhibit what could be a non-heterosexual orientation or discover a gender identity that conflicts with their biological sex. These children should be protected from bullying, abuse, discrimination, and even violence. Schools and homes should be perceived as safe havens, not places where the child feels unsafe, frightened, intimidated, or abused.

In locations where vaccination against the human papillomavirus is available, the vaccine should be administered before girls and boys become sexually active.

Gender considerations: Gender identity is well established, and boys and girls assimilate the roles assigned to them as children based on their sex. The traditional view of male and female roles tends to be consolidated as a result of broad socialization patterns. In other words, boys and girls are exposed to social and cultural models and patterns in a setting that fosters the supposed notion of male superiority and the secondary and subordinate role of women. At this stage, girls may temporarily or permanently stop attending school to care for their brothers and sisters and help with housework. The concept of manhood that emphasizes male dominance, power, and authority is usually transmitted by the family and community. Such notions, which are serious impediments to the development of equitable, egalitarian relations, are transmitted along with others that are highly detrimental to the health and well-being of men, including risk seeking, overconfidence, and stoicism in the face of pain and disease.

Should health professionals and the health services become involved in sex education?

In recent years, a marked division of labor seems to have appeared between sectors that often seem less interested in determining roles and responsibilities and more interested in building fences to demarcate their territory. Far from contributing to joint efforts and the attainment of common goals, this strategy, which is the equivalent of building "sectoral barricades," results in division, suspicion, unnecessary competition, fragmentation of resources, and incomplete or insignificant achievement of goals and objectives in the areas of well-being and community development.

Very often, even in the health sector itself, activities are confined to a repertoire that is essentially clinical in nature or limited to the medical-biological domain. Thus, the participation of the health sector in initiatives that promote sexual and reproductive health tends to focus exclusively on the prevention of disease and undesirable outcomes rather than the attainment of well-being that would permit full and satisfactory day-to-day individual, family, and community performance.

Although health professionals are considered reliable sources of information about sexuality, the truth is that they are not always up to date on the subject. Moreover, like many other people, many health professionals are uncomfortable talking about it, because they have not received the necessary sensitization and training that would allow them to do so naturally. For this reason, they often relate their personal opinions and views—and even their prejudices—instead of offering opinions grounded in research and evidence.

The situation is frequently no better among educators. Very often they have not received the training they need to comprehensively, naturally, and appropriately deal with issues of sexuality. Thus, schools' responsibility to provide sex education shifts to health professionals and the health services. In many schools, the "annual talk" by a doctor or a nurse is a permanent fixture in which the focus is mainly on reproductive functions, STIs, and HIV. With this intervention, the school's responsibility with respect to educating students about sexuality is considered concluded.

Unfortunately, these brief and sporadic interventions, which are usually too late, are not sufficient or are inappropriate for developing a positive and healthy view of sexuality. Clearly, the education sector must offer a better response to ensure the gradual and appropriate integration of sex education in the schools. However, the health sector cannot separate itself from the efforts made in education, because health promotion requires an educational effort. Only through education can people acquire the knowledge and skills necessary to exert autonomous control over their health and their lives and reduce social and cultural vulnerabilities, avoid unnecessary exposure to risks, make informed decisions, adopt self-care practices, and seek professional help to maintain and restore their health. The synergy between the two sectors (education and health) must occur such that the methods used serve as vehicles for essential content, and this essential content is transmitted through appropriate means.

Moreover, the educational process cannot be confined simply to schools, for several reasons. One of them is that, despite rising levels of schooling in the Region, many people do not have access to formal education or drop out of the system prematurely. Another is that people continue to learn throughout life, and knowledge is constantly being renewed. Thus, the health services, through informal education, should facilitate acquisition of knowledge and skills that will enable people to take care of and maintain their health, which includes sexuality and reproduction.

(continued)

Should health professionals and the health services become involved in sex education? (continued)

Synergy between health and education is absolutely essential for learning and applying the necessary abilities and skills that will enable people to enjoy complete sexual and reproductive health. Therefore, health professionals must:

- Receive training in sexuality and methods of communicating to provide appropriate information to different audiences
- Propose specific strategies (necessary steps) for teachers to educate the school system population about how to prevent problems associated with sexual activity and reproduction
- Participate in development and curriculum review processes, offering input about current developments in sexual and reproductive health and information on health situations and trends
- Develop skills to appropriately communicate with service users about sexuality, provide them with information, and offer pertinent recommendations
- Coordinate group learning activities in the common areas of health services (waiting rooms, meeting rooms, auditoriums)
- Design educational strategies that go beyond talks and pamphlets
- Support learning by parents and guardians to facilitate the sex education process at home
- Collaborate with teachers in schools, as required
- Provide accurate information and guidance to enable teachers to refer schoolchildren who may require treatment and care to health centers (or specialized clinics)

D. Adolescence

The term "adolescence" is a relatively recent cultural construct used to define the transitional phase between childhood and adulthood. The length of this period may range from very short in rural societies (or it may be almost nonexistent in these societies), where early marriage or union is expected as soon as a person has joined the work force, to an extended period of 10 years or more in urban societies. *(47)*

The World Health Organization's well-known definition of adolescence is the period from 10 to 19 years of age, although it is widely acknowledged that adolescence has different meanings and may occur at different chronological ages in different social and economic settings. Even within a given context, adolescents are anything but a uniform group: as aptly noted by Schutt-Aine and Maddaleno, "adolescents vary with their social settings, economic circumstances, the culture and subculture that surround them, gender, and marital status . . . and if they are to be truly effective, programs and policies must consider the richness and character of each and every adolescent subgroup." *(48)*

The classical period defined by WHO is too long and does not consider the social and developmental differences that occur over the adolescent years. This is why adolescence has often been divided into a series of stages linked more to developmental milestones than to specific ages.

For the purposes of this document, adolescence is divided into two separate phases: early adolescence (10 to 14 years) and late adolescence (15 to 19 years).

D.1 Early Adolescence (10–14 years)

SRH and HIV/STI prevention goals:

Early adolescence usually includes puberty and is characterized by the need to establish one's own identity, manifestations of abstract thinking and reasoning, and mood swings that are sometimes very intense.

Although there is growing recognition in Latin American and Caribbean society that this phase of adolescence is a period in which young people are still very dependent on their parents and families, in rural areas (and especially certain indigenous communities) early marriage or consensual unions may be encouraged even at this initial phase of reproductive maturation. Not enough research has been done in Latin America to identify the repercussions of early marriage on SRH and HIV prevention in these groups. Nor is there any documentation about the impact of parentally arranged marriages or the common acceptance of violence against women as a "normal" part of the life of these young couples.

Sexual identity and sexual orientation tend to be reconfirmed at this stage, which means that some young people may be questioning their identity or orientation or simply feeling that they are "different" from their friends. Schools and other institutions must protect these young people from discrimination and stigma, including bullying and intimidation by other adolescents. Families and communities must receive information and support if they are to offer support and understanding to those who are "questioning" and those who are already convinced that they are ready to "come out" and acknowledge their identity and orientation, whatever it may be.

Although most young people at this stage have not initiated sexual activity, there are populations in which young people become sexually active earlier than in others. Adolescent sex is often merely exploratory, but it also occurs in the context of deep infatuation, with young people sometimes convinced that they have met the "love of their life." These infatuations may be transitory, however, and adolescents may have multiple sex partners within a short period of time through a series of exclusively monogamous, short-term relationships. This phenomenon, associated with a higher risk of HIV and other STIs, is known as "serial monogamy" or "consecutive fidelity." Adolescents who live on the street (many of whom resort to selling sex in order to support themselves), young married women whose spouses often have sex outside marriage, and migrants are populations especially vulnerable to contracting HIV and other STIs.

It is very important to consider the needs of HIV-positive adolescents. This is the stage where they may discover their HIV status and very possibly wish to deny it. It can be very distressing that, just when they are beginning to experience desire and attraction, they are also beginning to receive distorted messages proscribing sexual activity among HIV-positive people. They may also encounter an intimidating health system that is difficult to access and use. In many cases, fear and mistrust of the medical system, in addition to a perceived lack of sensitivity on the part of providers, prevent adolescents from seeking the care they need. *(49)*

Gender considerations: Gender issues are especially important in early adolescence, since girls generally mature physically, and in some cases socially and emotionally, before boys of the same age. Menarche can mark the point at which adolescent girls are presumed to be "available" and, consequently, at risk of beginning sexual activity before marriage. This leads to the creation of more restrictive and vigilant environments for girls, who may find limitations imposed on their activities under the justification that they need to be "protected." In most societies, this is in direct contrast to the acceptance and even encouragement of sexual activity among boys.

Gender norms can place girls at risk for sexual violence, including rape or domestic violence.

Setting for addressing needs: Schools are the ideal setting for addressing the needs of early adolescents. Since the number of early adolescents who attend school is on the rise in the Region, ensuring that comprehensive sex education (including HIV and STI prevention) is part of the curriculum is critical. However, school-based sex education programs may not have the necessary characteristics to make them effective in preventing HIV infection and adolescent pregnancies. For example, abstinence-only programs may not provide clear and extensive information about contraceptives and the use of condoms. Moreover, many young people do not attend school, and thus outreach programs are needed to provide information about access to sexual and reproductive health services. *(50)*

The education sector should be working to ensure that sex education programs and services for adolescents are comprehensive and provide not only information but education in life skills, including negotiating skills, training for independent decision making to resist pressure, and components to help people of one gender understand the expectations of the opposite gender in terms of sexuality and the consequences of sexual activity. Laws and policies in this regard can be especially useful. Teacher training and an ample supply of good educational materials are indispensable for providing comprehensive sex education that is truly effective.

D.2 Late adolescence (15–19 years)

SRH and HIV/STI prevention goals and gender considerations

Late adolescence is a very important time with respect to SRH and prevention of HIV and other STIs. This is the stage in which the risks of sexual and reproductive health problems are highest and tend to be accompanied by greater complications and sequelae, both physical and emotional.

Most people begin sexual experimentation and even become sexually active in late adolescence. A significant number, which increases with age, pair up through marriage or free unions. The traditional values that persist in many places place an extraordinary emphasis on virginity in girls, while boys are subject to peer pressure (for example, from their friends) to begin sexual activity. Female adolescents are perhaps incapable of negotiating or are unprepared to negotiate the terms of sex, including the use of condoms.

During vaginal sex, women are biologically more susceptible to contracting HIV than men—and, adolescent girls, in turn, are more susceptible than adult women because the vaginal mucosa is thinner and more easily torn. This greater biological vulnerability explains the more efficient transmission of HIV from men to women than from women to men during vaginal coitus. Male adolescents may engage in dangerous and violent behavior as part of the accepted model of masculinity. The risk of contracting HIV through unprotected anal sex is relatively high among young men who have sex with other men, and the risk is higher for the partner who is penetrated than for the penetrator.

Setting for addressing needs: Adequately meeting all of the sexual and reproductive health needs of adolescents would require structural solutions such as poverty alleviation and cultural changes in the area of gender and sexuality. A clear example of the complexity of these needs is early unintended pregnancy. This situation, which poses emotional, physical, and social risks to the young woman and her baby, can stem from lack of appropriate information, resulting in improper or inconsistent use of contraceptives, unawareness of the risks of pregnancy in adolescence, lack of ability to resist sexual advances, and a poor understanding of the responsibilities as-

sociated with procreation. Moreover, it is important to consider that motherhood is often presented as the only option for the construction of a feminine identity and a woman's self-realization. Lack of educational, occupational, and social opportunities is intertwined such that young women, in addition to not having access to information and services, have no alternative for developing an identity as women that offers them respect and social recognition.

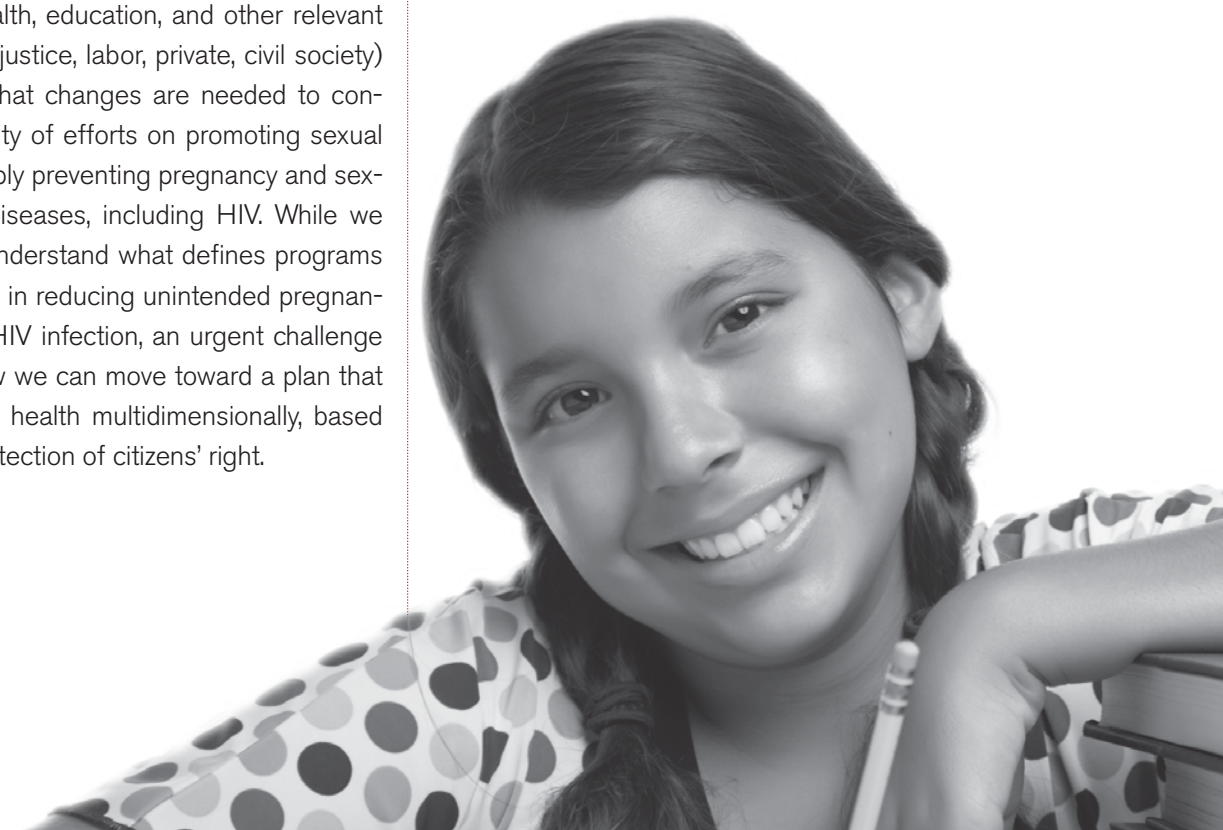
Although so big a challenge would seem virtually impossible to surmount, there are experiences that show that it is, in fact, possible to meet the needs of this group in a comprehensive manner. Many countries have developed comprehensive health sector programs and services aimed specifically at adolescents. The key to the success of these programs and services is the functional links established within the health sector and with other sectors, guaranteeing a comprehensive focus on the needs of the adolescent population. The first step in guaranteeing that these programs are effective is training health care providers to ensure that they promote and facilitate adolescents' access to appropriate, confidential, wide-ranging services.

Finally, the health, education, and other relevant sectors (economy, justice, labor, private, civil society) should be aware that changes are needed to concentrate the majority of efforts on promoting sexual health and not simply preventing pregnancy and sexually transmitted diseases, including HIV. While we are beginning to understand what defines programs that are successful in reducing unintended pregnancies and STI and HIV infection, an urgent challenge is to recognize how we can move toward a plan that approaches sexual health multidimensionally, based on respect and protection of citizens' right.

E. Early and middle adulthood (20–49 years)

SRH and HIV/STI prevention goals:

During these stages, which have no clear chronological boundaries, most people have established a more or less stable relationship, whether through marriage, a consensual union, or cohabitation. Early marriage and sex pose health hazards, especially for women. Apart from the fact that pregnancy at an early age can result in a greater risk of complications, lengthening of the fertile period of life increases the potential for unwanted pregnancies and multiparity beyond what is advisable for women's health and the expectations and potential of women and couples alike. However, the increasing use of contraceptives in most countries in the Region indicates changes in decision making about the number and spacing of children. Thus, access to all family planning methods should be guaranteed. The moderate prevalence of maternal mortality (1 in 160) in the Region with rather high foci in some locations poses a serious public health challenge. Some of these maternal deaths are associated with clandestine abortions performed in unsanitary conditions.



Comprehensive SRH programs for adolescents and young adults must:

- address the different characteristics and needs of each person in these populations
- promote the participation of youth in the design and execution of these programs
- operate in a climate of openness that recognizes the complex situations that young people deal with in their everyday lives
- focus on adolescents' needs and concerns about sexual health
- focus on the positive aspects of sexual health without ignoring such issues as unintended pregnancies or HIV and other STIs
- raise awareness about human rights in the areas of sexuality and reproduction
- offer continuous, ongoing, specialized access, when necessary, to information, education, and supplies to protect health and provide health care in general

—Adapted from: Piot P, Aggleton P. The global epidemic. *AIDS Care.* 1998;10(suppl 12):S200–S208.

The need for services to guarantee safe motherhood offers an excellent opportunity for integrating SRH with programs and services focusing on prevention of HIV and other STIs. Facilities that provide prenatal care should offer voluntary counseling and testing for HIV detection. Ideally, a single health facility should meet all SRH needs. However, barriers that limit services to a single location and time need to be overcome. Such barriers appear to be related less to budgetary issues than to the compartmentalization of health programs and the creation of "controlled territories" (in terms of programs, resources, and execution) that do not benefit users.

Activities designed to ensure safe motherhood should be expanded to women living with HIV who decide that they want to become pregnant.

Reproductive aspects aside, most sexual health services lack the competencies necessary to meet the absolutely basic need for enjoyable sex as part of a couple's life. In some locations, drugs may be prescribed for erectile dysfunction in heterosexual men. However, there is empirical evidence of serious neglect of women's need for sexual gratification. Such neglect evolves into indifference and even disdain when homosexuals, lesbians, transgender people, or transsexuals seek help. In fact, it is possible that the vast majority of people in these groups refrain from visiting sexual and reproductive health services because they fear encountering discrimination not only by guards, receptionists, and administrative personnel but by health workers. Moreover, health workers may not have all of the competencies necessary to meet the specific demands and sexual health needs of these populations—needs that also include the reproductive dimension (assisted paternity and maternity, prenatal care, care in childbirth).

Thus, once again we reiterate the need to train SRH service providers in sexuality and sexual health.

Gender considerations: As evidenced in the preceding paragraphs, it is almost impossible to separate factors related to gender from the main health concerns faced during this stage of life. In a recent address, the Director of PAHO noted that more than one third of women in Latin America and the Caribbean have experienced violence at the hands of their domestic partners, more than 22,000 die in childbirth each year from preventable causes, and women of all ages account for a significant (and growing) proportion of all new HIV cases.

In the case of men, violence and traffic injuries are major causes of morbidity and mortality. It should be recalled that aggressiveness and exposure to risks are part of the social script for masculinity.

Women are biologically and socially more vulnerable than men to HIV infection. Even married women usually lack the negotiating skills they need to insist that their partners use condoms as protection, or they simply refuse to believe that their partners may be having sex outside of the marriage. The younger the age, the greater the biological and social vulnerability, since the vaginal mucosa is thinner and friable and the girl's experience more limited.

Setting for addressing needs: Addressing the SRH needs of the young adult and adult population figures among the health priorities of many countries, with a special emphasis on maternal and child health programs that include family planning services, prenatal care, and care in childbirth. National AIDS programs can also meet some of the SRH needs of populations of reproductive age. However, both types of programs usually function in a compartmentalized manner as completely separate entities, and there are common problems that are not duly considered by either. Full coordination between SRH programs and HIV/STI prevention and control programs is a prerequisite for reaching intersectoral agreements on the promotion of sexual health. Health sector and gender institutes, where they exist, can play an especially important role in encouraging the education, social development, and other sectors to advance the sexual health agenda.

F. Maturity and old age (50 years and over)

SRH and HIV/STI prevention goals:

Most of the Latin American and Caribbean countries have undergone a demographic transition that is rapidly altering their age structure. Fertility rates are moving downward, while life expectancy is moving upward. Although children and young people are still the largest age group, the number of older persons is expected to increase substantially in the coming years. This will no doubt have implications for health profiles and quantitative and qualitative changes in the demands on health systems. Concerns and problems related to sexuality and reproduction in this age group are barely heeded, since there is a mistaken assumption, especially in the case of women, that desire and attraction disappear with the loss of reproductive functioning. It is assumed that custom holds couples together and that sex no longer matters. Menopause can be a difficult period for some women, and the loss of protection caused by reduced hormone production can pose general health risks such as osteoporosis and heart disease.

As changes in sexual response occur, men can have trouble achieving and maintaining an erection, problems that can also be associated with highly prevalent chronic diseases such as diabetes. Women can experience problems with vaginal lubrication during the arousal phase of the sexual response. However, older men and women are typically not offered treatment options for sexual dysfunction.

Concerning HIV, the success of ART may mean that more men and women will survive to old age. It is therefore necessary to bear in mind that problems resulting from the cellular aging process will be compounded by the side effects of the treatment and the problems caused by the infection.

Older persons can be especially vulnerable to abuse and domestic violence. Hostility against elderly people who have been widowed and begin sexual relations again is not uncommon. Such reactions are part of a social mythology that rejects any manifestation of sexuality between older persons.

Gender considerations: Major sectors of the older population may suffer the consequences of a life of poverty, lack of basic services, and inadequate health care. Women may experience problems as a

result of too many pregnancies, births that were too close together, poor nutrition, and neglect of their health needs. For example, problems with the pelvic floor may be accompanied by urinary incontinence, which limits a person's social life. Because of the differences in life expectancy between men and women and the fact that women usually marry men older than themselves, women tend to have longer periods of widowhood than men. The result can be more years of poverty and other difficulties.

Setting for addressing needs: Health systems must anticipate changing demographic situations and be prepared for the burden already represented by the growing number of older persons who demand services. Other areas of work in the health sector must be addressed as well, such as research on emerging issues (the growing number of new infections among older persons, technologies for managing dysfunction), professional training, and collaboration with the labor, education, welfare, and other sectors. Cultural changes are also needed to give new meaning to the aging process beyond the conventional concept of loss of abilities, skills, and even desire and attraction.

Most important, the prevention aspect of SRH and HIV programs should be intensified immediately so that the populations of tomorrow will face fewer problems.

5

Stages in the development of strategies for linking sexual and reproductive health programs and services with comprehensive HIV/STI prevention and care

Clearly, no strategy by itself can guarantee the linkage, articulation, or integration of health programs, initiatives, and services. However, a series of steps can be taken to facilitate achievement of the synergies sought.

A report by the United Kingdom's Department for International Development suggests that the integration of SRH services and HIV prevention programs may not always be feasible. According to the report, in countries with concentrated epidemics, day-to-day SRH services may have limited success in meeting the needs of vulnerable and stigmatized populations. *(51)*

Lush et al. *(52)* mentioned some of the barriers that must be recognized and faced from the very beginning of the process. They include:

- the tendency of institutional cultures to resist integration
- the disease—or problem—oriented approach employed by a number of technical and financial cooperation agencies, which has a significant influence on the health, education, and other social sectors in many countries
- the tendency of communities to seek specific services for specific problems (or not to seek services at all) and the lack of a widespread culture of promotion and prevention

Nevertheless, as previously noted, there is overwhelming evidence that an integrated, linked approach makes sense at the individual and community levels. Under optimal conditions, it results in health and social services that are well adapted to the realities in which people live.

What basic steps can policymakers, decision makers, managers, and other health workers take that will lead to an integrated approach in SRH and HIV?

A. Situational analysis: Verify what happens in real life

Obviously, community health workers have a better and more thorough knowledge of the health situation in their location. Moreover, they are the first line in collection and analysis of epidemiological data and a

wide range of local and national health statistics. For these providers, HIV prevalence, maternal mortality, access to contraceptives, and voluntary testing are not just statistics or figures on a page but tangible situations involving the people they serve in a very personal way. Members of the health team are quick to recognize the presence of problems related to SRH or HIV and other STIs; witness their dynamic up close; identify factors that are potentially related; and suggest strategies for action consistent with their observations—strategies that usually include action to promote the linkage, articulation, and integration of services and programs.

Examples

- A social worker at a maternity clinic in a provincial capital calls attention to the fact that six of the eight HIV-positive women who have given birth at the clinic in the past year have partners who were working far from home. The director of the clinic believes that it is important for the local AIDS program to contact these men so that it can offer them voluntary counseling, testing, and treatment before they leave again as migrant workers. The perinatologist suggests that this offer be made in the family planning clinic to bypass resistance to visiting an HIV/STI service, given that people often fear such visits because of the stigma associated with HIV/STIs.
- The psychologist at a neighborhood health center in the country's capital says that he is concerned about the fact that several transgender sex workers who are seen at the center believe that rectal cleansings prevent the transmission of HIV after unprotected coitus. Although none of them have tested positive for HIV, seven have had rectal gonorrhea in the past three months. A medical student says that the causative agent is clearly circulating in that population and that his clients are transmitting it. Someone comments that a large number of pamphlets and brochures on prevention been distributed to these clients, but the social worker points out that some of them do not know how to read. The medical student mentions that there is free dental service for people of limited means and suggests giving them "special passes" to "get their teeth fixed" at a convenient time for them. Here, the student and his colleagues will take advantage of the link with the service to provide information, answer questions, clarify beliefs, debunk myths, and offer special information. The psychologist says the idea is brilliant: break the chain of transmission of this STI, improve the oral health of these individuals, and increase their self-esteem by making them feel more attractive.
- The high number of cervical cancer cases among women in a department of one of the Region's countries (37 cases per 100,000 women) has led the health authorities to consider administering HPV vaccine to the 29,650 girls aged 14–19 who reside there. The director-general of health considers whether this should be done at schools. The epidemiologist proposes that it be done at local community centers through a campaign called "Come with Your Mother." The purpose of this activity is to vaccinate the girls, perform Pap tests on the mothers, provide information through talks and videos on the detection of cervical and breast cancer, and train mothers to talk to their daughters about sexuality and HIV prevention. Since three vaccinations are required, there will be an opportunity for three interventions. At the time of the second and third vaccinations, the state AIDS program will provide information on HIV and other STIs in women. The director likes the idea. Not only will it prevent HPV infection, but it will facilitate the early detection and treatment of cervical cancer and contribute to the prevention of HIV and other STIs.

Data collection for the local health team's situational analysis can be greatly tremendously facilitated by the use of a tool—for example, a registration card—that would make it possible to systematically organize the available data on sexual and reproductive health.

The following template is proposed for systematically documenting sexual and reproductive health problems, including those related to HIV and other STIs. This card could be used at health centers and clinics that provide prenatal care, family planning, and primary care services.

	Profile of the groups visiting the services, indicating: age (grouping by intervals or the stages of the life cycle mentioned earlier), sex (including the transgender population), ethnicity, whether the person is sexually active, the type of sexual practices he or she engages in (with people of the opposite sex, the same sex, both sexes, protected/unprotected, anal sex), marital status (married, living together, unmarried, etc.), HIV status (seropositive or seronegative), specific activities that increase risk of exposure to HIV and other STIs (e.g., sex work), reproductive history					
Main reason for the consultation to determine the burden of disease in the community **(hypothetical examples)**	(Late) pregnancy monitoring	STI/genital tract infection	HIV	Family planning	Unintended pregnancy	Questions, concerns, dysfunction
Identification of trends **(hypothetical examples)**	• Frequent appearance of signs of toxemia (10%) in the third trimester • Pregnant women with reactive syphilis tests in the final weeks of pregnancy (3 out of 322 seen in 4 months)	• 12 cases of gonorrhea among MSM in 7 weeks	• 3 women who gave birth in the past 6 months were HIV+	• Condom use by 7% of couples in the past 12 months	• 22% of pregnancies in the past year were considered "an unpleasant surprise" or "unexpected" • 25% of pregnancies occurred in women aged 16–21	• HIV+ patients do not know whether they can continue to have sex • 12% of women say that sex is an "unpleasant chore"
Impact of the interventions **(hypothetical examples)**	• 28% increase in the number of pregnant women monitored during the second trimester • Decline in signs of toxemia (7.3%) in the third trimester	• All MSM treated for gonorrhea report condom use • No new cases of gonorrhea	• Prevention of mother-to-child transmission measures applied • No infants infected	• Condom use among couples for "double protection" rose to 18%	• 15% of pregnancies in women aged 16–21 years	• Education for serodiscordant couples • No seroconversion in seronegative couples in a year of monitoring

It is always useful to look at the context with interest and an inquisitive spirit. What structural factors facilitate or hinder SRH promotion and care and HIV prevention? What are the laws and regulation that apply to reproductive health and HIV? What role do these factors and gender play in access to services? These and many other questions must be answered to have a clear understanding of the real-life situation.

B. Data collection and analysis: Evidence is needed

Evidence can be defined as "data that provide convincing proof." Although the evidence for integration is beginning to emerge, it is still limited. *(53)* Nevertheless, there is an abundance of information about the benefits of integration that is readily available in the Internet. In 2008, the International Planned Parenthood Federation (IPPF), WHO, UNFPA, UNAIDS, and the University of California, San Francisco (UCSF), conducted a review of the scientific literature very clearly demonstrating that linking sexual and reproductive health programs and services with HIV prevention leads to an overall improvement in access to essential services and their utilization. It also gives people living with HIV better access to SRH services that are well suited to their needs. Linkage, articulation, and integration enable people to fight the stigma and discrimination associated with HIV infection and, moreover, improve quality of care to better serve certain key populations whose coverage is not necessarily adequate. *(54)*

Evidence must be generated (a research function) and gathered on a wide range of matters such as barriers that prevent young people from visiting SRH or HIV/STI clinics, as well as the role of resistance among health care providers to integrating or linking services.

Evidence can be obtained from many sources, including, among others, facts, case studies, statistics, experiments, and logical reasoning.

It is also important to document best practices and examples of success; however, documentation of this type is uncommon in our Region. The experiences of other regions may prove useful in improving services. An examination of the available evidence from program evaluations and operations research that identify priority interventions for linkage and integration can be useful as well. *(55)*

The literature review conducted by IPPF, UCSF, UNAIDS, UNFPA, and WHO mentioned above called attention to the factors that foster the linkage, coordination, and integration of programs and services in SRH and HIV/STI prevention. *(56)* They are:

- Positive attitudes and the use of best practices and examples of success by service providers and personnel
- Ongoing capacity building
- Government and community participation in planning and implementation
- Simplification of procedures to offer additional services without increasing the cost of existing ones
- Services to which stigma is not attached
- Inclusion of couples, especially male couples
- Inclusion of vulnerable populations

All occasions such as congresses, conferences, and government meetings can be used to inform stakeholders at the different levels (for example, the health sector and other state sectors, the United Nations system, financial assistance agencies and donors, technical NGOs, civil society organizations, and vulnerable and affected communities) about global and local evidence of the need for and benefits of integration; forums can also be held to study such evidence.

C. Advocacy for the agenda: Become an ardent supporter

Integration and linkage are more effective in favorable settings, expressed, when possible, as public policy. Many countries in the Region have laws governing SRH and HIV on the books, as well as health policies to address gender and domestic violence, discrimination, and human rights, specifically reproductive rights. However, such laws and regulations are not always enforced. Public policies on SRH and HIV are almost always distinct entities, often administered and executed separately, thus reducing the possibility of integration or linkage at the location where the services are delivered. *(57)*

The reluctance to integrate is sometimes present among the members of the upper echelon of national government agencies responsible for HIV/AIDS and family planning, who may resist integration in cases where funds are allocated to agencies separately, viewing integration as a potential loss of resources or turf within the health sector structure. This same phenomenon can trickle down to the local health structure and even specific health facilities.

Promotion and defense (advocacy or intercession) can occur at many levels, which means that efforts should be made to find opportunities for participation at special meetings that include the health, education, and other sectors and regional conferences and meetings attended by academics and civil society representatives. Although it is always a good idea to include decision makers, senior officials, and legislators whenever possible, other contacts should not be ignored. The best partners are often mid-level government staff and the professionals who provide services.

It should be recalled that resistance to integration may result not only from a lack of information and knowledge but also from political considerations such as those mentioned above or even personal biases or prejudices, especially in the case of sexuality.

One strategy for overcoming resistance could be to set up a focus group or study group composed of a variety of stakeholders and subject specialists who could facilitate and monitor implementation of changes.

D. Promotion of training: Ensure that the parties involved learn and develop their competencies

An integrated program or service is only as good as its executors or providers. Many settings may have personnel who are extraordinarily well trained in reproductive health and the treatment of HIV and STIs. It is far more difficult to find personnel who are well trained in sexual health, notwithstanding the recent emergence of a large number of people in the Region, not trained in reputable academic institutions, who call themselves "sexologists." Even more difficult is finding professionals who can deal comfortably with all of these areas.

It is not suggested, however, that reproductive health and HIV service providers become experts in all relevant areas of SRH. For example, obstetricians and gynecologists who provide prenatal care may wish to enhance their expertise in the prevention of vertical transmission of HIV and syphilis, while HIV and STI specialists may need to learn more about contraception among people living with HIV or simply how to establish better referral systems when they feel that other professionals can better meet patients' needs and improve their quality of life.

There may, however, be some useful core competencies for every health worker that can be classified under the umbrella of sexual health. As noted by Dr. Julitta Onabanjo, one of the few studies on how health care providers are dealing with HIV concluded that HIV service providers rarely receive

training in sexuality, human rights, and the sociocultural determinants associated with reproductive health problems; moreover, they lack the skills to offer counseling and are uncomfortable talking about sex and sexuality. *(58)* The same holds true for most reproductive health care providers.

E. Intervention design: Spell out what is going to be done, how it is going to be done, and who is in charge

Before making specific suggestions, some basic premises regarding how reproductive health and HIV programs usually operate should be mentioned:

- They tend be administered and executed from the top down.
- Interventions gravitate around sporadic events (pregnancy, an infection, abortion) and not around people throughout their life cycle.
- Services and activities almost always focus on populations of childbearing age and, in the case of SRH, primarily women.

This traditional compartmentalized approach to SRH service delivery can be improved by identifying how and where to make the necessary connections. Some specific examples are as follows:

- During the prenatal visit, the obstetrician, obstetric nurse, and counselors provide information and counseling on sex during pregnancy and address common questions and misconceptions. This conversation is the starting point for discussing the vertical transmission of HIV and syphilis and providing the respective evidence. It is extremely desirable that these tests be done immediately so that the patient's interest and motivation do not flag and timely, appropriate care can be delivered.
- During the prenatal visit the obstetrician and obstetric nurse discuss the desirability of having the patient consider, at that moment, whether she wants to get pregnant again at some point and how long she wants to wait. Information is provided about postpartum contraception and the advantages of using a condom ("double protection"). The conversation about double protection is an opportunity to offer voluntary HIV testing.
- Staff in the emergency services are trained to provide emotional support for victims of sexual violence, who are also offered post-exposure prophylaxis to prevent infection with HIV and other STIs, as well as emergency contraception for women who have been raped.
- The service that provides voluntary counseling and HIV testing also gives women information and access to contraceptives, in addition to teaching them how to use condoms properly and distributing condoms to them.
- The STI clinic offers HIV counseling and testing, as well as access to contraceptives for women, along with teaching clients how to use condoms properly and distributing condoms to them.
- The primary care service provides counseling on HIV and STIs and the use of condoms to men seeking drugs for erectile dysfunction.
- The gynecology clinic provides HIV and STI counseling to all users and suggests HIV testing for all women with an abnormal Pap test.

It should be recalled that establishing linkages usually involves the challenge of improving the management of programs and services. Linkage, articulation, and integration are more likely to be successful when they are buttressed by good management. Managers should make sure that local goals are consistent with national goals. It is also good managerial practice to ensure that the different local agencies and sectors are represented in any plan-

ning and implementation activity. The same types of partnerships and associations should be forged at the professional level, whenever possible reaching out to professional associations and academic societies. Community participation should always be promoted and secured, especially from the potential users of integrated services, such as women, young people, people with HIV, men who have sex with other men, sex workers, and other vulnerable populations.

This component of the execution strategy implies considerable work on the vision of integration (that is, what an integrated approach would imply in real services) and also demands a very specific proposal for executing the changes implied. With the creation of linkages, managers should be able to reduce total costs substantially, including the cost to users of visits to different locations.

The challenges for integration may differ from country to country; therefore, the potential targets for programmatic change may also differ. In their analysis, Lush et al. reached pessimistic conclusions about the search for integration, since they believed that full integration occurs only rarely (as in South Africa, according to their case study); rather, it may be that some options for linkage and articulation (or partial/selective integration, as they termed it) will yield results that are not satisfactory enough to lead to full integration. In other words, between a full commitment to achieving total integration and a very limited commitment (resulting in inadequate, ad hoc integration) there are a range of options that include, for example, successful achievement of partial integration goals or linkage and articulation that lead to policies and services that clearly and verifiably improve SRH conditions and reduce the impact of HIV and other STIs.

F. Preparation of a plan of action: Develop a critical path with clear milestones and specific goals

Once a commitment has been made in the previous four areas (A- E) and all stakeholders agree about the model to be used in establishing linkages between SRH and HIV/STI prevention and treatment, a series of actions must be taken to ensure the progress of linked, articulated, or integrated programs and services.

G. Monitoring and evaluation: Ensure that you are moving in the right direction to obtain the desired results

A key limitation of many program changes is the absence of an adequate strategic information system. Designing an integrated monitoring and evaluation system that not only focuses on inputs and processes but recognizes results and the real impact is critical for all of the programs articulated and the health system as a whole. Moreover, if it is the only system in place in the area or country, it can serve as a model for monitoring situations in which a variety of determinants and actors are present.

Evaluation systems should be designed and set up in the initial planning stages of any integration activity. Clear indicators should be developed for different types of evaluations. These indicators should be used to recognize the benefits of the linkages established, whether through good systems of referral to fully integrated services or through linkage, articulation, and partial integration. The basic list of 17 indicators of reproductive health found in the WHO Reproductive Health Indicators for Global Monitoring *(59)* include three related to STIs and HIV: a) positive syphilis serology prevalence in pregnant women, b) HIV prevalence in pregnant women, and c) knowledge of HIV prevention practices. HIV

Sequence of steps necessary to implement an integrated service or program

- **Verify the feasibility and actual degree of acceptance of integration at the different levels.** Are managers prepared to share their turf, or do they prefer to keep the management of "their part" separate? Are providers prepared to acquire new skills, or do they prefer that others do so? It is very important to guarantee not only the articulation of programs but better results and to ensure that those achievements are maintained. To accomplish this, it is recommended that feasible changes begin to be made—changes that are acceptable to all parties and at the levels where the innovations will be welcome. It is a strategic error to attempt changes that are perceived as impositions or threats or whose merits are not widely recognized. It is also an error to propose integration models that are ideal in theory but not actually viable in practice.

- **Determine whether drastic changes will be needed in the operating procedures that each program uses in its daily work.** Radical changes usually upset staff accustomed to certain routines and make them uncomfortable. If new operating procedures are needed, they should be based on practices familiar to professionals in each program.

- **Remember that certain products will play a very important role in the work of these integrated programs and services.** It is therefore necessary from the outset to spell out the logistics for procuring and distributing these products (procurement, transport, storage, control, and distribution of condoms, contraceptives, reagents, drugs, equipment, etc.).

- **Draw up a detailed budget.** Even if the reasons for this step are obvious, it is necessary to quantify all the costs involved to ensure successful outcomes.

- **Prepare a detailed description of the services that must be offered.** Begin by making a list of interventions and transform them into treatment protocols (preferably as algorithms), charts describing educational activities, and other types of flow charts for the distribution of condoms, lubricants, contraceptives, and so forth.

- **Define the public awareness and training needs** that will guide continuing education programs for service and program staff and other stakeholders.

- **Develop a communications program** to ensure that people are aware of the availability of these integrated programs and that they demand and use them.

indicators have been prepared and used worldwide (for example, the UNGASS or universal access indicators), and WHO has recently worked on the development of sexual health indicators. However, at present there are no universally accepted indicators for monitoring integrated approaches.

H. Dissemination of lessons learned, information, and data: Share the challenges encountered and show, insofar as possible, why the linked, articulated, or integrated programs and services are effective, are not effective, or how they could be effective

One area requiring urgent attention in Latin America and the Caribbean is that of documentation of efforts, research results in the Region, and lessons learned in the daily work of programs and services. It is very probable that more integration activities are actually under way than is thought to be the case. It is important to document, compile, and disseminate information on experiences at all levels through reports, articles in peer-reviewed scientific journals, or other media. Efforts to integrate SRH and HIV/STI prevention can be useful for compiling, disseminating, and subsequently evaluating experiences in public health.

6

Architecture of integrated services

The purpose of this section is to provide a practical tool to facilitate the rapid integration of sexual and reproductive health services with HIV/STI prevention programs (and sexual health promotion in general). This tool considers three elements: **the settings** in which the service are offered, the **beneficiary populations and groups**, and the **interventions and actions** that make up the services.

Once a setting and population group have been identified, a look at the basic interventions proposed in the table at the end of this section will probably ease the integration process.

A. Settings: These are the sites where health, education, or other pertinent activities are carried out and where one or more additional services could be offered from an integration perspective.

> ***Settings can also be defined as sites and facilities that are programmed and set up to provide appropriate care for the public and whose optimal functioning is the responsibility of the respective authorities (health, education, etc.) and their service providers.***

In many countries, settings include:

a) Health services: Family planning/reproductive health, family medical clinics (primary care), prenatal care clinics, maternity and obstetric care centers, gynecology clinics, urology clinics, primary care for HIV and other STIs, specialized care and treatment of HIV, emergency services, health services for adolescents.

b) Public settings: Community centers, libraries, clubs, meeting halls (through community outreach activities).

c) The educational system: Locations where sex education is (or is not) provided. The public schools often are linked with the health system and can offer on-site health services (nursing, medical service, student counseling).

d) The media: The media are virtual rather than real forums. They are usually controlled by major corporations and have a great capacity to sway public opinion and influence social and sexual norms.

e) New information and communication technology: Also virtual, these are settings that offer the possibility of sharing enormous amounts of information, with implications for HIV/STI prevention and SRH promotion and care.

f) Community organization sites: These settings are created by communities to promote their interests and defend their rights. Sexual and reproductive health care and promotion and HIV/STI prevention ac-

tivities can be carried out at such settings (e.g., MSM and transgender groups; sex worker associations, female and male; labor unions and trade associations).

Some of these services are not necessarily conceived or provided by national or regional governments. They are in fact often created by local authorities, private institutions, or civil society organizations. At any rate, those involved should follow national policies established by law.

Settings are sometimes segregated to serve the needs of particular populations and groups. For example, some general dispensaries set aside specific hours for young people only. STI centers may have specific hours for MSM and sex workers.

Other settings can and do provide sex education, sexual health promotion activities, and counseling and emotional support, an example being the family. However, they were not included in the list above because, strictly speaking, they are not settings in which public policies are executed. Rather, they are private settings that, although they can be influenced by public policies, remain beyond their direct authority.

B. Populations and groups: Addressing the needs of populations and groups requires a life-cycle approach (as proposed in section 4), but gender, ethnicity, HIV status, and specific vulnerability must also be considered. For example, among men of different groups it is important to consider MSM and transgender people, as well as male sex workers. Among women, young women of childbearing age, pregnant women, and sex workers must be considered. Among infants, a focus is needed on those with perinatal exposure to HIV. Among youth and adults, special attention should be paid to MSM, transgender people, and those who are HIV positive. Finally, for all groups, the special needs of persons with disabilities should be considered. As a general recommendation, it should be recalled that every situation or condition involving social exclusion based on sex, marital status, ethnicity, sexual orientation and sexual identity, gender identity, immigration/migration status, occupation, and so forth increases people's vulnerability to sexual health problems.

C. Intervention and activity packages: The third element refers to "basic packages" that include one or more standard sexual and reproductive *health and HIV/STI care and prevention interventions*. In an unintegrated system, these packages are offered in only one or a limited number of settings and to only one or a limited number of groups and populations. In an integrated system, in contrast, these packages are included in the directives governing the procedures performed every day at all such sites. As mentioned in section 5, "basic packages" should be based on activities with which the providers are familiar, building on them with other interventions. Additional measures should also be considered (for example, in-service training, interdisciplinary training, logistics).

The specific services available during visits to a particular health service are not necessarily indicative of direct service delivery and in some cases imply referrals. The decision to directly provide new services instead of referring users should be the result of a careful analysis of the existing conditions and the feasibility of the two options (on-site intervention or referral) for each service.

The composition of a basic package of services depends on a) the conditions and capacities existing at the time it is defined, b) a clear vision of what can be accomplished in the short and medium term, and c) an evidence-based feasibility analysis.

The principal basic packages are the following:

HIV and other STIs

1. Voluntary HIV counseling and testing (with the option to accept), HIV testing suggested by the provider (with the option to decline)
2. Screening (suggested by the provider, with the option to decline) and treatment of treatable STIs
   - 2.1. Special protocol for MSM and transgender people, including detection of extragenital infections (pharyngeal, anal-rectal)
   - 2.2. Special protocol for sex workers, including detection of extragenital infections (pharyngeal, anal-rectal)
3. HIV and syphilis testing for pregnant women (suggested by the provider, with the option to decline)
4. Prevention of mother-to-child transmission (for women living with HIV) during pregnancy, childbirth, and breast-feeding; in most cases, offered in combination with packages 3 and 8.2; package 5.1 is also considered)
5. Specialized care and treatment of HIV infection (including screening/clinical management of coinfection); counseling and support
   - 5.1. Special protocol for pregnant women
   - 5.2. Special protocol for children

Sexuality and sexual and reproductive health

6. Comprehensive sex education (including HIV prevention)
7. Sexuality counseling and support
   - 7.1. Special protocol for adolescents (individual)
   - 7.2. Special protocol for people living with HIV (individual)
   - 7.3. Couples
   - 7.4. Treatment of sexual dysfunction (includes treatment of erectile dysfunction)
8. Family planning and contraception
   - 8.1. Special protocol for adolescents
   - 8.2. Special protocol for women living with HIV
9. Prenatal care (in many cases includes package 3 or 4)
10. Obstetric care (in many cases includes package 3 or 4)
11. Treatment of complications and the sequelae of incomplete abortion or access to safe abortion, where the law allows
12. Comprehensive care for victims of rape and violence (includes treatment of injuries and post-exposure prophylaxis for HIV/STIs, emergency contraception, emotional support, legal aid)
13. Periodic screening/treatment of gynecological cancers, especially cervical and breast cancer
    - 13.1 Special needs of women who have sex with women
14. Periodic screening/treatment of prostate cancer
    - 14.1 Special protocol for the detection of anal-rectal problems in MSM and transgender people
15. Assisted fertility and sexual/reproductive technologies
    - 15.1 Special needs of women who have sex with women (including "assisted motherhood")

16. Gender reassignment procedures and related technologies (use of hormones, surgery)

In Table 6.1, the three elements indicated above in an articulated manner define a system in which specific settings offer certain populations or groups basic packages of services. What form this system takes in a particular country or locality depends on the epidemiological profile, the existing settings and service packages, the available resources, and the degree of integration attained between SRH and HIV/STIs. Based on these elements, integration goals can be determined through consultation and participatory discussion with a representative group of stakeholders (e.g., users, providers, administrative personnel, managers). While a work proposal can be prepared by a rather small group of technical experts, a final policy change should not be made without the participation and explicit commitment of a larger group in which all stakeholders are adequately represented.

Table 6.1: Matrix of settings, populations, and groups, and basic packages of services used to define the architecture of an integrated sexual and reproductive health and HIV/STI prevention and treatment system

Stages in the life cycle	Fam. planning	Prenatal care	Obstetric care	Urology, Ob/Gyn clinics	Services for adolescents and youth	Primary care for HIV/ STIs	HIV care and TX	Emergency services	Educational syst. and health services	Media	Info./ commu-nication technology	Public settings, prison, outreach	Community organizations
< 5 years			**10, 4**				**5.2**						
5–9 years							**5.2**	**12**	**6**				
10–19 years, young men	1, 2, 7.1, **8.1**, 12			1, 2, 7.1, 8.1, 12	1, 2, **7.1**, 8.1, 12	**1**, **2/2.1**, 7.1, 8.2	**5/ 5.2, 2**	1, **12**	**6**, 2/2.1, 7.1, 8.1, 11, 12, 13.1	6, 7.1/ 7.2/7.3	6, 7.1/ 7.2/7.3	7.1	1, 2/2.1, 7.1, 8.1, 12
10–19 years, young women	1, 2/ 2.2, 7.1, **8.1**, 11.12	3, 4, **9**	**10, 3, 4,** 8.1/ 8.2	1, 2/ 2.2, 7.1, 8.1, 11,12, 13.1	1, 2/ 2.2, **7.1**, 8.1, 11,12, 13.1	**1**, **2/2.2**, 7.1, 8.2, 12	**5/ 5.1/ 5.2**, 2, 7.2, 8.2	1, **11**, **12**	**6**, 2/2.1, 7.1, 8.1, 11, 12, 13.1	6, 7.1/ 7.2/7.3	6, 7.1/ 7.2/7.3	7.1	1, 2/ 2.2, 7.1, 8.1, 11.12
20–49 years, men	1, 2, 7/7.3/7.4, **8**, 12			7.4,14, 16		**1**, **2/2.1**, 7, 8.2, 12, 14	**5**, 2, 7.2, 8.2	1, **12**	**6**, 2/2.1, 7, 8, 11, 12, 13.1	6, 7/ 7.2/7.3	6, 7/ 7.2/7.3	1, 2, 7, 12, 14	1, 2/2.1, 7/7.3/7.4, 8, 12
20–49 years, women	1, 2, 7/7.3/7.4, **8**, 11.12	3, 4, 9	10, 3, 4, 8/ 8.2	7.4, 11, 12, 13/13.1, 15, 16		**1**, **2/2.2**, 7, 8.2, 12, 13	**5/ 5.1**, 2, 7.2, 8.2	1, **11**, **12**	**6**, 2/2.1, 7, 8, 11, 12, 13.1	6, 7/ 7.2/7.3	6, 7/ 7.2/7.3	1, 2, 7, 11, 12, 13	1, 2/2.2, 7/7.3/7.4, 8, 11.12
> 50 years				13/13.1, 14, 15		**1**, **2/2.1**, 7, 13, 14	5, 2, 7.2	1, **12**	**6**, 2/2.1, 7, 8, 11, 12, 13.1	6, 7/7.1/ 7.2/7.3	6, 7/7.1/ 7.2/7.3	1, 2, 7, 12, 13.14	1, 2/2.1, 7/7.4, 13, 14

Note. See text for description of packages and their corresponding numbers. Numbers in boldface indicate the characteristic/primary package of services provided in that specific setting. In each setting, services can be provided directly or by referral to other services.

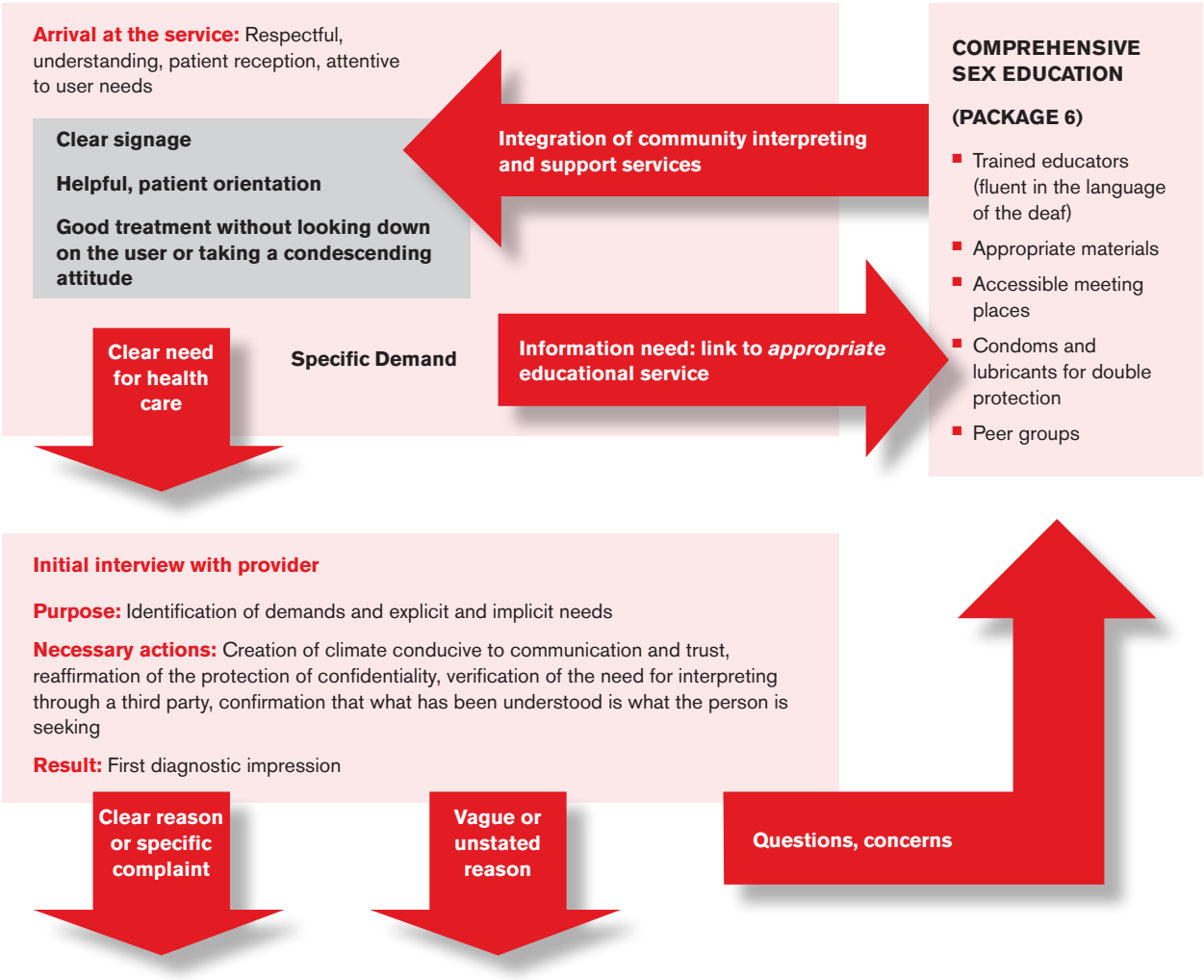
SAMPLE ALGORITHMS FOR DELIVERY OF BASIC PACKAGE OF SERVICES

EXAMPLE 1

Population: Adolescent males (aged 10–19) with hearing impairments or total deafness living in marginal urban areas

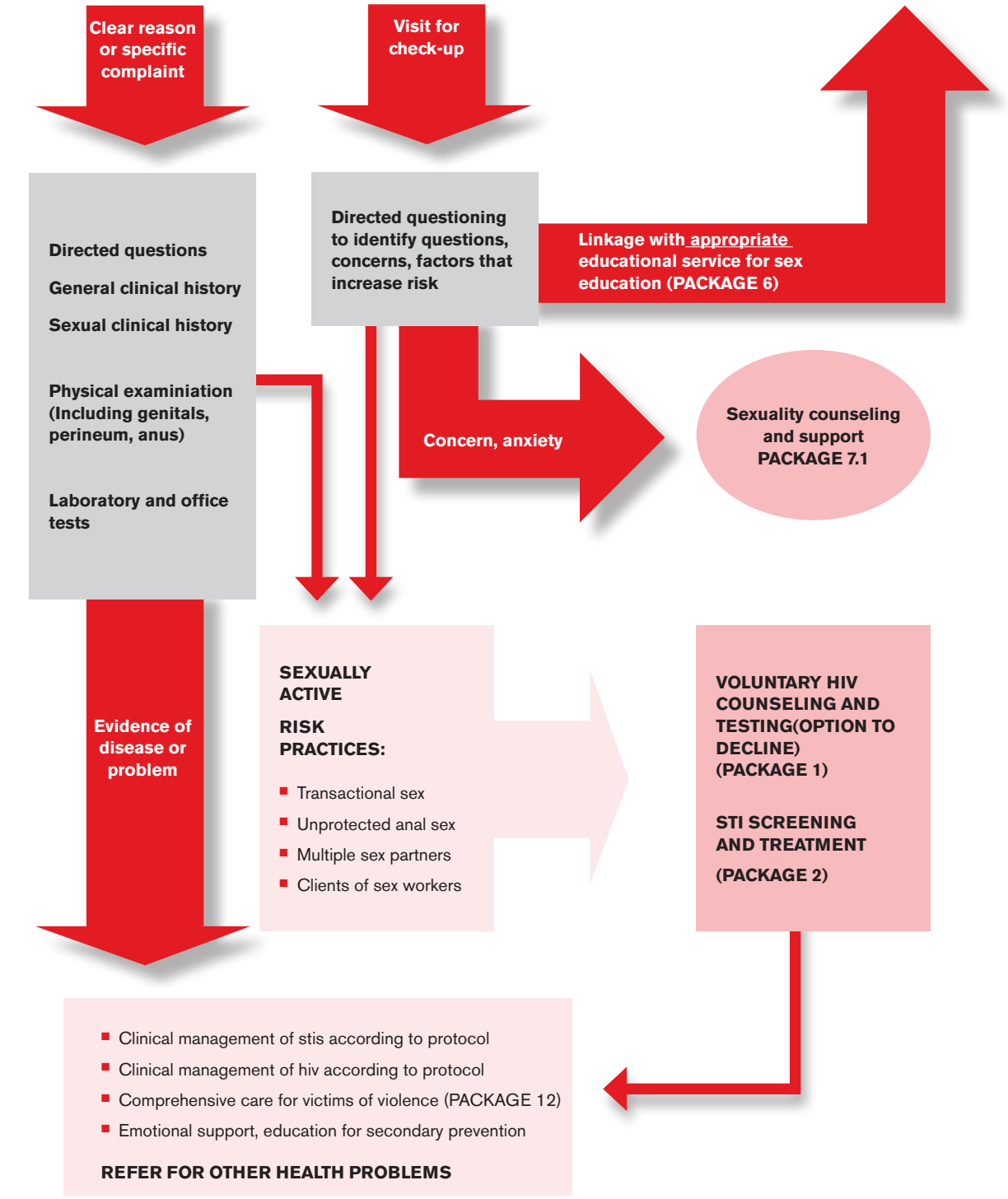
Setting for addressing needs: Health services for adolescents and young adults in an urban commune (delegation, district, area)

Considerations: Low educational status, limitations in communication, fear of stigma (double stigma if they are MSM), beliefs and social prejudices, limited knowledge about prevention



continued

EXAMPLE 1 (continued)



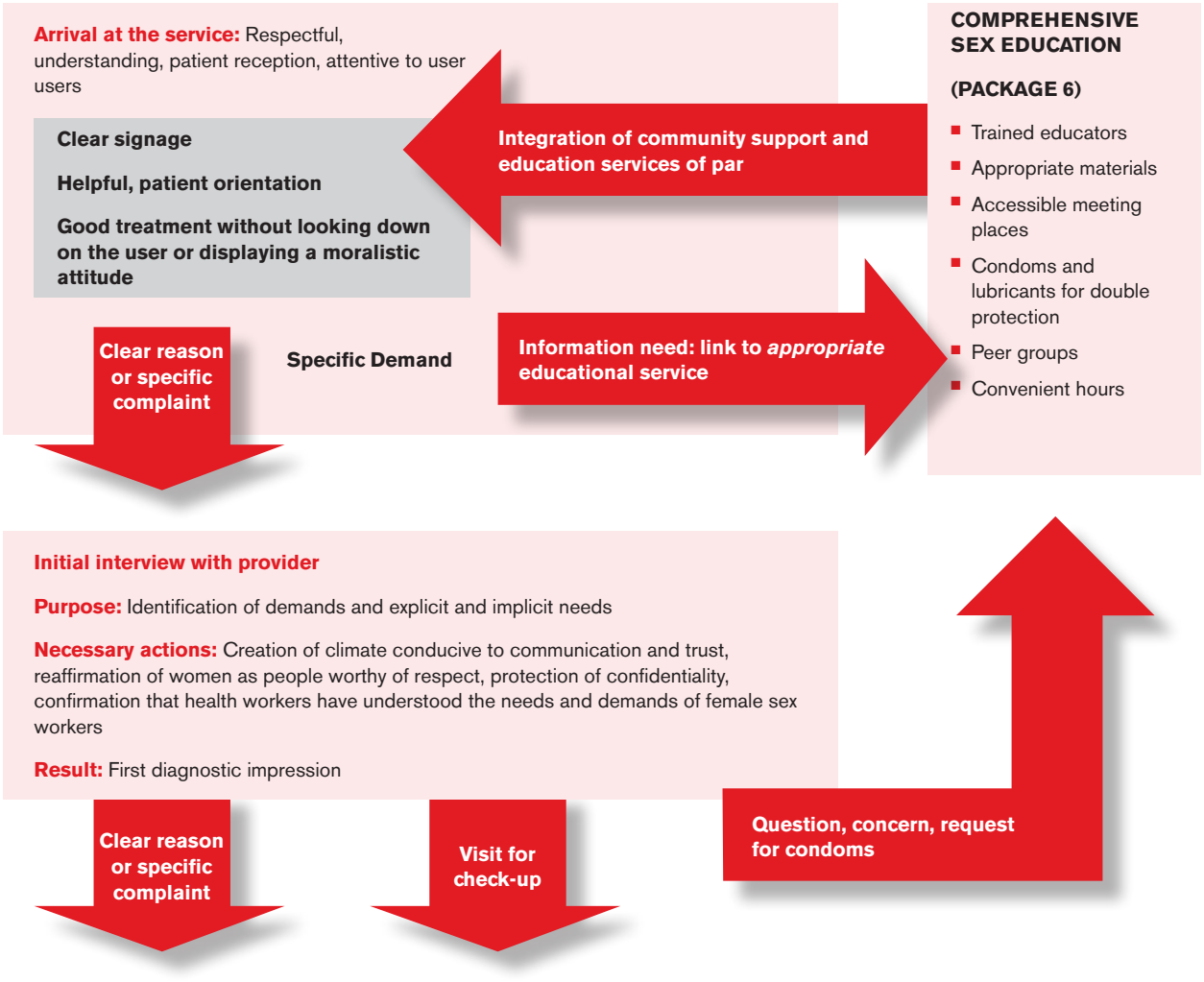
SAMPLE ALGORITHMS FOR DELIVERY OF BASIC PACKAGE OF SERVICES

EXAMPLE 2

Population: Adult women (aged 20 or over) whose main occupation is sex work in brothels and on the street downtown in the capital and who are residents of the marginal urban area

Setting for addressing needs: STI health care service in an urban commune (delegation, district, area)

Considerations: Low educational status, need for a regular income, fear of stigma, violence, beliefs and social prejudices, limited control in terms of prevention owing to economic needs



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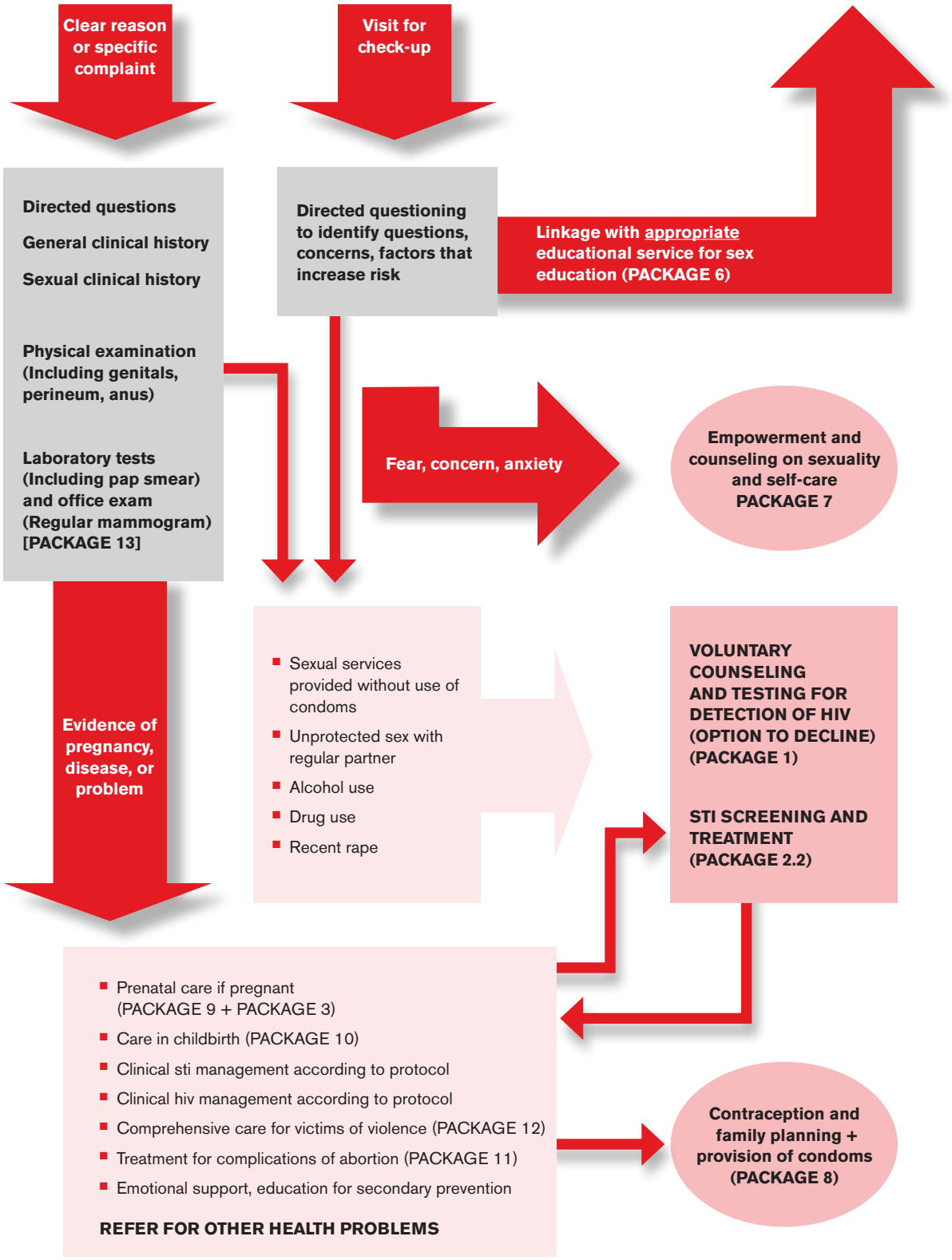
EXAMPLE 2 (Continued)



Final Considerations

- An exhaustive analysis of health systems' strengths, weaknesses, and opportunities with respect to carrying out the integration should be the starting point in every process designed to create interprogrammatic links. Selection of a strategy (linkage, partial articulation, or total integration] will depend on the conditions and capacities of the systems.
- The shift from theory to operations should be efficient, without causing problems that hinder or paralyze the operations of any of the programs or services being integrated.
- It is important to draw a clear distinction between integration and expansion that lacks a focus. The latter situation should be avoided at all costs. It is useless to add a multiplicity of actions if effectiveness, quality, and user satisfaction are not achieved.
- It is important to look at the environment and take advantage of other regional or global integration initiatives to make SRH and HIV/STI efforts more effective. This integration can of course be part of health family and community health initiatives and renewal of primary care.
- The possibility that rights might be adversely impacted through incomplete, improper, or deficient service delivery should be considered. Free and informed decision making, confidentiality, respect, fair treatment, protection from abuse and discrimination, and access to the highest attainable quality of care should always be the goal, and any situation that does not guarantee these rights should be avoided.

…179 countries agreed that population and development are closely linked, and that the empowerment of women and satisfaction of the population's needs in the areas of education and health, including reproductive health, are essential.

7

Annex 1
Milestones in the harmonization of efforts in sexual and reproductive health, the gender perspective, and programmatic responses to HIV/AIDS and other sexually transmitted infections

At the **International Conference on Population and Development (ICPD)**, 179 countries agreed that population and development are closely linked, and that the empowerment of women and satisfaction of the population's needs in the areas of education and health, including reproductive health, are essential. The ICPD definition of *reproductive health* implies the notion of sexual health and well-being in its allusion to the ability "to have a satisfying and safe sex life," together with the "ability to reproduce and the freedom to decide if, when and how often to do so." The Program of Action takes into account the *prevention and treatment of STIs, including HIV.*

At the follow-up meeting to the ICPD (ICPD+5), held in 1999, the participants noted the need for urgent action to fight the HIV epidemic. Among the key actions for fulfilling the Program of Action, they reiterated, is providing education and health services at the primary level to prevent STI and HIV transmission, especially among young people in the 15–25 age group. *(60)*

Analogously, during the **Fourth World Conference on Women**, held in Beijing in 1995, and its follow-up meeting in 2000 **(Beijing+5)**, the participants reiterated the importance of women's rights and women's empowerment, as established in Cairo in 1994. These two development platforms coincide in their affirmation of the human rights of women and the recognition that solving the world's most pressing problems will require the full *participation* and *empowerment* of the women of the world. *(61)* At the follow-up meeting (Beijing+5), there was clear and explicit mention of the need to focus on the issue of HIV within the context of efforts in sexual and reproductive health, as well as the use of gender approaches to fight the epidemic. *(62)*

The **Millennium Development Goals (MDGs)**, articulated in the United Nations Millennium Declaration (2000), focus the efforts of the global community to achieve substantial and quantifiable improvements in the lives of the peoples of the world. The MDGs are interrelated, and strategic efforts to meet them must be directed to the simultaneous achievement of all of the goals. In any case, they continue to serve as the starting point rather than the final steps toward eradicating poverty, protecting human rights and human security, and achieving sustainable development. The MDGs are also closely linked with the agreements reached at the ICPD and ICPD+5. Poverty cannot and will not be eradicated if ICPD targets are not met. Universal access to education and reproductive health care, including the prevention and treatment of HIV/AIDS, is a critical step in efforts to eradicate poverty. Reproductive rights are a core aspect of the empowerment of women and of gender equality and equity. Meeting these ICPD targets will level the playing field on the path toward attainment of the MDGs. *(63)*

The **United Nations General Assembly Special Session on HIV/AIDS (UNGASS)**, held in June 2001, proposed an integrated national and international response to the HIV/AIDS epidemic. Based on and endorsing the recommendations on HIV/AIDS that the participating governments proposed in the ICPD and in the ICPD+5, it committed to a) preventing the continued spread of the epidemic; b) reducing mother-to-child transmission; c) delivering treatment and comprehensive care to people already infected; d) ensuring progress in research, especially in developing a vaccine; and e) mitigating the impact of AIDS among the most vulnerable populations, especially children orphaned by the epidemic. The purpose of this meeting, convened at the highest political level, was to intensify national and international action to fight the epidemic and mobilize the necessary resources. It was proclaimed by the Secretary General as a decisive point in the fight against the HIV epidemic. *(64)*

In 2004, UNFPA and UNAIDS convened a high-level consultation on HIV/AIDS. The participants agreed that strengthening ties among HIV/AIDS and sexual and reproductive health programs would be key to the success of these programs and their contribution to achievement of the MDGs. The agreements are summarized in the 2004 *New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health. (65)*

That same year, the Glion Call to Action on Family Planning and HIV/AIDS in Women and Children was issued. That document makes explicit reference to the need to strengthen the links between planning and prevention of mother-to-child transmission of HIV. *(66)*

In Latin America, a pioneering meeting on sexual health promotion was held in Antigua Guatemala, Guatemala, in 2000, organized jointly by PAHO/WHO and WAS (known at the time as the World Association for Sexology and currently as the World Association for Sexual Health, although it maintains the original acronym).

This meeting discussed aspects of comprehensive care such as prevention, treatment, education, and counseling in services and programs to address people's sexual health problems (including increased risk and vulnerability to HIV and other STIs). The importance of sexuality in health programs, especially reproductive health programs, also was widely discussed. The main thrust was to develop a conceptual framework for sexuality and sexual health that would make it possible to develop strategies that would comprehensively meet the population's needs and demands in the areas of SRH and HIV/STI. *(67)*

Annex 2
Experiences reflecting major efforts to integrate sexual and reproductive health services with HIV/STI prevention activities

A WHO consultation on sexual health held in 2002 reviewed several positive experiences in linking sexual health (and HIV prevention) with programs and activities in reproductive health, including a campaign designed to raise awareness among decision makers. These campaigns sought to achieve a more inclusive approach to sexual health and sexual rights in the workplace. Issues such as public health, the HIV epidemic, violence against women, and the sexual health of adolescents were viewed from a comprehensive standpoint that included gender specificity. Although the experts attempted to draft conclusions that could be valid anywhere in the world, they were faced with the fact that, for practical purposes, generalizations could not be made given the multiplicity of national and regional views about sexuality and sexual health. Thus, the group recommended that all programs be based on the principles and fundamentals of human rights.68

Analogously, the International Planned Parenthood Federation (IPPF) put together a strategy for integrating sexuality and sexual health into reproductive health and family planning programs. This strategy included transforming family planning programs into sexual health agencies in certain Caribbean countries, in addition to work on gender violence, integration of sexual health and HIV/AIDS/STI issues in radio programs, and, finally, preparation of guidelines, in English and Spanish, for the work of health care providers. *(69)*

Another joint publication by UNFPA, UNODC, YouthNet, and WHO was based on a global consultation held in 2003 in which these agencies, in collaboration with UNAIDS and UNICEF, addressed the health service response to HIV/AIDS prevention and treatment needs among young people. The publication specifically mentions the global targets for young people and HIV/AIDS and the ICPD of 1994, which reaffirmed the right of adolescents to receive counseling, information, education, communication, and services. The publication provides a general overview of the available evidence on integrated interventions in the health services that are important for meeting global targets for young people and HIV/AIDS: information and counseling; reduction of risk through systematic, proper use of condoms (that is, the risk of becoming pregnant or infected with HIV and other STIs), as well as harm reduction; and, finally, diagnosis and treatment of HIV and other STIs. It also describes the key strategies for carrying out these interventions, including the need to explore and attempt integrated approaches. *(70)*

Through a series of guidelines, a WHO document describes the clinical and managerial recommendations for women living with HIV in terms of family planning; care in pregnancy, childbirth, and the postpartum period; prevention of mother-to-child transmission (PMTCT); prevention and treatment of urogenital infections; and management of other sexual and reproductive health problems. The guidelines use the available evidence on the delivery of interventions through functional links between HIV/AIDS and sexual and reproductive health services. *(71)*

Another document, prepared by the WHO Regional Committee for Africa, attempts to formulate guidelines orientations for that region of the world on how to revitalize the family planning component of national reproductive health programs to guarantee an integrated approach that will improve maternal and child health in the context of the MDGs. Voluntary counseling and testing services for HIV detection are viewed as the gateway to family planning, since these services and contraception are complementary. Family planning offers the opportunity to strengthen voluntary counseling and testing services, and this in turn can strengthen family planning by emphasizing the dual protection that condoms provide for the prevention of pregnancies and HIV infection. *(72)*

In this same area, International Pathfinder has developed a model for building partnerships between health facilities and communities to prevent mother-to-child transmission.73 This model uses the lessons learned from the home care provided by members of the community and PMTCT programs. It underscores that effective prevention depends on improving safe motherhood services in general and not limiting PMTCT simply to offering voluntary counseling and testing and providing antiretrovirals and information on breast milk substitutes. This broader approach requires that mechanisms be developed to create links between health facilities and community resources to ensure a maximum impact on maternal and child health.

A key strategy for strengthening the programmatic links between sexual and reproductive health and HIV/STI services has been the work in the area of men and masculinity and its relation to sexual health. In this regard, the Interagency Working Group on Gender of the U.S. Agency for International Development (USAID) held a conference in September 2003. The conference report covers critical issues such as attitudes toward masculinity, outreach strategies for different target groups, and future directions for working with men in sexual and reproductive health. *(74)*

The report includes case studies of programs in Nigeria, South Africa, and Pakistan. The objectives of the conference were to increase participants' knowledge about effective, concrete strategies for working with men in matters of reproductive health from a gender equity perspective; to make a commitment to implementing these strategies; and to promote skill building and access to the tools needed to implement the strategies. One of the fruits of this conference was a guide for the implementation of effective strategies to collaborate with men in the development of reproductive health programs and activities.

A key document in connection with this summarizes the research findings and other programmatic information exchanged among participants at the 1998 Oaxaca symposium on male participation in sexual and reproductive health, as well as the recommendations and actions suggested in the plenary sessions, working groups, and national action plans. The document is organized by subject to highlight the issues of masculinity, sexuality, HIV and other STIs, violence, and paternity while illustrating these discussions with activities and experiences. *(75)* A relevant bibliography is included for readers' reference. *(76, 77)*

A particularly useful document prepared by UNICEF and the Population Council presents the main findings of an assessment of PMTCT pilot projects supported by the United Nations in 11 countries. The assessment covers feasibility and coverage, factors associated with program coverage and challenges, scaling up activities, and the special case of countries with low prevalence rates. The recommendations include increasing coverage and providing counseling on infant nutrition, strengthening post-

natal support and the monitoring of HIV-positive women and their babies, assisting with infant feeding and care for HIV-positive women and their families, evaluating the projects, and expanding PMTCT programs. *(78)*

Finally, a document has been prepared by SHARE-NET, WFP, and Stop AIDS Now to increase knowledge and understanding about the need to create links between HIV prevention activities and comprehensive treatment for people living with HIV/AIDS that addresses health and sexual and reproductive rights. The document briefly explains the concepts of gender and sexuality, as they are the foundations of sexual and reproductive health and include elements that are causative or associated with HIV infectability. The principal international agreements on these matters are reviewed as well, and the rights-based context necessary for effective integration is described. The document also discusses the current threats and opportunities identified for achieving linkage and integration in the two fields and concludes with specific recommendations on how to guarantee effective integration of health and sexual and reproductive rights with HIV prevention. *(79)*

8

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