Sexual Health: The Emergence, Development, and Diversity of a Concept

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The concept of *sexual health,* which was developed at a 1975 conference of the World Health Organization (WHO), is currently being used to set up nationally based public health programs in various countries. I outline the history of sexuality as a public health issue since the 19th century, analyze the history of the concept of sexual health since its emergence in 1975, and make a comparative analysis of the contemporary documents dealing with sexual health generated in the U.S. and England, and by organizations such as the WHO and the Pan American Health Organization (PAHO). The analysis of these documents gives evidence that there is no international consensus on the concept of sexual health and its implementation in public health policies. The conceptions of sexual health remain embedded in national and political contexts. Conceptions for sexual health appear to be the result of political compromises and take place in the public health culture and practice of each country. Depending on the context, these different initiatives focus either on individual responsibility or on an appropriate sexual health services organization, and sexual health may be conceived as an ideal state of well-being or as the reduction of negative consequences of sexual activity.

Key Words: health policy, HIV/AIDS prevention, public health, reproductive health, sexual dysfunction, sexual health.

The concept of *sexual health*, which was developed in a 1975 conference of the World Health Organization (WHO), is currently being used to set up nationally based public health programs in various countries (e.g., U.S., England) and internationally by organizations such as the WHO and the Pan American Health Organization (PAHO). In Australia, the topic of sexual health is included in a special section of the Australia Health 2000 (Seventh biennial health report of the Australian Institute of Health and Welfare). The sexual health approach is focused mostly on STDs and reproductive issues (contraception, pregnancy, abortion, and perinatal problems) (Australian Institute of Health and Welfare, 2000). In other

This article was translated from French by "Coup de Puce-Expansion," Toulouse, France. I wish to thank Gerald Oppenheimer, John Gagnon, and an anonymous reviewer for their careful reading of an earlier draft of this paper and for their constructive suggestions. Correspondence concerning this article should be addressed to Alain Giami, PhD, INSERM (Institut National de la Santé et de la Recherche Médicale) U. 569, 82 rue du Général-Leclerc, F-94276 Le Kremlin-Bicêtre Cedex, France. (giami@vjf.inserm.fr)

countries, particularly in France, the concept of sexual health is not used in public health programs, which usually differ according to the theme (campaigns for contraceptive information, campaigns for preventing HIV infection, campaigns providing information to counter sexual violence). However, the documents issued by different national and international public health organizations reveal several differences in definitions of the concept of sexual health that are discussed in this paper.

The treatment of sexuality as a public health issue goes back to the mid-19th century and has historically been based on political choices and strategies. At that time, sexuality was primarily conceived as oriented toward procreation. The main ideas and practices of public health institutions were to preserve the best conditions for procreation in the context of marriage, expressed both as a biological function and a moral value for society. During a later stage, from the 1960s on, this perspective shifted. The introduction of oral contraception had the effect of socially legitimizing nonprocreative sexual activity inside and outside of marriage.

The concept of *reproductive health* emerged at this time to take into account the individual choice behind procreation (Frank, 1994), and it has it own history (Lottes, 2000). The preventive strategies developed in response to the HIV-AIDS epidemic then led to an acknowledgement of the diversity of sexual cultures. The inclusion of sexuality as a public health issue widened the scope for the medicalization of sexuality by focussing on populations rather than individuals. This meant going beyond the clinical doctor/patient model and implementing health prevention and control strategies through public information campaigns.

In order to understand the significance and the practical and political implications of sexual health issues in public health, I will (a) briefly outline the history of sexuality as a public health issue since the beginning of the 19th century and identify which aspects of sexuality have been at stake, (b) analyze the history of the concept of sexual health since its emergence in 1975 (WHO, 1975), and (c) make a comparative analysis of the contemporary documents dealing with sexual health. My intention is not to criticize the different initiatives that have been taken in the field, nor to suggest a better or a more appropriate definition of sexual health (Kontula, 2000; Lottes, 2000). My aim is to determine the place and status of sexuality in public health and to underline the fact that social regulation of sexuality in terms of sexual health depends on its national, political, and cultural context. Furthermore, my intention is to identify the diverging interpretations of the concept of sexual health and the different public health strategies envisaged in different countries and international organizations more than it is to highlight the extent of the consensus on sexual health (Coleman, 2002). This work is an attempt at

"historical epistemology" and an analysis of the "formation of concepts" (Davidson, 2001).

I have tried to identify the different definitions of the sexual health concept and to analyze the causative factors. I decided to use a detailed comparative analysis of the different current documents, in an historical perspective, to show how concepts have evolved and diverged according to the context in which they were formulated. This analysis is an attempt to identify (a) the different definitions of sexual health and sexuality used in various sources, (b) the choice of sexuality problems which are considered to be important for sexual health and which should be dealt with, (c) the individuals and groups for which sexual health interventions may be necessary, (d) the different types of intervention and the professionals in charge of them, and (e) the role of health organizations and institutions (public or private).

Historical Landmarks: Sexuality and Public Health Since the 19th Century

Public health includes those fields of human activity defined as health problems, which may be regulated in a planned way by government or nongovernment institutions. Initially, public health was applied in two fields (Lupton, 1995): first, to improve the urban environment, which was considered to be pathogenic, and, second, to control people's bodies and to modify their behavior for the purpose of promoting a healthy life (Vigarello, 1988). Foucault defined these conceptions and interventions as a sort of "biopower," concerned mainly with managing the reproduction of populations and with controlling deviant behavior by means of a combination of medical and legal provisions (Foucault, 1976).

Sexuality was first taken into account as a public health issue during the 19th century, at a time when the ruling classes began to recognize public health as a scientific discipline and a means for applying social policies. Historically, sexuality, or sexual activity, emerged in the public health field as an activity to be regulated, normalized, and channeled under the primacy of procreation. Monogamous marriage was the only recognized social situation in which sexual activity and procreation was legitimized. This conception of sexuality was thus based on the idea of a "natural sexual act" whose only goal was procreation (Acton, 1865). From this perspective, at the end of the 19th century, venereal diseases were considered as serious risks to procreation, and the fight against prostitution was seen as a combat against the degeneration of the human species (Corbin, 1978). Masturbation and all other forms of "spermatorrhea" were considered to be a potential cause of sterility and impotence (Barker-Benfield, 1983). Medicine was much more concerned

with impotence because it prevented procreation than because it prevented sexual satisfaction.

Furthermore, the preoccupation with developing a "healthy race" had led to the onset of the first eugenic concepts and to individuals being forbidden to procreate if they were considered to be "unfit" to do so, due to the risk of them transmitting their hereditary defects and possible criminal tendencies (Kevles, 1985). In this context, the compulsory sterilization of individuals was intended to reduce their libido in order to prevent them from having sexual intercourse and procreating (Reilly, 1991). This policy was strengthened during the 1930s in Scandinavian countries and in Germany by the application of eugenics programs, and it still continues today in some Western countries, mainly applied to mentally handicapped women (Giami, 1998) and in some developing countries (Giami, & Leridon, 2000). Consequently, until the beginning of the 1960s, sexuality represented a two-fold problem for public health, which, on the one hand, had to support and to restrict sexual activity and procreation within marriage in order to increase the population and, on the other hand, had to control, reduce, and eradicate "dangerous sexual practices" and outcomes (Mort, 2000), including masturbation, same-gender sex, prostitution, venereal diseases, and pregnancies out of wedlock.

As early as the 1920s, however, the movements for the emancipation of women had already begun to advocate free access to contraceptive methods and abortion. Professional associations involved in politics have sometimes supported the demands of feminist movements. For example, The World League for Sexual Reform, created in 1928 and led successively by Magnus Hirschfeld, Havelock Ellis, and Auguste Forel, represented the reformist movement for the development of contraception. At this time contraception and abortion had been legalized in England, in the Scandinavian countries, and in some states in the U.S. (Walkowitz, 1992). They were, on the other hand, illegal in countries such as France and Italy (Haire, 1934). In these two countries, the predominant effect of natalist policies (i.e., policies that encourage the quantitative and nonselective increase of the population) forbade, until fairly recently, any propaganda in favor of contraception (Mossuz-Lavau, 1991). Finally, the protection and improvement of the living conditions of children born out of wedlock and of their mothers also became a public health problems for which pragmatic solutions had to be found, given a highly Malthusian context and the decrease in births in certain industrialized countries.

The development and marketing of the contraceptive pill radically changed the place and status of sexuality in the field of public health (Watkins, 1998). The pill created a legitimate medical basis for distinguishing between sexual activity and procreation. This happened at

about the same time that Masters and Johnson (1966) described their work on the "human sexual response" and orgasm, including female orgasm, which gave sexual activity its own erotic purpose, independent of procreation. Masters and Johnson even considered procreation and pregnancy, in theoretical terms, as a potential obstacle to having an orgasm. The political struggle related to the freedom to procreate, or not, was made possible by the discovery of an efficient, medical form of contraception and the political movements, in turn, adopted this discovery (Wolton, 1974). This stimulated the promotion and distribution of all the previously known contraceptive methods and was considered to be the "second contraceptive revolution" (Leridon, Charbit, Collomb, Sardon, & Toulemon, 1987).

At the beginning of the 1980s, the HIV-AIDS epidemic dramatically modified the place and status of sexuality in the field of public health. To the extent that sexual intercourse was one of the principal transmission routes for the virus and given that there was not an efficient vaccine for prevention, it appeared to public health specialists that one of the most efficient ways of preventing infection was to change individual sexual behavior. A series of national surveys on sexual behavior were conducted in most of the industrialized and developing countries. At the time when oral contraception was introduced, the surveys focused on heterosexual relationships, defined as premarital, marital, or extramarital intercourse (Clement, 1990; Michaels & Giami, 1999). The surveys undertaken in the context of HIV-AIDS were focussed more on homosexual behavior, anal practices, and multiple partner situations as part of an epidemiological construction of sexuality (Giami, 1996). Never before in the history of research on sexuality (Ericksen & Steffen, 1999) had so many in-depth studies been devoted to sexual behavior (Catania, Moskowitz, Ruiz, & Cleland, 1996; Cleland & Ferry, 1995; Giami & Dowsett, 1996, Laumann, Gagnon, Michael, & Michaels, 1994b). The idea of modifying sexual behavior as the main way of preventing HIV infection acutely raised the question of society interfering in individual sexual behavior, which was considered to be private matter (Bayer, 1989, 1991). Two conflicting positions emerged, with some recommending that minority sexual cultures be respected and that preventive strategies be developed accordingly (Parker, Herdt, & Carballo, 1991) and others, from conservative ranks, trying again to impose abstinence outside of monogamous marital intercourse as the only efficient way of preventing HIV transmission.

More recently, an attempt was made to define erectile dysfunction and sexual disorders as a public health problem. The strategy adopted by those parties with a vested interest in treating these disorders (e.g., professionals, medical corporations) consisted, first, of modifying or expand-

ing the medical definition of erectile disorders, in order to develop a new clinical entity, and, then, of undertaking an epidemiological survey based on the new definition of the so-called disease. The survey showed that there was a much higher prevalence of erectile disorder than had been found using the previous definition (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994). Once the new prevalence of erectile dysfunction had been established, it was possible to show that most men suffering from the condition did not have sufficient access to medical care and that it was necessary to overcome cultural obstacles preventing the development of access to new treatments for erectile dysfunction (Shabsigh, Alexandre, Nielsen, Fitzpatrick, & Melchior, 2000). This is an outstanding example of the social and professional reclassification of a sexuality problem as a public health problem. The economic aspect of reimbursement by health insurance systems and of the cost borne by society emerged as a key issue for the development of treatments. The reliance on epidemiology and on health economics henceforth became the main strategic argument for including a health problem in the public health field (Giami, 1999). Lastly, this story gives evidence that the public health discourse has become the major justification to legitimize a "disease" and its treatment. The role of the pharmaceutical industry in "selling sickness" has also become more explicit (Moynihan, Heath, & Henry, 2002)

Public Health and the Medicalization of Sexuality

The introduction and development of sexuality in the field of public health is an extension and an intensification of the medicalization of society (Conrad & Schneider, 1980) and of sexuality (Giami, 2000; Tiefer, 1996). The medicalization of sexuality refers generally to a body of basic knowledge and scientific concepts on sexuality which evolve over time; a social organization of health professions founded on professional training and certification, professional practices, and interaction between members of health professions (doctors and psychologists in particular) and their patients; a form of social control and regulation of sexuality based on efficient technologies and on the ideology of health which reinforce or counter other forms of control such as those previously exercised by religion (Conrad, 1992). Medicalization is marked by the predominance of the clinical treatment of individuals and by the curative model in the context of a doctor/patient relationship. The development of sexuality as a public health issue expanded the problem to include the collective dimension involving public information, education, prevention, and health care. It is, of course, based on the evolution of social, scientific, and medical conceptions of sexuality but, nevertheless, relies upon forms of social intervention and behavioral regulation that are different from

those in the clinical model. In the public health context, clinical medicine is no longer the only theoretical and practical framework. The individual clinical approach is now being broadened by references to education, epidemiology, statistics, economics, and law. Clinical treatment, in terms of a doctor/patient relationship, has thus become only one of the many forms of intervention currently being practiced.

Public Health and Morality

Historically speaking, the inclusion of sexuality in the field of public health is somewhat of a break from traditional conceptions, in which sexuality is, above all, a moral issue. Conceptions of sexual health and its promotion may sometimes conflict with certain religious positions (in particular, the issue of sexual abstinence for teenagers, but also contraception, the use of condoms, and abortion). The inclusion of sexuality as part of public health is sometimes considered as a kind of moralization of a population's behavior, which means that health recommendations replace, but have the same goal as, moral values (Lupton, 1995). The construction of the sexual health concept, thus, has moral and political implications. Health also becomes an ideological argument that sometimes attacks the positions of dominant sexual morality and sometimes helps reinforce them.

Thus, during the 19th and 20th centuries (and until the middle of the 1960s), sexual activity was treated as a public health issue in that it threatened procreation within the legal framework of marriage. Public health interventions were aimed mainly at regulating and repressing types of sexual activity taking place outside of marriage or considered to be a deviation from genital sexuality, while preventing or treating their consequences (pregnancy outside of marriage, procreation by people considered to be "unfit," sexually transmissible diseases), both individually and collectively. With the availability of oral contraception, followed by the AIDS epidemic, and with the sexual revolution in the background (Allyn, 2000), public health officials drastically modified their approach to sexual activity and its consequences by acknowledging the legitimacy of nonreproductive sexual activity that could also take place outside of marriage. This history enables one to understand how the concept of sexual health arose as a contemporary expression of the place and status of sexuality in public health. The main aspects of sexuality that are now considered public health issues are contraception and abortion, prevention of HIV infection and sexually transmitted diseases, prevention of sexual abuse, and the treatment of sexual disorders. Thus, I examined the responses of various public health organizations to these issues and the resulting new conceptions of sexual health.

The Emergence of the Concept of Health

The concept of sexual health is grounded in the definition of the concept of *health* that appeared in the preamble to the constitution of the WHO at a meeting that took place in New York in 1946. "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946, p. 1). This definition, which has not been changed by the WHO since 1946, frees the question of health from the limits of curative medicine by showing that health cannot be restricted simply to the treatment or prevention of physical illness (Herzlich & Pierret, 1987). Furthermore, in this definition the assumption is that health cannot be reduced to the somatic dimension: It includes the psychological and social dimensions of individuals and defines both society and the environment as conditions for health. In the WHO document, one emphasis is that governments are responsible for organizing access to health care and services in order to ensure their population's health. Also emphasized is information that can help individuals play an active and enlightened role in maintaining and developing their health. Finally, health is defined as a fundamental right of individuals and communities. This new definition of health frees it from the restrictions of disease alone and introduces the notion of *well-being* into the field of health. Moreover, this definition introduces the issue of health as a political problem that must be managed by governments that also have to guarantee the rights of individuals and communities in this respect.

This definition of health was broadened during the Ottawa conference of the WHO in 1986 by the addition of a *health promotion* concept:

> Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. (WHO, 1986, p. 1)

The idea of health promotion was an important shift from the initial WHO perspective to the extent that, in parallel with government services and care, it reinforces the role of individuals being responsible for controlling and producing their own health. It thus makes the preservation of health and its development a major concern for individuals in their daily lives.

The concept of sexual health was developed in 1975, involving both governmental responsibility (political) and individual responsibility. For governments, this involved setting up and developing suitable, efficient services and ensuring equal access to them, whereas the notion of individual responsibility concerned promoting behavior to preserve individual health. Health was, thus, no longer considered to be a static state but a dynamic process based both on individual and political responsibility. It is, however, interesting to note that the concept of sexual health was not used in the 1946 document, nor in that of 1984, which was drawn up 9 years after sexual health had first been defined. Although the 1946 definition of health has never been changed, the definition of sexual health has undergone a number of changes, in association with the different contexts in which it has been applied.

Moreover, the concepts of *reproductive health* and *reproductive rights* were defined at the end of the 1970s in the framework of international population conferences and at the instigation of feminist groups involved in the development of women's health (Lottes, 2000). The 1980s saw a significant development of the notion of reproductive health and the gradual dissociation of sexual health initiatives from that of reproductive health. The concept of sexual health appeared, in some cases, to be included in the field of reproductive health and, in others, to be a clearly distinct and autonomous field of intervention.

The Emergence of the Concept of Sexual Health: WHO, 1975

In 1972, at a WHO meeting held in Geneva from September 13-19, Willy Pasini and Georges Abraham, two Swiss medical sexologists, presented a review of the teaching of sexology and, in particular, of medical sexology. They concluded that sexology was not taught in most countries, with the U.S. being a notable exception. Furthermore, they recommended the development of training in sexology for health professionals and, in particular, for professionals involved in family planning activities (Pasini, 1975). The conclusions of this first meeting were taken up again and given official recognition at a meeting held in Geneva in 1974. This consultation brought together 29 participants from 12 countries (mostly European and North American), among whom were Coenrad von Emde Boas (Netherlands), Preben Hertoft (Denmark), John Bancroft (Great Britain), Jacqueline Kahn-Nathan (France), Romano Forleo (Italy), Jan Raboch (Czech Republic), Willy Pasini and Georges Abraham (Switzerland), Herbert Vandervoort, John Money, Paul Gebhard, Mary Calderone, Helen S. Kaplan, Philip M. Sarrel, Lorna J. Sarrel, and Harold Lief (U.S.). The report written after this consultation legitimized and promoted modern sexology, which was then being reinvented and structured at the international level.

The emergence of modern sexology is based, moreover, on the development of sexology research: Witness the founding of several scientific journals and societies in the U.S. at about this time. For example, the first issue of the *Archives of Sexual Behavior* appeared in 1971. The *International Academy of Sex Research* was founded in 1975, and the *Journal of Sex and Marital Therapy* first appeared at about the same time (Zucker, 2002). An international consensus emerged with the aim of defining professional criteria and the division of labor among the various professional groups that might be involved in the treatment of sexual disorders and the consequences of sexual activity.

The WHO report was drawn up by clinical sexologists, including a majority of physicians from different specialized fields of medicine (mainly psychiatry and gynecology) and a minority of psychologists and sociologists. A definition of sexual health was provided, the main problems related to sexuality were identified, the various types of intervention were organized and ranked, a function and a role was assigned to each of the professional groups involved in treating the problems, and a training program for various health professionals in the field was drawn up. Furthermore, the authors of the report assumed the necessity of a change in attitudes of members of the health professions. Most health professionals were presumed to have negative attitudes toward sexuality due to their ignorance of the scientific facts on sexuality. They were encouraged to become more tolerant of sexual diversity. The report contained a plea for the recognition of sexology as a scientific discipline. In a discussion of sexual health, Erwin Haeberle argued that this document mainly represented the expression of Western, middle class sexual values (Haeberle, 1998).

The Definition of the Concept of Sexual Health (1975)

> Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love. Thus the notion of sexual health implies a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relationships and not merely counseling and care related to procreation or sexuality transmitted diseases. (WHO, 1975, p. 41)

This definition of sexual health fits into the broader health concept in that sexual health is not limited to diseases of the genital organs or the treatment thereof, or to procreation (and its control by individuals). This definition, which places an emphasis on the positive aspect of sexuality, including its relationship to love and the development of the personality, is consistent with the trend of sexual optimism defined by Paul Robinson (1976). This definition also identifies the concept of well-being, which

becomes the goal of sexual expression and the main cultural significance attributed to sexuality. At the same time, however, well-being becomes a health category. Erotic sexual activity is separated from the reproductive function, becoming the main goal of sexual activity and an individual right (Béjin & Pollak, 1977). This right to sexual health must be won through a struggle against ignorance of the scientific facts of sexuality and against "cultural myths and taboos," that are obstacles to the development of sexual health. In the WHO report, a strategic vision for the development of sexual health was suggested by including it on the agenda for reproductive health interventions, as family planning centers are already dealing with sexuality problems:

> The fact remains that family planning information and counseling on sexuality are logical companions, and that family planning is a suitable context in which to introduce training and therapy programs in human sexuality. Nevertheless, in certain situations, sexuality programs could also be developed outside this context because of the connotations of birth control. (WHO, 1975), p. 44)

Sexual health is seen as being more holistic than reproductive health. The authors of the report defended the general principle of keeping erotic sexual activity autonomous and separate from reproductive sexuality, family planning, and the prevention of sexually transmitted diseases, but, for practical and organizational purposes, they proposed including sexual health intervention in the framework of existing reproductive health interventions.

Sexual Health Problems

The report then contains a list of health problems likely to negatively affect sexual health.

> (a) Problems related to infection: not only sexually transmitted diseases but such problems as vaginitis and cystitis, which may cause a variety of sexual difficulties. (b) Problems related to the life-cycle: those sexual problems that occur in conjunction with pregnancy, childbirth, and the postpartum period, those associated with the menstrual cycle, etc. (c) Problems related to a changing technology: e.g., use of condoms, hormonal contraception, of IUDs, when breakthrough bleeding may be a problem. (d) Problems that are related to sociocultural factors, including legal and economic factors. (WHO, 1975, p. 52)

It is interesting to note that this outline of sexual disorders mainly develops a somatic conception of the etiology of these disorders. Psychological, psychopathological, and relational factors, which are crucial elements in interventions during treatment by professionals, are not taken into account. The document bears the characteristics of the medicaliza-

tion of sexuality (Tiefer, 1996) in that sexual health is mostly based on satisfactory somatic health.

Levels of Intervention: Education, Counseling, and Therapy

The levels of intervention for sexual disorders are defined and ranked dividing them into education, counseling, and therapy. These different levels of intervention are assigned according to the knowledge and skills assumed for the different health professions.

> Education, counseling, and therapy may be regarded as inseparable parts of a total effort in sexual health care. First, the provision of sexual health *education* to the community, to the physician, and to other health workers has the highest priority because this can be done with the least amount of training and will affect the greatest number of people. While sex education should be a basic part of preventive medicine, it has also been shown to be effective in assisting individuals and couples to overcome sex problems. Second, there is a need for *counseling* of individuals and couples with slightly more complicated problems; this can be carried out by the nurse/midwife, the general practitioner, the gynecologist, and others. Third, there is a need for *sex therapy* in depth by specially trained professionals who see the people with the most complicated problems. Health and other community workers require more specialized training to undertake sex counseling and sex therapy. (WHO, 1975, p. 43)

Physicians, general practitioners, and other specialists can intervene at each of the levels, whereas members of other health professions (midwives, in particular) may only intervene at the first two levels (education and counseling). The emphasis is placed on professionals who intervene in somatic and reproductive health (physicians and midwives) and also social workers. Psychologists are never mentioned as a health profession implicated in these interventions.

Although the three levels of intervention are given the same status, education is ranked first in terms of the one that can reach the greatest number of individuals. It should be noted, however, that the various intervention techniques and methods are only described in detail for sexual therapy. Three pages of the report are devoted to a description of different sexual therapy approaches, whereas educational and counseling methods are described with much less detail. This imbalance in the presentation strongly suggests that therapy is considered to be more important than the other types of intervention.

Training of Health Professionals: A Political Project

The emphasis in the document is on a description of the training of health professionals, whether they encounter sexuality problems during

other health interventions (in particular, reproductive health) or whether they specialize in sexology. Professional training in applied sexology is provided for all levels. The training is designed to prepare health professionals who deal with reproductive health and family planning, or deal with sexual disorders that may be encountered during family planning sessions. The training involves acquiring theoretical knowledge and technical skills, and communication and psychological skills. It includes, as well, positive attitudes toward nonreproductive sexual activity. In fact, one of the most important aspects of this training has to do with the struggle against myths and taboos that preclude acknowledgement of the validity and positive nature of nonreproductive sexual activity.

> In many countries and in many subcultures the existence of sexual taboos and myths and the resulting guilt or secrecy imposed by society on sexual matters are important obstacles to sex education. So also in certain societies is the cult of machismo, or male dominance and victimization of women; this makes it difficult to introduce the idea of sexual enjoyment for both partners that would appear essential for the achievement of healthy sexual relationships. Feelings of sexual guilt sometimes result from the influences of extraneous cultures that may bring about radical changes in patterns of behavior. Another major barrier to sex education is the attitude that sex is sinful unless it is meant for procreation—a common teaching and one that can create feelings of guilt in the use of contraceptive methods. (WHO, 1975, p. 51)

In the WHO document the dominant values and meanings attributed to sexuality are strongly criticized. In this context, the development of the concept of sexual health and methods suggested for developing it represent a radical departure from religious views of sexuality, which are seen as obstacles to the achievement of the sexual health program. The negative influence of religion toward sexual pleasure is not explicitly mentioned but appears as an undercurrent with the mention of the notion that "sex is sinful." The document contains a plea for sexual equality and the right of women and men to experiment with sexual pleasure under better psychological and social conditions. Sexual health is a new cultural conception of sexuality based on acknowledging the positive nature of nonreproductive sexual activity and its independence from the reproductive life, and recognizing the role of medicine and modern technology in achieving and supporting the recommended transformations. It should be noted, however, that homosexuality is practically never mentioned in the document, although it has not been considered to be a mental illness since 1973 (Bayer, 1981).

This document was the first basis for structuring the group of professional sexologists. Within the framework of the WHO, sexologists were

able to define their conceptions of sexuality, their working methods, and their therapeutic goals. The organization of the sexologists as a professional group was strengthened in 1978, at a meeting held in Rome, with the founding of the World Association of Sexology (WAS), which has become the leading international association of professional sexologists and has continued to develop its partnership with the WHO.

A Time for Reflection Before the Emergency : WHO-Europe, 1987

In the introduction of the document, the WHO Acting Director (Lifestyles and Health) explored "whether there is a need for a separate sub-category of 'sexual health' [and] questioned whether a definition of sexual health would be medical, moral, social or psychological and suggested there is a power element to any such definition." (WHO, 1987, p. 1). The emergence of the HIV-AIDS epidemic provided one of the main motivations for the WHO to enter the debate on sexuality. But, strangely, the entry of the WHO into the field of HIV-AIDS prevention did not occur through the emerging discussion on sexual health. This may be explained by the fact that HIV-AIDS was originally framed as a "major public health issue." The 1987 WHO report did not consider sexual health from a public health perspective but as an issue relating to the contradiction between individual choice and cultural values. The perspective that was adopted at this 1987 meeting was not on the agenda of the WHO, which was focusing on the reduction of risky behavior as a normative challenge. This might also explain why this report had such little impact and is still never seriously discussed (Lottes, 2000).

Of specific interest is that almost half the contents of this document were devoted to discussing the conceptual difficulties relating to definitions of sexual health. According to the authors, these difficulties arose from the fact that "sexual health is not a scientific concept. Concepts of sexual health are related to culture and time and express values and norms of the society of which they come" (WHO, 1987, p. 2). Following this preliminary statement, the authors developed the ideas that (a) there is a danger in attempting to establish a norm for sexual health, (b) a definition of sexual health would be normative and restrictive, and (c) there is an implicit concept of sexual health in all services and education related to sexuality. The group's reflections were deeply influenced by a kind of resistance to developing a framework for sexual health. This position appears quite opposed to the one that was developed in the 1975 WHO report, in which sexual science was strongly advocated. From a more positive point of view, the authors recognized that

> The concepts of sexual health or sexual well-being that are valid and feasible are those that recognize the variety and uniqueness of individual sexual experience and sexual needs, and affirm the rights of individuals to be free from sexual exploitation, oppression and abuse. The goals of policies, programs and services relating to sexuality are not that they achieve a measurable level of "sexual health" in the population, but that they enable individuals to meet their respective needs in the area of sexuality and enable them to have the personal resources to deal with problems and difficulties that arise. (WHO, 1987, p. 4)

Then, an elaborate discussion of variations in sexual needs and experiences according to culture, age, disability, chronic disease status, and sexual preference was developed. The 1987 WHO report was predicated on an individualistic approach to sexual issues, considering that every individual is unique according to his/her needs and expectations. Therefore, the authors feared that the establishment of a new concept of sexual health would inevitably lead to a strong normative outcome. Central to this approach was a recognition of a concern with a wide diversity of social and individual meanings attributed to sexuality. This view had been developed in relation to issues about contraception and family planning:

> Family planning is considered essential to the sexual wellbeing of women in industrial societies, where the predominant values stress the pleasure aspects of sexuality, and childbearing is seen as a limited part of the woman's role. However for women with a different cultural background, family planning may have much less relevance to sexual wellbeing. A woman in a culture where childbearing has high value may find that using contraception reduces her sense of sexual wellbeing. (WHO, 1987, p. 12)

The 1987 report followed the model of intervention that was elaborated in the WHO 1975 report and includes education, information, counselling, and sex therapy. The need to enhance professional training and research was also strongly reaffirmed. But the 1987 WHO report took a different perspective by concerning itself with cultural and religious variability. Whereas the authors of 1975 report stated the necessity of struggling against religious values and conceptions of sexuality perceived as obstacles to sexual health, the authors of the 1987 WHO report considered that the cultural meanings (including the religious meanings) attributed to sexuality deserved respect and understanding. According to this perspective, the implementation of sexual health programs need to take place within the framework of existing values and beliefs, not against them. The "values and preferences of middle-class white people" were criticized and considered potentially inappropriate.

> Many health professionals do not have the knowledge of taboos, religious and health beliefs and cultural factors generally, that influence the inner lives of their clients. Instead of viewing them as acceptably different, the professional may regard them as ignorant and superstitious. There is a danger of stereotyping. (WHO, 1987, p. 16)

Finally it is interesting to note that the 1987 WHO report did not contain a list of "sexual health problems." The approach was focused on social and cultural issues affecting individual behavior rather than on organic aspects and clinical treatment. The major objectives of the program that was developed in the 1987 WHO report represented an attempt to reduce the gap between individual needs and the necessities required for sexual health "the uniqueness of each individual's sense of sexual well being, their choice and preferences, their behavior, relationships, and attitudes, and some concepts that are necessary for sexual health" (WHO, 1987, p. 14). The 1987 WHO report was not widely disseminated and was not even considered "a formal publication." The WHO did not officially endorse its conclusions.

The Consolidation of Sexual Health: PAHO/WHO, 2000

The document *Promotion of Sexual Health: Recommendations for Action* was finalized during a seminar held in Antigua (Guatemala) from May 19-22, 2000, under the auspices of the PAHO and the WHO, in cooperation with the WAS. A shift in perspective in the sexology world is revealed in this report. Whereas the initial 1975 document had been written by North American and European sexologists, the new document was written mostly on the initiative of sexologists from Central and South America working within their own professional organization, in cooperation with the WAS. It should also be noted that Eli Coleman (University of Minnesota), the president of the WAS at that time, also participated and considerably contributed to the text. Another participant was Marc Ganem, a French gynecologist and sexologist, who was elected the WAS president in June, 2001. This shows how most sexology research and practice centers are now in North and South America and also reveals the vitality of the Latin American sexology and public health organizations. It also reveals the emergence of the treatment of sexuality disorders independently of reproductive health (for which there had been many international interventions for several years in these countries, in particular through the Ford and MacArthur foundations).

The 2000 document is a good illustration of how the scientific bases for sexology were being reinforced. Whereas the 1975 and 1987 documents did not contain any scientific references, the 2000 one lists 65 scientific references to work done in English and Spanish speaking countries, on

which the new conceptions and recommendations are based. Sexology has thus been built on the results of international sex research, which has increased both quantitatively and in complexity over the last 20 years, against the background of the AIDS epidemic and the discovery of new pharmacological treatments for sexual disorders (Zucker, 2002). Also included in the document is a description of the evolution of the biopsychosocial model in medicine (Engel, 1977) and the development of "evidence-based medicine" (Sackett et al., 1996) in public health. The model fits neatly into the conceptual framework of health promotion developed in Ottawa in 1986, focusing on the development of individual responsibility for health management in parallel with the development of health services specialized in sexual and reproductive health. The work done by sexologists, thus, goes beyond academic research in contributing to public health actions (i.e., information, prevention, therapy) and, more generally, in keeping up with social change (Gagnon, 1975). Finally, also noted in the document are new issues related to sexuality and the increasing HIV-AIDS pandemic around the world: acknowledgement of sexual violence against women, recognition of gay and lesbian rights, and developments in feminist theory and women's rights in terms of sexuality.

The objectives of the consultation were "to develop a conceptual framework for the promotion of sexual health; to identify sexual health concerns and problems in the region of the Americas; to suggest actions and strategies to achieve and maintain Sexual Health" (Pan American Health Organization/World Health Organization [PAHO/WHO], 2000, p. 3). In particular, in *The Promotion of Sexual Health*, the major conceptual evolutions I will be discussing are described. First, this document differs from the 1975 and 1987 documents in that it contains definitions of concepts of *sex* and *sexuality*, and the concept of sexual health is linked to the concepts of *responsible sexual behavior* and *sexually healthy society*. In addition, these two concepts are associated with that of *sexual rights*, for which a solemn declaration had been adopted at the 14th WAS conference held in Hong Kong in 1999. The field of sexual health is, thus, defined in terms of responsibility, both individual and collective, and of sexual rights. Finally, the main sexual problems facing societies and individual are redefined, a nomenclature of *clinical syndromes*, which demonstrates how the approach to sexual problems has become medicalized. This was one of the principal conceptual innovations of the report, matching the logic of the major international classifications of diseases and states of health proposed by the WHO. The document thus develops the conception of sexual life based on the principle of well-being. The prevention and treatment of sexual disorders, negative consequences of sexual activity, and reduction of situations

that might lead to these negative consequences were also described as necessary for sexual well-being.

Sexual Health, Sexual Rights, and Responsible Sexual Behavior

> Sexual health is the experience of the ongoing process of physical, psychological, and socio-cultural well-being related to sexuality. Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. For Sexual Health to be attained and maintained it is necessary that the sexual rights of all people be recognized and upheld. (PAHO/WHO, 2000, p. 6)

The new definition of sexual health remains tied to the idea of well-being, which was also one of the main dimensions of the 1975 definition. Nevertheless, the authors of the document consider that the notion of well-being is based on a system of values, especially when referring to sexuality.

> The expert working group recommended that a more plausible position is one that recognizes that scientific activity, and therefore, science-based health care and promotion cannot be performed from a totally value-free stance, and thus, value-defined propositions, definitions and concepts are unavoidable. It should be clear from the above definition that in this document, a comprehensive meaning of the concept is proposed. The World Health Organization states that "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." The WHO health definition is perhaps the best example of this, where health is basically defined in terms of well-being. Well-being is understood to be a value-defined state. Thus, the expert working group agreed that establishing a definition of Sexual Health is both possible and desirable provided that the definition is derived from, and embodies the concept of sexual rights. (PAHO/WHO, 2000, p. 10)

In the 1975 report, a critical position with respect to dominant conceptions of sexuality had been taken and the authors were particularly critical of religious conceptions that were considered to be myths and taboos. The view espoused in *The Promotion of Sexual Health* is less critical, being part of a more positive approach and strategy, proposing a new system of values. The relation between health and human rights, developed from the 1990s on under the influence of Jonathan Mann (Mann et al., 1994; Parker, 1997), had the effect of defining health as a moral and political value. Health thus became one of the fundamental values of social life and one of the main criteria for evaluating institutions and political and ideological systems. It was, henceforth, to be a political challenge to other value systems that might be an obstacle to

respect for the right to health. In the middle of the 1990s, Mann had even thought of creating an international political coalition (the "blue party") based on the ecology model of political activism (the "greens") in order to be more politically effective in the advocacy for health.

The concept of sexual rights, supported by the WHO, is based on the Declaration of Sexual Rights issued by the WAS. It contains

> 1. The right to sexual freedom. 2. The right to sexual autonomy, sexual integrity, and safety of the sexual body. 3. The right to sexual privacy. 4. The right to sexual equity. 5. The right to sexual pleasure. 6. The right to emotional sexual expression. 7. The right to sexually associate freely. 8. The right to make free and responsible reproductive choices. 9. The right to sexual information based upon scientific inquiry. 10. The right to comprehensive sexuality education. 11. The right to Sexual Health care. (Declaration of the 13th World Congress of Sexology, 1997, Valencia, Spain. Revised and approved by the General Assembly of the World Association for Sexology (WAS) on August 26th, 1999, during the 14th World Congress of Sexology, Hong Kong, People's Republic of China). (PAHO/WHO, 2000, p. 37)

The Declaration of Sexual Rights defends a universal value system that overrides specific cultural differences. The action undertaken by international organizations fits explicitly into a perspective of social and cultural change, based on the idea of cultural progress towards the achievement of the ideals of health and freedom. The authors of the WHO document, thus, called for the development of an international consensus in favor of sexual rights.

> Human rights are inherent to human beings; however, recognition of inherent rights does not create rights per se. Human rights are above cultural values. If a particular culture has a practice that contravenes a human right, the cultural value should be changed, as in the case of the cultural practice of female genital mutilation. The human rights approach to health promotion has been explicitly stated in the case of the promotion of reproductive health. The recognition of sexual rights is evolving. Human rights are those principles that are universally perceived as protecting human dignity while promoting justice, equality, liberty, and life. Since protection of health is a basic human right, it follows that Sexual Health involves sexual rights. The expert working group strongly recommends that international organizations such as the WHO and other United Nations agencies promote and serve as advocates to achieve a consensus on the World Association for Sexology's statement of universal human sexual rights. (PAHO/WHO, 2000, p. 10)

In this declaration of sexual rights, other violations of these sexual rights that might be due to less extreme situations than genital mutilation and which would not result in the same level of international consensus, including in industrialized countries, were not explicitly mentioned. I

am thinking, for example, of adolescents' sexual relations outside of marriage and of the question of abstinence, which is the subject of political debates in the U.S. (Bancroft, 2002). A set of positive principles, which, when carefully read, clearly indicate that they are violated in several countries was repeated. On the other hand, these sexual rights are a normative construction of sexuality based on so-called universal principles. The association of sexual health and sexual rights is part of a strategy for building an international consensus in favor of a new sexual morality based on the principle and ultimate objective of health. The concept of *responsible sexual behavior* established moral criteria for behavior, which is to preserve and develop health and well-being.

> Responsible sexual behavior is expressed at individual, interpersonal and community levels. It is characterized by autonomy, mutuality, honesty, respectfulness, consent, protection, pursuit of pleasure, and wellness. The person exhibiting responsible sexual behavior does not intend to cause harm, and refrains from exploitation, harassment, manipulation and discrimination. A community promotes responsible sexual behaviors by providing the knowledge, resources and rights individuals need to engage in these practices. (PAHO/WHO, 2000, p. 8)

This definition of the concept of responsible sexual behavior is evidence, more so than in other health fields, of the changing conceptions of the production and preservation of health that are now based on behavior change rather than medical intervention. As far as sexuality is concerned, the concept of sexual health places greater emphasis on behavior change under the rationality of health, which becomes the moral value.

Clinical Syndromes

The classification of Clinical Syndromes is a usual WHO practice in order to define international standards for the epidemiological evaluation of diseases and the state of health of populations. The classification proposed in the 2000 document contains a list of health conditions that are obstacles to the achievement of sexual health. The classification includes eight syndromes.

> (1) Clinical Syndromes that Impair Sexual Functioning (Sexual dysfunctions), (2) Clinical Syndromes Related to Impairment of Emotional Attachment/Love (also known as Paraphilias), (3) Clinical Syndromes Related to Compulsive Sexual Behavior, (4) Clinical Syndromes Involving Gender Identity Conflict, (5) Clinical Syndromes Related to Violence and Victimization, (6) Clinical Syndromes Related to Reproduction, (7) Clinical Syndromes Related to Sexually Transmitted Infections, (8) Clinical Syndromes Related to Other Conditions. (PAHO/WHO, 2000, p. 20)

The achievement of sexual health, conceived as a social norm for

healthy sexual activity, is thus based on treating a set of mainly somatic, but also psychological, conditions. The WHO document is the most comprehensive list of health problems associated with sexual activity that should be dealt with when promoting sexual health. Most of these problems concern mainly clinical therapy.

The WHO document is based on the idea that sexuality and the free practice of sexual activity are a crucial part of overall health, well-being, and individual human rights. From this perspective, the WHO document considers "erotic pleasure" and "autoeroticism" to be basic components of sexuality and the expression of the individual sexual rights that have to be protected and promoted. The definition of sexual health problems and concerns, clinical syndromes, and the resulting types of intervention (i.e., information, counseling, and therapy) is intended to reduce or to remove obstacles (social or health obstacles) to the free exercise of sexual rights and sexual health, conceived as a free and fulfilling sexual activity. This is further promoted by responsible sexual behavior, which may reinforce the fulfilling and positive nature of sexual activity. The different negative consequences of sexual activity (e.g., sexually transmitted illnesses or unintended pregnancies) are seen as obstacles to the expression of sexual health and as the result of poor sexual health and irresponsible sexual behavior. The position adopted in this conception of sexual health and strategies for promoting it is entirely original and universal. It is not found in documents expressing the positions and strategies of government public health agencies responsible for dealing with sexuality-related problems.

Sexual Health and Responsible Sexual Behavior: The Surgeon General of the U.S.

The document entitled *Call to Action to Promote Sexual Health and Responsible Sexual Behavior* was officially published on July 9, 2001, by the Surgeon General of the U.S. (Dr. David Satcher). This document was written following a series of consultations and meetings involving the heads of administrative departments concerned, who were assisted by more than 1,000 experts in various fields of sexuality, sexology, family planning, HIV prevention, and public health, as well as representatives of various philosophical trends of opinion and the main religions. John Bancroft observed that "The key person in this process outside government circles was Eli Coleman, who did a superb job of liaising between government and the outside world. The scientific writing was edited by Janet Hyde and Michael Ross" (Bancroft, 2002, p. 10). It should be remembered that Eli Coleman, who is not mentioned in the *Call to Action* as the WAS president, but as "Professor and Director of a program on Human Sexuality at

the University of Minnesota," also played a major role in writing and editing the PAHO/WHO 2000 document, in which he is identified as the WAS president. The involvement of the same individuals in writing the various documents and the fact that these documents represent different perspectives in sexual health confirms that they are the result of compromise and political trade-offs between different partners, both governmental and nongovernmental. Some proposals can be made within an international organization, such as the WHO, even if it is not possible to do so in the political and cultural context of the U.S.

First, in the *Call to Action*, it is specified that

> in the present case, public health responds to the problem of sexually transmitted diseases, unintended pregnancies, and sexual violence by asking what is known about its distribution and rates, what factors can be modified, if those modifications are acceptable to the community, and if they are likely to address the problem. (U.S. Surgeon General, 2001, p. 2)

Problems of public health with respect to sexuality are, thus, clearly limited to some of the problematic consequences of sexual activity, whose prevalence has been well documented by many epidemiological and demographic studies. These problems, once identified, should then be eliminated by actions that are acceptable to communities. The public health perspective and the promotion of health imply, moreover, identifying risk factors as well as protective factors. The protective factors selected in the *Call to Action*—biological factors, parents and other members of the family, schools, community, media, religion, health professionals, the law, and accessibility to reproductive health services—refer mostly to social and psychosocial risks that may affect people's behavior. Risky behavior can be changed by actions that affect the risk situations in which individuals find themselves. This list of risk factors and protective factors is based on a conception of sexual development that is gradually constructed under the positive or negative influence of the social environment. Evidence-based intervention models are used in the *Call to Action*, and types of social intervention that have proven effective and that should guide actions for the future are described. The *Call to Action* is based on two key concepts: sexual health and responsible sexual behavior, both of which have been defined very differently from their definitions in the PAHO/WHO 2000 document.

Sexual Health and Responsible Sexual Behavior

> Sexual health is inextricably bound to both physical and mental health. Just as physical and mental health problems can contribute to sexual dysfunction and diseases, those dysfunctions and diseases can contribute to

> physical and mental health problems. Sexual health is not limited to the absence of disease or dysfunction, nor is its importance confined to just the reproductive years. It includes the ability to understand and weigh the risks, responsibilities, outcomes and impacts of sexual actions and to practice abstinence when appropriate. It includes freedom from sexual abuse and discrimination and the ability of individuals to integrate their sexuality into their lives, derive pleasure from it, and to reproduce if they so choose. (U.S. Surgeon General, 2001 p. 1)

The definition of sexual health in the *Call to Action* is based on the WHO conception of health, according to which health is not limited to the absence of disease. Unlike the WHO definition, which emphasizes well-being and the free and responsible expression of sexual ability, the *Call to Action* insists on the ability of individuals to understand and to measure the intrinsic risks and responsibilities involved in sexual behavior and to choose to abstain when it is appropriate to do so. The PAHO/WHO 2000 document, which was based on an optimistic conception of sexuality and well-being, does not mention the theme of abstinence in the main section of the document. It appears only in an appendix and only as a possibility for teenagers ("Help young people delay the initiation of sexual intercourse, if directed at young adolescents. Do not encourage young people to begin intercourse and do not increase the frequency of sexual intercourse." PAHO/WHO, 2000, p. 41). This topic receives much more attention in the *Call to Action* in which this theme appears on the first page.

The "responsibility" rhetoric becomes clearer in the definition of sexual responsibility.

> Sexual responsibility should be understood in its broadest sense. While personal responsibility is crucial to any individual's health status, communities also have important responsibilities. Individual responsibility includes: understanding and awareness of one's sexuality and sexual development; respect for oneself and one's partner; avoidance of physical or emotional harm to either oneself or one's partner; ensuring that pregnancy occurs only when welcomed; and recognition and tolerance of the diversity of sexual values within any community. Community responsibility includes assurance that its members have: access to developmentally and culturally appropriate sexuality education, as well as sexual and reproductive health care and counseling; the latitude to make appropriate sexual and reproductive choices; respect for diversity; and freedom from stigmatization and violence on the basis of gender, race, ethnicity, religion, or sexual orientation. (U.S. Surgeon General, 2001, p. 1)

Sexual responsibility is, thus, an individual value and an ideal behavior, supported by a community. The key concept of sexual responsibility is not based on the idea of free involvement in sexual activity but on the ability to make appropriate choices. The question of the

social norm developed by society and by communities, which decide what behavior is appropriate or inappropriate, remain of crucial importance. It is, thus, no longer the idea of a search for universal well-being and the positive value of sexual pleasure that orients the construction of sexual health and the achievement of sexual rights, but the ability to make "appropriate choices" with respect to sexual activity and procreation, and in accordance with basic community values. It is interesting to note that local community values are taken into account much more in the U.S., even when they represent serious obstacles for sexual fulfillment, in comparison to the global international level discussed in the PAHO/WHO 2000 document. In other words, the conception of a universal value of sexual health does not seem to apply in the U.S. These appropriate choices mainly concern avoiding sexually transmitted diseases and unintended pregnancies. In the *Call to Action*, sexual health is not considered as a type of free expression based on sexual rights for the purpose of general well-being and is not, thus, considered to be the final objective of public health interventions. Sexual activity is perceived basically as a source of health and social problems, which can only be reduced by taking action on sexual behavior and factors influencing it. Concerning the prevalence of sexual dysfunction in the U.S., the effect of other health problems on the ability to have harmonious sexual intercourse is scarcely mentioned. Nor is the positive nature of erotic pleasure (and, in particular, autoerotic pleasure) mentioned or recognized in the *Call to Action*. In this respect, the firing of Jocelyn Elders, a previous Surgeon General in the Clinton administration, on December 9, 1994, after only 15 months of tenure in this position, for a declaration on masturbation, comes to mind.

Intervention Strategies

The intervention strategies described in the *Call to Action* refer to preventive approaches undertaken in the framework of the institutions that affect the life of various communities (Community Based Programs, School Based Programs, Clinic Based Programs, Religion Based Programs). These different approaches are evaluated using data available in the scientific literature. The authors of the *Call to Action* based their position on the scientific criteria mentioned in the main debates that have taken place in the U.S., with those in favor of abstinence for adolescents on the one side and those who defend harm reduction programs on the other. These approaches are based on information, education, and counseling. The level of clinical intervention, discussed in detail in the WHO document, is not mentioned. Likewise, the authors of the *Call to Action* did not specifically defend the actions of the group of

professional sexologists but addressed many social actors, including health professionals, parents, community leaders, the media, and ecclesiastics. Sexuality is the target of the whole community, not just professional sexologists and health professionals.

In the *Call to Action*, a much greater emphasis is placed on information and actions intended to change risky or inappropriate behavior than on individual therapies, which were discussed in detail in the WHO document. The clinical approach towards the treatment of sexual dysfunction is hardly mentioned and appears not to be regarded as a public health priority.

The Political Question

The authors of the document are perfectly aware that their observations and proposals, although based on scientific data, are neither unanimously acclaimed in the different communities nor entirely consistent with the various trends of opinion in the U.S. Many Americans do not accept the very idea that a health strategy for sexuality could be founded on scientific data rather than on moral criteria. The authors, thus, called for a dialogue with the most influential opinion leaders in order to try to find appropriate and efficient solutions to the serious public health problems that the U.S. is facing.

Since it was published, the *Call to Action* has been criticized by a coalition of political conservative groups (see Bancroft, 2002). This confirms the view that sexuality has a status in the U.S. as a political issue (Laumann, Gagnon, Michael, & Michaels, 1994b) in that simply referring to sexuality problems and suggesting that they could be treated is considered a criticism of the dominant sexual morality. The authors of the *Call to Action* nevertheless took care to point out that "Doing nothing is unacceptable. More than anyone, it is our children who will suffer the consequences of our failure to meet these responsibilities" (U.S. Surgeon General, 2001, p. 16), as if they had anticipated the criticism of their conservative opponents.

Better Prevention, Better Services, Better Sexual Health: The National Strategy for Sexual Health and HIV (Department of Health, England)

The National Strategy for Sexual Health and HIV is part of the Department of Health of England's overall program known as "The N.H.S. Plan," which was published in July of 2001 and which is a major attempt to modernize and to adapt to the English health system. In *The National Strategy*, the specific section on sexual health is developed as

a part of this overall public health plan. I should mention, straight away, that the observations and proposals in *The National Strategy* mainly concern the English health system, which is organized in a very centralized way. It includes an analysis of the sexual health situation, which in turn covers mainly HIV infection, sexually transmitted diseases, unintended pregnancies, and access to abortion in England, and it makes specific proposals for a better organization of the sexual health services. This analysis is based on the most recent epidemiological data. In addition, the idea of a partnership with nongovernmental organizations and the evaluation of the cost and resources necessary for undertaking joint actions are developed. The economic analysis of the proposals made in *The National Strategy* was intended to demonstrate that the cost of making the proposed changes would be much lower than the costs for health care and treatment that might be necessary if the new services were not provided.

The document was written during a lengthy consultation involving officials of the English NHS, representatives of users of the health system, professionals, and representatives of nongovernmental organizations. Surprisingly, the sexologists and, in particular, those who were members of the *British Association for Sexual and Relational Therapy* (the main sexologist association in England) were not represented in this group. The consultation was based on ethical, technical, and political criteria that are explained in an appendix to the document. The document is the first stage of a much wider consultation. Each chapter of the document concludes with a series of questions designed to stimulate public debate. The editor of the report explicitly calls on the public and concerned organizations to send additional contributions according to the rules laid down by the procedure.

The National Strategy is considered to be the first of this type of initiative to deal with a set of health problems grouped together under the banner of sexual health. Yvette Cooper, who signed the foreword on behalf of the Secretary of State for Public Health, considers that sexual health and HIV services should be radically improved and modernized. Consequently, the document contains specific proposals for reorganizing the health system in order to deal more effectively with sexual health problems.

> This is the first national Strategy for sexual health and HIV. It is a Strategy that will modernize sexual health and HIV services in this country. It addresses the rising prevalence of sexually transmitted infections (STIs) and of HIV. The consequences of poor sexual health can be serious. Unintended pregnancies and STIs can have a long lasting impact on people's lives. The number of visits to genito-urinary medicine (GUM) clinics has

> doubled over the last decade and now stands at over a million a year. There is a clear relationship between sexual ill health, poverty and social exclusion. There is an unequal impact of HIV on gay men and on certain minority ethnic groups. For too long there have been significant variations in the quality of sexual health services across the country. This is not acceptable. This is a Strategy that addresses the need to raise standards of services in line with the principles set out in the NHS Plan. HIV remains a life-threatening condition. There is still no cure. The introduction of drug therapies has improved the lifespan of people infected with HIV. But this has presented fresh and difficult challenges for those involved in their treatment, support and care. This is a Strategy that acknowledges and addresses the complex issues associated with HIV. (Department of Health, 2001, p. 3)

The National Strategy document is focused mainly on the negative consequences of sexual activity (e.g., HIV infection, STIs, unintended pregnancies) affecting a large part of the population. It immediately claims that these various health problems are correlated with "poverty and social exclusion" (Department of Health, 2001, p. 3), that HIV infection mainly affects gay men and ethnic minority groups, and that significant social inequality affects access to health services. A specific emphasis is placed on HIV infection, its prevention and assistance for people living with the virus. The strategy aims to improve epidemiological surveillance of the incidence of these problems, to ensure earlier diagnosis of infection, and to reduce inequality in access to abortion in England. Unlike the *Call to Action*, *The National Strategy* seems to be based on a wide consensus that it is legitimate to facilitate access to contraception, abortion, and the use of condoms for the whole population, including young people. Thus, the harm reduction perspective that British people proudly and rightly believe to have limited the extent of HIV infection to the lowest level in Europe was deliberately adopted in the document. Concerning unintended pregnancies and, more particularly, adolescent pregnancy, the document never mentions abstinence as a method for reducing the consequences of the sexual activity of this population. Quite the contrary, it considers that young adults suffer from a relative inequality in terms of treatment for their sexual problems as opposed to other groups at risk, such as gay men, ethnic minorities, sex workers, or prisoners and that this inequality tends to reinforce their vulnerability towards sexuality-related risks.

The methods recommended, as part of a project for reorganizing health service institutions, are mainly based on improving information for the population so that individuals can be better informed when deciding how to manage the consequences of their sexual life and which treatment is the most suitable. The health promotion perspective

decided upon in Ottawa is explicitly acknowledged: "Developing personal and social skills regarding sex, sexuality and sexual health—the better information and knowledge that the strategy encourages will help people to develop skills and make informed choices" (Department of Health, 2001, p. 15). The authors of the document never explicitly mention sexual morality. They have a pragmatic approach, which takes social evolution into account and tries to develop ways of reducing the negative consequences of these changes.

Sexual Health

> Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfillment with access to information and services to avoid the risk of unintended pregnancy, illness or disease. (Department of Health, 2001, p. 5)

As can be seen from this quotation, in this document sexual health is viewed as a fundamental human right, as an individual choice. The document also develops the idea that egalitarian relationships contribute to the sexual health of individuals. This postulate is based on work done in the context of HIV-AIDS that revealed the growing ability of women to negotiate the way in which they participate in sexual relations and, in particular, the use of condoms to ensure better protection against STIs and HIV. Furthermore *The National Strategy* does not associate the concept of sexual health with either well-being or responsibility. It qualifies sexual health and sexual fulfillment. This idea appears to be morally neutral and does not speculate on the meaning individuals may give to their sexual lives. The quests for pleasure or possible procreation are not mentioned as necessary components of sexual activity. The duty of the health system is not to attribute meaning to sexual activity but only to prevent the negative consequences of sexual activity, which depends on individual choice by providing individuals with information and efficient, appropriate services. The sexual morality of the document implicitly remains part of democratic ideals and human rights. *The National Strategy* does not fit into the framework of the health concept as defined by the WHO. Its strategic orientation is based on a more restrictive idea of health, on prevention, on avoidance, and on the

[1] The European Parliament voted on the July 4th, 2002, in favor of the report on Sexual and Reproductive Health and Rights in Europe authored by Anne Van Lancker (European Parliament resolution on sexual and reproductive health and rights (2001/2128 (INI). The publication of this document occurred too late to be included in this discussion.

absence of disease, thus making it possible to keep the population in good health. *The National Strategy* develops the notion of "informed choice" rather than that of "responsible sexual behavior" which indeed confirms that it does not refer explicitly to any sexual morality for orienting its strategy.

The Reorganization of the Health System

In *The National Strategy* document, an organizational strategy that distinguishes clearly between health prevention and services is proposed. Prevention is defined as the first level intervention. From this perspective, the public health system should take the initiative to develop partnerships with nongovernmental organizations representing the different communities, the media, and local health authorities. Telephone help lines are envisaged. The aim is to develop training and information for health professionals who are considered to play an important role in relaying information to target populations. Prevention mainly concerns HIV infection. The development of prevention requires that the public health system become more accessible to the civil society for which the evidence-based actions are intended.

The development of health services is based on the construction of a three-tiered intervention model. The first level consists of evaluating and monitoring the health of the population, including evaluation, diagnosis, counseling, and guiding people to the appropriate services. The second level consists of ordinary medical interventions for prescribing contraceptive methods, treating STIs, taking blood samples necessary for diagnosing HIV infection, and performing vasectomies. The third level of intervention delivers specialized services for contraception and the treatment of STIs and AIDS.

The main actors in the system are general practitioners, who are the first contacts made by the population with the health system. Primary Care Teams are also responsible for diagnosing, treating, and referring patients to specialists. Other health professions are associated with the program, in particular, pharmacists who are responsible for providing emergency contraceptives without medical prescriptions. The project also aims to reinforce partnerships with associations of health system users. It has explicitly adopted the networking model. Furthermore, the creation of new structures, such as the "One-stop" sexual health clinics, is envisaged.

In addition, integrating all services concerned with the various aspects of sexual health (e.g., contraception, abortion, prevention, and treatment of HIV and STIs), to which it adds sexual dysfunction, is proposed. The grouping of all of these services is based on a holistic concep-

tion of sexual health, including all of the contemporary risks related to sexual activity.

It is recommended that the whole project be regularly evaluated. The document estimates its financial cost. The main criticism that has been made of this project, which is considered to be "too ambitious," concerns the lack of resources to invest in it (Kinghorn, 2001).

The National Strategy is the most medicalized intervention program in the field of sexual health and also the one that most precisely defines its objectives and the logistical means and resources to be mobilized. The program does not take any stand on sexual morality, nor does it offer an ideal model of sexual health. The principal aim of the interventions is to avoid and prevent diseases.

Discussion

Analysis and comparison of these documents show that the concept of sexual health has grown in importance over the last 30 years and is now unavoidable in the major industrialized countries, and in some developing countries.[1] Concern with sexual health is related to the development of scientific research in the field of sexuality, in both biomedical and behavioral disciplines, and also to the increase in the HIV-AIDS epidemic, STIs, and in unintended pregnancies in several countries. Furthermore, the question of sexual health has emerged in an international cultural context characterized by the development of alternatives in terms of sexual morality and a decrease in the legitimacy of religious references for guiding sexual behavior in many Western countries (Schmidt, 1998; Sigusch, 1998). Recourse to the health concept for treating problems related to the sexual and reproductive life is one way in which societies deal with problems resulting from the cultural legitimization of nonreproductive and nonmarital sexual activity, and is mainly based on developing the use of contraceptives (reproductive health) and the prevention and treatment of STIs. Given this situation, the documents that have been analyzed propose different or even contradictory perspectives.

On the one hand, the authors of PAHO/WHO document proposed a general model based on the prevention and treatment of a set of clinical syndromes and sexual problems for the purpose of developing an ideal conception of sexual health, which is considered to be a fundamental aspect of an individual's well-being and a basic individual right. In this conception, sexual life, which is based on the principle of individual responsibility, is the element that has to be protected and promoted against all organic, psychological, and social aggression threatening its harmonious development. Erotic pleasure, including autoerotic plea-

sures, is recognized and considered to be an essential component of sexual well-being. The recognition of sexology as a scientific discipline and of sexologists as a professional group, and the training of health professionals are among the main actions proposed. Moreover, the promotion of sexual health requires a global transformation of local cultures and elements that are obstacles to free, fulfilling sexuality and well-being. The international organization undertakes to have the sexual rights of individuals acknowledged and respected. Furthermore, the very important role played by the clinical model in the individual treatment of sexual disorders is assumed.

On the other hand, the documents written in the U.S. and England appear to be much more concerned with the negative consequences of sexual activity and a conception of sexuality as a source of problems to be reduced by social (education, information, prevention) and medical (treatments) interventions. The main objective is to reduce these problems, with the intervention contributing to a certain form of well-being. Both of these documents emphasize public health measures (prevention, information, and changing behavior) much more than the individual clinical approach to sexual disorders, which are not considered to be a public health issue.

Nevertheless, both documents (U.S. and England) make proposals based on diverging principles of public health: the reduction of risks associated with behavior and the reduction of the behavior itself in order to attempt eradicating risks at their source. The use of illicit drugs is the clearest example for comparing the two perspectives. Some countries have used penal repression in trying to reduce drug use, whereas others, such as England, have placed an emphasis on reducing the risks associated with the consumption of these substances. The strategy has made it possible to limit the incidence of the HIV-AIDS epidemic in this country to the lowest level in Europe (UNAIDS/WHO Collaborating Centre on AIDS, 2000). The promotion of sexual health fits into the same public health framework and remains tied to the dominant conceptions and practices of each of the countries. The U.S. has suggested developing a response that associates the reduction of sexual behavior considered to be risky and, in particular, adolescent sexual activity, via a national educational strategy to reduce risks by means of information and prevention actions. England, through the NHS, has chosen to develop a strategy solely for reducing risks following sexual activity, without intervening in factors that influence the behavior itself. The choice of this behavior is left to the individuals concerned. Society only intervenes to encourage informed choice to behave in a certain way, thereby limiting the negative consequences. Moreover, the reduction of

the negative consequences of sexual activity is considered to be an economic necessity for reducing costs related to the treatment of these problems. In the *Call to Action*, the idea of education is stressed, whereas in *The National Strategy* document, information and prevention are emphasized. Furthermore, a complete reorganization of the health system is proposed to deal more efficiently with these problems, whereas, in the *Call to Action*, developing a national political dialogue is suggested to consider what can be done to resolve these problems for which there is, as yet, no national consensus.

Paradoxically, even though it is not based on a national consensus, in the *Call to Action*, a precise definition of sexual health that, nevertheless, includes the idea of responsible sexual behavior was developed, whereas, in *The National Strategy*, much more is stressed regarding the type of action to be undertaken, rather than on the definition of sexual health. Finally, *The National Strategy* document contains the most medicalized perspective of the two, but its perspective only deals with the prevention and treatment of the negative consequences of sexual activity and not with sexual activity itself. In the *Call to Action*, proposals that are not strictly part of the field of health, but, rather, are aimed at sexual activity are offered.

This analysis has allowed the identification of the different conceptions inspired by the idea of sexual health but developed in different contexts. It shows that although it is possible to identify the attempt to reach a consensus and its achievement within international organizations, the documents analyzed reveal very different approaches to sexual health in different countries. There is, thus, no general consensus about the meaning of sexual health, and I would suggest that there cannot be because sexual health is embedded in politics and in the health systems of the different countries.

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