BRIEF SEXUALITY-RELATED COMMUNICATION

Recommendations for a public health approach

World Health Organization

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ABBREVIATIONS AND ACRONYMS

ASSESS	Awareness, Skills, Self-efficacy/Self-esteem, and Social Support
BSC	Brief sexuality-related communication
CDC	United States Centers for Disease Control and Prevention
CINAHL	Cumulative Index to Nursing & Allied Health database
CREA	Creating Resources for Empowerment in Action
FGM	Female genital mutilation
GDG	Guideline Development Group
GRADE	Grading of Recommendations, Assessment, Development and Evaluation
LNK	WHO Library and Information Networks for Knowledge
MCA	WHO Department of Maternal, Newborn, Child and Adolescent Health
MDG	Millennium Development Goal
MSB	WHO Department of Mental Health and Substance Abuse
MSM	Men who have sex with men
NGO	Nongovernmental organization
PICO	Population, intervention, comparison, outcome(s)
RHR	WHO Department of Reproductive Health and Research
STI	Sexually transmitted infection
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization
WONCA	World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians

EXECUTIVE SUMMARY

Sexual health is gaining more and more attention from public health practitioners and health service providers because of its contribution towards overall health and well-being in both adults and adolescents. Health risks arising from unsafe sexual practices and sexuality-related human rights abuses such as sexual coercion together contribute to the global burden of disease.

Both research and consultations over the last decades have identified sexuality-related communication as an issue that requires urgent attention. While clients would like their health-care providers to discuss sexual health concerns, health workers lack the necessary training and knowledge to feel comfortable addressing such issues. There is a lack of clarity in the field as to the role of sexuality communication in primary care.

In 2008 the World Health Organization (WHO) commissioned a set of case studies on the integration of sexuality counselling into sexual and reproductive health services to serve as background to the development of this guideline. In 2010 an expert consultation convened by WHO's Department of Reproductive Health and Research (RHR) recommended the development of a guideline to facilitate the integration of this counselling into primary care services. A Guideline Development Group (GDG) was established in June 2012 comprising members working on sexual health in low- and middle-income countries, from all WHO regions and with equal gender representation. The GDG included academics, psychologists, doctors, public health specialists, lawyers and social scientists, all with expertise in developing programmes or offering clinical services to promote sexual health and well-being. It also included representatives of key constituencies with overlapping sexual health and rights expertise. Under the guidance of the GDG, a systematic review was undertaken and evidence from it was assessed by an independent researcher and a Grading of Recommendations, Assessment, Development and Evaluation (GRADE) methodologist using the GRADE framework. The GDG developed one good practice recommendation and two policy recommendations drawing on the expertise of the group and peer reviewers, the systematic review and insights from the Guideline Review Committee.

As this is an under-researched field, the recommendations in this guideline document provide health policy-makers and decision-makers in health professional training institutions with advice on the rationale for health-care providers' use of counselling skills to address sexual health concerns in a primary health care setting. Subsequent to the development of this guideline document on brief sexuality-related communication (BSC), WHO will develop and test specific techniques of BSC to guide health-care providers in improving the quality of their care. These will be published as a technical guideline.

The recommendations are summarized below.

SUMMARY OF RECOMMENDATIONS

Good practice recommendation:

Health policy-makers and decision-makers in health-care professional training institutions need to ensure that, where BSC is introduced, it respects, protects and fulfils clients' human rights.

Policy recommendations

ONE

BSC is recommended for the prevention of sexually transmitted infections among adults and adolescents in primary health services

Quality of evidence: low – moderate
Strength of recommendation: strong

TWO

Training of health-care providers in sexual health knowledge and in the skills of brief sexuality-related communication is recommended.

Quality of evidence: low – very low
Strength of recommendation: strong

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND AND RATIONALE

The global focus on sexual health is partly based on concern about the high contribution to the global burden of disease of risks arising from unsafe sexual practices. There is also increasing recognition of the prevalence of the abuse of human rights in relation to sexuality, as evidenced, for example, by the high proportion of young people's experience of sexual coercion (*51, 74*). "[A]t the centre of a definition of sexual health lies the notion of human sexuality underpinned by concepts of autonomy; well-being; and the fulfilment, promotion, and protection of human rights." (*71: e377*). There is increasing recognition that human rights approaches underpin effective sexual health promotion (*4, 112*).

WHO has been working in the area of sexual health since 1974, and there is global recognition of the importance of addressing sexual health in international covenants, treaties, programmes and guidelines. Sexual health is also enshrined within Millennium Development Goals (MDGs) 5 (Improve maternal health) and 6 (Combat major diseases including HIV). In 2008 WHO's Department of Reproductive Health and Research (RHR) commissioned a set of case studies on the integration of sexuality counselling into sexual and reproductive health services to serve as background to the development of this guideline document. In 2010 RHR convened an expert consultation on sexual health to review its work in this field and to make recommendations on areas for further work by the Department of Research. One of the recommendations was for RHR to undertake the development of a sexuality counselling guideline for health-care providers to help integrate this counselling into health services, mainly via primary health workers (physicians, nurses and others). The ultimate goal of this initiative, for which this guideline is only an initial step, is to ensure that health-care providers integrate brief sexuality-related communication (BSC) into sexual and reproductive health services. By initiating such discussions, health workers can thus promote sexual health rather than merely treating sexually transmitted infections (STIs) and HIV, or addressing other negative health outcomes such as sexual violence, harmful practices such as female genital mutilation (FGM), and unintended pregnancy. As a first step towards developing a technical clinical guideline on BSC, the development process for this guideline document aimed to assess the effectiveness of BSC in primary health-care services as well as the level of health-care providers' skills in BSC.

This guideline document provides recommendations on content and ways to deliver BSC that complement the following WHO documents and guidelines on related topics:

- Sexual and reproductive health: core competencies in primary care – Attitudes, knowledge, ethics, human rights, leadership, management, teamwork, community work, education, counselling, clinical settings, service, provision, 2011 (http://whqlibdoc.who.int/publications/2011/9789241501002_eng.pdf)
- Guidelines: prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach, 2011 (http://whqlibdoc.who.int/publications/2011/9789241501750_eng.pdf)
- Guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries, 2011 (http://whqlibdoc.who.int/publications/2011/9789241502214_eng.pdf)
- Preventing intimate partner and sexual violence against women: taking action and generating evidence, 2010 (http://whqlibdoc.who.int/publications/2010/9789241564007_eng.pdf)
- Global strategy to stop health-care providers from performing female genital mutilation, 2010 (http://whqlibdoc.who.int/hq/2010/WHO_RHR_10.9_eng.pdf)
- A handbook for improving HIV testing and counselling services – field-test version, 2010 (http://whqlibdoc.who.int/publications/2010/9789241500463_eng.pdf)
- Counselling for maternal and newborn health care: a handbook for building skills, 2013 (http://whqlibdoc.who.int/publications/2010/9789241547628_eng.pdf)
- Packages of interventions for family planning, safe abortion care, maternal, newborn and child health, 2010 (http://whqlibdoc.who.int/hq/2010/WHO_FCH_10.06_eng.pdf)
- Sexually transmitted infections among adolescents: the need for adequate health services, 2005 (http://whqlibdoc.who.int/publications/2005/9241562889.pdf)
- Guidelines for the management of sexually transmitted infections, 2003 (http://whqlibdoc.who.int/publications/2003/9241546263.pdf)
- Counselling skills training in adolescent sexuality and reproductive health: a facilitator's guide, 2001 (http://whqlibdoc.who.int/hq/1993/WHO_ADH_93.3.pdf)

1.2 OBJECTIVES AND TARGET AUDIENCE

The objective of this guideline document is to provide policy-makers and health-care professional training institutions with advice on the effectiveness of BSC as part of primary health care-level services, in order to improve the quality of sexual health-care and of training of health-care providers in BSC knowledge and skills.

There are two primary target audiences for this guideline:

- *health service policy-makers who need to plan for the inclusion of BSC in health services and in performance monitoring systems*
- *decision-makers in health-care provider educational institutions who need to train health-care providers on how to incorporate BSC into their practice.*

This guideline document assesses the effectiveness of BSC at the primary health-care level. The first point of care is variable, both within a country and internationally. For example, in some cases it may be general or family practitioners, while in others it may be local clinics, specific sexual health services such as STI clinics or HIV/AIDS centres, or reproductive health services such as family planning services, maternal care services or abortion services. In some areas the first point of care may be targeted to a specific population; e.g. youth, men who have sex with men, or sex workers. Such services may be in the public or private sector and can include nongovernmental organizations (NGOs) and community-based organizations involved in health-care provision.

Those responsible for curriculum development in health education institutions will also benefit from this guideline document, particularly trainers of health-care providers or sexual education teachers. While this guideline document does not provide technical advice on specific content for such training (a topic that will be the subject of a subsequent guideline development process), it does assess the need to train health-care providers in BSC skills.

1.3 SCOPE OF THIS GUIDELINE DOCUMENT

This guideline document aims to assess the effectiveness of BSC at the first point of entry to health services. It does not address the role of systematic formal counselling, but rather the value of opportunistic support provided by diverse health-care providers at the primary level.

1.4 DEFINITIONS AND APPROACH

1.4.1 Sexual health and sexuality

Sexual health is fundamental to the physical and emotional health and well-being of individuals, couples and families, as well as to the social and economic development of communities and countries. The current WHO working definition of "sexual health", which arose from an international meeting of experts in 2002, captures a broad view:

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (*37: 3*)

Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health. The WHO working definition of "sexuality" is:

… a central aspect of being human throughout life [that] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors. (*37: 4*)

In the context of sexual health, "well-being" includes the creation of enabling environments which promote and protect the fulfilment of personal goals in relation to sexual health, while acting responsibly towards others. Autonomy relates to the rights of individuals to self-determination in sexual health; rights that need to be recognized by the state and enabled by everyone – from partners and families to global institutions" (*71: e378*). Autonomy may be promoted and protected in diverse ways, including through laws and policies as well as through building the negotiating skills of individuals or groups (*38, 71*).

→ Sexual health programmes based on the core principles of autonomy, well-being and fulfilment, promotion and protection of human rights should:

→ Address violations of human rights related to sexuality and reproduction

→ Promote people's ability to engage in safe and satisfying sexual relationships

→ Address people's needs or concerns in relation to sexual orientation and gender identity.

In addition, sexual health programmes need to address the prevention and treatment of sequelae and complications of sexual ill-health, namely:

→ infections and their sequelae (HIV, STIs, and associated outcomes such as cancers, infertility, etc.) (*37*)

→ Unintended pregnancy (includes family planning, contraceptive counselling and abortion) (*37*)

→ Sexual problems, concerns and difficulties, whether resulting from emotional causes (*7, 113*) or relationship distress (*97*), illness such as diabetes, hypertension (*51, 113*) and cardiovascular disease (*79*), or negative consequences of particular medications, e.g. example cancer treatment and palliative care (*29, 111, 117, 126*)

→ Infertility

→ Violence related to gender inequality, sexual orientation and gender identity

→ Harmful and traditional practices related to sexual health (*54*); e.g. FGM, "widow cleansing" (a requirement for a widow to have sexual relations with a relative of her

husband), and a range of vaginal practices that may be associated with negative health outcomes (*75*)

→ Mental health issues related to sexual health including:
- the sexual health needs of people with mental health problems; e.g. higher rates of sexual dysfunction in people with depression (*8, 113*) or other sexual problems treated with certain antidepressants (*105*), and the influence of antidepressant drugs on sexual health (*8*)
- mental health issues associated with sexual health and high rates of stress, stigma and discrimination e.g. higher rates of mental disorders and mental distress among some populations of gay, lesbian, bisexual and transgender persons (*14, 101*).

Specific populations are highlighted as being particularly in need of sexual health services, including young people of all sexual orientations; people with physical disabilities, mental challenges and chronic illnesses; intersex people; incarcerated populations; transgender populations; and indigenous populations (*71*).

The ability of people to achieve sexual health and well-being depends, among other things, on their access to comprehensive information about sexuality, their knowledge about the risks they face, and their vulnerability to the adverse consequences of sexual activity. To achieve sexual health, people also need opportunities for social support, access to good-quality sexual health care (i.e. addressing all elements of sexual health according to the WHO working definition, including products and materials), and an environment that affirms and promotes sexual health for all. These include counselling and communication programmes.

1.4.2 Brief sexuality-related communication

"Counselling" refers to "systematic consultations in primary care for addressing emotional, psychological and social issues that influence a person's health and well-being" (*19: 4*). Counselling is characterized by its continuity; that is, a specific provider builds trust with a client over time (*6, 19*). While counselling is appropriate for addressing sexual concerns and difficulties, addressing dysfunctions or disorders may require systematic psychological therapy or physiological medical treatment. It is for this reason that this guideline document makes reference to "clients" rather than "patients". Carl Rogers' concept of "client-centred therapy" clarifies the distinction: while the term "patient" presumes a hierarchy in which the health-care provider knows best, the term "client" is positions the health-care provider as a supporter to help the person concerned to find solutions for him or herself (*121*).

This guideline document focuses on the opportunistic use of counselling skills, rather than formal – systematic and continuous – counselling. It frames this approach "brief sexuality-related communication (BSC)". In BSC, the provider – whether a nurse, doctor or health educator – uses counselling skills "opportunistically with much less certainty about the duration of the encounter" (*19: 10*) to address sexuality and related personal or psychological problems (as defined above) as well as to promote sexual well-being

(*26, 37*). Unlike professional counselling, BSC does not require provider continuity. In addition, these skills are applied during the length of a typical primary health care visit.

BSC takes into account the psychological and social dimensions of sexual health and well-being as well as the biological ones (*99*). It aims to support clients in reformulating their emotions, thinking and understanding, and subsequently, their behaviour; that is, by developing their capacity for self-regulation, clients are able to exercise their sexuality with autonomy, satisfaction and safety (*38, 140, 121*). It is rooted in the understanding that there is often a gap between intention and behaviour. BSC can enable clients to bridge this gap by helping them to establish clear goals, as well as to initiate and sustain their motivation and actions towards achieving these (*38*).

BSC uses an approach in which most of the time during a primary health care visit is spent listening to the client's concerns, in contrast to the health-care provider using most of the time to impart his or her expertise (*11, 19*). The aim is to help clients identify ways to address their concerns. This is described as a "client-centred" approach (*134*), which respects clients' ideas, feelings, expectations and values (*52*), as opposed to the "disease-centred" model in which the provider makes decisions on behalf of the client (*25: 69*).

There are a range of models that can inform the health-care provider's approach, mainly along the theoretical dimensions of the "information, motivation and behaviour" model (84). In general BSC uses open-ended rather than direct questions (3). Most approaches incorporate the following four components (*25: 62*):

- Attending: setting up the relationship with the client. While BSC is shaped around the context and needs of the individual client, there are some typical questions that health-care providers can use in a socially appropriate manner to initiate the subject of sexual health, such as, "Do you have any questions or concerns about sexual matters?" (*69*)

- Responding: asking questions that open the conversation about sexual health and sexuality such as, "Are you satisfied with your sexual life?" (*69*); "Is your sexual life going as you wish?"; or "How do you feel in your sexual relationships with others?" (*139*)

- Personalizing: identifying the existence of sexual concerns, difficulties, dysfunctions or disorders and the dynamics of any interplay between these, such as, "What difficulties do you have in using condoms?" (*139*); "Some people who have had a particular problem (e.g. cancer, hypertension, diabetes or AIDS treatment – whatever the client is facing) tell me that they have had sexual problems; how is it for you?" (*105, 141*)

- Initiating: providing information and, with the client, identifying steps that need or could be taken (*44, 85, 138*).

The process concludes by planning a follow-up or providing a referral for other resources and services when needed. In this way the client is supported in exploring, understanding and acting for their sexual health (*25*).

CHAPTER TWO

METHODOLOGY AND PROCESS

2.1 ESTABLISHMENT OF THE GUIDELINE DEVELOPMENT GROUP

A Guideline Development Group (GDG) was established in June 2012 comprising members working on sexual health in low- and middle-income countries, from all WHO regions and with equal gender representation. The GDG included academics, psychologists, doctors, public health specialists, lawyers and social scientists, all with expertise in developing programmes or offering clinical services to promote sexual health and well-being. It also included representatives of key constituencies with overlapping sexual health and rights expertise. They were from organizations focused on the rights of women, men who have sex with men, and transgender persons. See Annex 2 for the names of those who participated in this guideline document development process.

2.1.1 Declaration of interest by Guideline Development Group members and peer reviewers

All GDG members completed a declaration of interests form. These forms were reviewed by the responsible officer at WHO, Igor Toskin, Medical Officer, Department of Reproductive Health and Research, before finalization of the group composition and invitation to attend the first GDG meeting. All non-WHO participants signed and submitted a Declaration of Conflict of Interest form. One potential conflict was declared. Dr Marlene Wasserman, DHS Clinical Sexologist, South Africa, declared being contracted by pharmaceutical companies Adcock Ingram, AstraZeneca, Bayer, Lilly, Novartis and Pfizer prior to the time of the GDG establishment, but this was assessed by the WHO Secretariat, presented to the meeting participants, and deemed not significant enough to preclude Dr Wasserman's participation in the consultations and in the process of formulating the recommendations. For the others, it was agreed that there was no conflict of interest. The peer reviewers also submitted a declaration of interest form, and these were similarly reviewed before their selection was finalized. Procedures for management of conflicts of interest were based on the *WHO handbook for guideline development* (*150*).

2.2 IDENTIFYING, APPRAISING AND SYNTHESIZING THE AVAILABLE EVIDENCE

No external funding for this guideline was obtained. WHO funded this guideline document's development entirely.

2.2.1 The GRADE framework

WHO follows the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach for the development and review of recommendations (*150*). This approach is increasingly being adopted by organizations worldwide to rate the quality of evidence and strength of various types of recommendations (*61*). GRADE emphasizes a structured, explicit and transparent approach to grading and consensus-building (*64*).

GRADE separates the rating of the quality of evidence from the grading of the recommendation. In the context of recommendations, quality reflects the confidence that the estimates of effect are adequate to support a particular recommendation *(9)*. The GRADE system classifies the quality of evidence into one of four levels: high, moderate, low or very low (*58, 59, 60, 62, 63*).

The strength of a recommendation reflects the extent to which we can be confident that the desirable effects of an intervention outweigh the undesirable effects (*64*). The GRADE system classifies recommendations into two strengths: strong and conditional. A recommendation can also be either in favour of or against the intervention of interest. The strength and direction of a recommendation are affected by the quality of evidence, balance of benefits and harms, values and preferences, resource use and feasibility of the intervention.

One good practice recommendation is also included in the framework. This is a type of recommendation that does not require supporting evidence (see Chapter 3) and thus its development does not follow the above-described process (57).

2.2.2 Search strategy

An independent researcher conducted a systematic review based on the population, intervention, comparator and outcomes (PICO) questions. The following electronic databases were searched: PubMed, ProQuest, Cumulative Index to Nursing & Allied Health (CINAHL), Jstor, Scopus/Science Direct, Cochrane Library, EBSCO, PsychINFO and Web of Knowledge. The search was reformatted from a Medical Subject Headings (MeSH)-based approach to a keyword search in order to focus on other databases and increase the number of unique citations. Keyword searches on Summon (covering ProQuest, CINAHL, Jstor, Scopus/Science Direct, Cochrane Library, EBSCO, CINAHL, Ovid Medline/PubMed, PsycINFO and Web of Knowledge) were performed using the following terms: sexual health, primary care, counselling, sexual dysfunction, sexual distress, sexual concerns, sexual misconceptions, STIs, HIV, unintended pregnancy, abortion, sexual violence, harmful practices, knowledge increase, well-being, autonomy, pleasure and training. No language or date restrictions were applied. Reference sections of included articles were also searched. Grey literature was retrieved from New York Academy of Medicine Grey Literature Report. Both published and unpublished articles were searched.

2.2.3 Study selection

Studies were included that examined elements, outcomes and/or techniques of brief communication or counselling interventions within a public health or primary care setting and which sought to prevent or address sexual difficulties, concerns, distress and/or misconceptions; STI/HIV; unintended pregnancy and abortion; sexual violence; harmful practices; and sexual health knowledge. Articles were also considered that examined the elements, outcomes and/or techniques of brief interventions that encourage sexual well-being. Finally, other articles considered described the elements of training programmes for primary health-care providers to increase their knowledge and skill in sexuality counselling and communication. Abstracts were reviewed by two independent readers and one WHO reader (see Figure 1). For those articles that were considered relevant, full-text versions were retrieved. Studies were included that satisfied the requirements for the PICO criteria described in Annex 2. Criteria for the first two PICO questions required that the research was a controlled study and the intervention was between 15 and 60 minutes and could feasibly occur at the primary care level. For the third PICO question, the requirement was any evaluated training or sensitization intervention with the aim of improving primary health-care providers' ability to communicate about sexual health-related issues. Data from articles were extracted for setting, population, types of study, randomization, blinding, intervention, comparator, outcome and results. The evidence was assessed by GDG according to the outcomes.

The systematic review sought evidence of whether BSC was an effective approach – that is, whether there is a rationale for BSC. It did not assess the strengths and weaknesses of different techniques of BSC, but rather its overall effectiveness in improving sexual health services outcomes. The GDG saw this process as a necessary first step before specific clinical techniques of BSC could be assessed. The next step would be the development of a technical clinical guideline for BSC, based on a systematic review of the effectiveness of different BSC techniques.

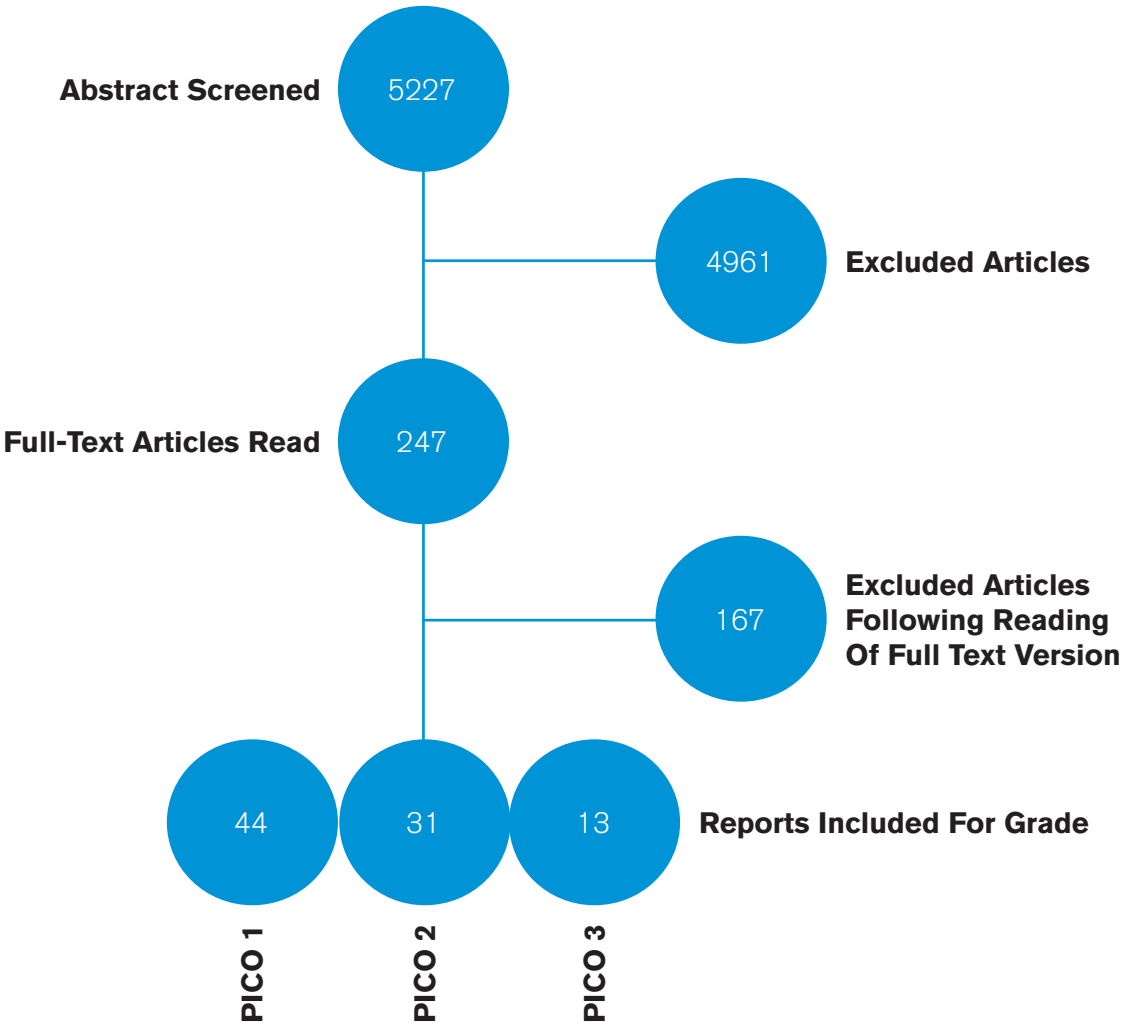
FIGURE 1. SYSTEMATIC REVIEW SELECTION PROCESS

Records identified through database searching:

Summons: 4057
PubMed: 870
Cochrane: 53
Grey literature: 9
Preliminary review: 73

Records identified through reference search and GDG:

References: 113
GDG: 52



2.3 THE PROCESS OF DEVELOPING THIS GUIDELINE DOCUMENT

The first face-to-face meeting of the GDG was conducted on 10–12 October 2012. The main outcomes of the meeting were decisions on:

- the scope of this guideline document;
- the use of PICO questions to govern the systematic search of the evidence (see Annex 2), and the evidence-retrieval strategy; and
- the modus operandi of the group and a common understanding of the process for the development of a guideline according to WHO requirements.

The GDG held several telephone conferences during this process as well as email conversations. These enabled the WHO Secretariat to finalize the outcomes in relation to each PICO question. Group members then scored the relative importance of each outcome on a scale from 1 to 9, where 7–9 indicates that the outcome is critical to a decision, 4–6 indicates that it is important, and 1–3 indicates that it is of low importance for decision-making. The average score for each outcome was used to determine the relative importance of each outcome. Outcomes and ratings are presented in Annex 3.

The GDG had its second meeting on 10–12 July 2013 to develop recommendations based on the available evidence as well as on the group's own technical expertise by following the GRADE process. The GDG set the evidence into context, considering: the relative benefits and harms of possible recommendations; the likely values and preferences of health-care providers and clients, as well as human rights standards such as the rights to information, respect and dignity; costs and resource use, as well as other relevant feasibility issues of providers, including in low- and middle-income settings and diverse social and cultural contexts.

The recommendations were shaped with a consideration of the diversity of target groups for this guideline document, including health-care policy-makers and decision-makers in health training institutions. Agreements were reached by unanimous consensus. If the group could not reach consensus, voting was conducted by hand raising (hence not anonymous), and a simple majority rule was applied.

Where there was a need for guidance but only low- to very low-quality research evidence was available, a recommendation was developed using the expertise of the GDG and the considerations given above (Recommendation 2).

The decisions of the GDG were then used to draft this guideline document. The first draft was reviewed by the GDG. All comments were collated by the Secretariat, with each comment reviewed and responses added to the comments in a table format. Relevant changes were then made to the document before the revised version was sent back to the members of the GDG for final review.

2.4 DOCUMENT PREPARATION AND PEER REVIEW

A second draft of the BSC guideline was reviewed by GDG members and peer reviewers of the various constituencies with a direct interest in this guideline document. They are listed in Appendix 2. Peer reviewers indicated that they found this guideline document relevant, appropriate and timely. Relevant revisions suggested by the GDG and peer reviewers and agreed upon by the Secretariat were made. The Guideline Review Committee subsequently reviewed this document and further revisions were made.

CHAPTER THREE

GOOD PRACTICE RECOMMENDATION

3.1 DEFINITION

"Good practice recommendations" are overarching principles derived from the pooling of common sense, expert opinion, professional standards of practice, and established international agreements on ethics and human rights; they may or may not be informed by scientific evidence (*76*).

Good practice recommendations are considered essential for clarifying or contextualizing specific technical recommendations. They are particularly important when change needs to be implemented in environments that can be hostile or negative, such as those involving sexuality and sexual health and well-being. Given the prevalence of taboo and stigma associated with sexual norms and practices in many parts of the world, as well as the existence of legal barriers to the inclusion of some populations in accessing health services – be they private or public – the GDG found it necessary to include one such recommendation in this guideline document (see section 3.2.1).

3.2 RESPECT, PROTECT AND FULFIL HUMAN RIGHTS

Violations of human rights – including through social exclusion and gender inequality – increase the vulnerability of the general population and of specific groups to a range of poor sexual health outcomes. For example, lack of power in sexual relationships can reduce the capacity for negotiating protection against pregnancy or disease (*30, 40*); disability puts people at increased risk of gender-based violence (*39, 104, 21*); lack of access to education, including sexuality and life-skills training, can leave young people disempowered and unable to make safe sexual choices and develop sexual relationships

that support their health and well-being (*4*); sexual stigma or homo-prejudice (*92*) may place lesbian, gay and bisexual people at heightened risk for poor mental and sexual health outcomes and violence (*101*); and violence and stigma may put transgender people and sex workers at higher risk of poor sexual health outcomes, and decrease their access to services (*93*). Gendered expectations for men can also endanger sexual health; for example, the social construction of masculinity in some settings can lead to increased pressure on (young) men to take risks and demonstrate sexual proficiency, while there is a lack of sexual health services specifically intended to meet the needs of young men (*70*).

Respect for, and protection and fulfilment of, human rights can have a measurable impact on sexual (and other) health outcomes (*55, 71*). Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents, in other consensus documents and in national laws. Thus the application of existing human rights to sexuality and sexual health constitutes sexual rights. The international treaties that describe these human rights include: the International Convention on the Elimination of All Forms of Racial Discrimination (adopted by the United Nations General Assembly in 1965); the International Covenant on Civil and Political Rights (adopted in 1966); the International Covenant on Economic, Social and Cultural Rights (adopted in 1966); the Convention on the Elimination of All Forms of Discrimination against Women (adopted in 1979); the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted in 1984); the Convention on the Rights of the Child (adopted in 1989); and the Convention on the Rights of Persons with Disabilities (adopted 2006).

The human rights that are particularly relevant to matters of sexual health and well-being are the rights of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of health, including access to sexual and reproductive health services;
- seek, receive and impart information related to sexuality;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children, how many; and
- pursue a satisfying, safe and pleasurable sexual life (*71*).

Stigma, discrimination and gendered stereotypes have hampered the quality of sexual health services (*5, 8, 16, 69*). Key dimensions of a rights approach to BSC include informed consent; that is, clients have the right to be fully informed concerning their sexual

health status and prevention and treatment options so they can make informed decisions about addressing sexuality-related concerns and ill-health (*37*). Also, in keeping with the right to enjoy the benefits of scientific progress and its applications (*119*) and the right to autonomy (*71*) – a cornerstone of clinical ethics – the client has the right to "evidence-based diagnostic and treatment options that are available, in order to participate actively in the decision-making process" (*69*). A rights approach to BSC also requires provider commitment to confidentiality and an environment for the BSC process that allows for confidentiality.

There is very limited attention in society to clients' human rights and their ability to realize those rights (*94, 96*). Van Reeuwijk and Nahar note, "[a] rights-based and sex positive approach leads to inclusion of outcomes such as empowerment and reduction of gender inequality, sexual violence, shame, fear and insecurity, discrimination and stigma" (*143: 67*). Moreover, an empowerment approach to sexuality education and communication is more likely to achieve desired sexual health outcomes than one without a rights orientation (*122, 131*).

GOOD PRACTICE RECOMMENDATION

Health policy-makers and decision-makers in health-care professional training institutions need to ensure that, where BSC is introduced, it respects, protects and fulfils their clients' human rights.

CHAPTER FOUR

EVIDENCE AND RECOMMENDATIONS

4.1
RECOMMENDATION 1:
BRIEF SEXUALITY-RELATED COMMUNICATION TO PREVENT STIS

RECOMMENDATION 1

BSC is recommended for prevention of STIs among adults and adolescents in primary health services.

Strong recommendation, low to moderate quality of evidence

4.1.1 Background

Adults and adolescents view health-care providers as a trusted source for health information (*49*) and often wish to discuss sexuality-related issues with them (*10*). However, health-care providers tend not to proactively engage their clients about sexual health and well-being (*6, 17*). Clients often have to raise the issues themselves, even though they may be embarrassed to do so (*41, 44*).

The focus of most sexual health programmes is prevention of unintended pregnancies and prevention and treatment of STIs, and most of the literature on the use of sexual health counselling skills addresses STIs. It demonstrates that provider support can make the difference in enabling clients to prevent STIs (*46*).

However men, women and people living with alternate genders and sexualities across diverse cultures have different perceptions and capacities to prevent STIs, and these may be influenced by a wider range of concerns and problems relating to their own (or their partners') sexual health and well-being, for which they also need health service support (*140*). These may be disease-related problems; for example sexual problems that result from chronic diseases, cancer treatment or diabetes, or STIs (*45, 111*); or they may be interpersonal, psychological or social problems (*12, 69*). Yet aside from psychologists, sexologists or sex therapists,

health-care providers are often not encouraged or sufficiently trained to feel comfortable in diagnosing these concerns in order to help those who are seeking care (*2, 44, 55, 132*).

People's own perceptions of sexual concerns or problems are quite diverse, subjective and relational in nature and severity. Key dimensions identified as outcome indicators for individual sexual health concerns include people's concern regarding the shape and size of their penis, vagina or breasts; their sexual performance or satisfaction, or that of their partner; their gender identity; and their sexual orientation and relationships.

Adolescence is a period of personal development and self-construction, and is thus a critical opportunity for ensuring successful transition to adulthood (*56*). Expression of sexuality and sexual experimentation are an expected and healthy dimension of adolescence (88). Many adolescents grapple with their changing sense of self and body image and their sexual development in the absence of information and psychosocial support to counteract misconceptions, fears and insecurities (*5, 143*). Adolescence is a time of exploration and defining personal limitations as part of the process of transforming towards adulthood (*141*). Negative responses to adolescents' disclosure of being gay, lesbian or bisexual have been shown to negatively affect their health, resulting in higher levels of depression, drug use and unprotected sex – with the associated increased vulnerability to STIs (*124*).

Adolescents have an evolving capacity to take action to fulfil their right to health (30), and this can be enhanced through provision of appropriate services (*34, 96*). One of the studies that form the evidence base for this guideline document showed that adolescents who talked to their provider about HIV were more likely to use condoms and take other precautions to prevent infection (*41*). Yet adolescents' access to services, which could provide the support they need in this process, is often hampered by cultural norms (*13, 96, 129*). There is a wide gap between what adolescents would like health services to address and what is offered (*96, 143*).

WHO's Framework for Sexual Health Programmes notes: "specific strategies are needed to expand services to hard-to-reach groups, such as adolescents and young people who do not attend school, or who are unemployed, refugees, young sex workers, street children, sexually abused children, lesbian, bisexual and gay young people, and drug users. An important aspect to consider when identifying people who are hard to reach is the complex nature of vulnerability. Services should be available and accessible without parental consent, taking into account the young people's evolving capacity and best interests" (*37: 38*).

Approaches to adolescent sexual health need to accept sexuality as a normal and positive aspect of a person's life, "enabling young people to explore, experience and express their sexuality in healthy, positive, pleasurable and safe ways. This can only happen when the sexual rights of young people are respected." (*143: 69*).

4.1.2 Available evidence

The evidence identified in the systematic review showed that BSC improves sexual health knowledge, attitudes towards and intentions to engage in safer sex, and STI prevention skills; these improvements were sustained over a 12-month period (*24, 107*).

Studies described the effects of these improvements in different ways and on different populations, including particularly vulnerable groups. Studies found BSC resulted in: fewer sexual risk behaviours; an increased reported consistency of male condom use (*32, 85, 107*), especially in high risk populations (*47, 81, 114*); and decreases in STI incidence (*32, 47, 79, 85, 107, 147*). Four studies found fewer sexual partners and fewer episodes of unprotected sexual events with BSC (*24, 81, 85, 114*). One article found a significant increase in glove use during digital-vaginal sex post-treatment for bacterial vaginosis (BV) among same-sex female partners (*95*).

There is no single model of BSC, and not all study reports use the same terminology to describe their methods or outcomes. The BSC studies that were accepted as evidence from the systematic review for this guideline all had similar components of BSC, such as asking sexual health questions, providing information, and supporting clients by building their self-confidence and skills to take steps towards protecting their sexual health and well-being. All of these components used a client-centred approach, including how to use condoms correctly (*32, 47, 81, 114*) and how to negotiate condom use (*32, 47, 81, 107, 114*), both of which are key to STI prevention.

A study of female sex workers at clinics in Antananarivo and Tamatave, Madagascar used BSC. Nurses spent 15 minutes in a two-way exchange with the client that included: conducting an individual risk assessment; discussing transmission and verifying the client's basic knowledge about STIs and HIV; dual protection; demonstrating condom use and giving the client the opportunity to practice with models; reinforcing skills for negotiating condom use; and promoting the "no condom equals no sex" policy. The nurses tailored the BSC to individual circumstances (*47*).

BSC was used in a study with women who have sex with women. At a dedicated women's health research clinic in the United States, health-care providers began with a computer-assisted self-interview to assess behavioural risks, because this method has been shown to yield significantly higher rates of disclosure for same-sex behaviour and undesirable social behaviours when compared directly with self-administered questionnaires (*95, 142*). The intervention addressed four factors. To address perceived susceptibility to BV, participants were educated about the relatively high prevalence of BV among women reporting sex with other women and the high degree of concordance of BV within monogamous female sexual partnerships. Perceived severity was addressed by educating participants on the symptoms of BV and its consequences. To address perceived benefits, providers "emphasized the benefits of treating and preventing BV, including the possibility of the reduced likelihood of BV transmission to female sex partners. Finally, perceived barriers to implementing the behavioural intervention were explored with participants, including ways to incorporate cleaning of sex toys or using male condoms on sex toys [in] participants' sexual routines." (*95: 3*)

In a study with female sex workers in Tijuana and Ciudad Juarez, Mexico, BSC addressed four areas: "(i) motivations for practicing safer sex (e.g. to protect one's own health, to avoid STIs, to feel clean) versus those for practicing unsafe sex (e.g. financial gain); (ii) barriers to condom use (e.g. threats of physical violence); (iii) techniques for negotiating safer sex with clients; and (iv) enhancement of social supports." (*114: 2052*)

Two studies found that there is no difference in outcomes between BSC interventions and more intensive interventions, both of which had some behavioural dimension (24, 85), while another showed that individual BSC by a clinician is more effective than peer education (*47*).

Kamb et al. (85) found that in addition to the value of the interactive dimension of the conversation between provider and client, including the development of a personalized risk reduction plan played a key role in the effectiveness of BSC (e.g. increased condom use and fewer STIs). Other studies elaborated this; for example Patterson et al. (*114*) described how BSC would identify barriers to implementation and how to overcome them. This included considering potential risks of violence and how to avoid these.

Regarding group interventions, a study in two public STI clinics in New York City that used a 45-minute intervention with groups of 4–8 participants resulted in a 23% reduction in STI incidence over 17 months of follow-up and better attitude, knowledge of condom use and efficacy (*138*). A study in Los Angeles inner-city STI clinics of a waiting room group intervention that compared different types of input – a social influence approach versus a skills approach – found a decrease in STI reinfections among men, but not among women, with both group approaches (*32*). This study led the GDG to conclude that, while group interventions can be effective, one-on-one BSC is more likely to reach a broader range of clients. This view is reinforced by the above-mentioned study of female sex workers in Madagascar comparing peer education alone with peer and health-care provider BSC, where health-care provider counselling produced stronger outcomes regarding reduction in STIs (*47*).

The key study regarding adolescents that supports this recommendation is a study in Washington DC that used the Awareness, Skills, Self-efficacy/Self-esteem, and Social Support (ASSESS) Programme. It advocates "increasing adolescent awareness about sexual risks, skills to avoid risky sexual situations, self-efficacy (such as a feeling that peer pressure can be resisted), and social support (such that adolescents felt encouraged by the physician)" (*17: 109*). It involved an 11-question risk assessment for young adolescents and an audio recording responding to their concerns, followed by health-care provider STI/HIV-prevention counselling and supported with information pamphlets for the adolescents and their parents. After three months, the clients in the intervention group were making greater use of condoms if they had sexual intercourse, but this impact dissipated by nine months. However, self-reported STI outcomes suggested a positive programme impact at nine months, indicating that "the cumulative effect of the increases in adolescent awareness and condom use was a decrease in sexual risk" (*17: 113*).

While BSC takes many forms, in this case the sexual health assessment portion of the audio recording that adolescents listened to at the start of the session asked 11 questions (with response options of "yes", "no" and "does not apply") about feelings and behaviours that may be associated with STI/HIV transmission (including feelings of sexual attraction; history of holding someone in your arms; history of kissing; ability to say no to sexual intercourse; history of masturbation; history of vaginal, oral or anal intercourse; condom use; and use of street drugs or alcohol). The final educational portion of the recording described the possible relationship of each response option to STI or HIV infection risk (*17*). The conversation between provider and client took place

after the client had listened and responded to the tape. Both parents and adolescents were given reading materials to take home.

It has been suggested that multiple-session interventions are needed for effective change of sexual behaviour, but the evidence challenges this view. Six studies found that a single BSC intervention was as effective as several (*17, 24, 81, 107, 114, 147*).

Four studies found that brief interventions were as effective as intensive ones, where "brief" refers to one-on-one provider BSC, and "intensive" refers to more thorough skills training, usually in groups with peer support and interactive processes such as role-play (*24, 81, 85, 95*). This further increases the appropriateness of incorporating BSC into routine services.

Two studies found that client motivation may influence the effectiveness of BSC. For example, people who already have an STI have greater motivation to prevent future sexual health problems (*85, 147*). Lack of client motivation to attend intensive interventions also reinforces the value of incorporating BSC into routine provider-client visits. Carey et al. noted that the process of completing a baseline assessment in itself may have influenced behaviour (*24*).

4.1.3 Balance of benefits and harms, feasibility and acceptability

Benefits and harms
The benefits of the intervention outweigh the harms.

Everyone has the right to sexual health services that help them prevent and deal with STIs. At the same time, the process of BSC, if effective, might lead clients to be more assertive with their partners (e.g. about condom use), and this assertiveness could in turn endanger the client (*32*). Well-trained providers will be aware of this risk and can broach the subject with clients and suggest ways to address it. While in the short term, breaking the silence about sexual concerns may cause clients stress, the process is essential for ultimately improving their sexual health. In addition, failure to support clients in protecting and promoting their health not only undermines their health, it also results in increased costs to the health system (*28, 109*).

Adolescents have the right to seek and receive information (*118*). In the absence of the information, support and skills needed to promote and protect their health and well-being, adolescents can suffer harms such as stigma, sadness, shame, guilt and anxiety, as well as STIs and unintended pregnancies (*87, 117*).

There is no evidence that BSC leads to increased sexual activity in general, including among adolescents (*17*).

The recommendation for the provision of brief sexuality-related communication (BSC) requires that health-care providers have been given appropriate training (see Recommendation 2).

When providers have appropriate training, sexual issues raised by clients can be dealt with in a brief visit to their primary provider, with only more complex issues requiring referral (88). However, sometimes people's sexual health problems (or physiological health problems that are giving rise to sexual difficulties) are beyond the professional capacities of providers at the first level of care. In this context, providers need to know what other services are available and refer clients as necessary. To offer BSC in a context where providers lack the capacity to address certain issues, either directly or through referral, may be suboptimal.

Feasibility and acceptability

Some studies directly assessed the feasibility of the intervention. A recent study in Russia recruited men and women to receive either a 60-minute motivational/skills building intervention to reduce HIV risk behaviours, or written HIV prevention material alone. With follow-up occurring at three and six months, the intervention group showed a significant decrease in the number of unprotected sexual acts (*84*). The feasibility of BSC in a single session in health-care settings was evaluated in South Africa (*84*), Kenya, Tanzania and Trinidad (*137*), and Mexico (*114*). Results showed that the intervention is feasible within the STI/HIV prevention programmes in low- and middle-income settings, as well as in different cultural contexts.

A study conducted in the United States compared women randomized to a single-session skills-based sexual risk reduction intervention – i.e. a BSC intervention – with women in an AIDS-only education intervention. In this case, almost every patient from the BSC intervention group returned for follow-up assessment at three months, and this group reported significantly higher condom use. BSC was found to be more feasible than group interventions, the method of intervention thought of as more cost-effective (*10*).

Although the above studies found implicit acceptability insofar as clients returned for more sessions, few directly assessed the acceptability of BSC. Some studies questioned its acceptability by patients and health-care providers when it is conducted in couples (*137*), and its acceptability by patients only when it is linked to HIV/STI testing (*84*). However, other studies confirmed the acceptability of the intervention in some populations. In a mixed-method study on the acceptability of BSC for postpartum and breastfeeding women in the United States, the vast majority of women found the assessment to be both acceptable and important (*43*). More studies are needed to evaluate acceptability of the intervention, particularly in low and middle-income countries in order to adapt it to the needs of different populations within the various local contexts.

Additional points of discussion

Because BSC is provided by a health worker, it has greater a likelihood of overcoming cultural sensitivities that exist in many contexts around information dissemination and support for adolescents in relation to sexuality, assuming that the provider has received appropriate training, as discussed in section 4.2. Nevertheless, parents of young adolescents may need reassurance regarding the BSC (*17*).

BSC is but one of the interventions necessary to support adolescents in addressing their sexual health concerns and to reduce STIs and unintended pregnancies. Therefore, BSC should not be chosen in preference over other effective interventions such as comprehensive sexuality education in schools. Moreover, since the evidence shows that not all changes that BSC contributes towards are sustained in the long term, there is a need for continued intervention.

4.2 RECOMMENDATION 2: TRAINING OF HEALTH-CARE PROVIDERS

RECOMMENDATION 2

Training of health-care providers in sexual health knowledge and the skills of brief sexuality-related communication is recommended.

Strong recommendation, low – very low quality of evidence

4.2.1 Background

Few studies were identified that focused on training health-care providers to address sexuality-related topics with their clients (*2, 55, 57, 77*). Health workers may not recognize signs of sexual health problems; for example, they may focus on the physical symptoms of intimate partner violence while overlooking less obvious ones such as poor mental health (*68*). Discomfort with discussing sexual practices, perceived inadequacy in their skills, discomfort with sexual language, lack of information about treatment options, fear of offending the client, the provider's embarrassment about sexuality, and time constraints have all been identified as important barriers to taking a sexual history and providing counselling (*41, 44, 49, 55, 69, 110, 61, 132*). Such discomfort is not necessarily the same for all sexual health issues. For example, one study found that providers found it easier to talk with clients about HIV prevention in general and about the importance of using condoms than about specific sexual risk behaviours or how to talk to a partner about condom use (*41*). One study of general practitioners and nurses reported that they experienced particular barriers with clients who differed from themselves, for example in sexual orientation or gender or ethnicity (*55, 73*) or who had intellectual disabilities (*1*). Religion, politics, family dynamics and other factors shape what health-care providers believe and what they do in practise (*66, 86, 98*).

Studies on sexuality-related issues as diverse as abortion (*65, 91*), maternal health (*82, 125*) and HIV (*67, 135*) have found some health-care providers' negative attitudes to be barriers to care. Similarly, groups that experience social stigma, marginalization or violence on the basis of disability or sexual orientation sometimes have this same experience repeated

with health-care providers, who should be serving them in a supportive and non-judgmental manner (*83, 151*). In addition, gender stereotypes often shape health-care providers' interactions with clients (*115*), and providers' response to adolescents seeking sexual health care can be similarly shaped by their own personal views and experiences (*38*). For all of these reasons, health-care providers' may then promote interventions that are more in keeping with their own beliefs than with the needs and desires of their clients (*37*).

The quality of the client's relationship with the health-care provider influences the subsequent actions that they take (*66, 144*). Once providers have the knowledge and skills to deliver those programmes to their clients, they can help them make enduring changes in their health-related behaviours (*138*).

Increasing clinician's involvement in promoting preventive behaviours can be done with clinician's education and environmental supports (17). Training providers in communication skills improves their level of comfort in dealing with sexual issues (69). Training of service providers in sexuality and sexual health has been demonstrated to be one of the key factors in increasing service use, including adolescents. Interventions such as "values clarification" (103), Health workers for change (72), Stepping stones (148), and Inner spaces outer faces (23) have been shown to make a significant improvement in clients' experience of provider attitudes on socially challenging issues such as sexual and reproductive health and rights (66, 87, 76, 145).

Therefore, the need for effective training and preparation of health-care providers is essential for supporting and sustaining behaviour change among clients (*16, 19, 21, 24*). Yet a literature review of medical school curricula across countries found that training in recording sexual histories, assessment of medication for sexual issues, and treatment was "variable, non-standardized, or inadequate" (*110*). A summit of medical school educators and sexual health experts had a similar finding in the United States and Canada (*33*). Finally, specific training on adolescent health is lacking in health-care curricula throughout the world (*133*).

Improving sexuality-related communication depends on investment in training that clarifies and positively influences service providers' values, with intensive follow-up supervision and support (*36*).

GDG experience indicates that training to meet sexual health-related challenges experienced by health-care providers should involve the acquisition of knowledge on those dimensions of sexuality that most frequently arise in a primary health care setting. It also has to build providers' counselling and brief intervention skills. These include active listening with empathy and the ability to ask questions; the capacity for reflexivity, including understanding of their own practice and attitudes towards sexuality; and the ability to conceptualize and optimize their response in ways that are appropriate to the different needs of different clients (*27*).

4.2.2 Available evidence

Training needs to first sensitize providers to enable them to recognize their own values and responses on diverse dimensions of sexuality and sexual health. It needs to build their knowledge of and skills in BSC (*17, 20, 41*).

Three studies of in-service BSC training were accepted as evidence for this guideline document:

1. In a study during which all clinic staff at seven HIV care clinics in different parts of the United States were trained using the Positive Steps curriculum, providers showed significant increases in their comfort level and willingness to counsel clients after the training, and they conducted prevention counselling with clients more frequently (*138*). Clients reported that their providers and other clinic staff discussed safer sex and disclosure with them more frequently 12 months after the intervention started than before the intervention was initiated (*138*). The training included a pre-workshop self-study component, a four-hour workshop and a two-hour booster session four to six weeks after the initial training. Training was interactive, using lectures, discussions, modelling of prevention discussions and role-plays. Training covered four domains: enabling providers to acknowledge that their clients engage in unsafe sexual behaviours; to open a conversation about risk with their clients; to jointly develop a risk-reduction plan with their clients; and to recognize the need for ongoing discussions on risk with their clients (*138*). The study concluded that training all clinic staff in BSC can create an enabling environment for clients to explore their sexual health concerns (*138*).

2. A training intervention in two primary care clinics at a health maintenance organization in Washington State found that, after BSC training, the proportion of visits during which the provider asked about the client's sexual activity increased. Similarly, there was an increase in cases where the provider talked to the client about HIV/STIs, with higher levels for high-risk clients. Providers discussed personalized risk-reduction strategies, an element important for behaviour change. The effects on provider effort were sustained during nine months of follow-up (*41*).

3. The third study, which was among physicians in the Washington DC metropolitan area, found that providers who used the educational materials on how to address STIs with a client performed significantly better than those who did not use them in eliciting more information, displaying better client interaction skills and meeting more of the educational goals (*20*).

The training programmes differed, but all included some element of education to improve knowledge, and some element of practising and interactive skills-building. Provision of materials alone, without the interactive dimension, has limitations. A study by Bowman et al. (*20*) gave health-care providers educational materials (monograph, pamphlet and audio recordings) to help them prepare for a simulated client visit. The simulated client subsequently gave feedback to the provider about the quality of the experience from the client perspective. While those who used the materials performed better than those who did not, outcomes were not ideal. More than 90%

of the physicians performed client comfort skills; but only 61% acknowledged client discomfort, and even fewer elicited client concerns (*20*). This suggests the importance of interactive training that incorporates skills-building through simulated provider–client interaction (*20, 44, 138*).

These studies all reinforce the value of supporting providers with a risk-screening tool that prompts them to ensure that the BSC focuses on the specific concerns and context of the client. In the GDG's assessment, the limitation of these studies was their focus on sexually transmitted disease prevention; thus, the provider assessments did not necessarily address broader sexual health concerns. The use of a tool to guide assessment is a key finding, but the GDG proposes that the tool should cover all aspects of sexual health and well-being as defined by WHO. Another component of the provider training that was found effective in these studies was their ability to support clients in developing a personal plan for protecting their sexual health (*44, 138*), and this reinforces evidence outlined in earlier sections of this guideline document.

The systematic search did not identify acceptable evidence on what types of pre-service training most successfully build health-care providers' capacity to offer effective BSC. However, GDG's experience indicates that pre-service training provides an opportunity for more systematic knowledge- and skills-building of health-care providers. In addition, lessons learned from studies of what makes in-service training effective could be applied to the pre-service context.

4.2.3 Balance of benefits and harms, feasibility and acceptability

Balance and harms

The benefits of the intervention outweigh the harms. However, larger cost-effectiveness studies or investment cases are needed to promote appropriate training modalities, particularly in low- and middle-income countries.

Lack of adequate training undermines health-care providers' competence and confidence in providing sexual health care, including brief sexuality-related communication. Providers who feel inadequate or uncomfortable in addressing sexual health issues, as discussed in the background above, are likely to avoid providing essential services. Discomfort with discussing sexual practices, perceived inadequacy in their skills, discomfort with sexual language, lack of information about treatment options, fear of offending the client, providers' own embarrassment about sexuality, and time constraints have all been identified as important barriers to taking a sexual history and providing counselling (*41, 44, 49, 55, 69, 78, 110, 132*). This makes clients vulnerable not only to poor quality care, but also to personal abuse from health-care providers incapable of distinguishing their personal feelings from their professional role. High-quality training can benefit from both the achievement of health service goals and the clients who need providers to recognize and effectively address their sexual health concerns. When balancing the time and resources for BSC training against other priorities, the preventive effects of BSC should be borne in mind.

Feasibility and acceptability

Several studies evaluated the feasibility of in-service BSC training in health-care providers with no prior counselling skills or minimal training. The duration of the training sessions evaluated in those health-care providers who were not exposed to any prior training ranged from eight hours (*81*) to two weeks (*128*); among those who had basic counselling skills, the range was from two hours (*84*) to three days (*35*). All studies concluded that in-service training is feasible in primary health care settings.

The Bowman study, as explained in the previous section, paired physicians with simulated patients (*20*). The physicians reported that this method of training was acceptable, appealing, and an effective educational experience. A randomized controlled trial conducted in Australia studied a three day in-service sexuality training programme for interdisciplinary teams working with patients suffering from spinal cord injuries. The intervention group showed improvements in both comfort and attitude in addressing sexual health with their patients (*50*).

Additional points of discussion

The lack of more studies on the issue of effective training in BSC, and of any studies in the pre-service context, indicates the need to identify training programmes that approach sexual health in its broadest sense (rather than with a purely disease-oriented focus) and which move beyond imparting information to building skills within a human rights orientation. Such training programmes should be studied in order to build a stronger body of evidence to guide health-care provider curricula development for pre- and in-service training.

CHAPTER FIVE

PUBLICATION, DISSEMINATION, IMPLEMENTATION AND MONITORING

This guideline document will be published and will be made available in English, French, Spanish and Russian. Depending upon the availability of funds, the book will be also translated into Arabic and Chinese. It will be available and accessible in electronic format through WHO and partner organizations' websites. The synthesis of evidence and recommendations will be published in one or more journal articles and presented at sexual and public health conferences.

It is designed for health policy-makers and decision-makers in health-care professional training institutions. Dissemination will occur through regional and country offices, collaborating centres, professional associations and partner agencies. The implementation process should be based on STI/HIV epidemiology as well as the local context of the epidemic, in line with national STI control and prevention strategies, and it should be inclusive of all national stakeholders. In order to facilitate such an implementation process, a series of the regional introduction and validation workshops are envisaged, if resources allow.

Taking into consideration the sensitivity and complexity of some sexual health constructs, the translation process will be assisted by a technical expert native speaker of one of the official United Nations languages from the GDG or technical partner organization, in order to ensure adequate translation of the main concepts and technical terminology, adapted to local socio-cultural contexts.

Implementation will require a phased approach. The distribution will specifically target health policy-makers and advocates concerned with STIs including HIV and AIDS, such as government, NGOs, donors and civil society and, where they exist, national HIV and AIDS multi-stakeholder working groups. The first phase of implementation will focus on building understanding among these groups of the rationale for, and value of BSC. Once their interest in incorporating BSC is developed, they will consider what policies and practices would need to be changed to guide health-care provider interventions.

Distribution will also target medical and nursing professional associations, as well as lecturers responsible for public health, psychology and STIs in medical and nursing schools. Monitoring would look for processes to engage these persons in assessing existing curricula with a view to ultimately including BSC in training curricula.

CHAPTER SIX

RESEARCH IMPLICATIONS

The limited evidence available for the development of this guideline document indicates that substantially more work needs to be done to study and validate BSC techniques in diverse country and clinical settings and with diverse clients, as well as with diverse providers. Is it more or less effective when delivered by a provider of one gender, sexual orientation or age group to a client of the same or a different group? Are results different depending on whether the provider is a doctor, nurse or social worker? To what extent does a client's awareness of having a current or prior sexual health concern affect their motivation and hence the effectiveness of BSC? What are the implementation barriers for BSC in resource-poor settings? How might implementation differ in sexual-health-specific settings, as compared with general health-care settings?

In addition to these implementation questions, there is little evidence regarding the role of BSC in addressing the drivers of poor sexual health and rights such as low self-esteem (particularly as a result of discrimination, coercion or violence), low self-efficacy and a low sense of sexual well-being.

With these questions in mind, the GDG has identified several research priorities, outlined in the following sections.

6.1 DEVELOPING AND TESTING A CLINICAL TOOL

RESEARCH PRIORITY

Develop a simple and standardized brief sexuality-related communication guideline. Pilot and adapt it for diverse country, cultural, health service, income and target client audiences.

In developing and testing the BSC clinical tool, there should be a move beyond STI prevention to address sexuality more holistically, with an emphasis on promoting positive sexuality rather than merely addressing sexual dysfunction. The tool should

pay particular attention to a holistic and positive understanding of sexual health, assessing the effectiveness and efficaciousness of BSC on parameters of wellness such as self-esteem, sexual well-being and satisfying relationships, as well as on risk reduction and disease prevention. This would include recovery from violence, bullying and discrimination in diverse populations, including those that are stigmatized in relation to their gender expression or sexuality, those with non-normative sexual orientations, disabled populations, and people living with HIV.

6.2 IN-SERVICE TRAINING OF HEALTH-CARE PROVIDERS

RESEARCH PRIORITY

Test the provision of in-service training to health-care providers in diverse health-care settings (including those providing general care rather than sexual health care) in the use of the above clinical tool, with the goal of integrating the tool into existing procedures.

Immediate testable outputs include health-care providers' capacity to:

- build rapport (and "desensitization" so that their own experiences do not impinge on their response to clients);
- take a history and provide accurate and appropriate information in a non-judgmental and open manner; and
- support clients in creating plans for how they will take steps to promote their sexual health and well-being.

Outcomes to assess include whether the health-care providers' confidence after training correlates with behaviour change in the client, taking into account factors such as client

retention, client adherence, client health and client satisfaction. This research would also test the relationship between length of BSC and the desired outcomes in order to give clearer guidance on the optimal length of time for BSC to result in change. The research would consider the balance between costs and maximum effects and whether there are minimum standards for training.

Nested within this study should be an assessment of the effectiveness of the training modules among diverse providers in a health system.

6.3 ADDRESSING HEALTH SYSTEM AND OPERATIONAL BARRIERS TO BSC IMPLEMENTATION

RESEARCH PRIORITY

Test the implementation of the BSC by trained providers in diverse health-care settings, particularly in resource-poor settings and settings offering general health care rather than sexual health care.

The aim would be to identify and understand the dynamics of operational, implementation and health system barriers, as well as factors that enable BSC implementation. The study would assess the additive or synergistic value of including BSC along with more routine preventive services (such as STI testing, provision of condoms and contraception, and vaccination) in primary care settings.

CHAPTER SEVEN

REFERENCES

7.1
ALL REFERENCES

1. Abbott D and Howarth J. Still off-limits? Staff views on supporting gay, lesbian and bisexual people with intellectual disabilities to develop sexual and intimate relationships. J Appl Res Intellect Disabil. 2007;20:116–26. doi:10.1111/j.1468-3148.2006.00312.x.

2. Akers A, Gold MA, Borrero S, Santucci A, Schwarz EB. Providers' perspectives on challenges to contraceptive counseling in primary care settings. J Womens Health (Larchmt). 2010;19(6):1163–70. doi:10.1089/jwh.2009.1735.

3. Andrist L. Taking a sexual history and educating clients about safe sex. Nurs Clin North Am. 1988;23(4):959–73.

4. Applications of human rights to reproductive and sexual health. New York (NY): United Nations Population Fund and Office of the High Commissioner for Human Rights; 2001 (http://www.ohchr.org/Documents/Publications/Reproductiveen.pdf, accessed 28 January 2015).

5. A qualitative review of psychosocial support interventions for young people living with HIV. Geneva: World Health Organization; 2009 (http://whqlibdoc.who.int/hq/2009/WHO_FCH_CAH_ADH_09.05_eng.pdf, accessed 28 January 2015).

6. Atalla E. Physician's attitudes regarding sexual dysfunction management' [dissertation]. Perth, Australia: Curtin University of Technology; 2009.

7. Baldwin DS. Depression and sexual dysfunction. Br Med Bull. 2001;57:81–99.

8. Baldwin DS and Foong T. Antidepressant drugs and sexual dysfunction. Br J Psychiatry. 2013;202:396–97. doi:10.1192/bjp.bp.112.110650.

9. Balshem H, Helfand M, Schünemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011;64(4):401–6. doi:10.1016/j.jclinepi.2010.07.015.

10. Belcher L, Kalichman S, Topping M, et al. A randomized trial of a brief HIV risk reduction counseling intervention for women. J Consult Clin Psychol. 1998;66(5):856–61.

11. Benoit C and Millar A. Short report: dispelling myths and understanding realities: working conditions, health status, and exiting experiences of sex workers. Victoria, Canada: University of Victoria and Prostitutes Empowerment, Education and Resource Society; 2001.

12. Bhavsar V and Bhugra D. Cultural factors and sexual dysfunction in clinical practice. Adv Psychiatr Treat. 2013;19:144–52. doi:10.1192/apt.bp.111.009852.

13. Binagwaho A, Fuller A, Kerry V, Dougherty S, Agbonyitor M, Wagner C, et al. Adolescents and the right to health: eliminating age-related barriers to HIV/AIDS services in Rwanda. AIDS Care. 2012;24(7):936–42. doi:10.1080/09540121.2011.648159.

14. Blosnich JR, Brown G, Shipherd J, Kauth M, Piegari R, Bossarte R. Prevalence of Gender Identity Disorder and suicide risk among transgender veterans using veterans health administration care. Am J Public Health. 2013;103(10):e22–32. doi:10.2105/AJPH.2013.301507.

15. Bluespruce J, Dodge W, Grothaus L, Wheeler K, Rebolledo V, Carey J, McAfee T, Thompson R. HIV prevention in primary care: impact of a clinical intervention 2001;15(5):243–53.

16. Bockting W, Robinson B, Forberg J, Scheltema K. Evaluation of a sexual health approach to reducing HIV/STI risk in the transgender community. AIDS Care. 2005;17(3):289–303.

17. Boekeloo B, Schamus LA, Simmens SJ, Cheng TL, O'Connor K, D'Angelo LJ. A STD/HIV prevention trial among adolescents in managed care. Pediatrics. 1999;103(1):107–15.

18. Bolu O, Lindsey C, Kamb ML, Kent C, Zenilman J, Douglas JM, Malotte CK, Rogers J, Peterman TA, et al.; Project RESPECT Study Group. Is HIV/sexually transmitted disease prevention counseling effective among vulnerable populations? Sex Transm Dis. 2004;31(8):469–74. doi:10.1097/01.olq.0000135987.12346.f2.

19. Bond T. The nature and role of counseling in primary care. In: Keithley J, Bond, T, Marsh G, editors. Counselling in Primary Care. 2nd edition. Oxford: Oxford University Press. 2002:3–24.

20. Bowman MA, Russell NK, Boekeloo BO, Rafi IZ, Rabin DL. The effect of educational preparation on physician performance with a sexually transmitted disease-simulated patient. Arch Intern Med. 1992;152:1823–8.

21. Brownridge DA. Partner violence against women with disabilities: prevalence, risk and explanations. Violence Against Women. 2006;12(9):805–22.

22. Bryan AD, Aiken LS, West SG. Increasing condom use: evaluation of a theory-based interevention to prevent sexually transmitted diseases in young women. Health Psychol 1996;15:371-82.

23. ISOFI Toolkit: Tools for action and learning on gender and sexuality. Atlanta (GA) and Washington (DC): Cooperative for Assistance and Relief Everywhere, Inc. (CARE) and International Center for Research on Women (ICRW); 2007. (http://www.icrw.org/files/publications/ISOFI-Toolkit-Tools-for-learning-and-action-on-gender-and-sexuality.pdf, accessed 28 January 2015).

24. Carey MP, Senn TE, Vanable PA, Coury-Doniger P, Urban MA. Brief and intensive behavioral interventions to promote sexual risk reduction among STD clinic patients: results from a randomized controlled trial. AIDS Behav. 2010;14(3):504–17. doi:10.1007/s10461-009-9587-1.

25. Carkhuff R. The Art of helping in the 21st century. Eighth Edition. Amherst, MA, USA: Human Resource Development; 2000.

26. Carlson M, Brennan RT, Earls F. Enhancing adolescent self-efficacy and collective efficacy through public engagement around HIV/AIDS competence: a multilevel, cluster randomized-controlled trial. Soc Sci Med. 2012;75(6):1078–87. doi:10.1016/j.socscimed.2012.04.035.

27. Diplôme Universitaire Paris Diderot: Conseiller en Santé Sexuelle. In: Chaire UNESCO Santé Sexuelle et Droits Humains [website] (http://www.santesexuelle-droitshumains.org/Diplome-Universitaire-Paris-Diderot-Conseiller-en-Sante-Sexuelle_a28.html, accessed 23 January 2015)

28. Chesson HW, Blandford JM, Gift TL, Tao G, Irwin KL. The estimated direct medical cost of sexually transmitted diseases among American youth, 2000. Perspect Sex Reprod Health. 2004;36(1):11–19.

29. Chorost MI, Weber TK, Lee RJ, Rodriguez-Bigas MA, Petrelli NJ. Sexual dysfunction, informed consent and multimodality therapy for rectal cancer. Am J Surg. 2000;179(4):271–4.

30. Clarke LE, Allen RH, Goyal V, Raker C, Gottlieb AS. Reproductive coercion and co-occurring intimate partner violence in obstetrics and gynecology patients. Am J Obstet Gynecol. 2014;210(1):42.e1–8. doi:10.1016/j.ajog.2013.09.019.

31. Cohen D, Dent C, MacKinnon D. Condom skills education and sexually transmitted disease reinfection. J Sex Res 1991;28:139-44.

32. Cohen DA, Dent C, MacKinnon D, Hahn G. Condoms for men, not women. Results of brief promotion programs. Sex Transm Dis. 1992;19(5):245–51.

33. Coleman E, Elders J, Satcher D, Shindel A, Parish S, Kenagy G, et al. Summit on medical school education in sexual health: report of an expert consultation. J Sex Med. 2013;10:924–38. doi:10.1111/jsm.12142.

34. Cook RJ, Erdman JN, Dickens BM. Respecting adolescents' confidentiality and reproductive and sexual choices. Int J Gynaecol Obstet. 2007;98:182–7.

35. Crosby R, DiClemente RJ, Charnigo R, Snow G, Troutman A. A brief, clinic-based, safer sex intervention for heterosexual African American men newly diagnosed with an STD: a randomized controlled trial. Am J Public Health. 2009;99(suppl 1):S96–103.

36. Defining sexual health. Report of a technical consultation on sexual health, 28–31 January 2002, Geneva. World Health Organization; 2006 (http://www.who.int/reproductivehealth/publications/sexual_health/defining_sh/en, accessed 28 January 2015).

37. Developing sexual health programmes: a framework for action. Geneva: World Health Organization; 2010 (WHO/RHR/HRP/10.22; http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.22_eng.pdf, accessed 28 January 2015).

38. de Ridder D, de Wit J, editors. Self-regulation in health behavior. John Wiley and Sons, 2006 (http://ca.wiley.com/WileyCDA/WileyTitle/productCd-0470024089.html, accessed 28 January 2015).

39. Diaz-Olavarrieta C, Campbell J, Garcia de la Cadena C, Paz F, Villa AR. Domestic violence against patients with chronic neurological disorders. Arch Neurol 1999;56(6):681–5.

40. Dixon-Mueller R. The sexuality connection in reproductive health. Stud Fam Plann. 1993;24(5):269–82.

41. Dodge W, BlueSpruce J, Grothaus L, Rebolledo V, McAfee TA, Carey JW, et al. Enhancing primary care HIV prevention: a comprehensive clinical intervention. Am J Prev Med. 2001;20(3):177–83.

42. Dreisbach S, Devine S, Fitch J, Anderson T, Lee T, Rietmejer C, Corbett K. Can experiental-didactic training improve clinical STD Practices? Sexually Transm Infect 2011 38(6) 516-21.

43. Dunlop AL, Dretler AW, Badal HJ, Logue KM. Acceptability and potential impact of brief preconception health risk assessment and counseling in the WIC setting. Am J Health Promot. 2013;27 Suppl 1:S58–65. doi:10.4278/ajhp.120109-QUAL-7.

44. Dyer K and das Nair R. Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. J Sex Med. 2013;10:2658–70. doi:10.1111/j.1743-6109.2012.02856.x.

45. Erol B, Tefekil A, Ozbey I, Saiman F, Dincag N, Kadioglu A, Tellaloglu S. Sexual dysfunction in type II diabetic females: a comparative study. J Sex Marital Ther. 2002;28 Suppl 1:55–62.

46. Family planning: a global handbook for providers. 2011 update. Geneva: World Health Organization, Johns Hopkins Bloomberg School of Public Health, USAID; 2011 (http://whqlibdoc.who.int/publications/2011/9780978856373_eng.pdf, accessed 28 January 2015).

47. Feldblum PJ, Hatzell T, van Damme K, Nasution M, Rasamindrakotroka A, Grey TW. Results of a randomized trial of male condom promotion among Madagascar sex workers. Sex Transm Infect. 2005;81:166–72. doi:10.1136/sti.2004.010074.

48. Fisher JD, Fisher WA, Cornman DH, Amico RK, Bryan A, Friedland GH. Clinician-delivered intervention during routine clinical care reduced unprotected sexual behaviour among HIV-infected patients. JAIDS 2006;41:44–52.

49. Fredman L, Rabin DL, Bowman M, Bandemer C, Sardeson K, Taggart VS, et al. Primary care physicians' assessment and prevention of HIV infection. Am J Prev Med. 1989;5:188–95.

50. Fronek P, Booth S, Kendall M, Miller D, Geraghty T. The effectiveness of a sexuality training program for the interdisciplinary spinal cord injury rehabilitation team. Sexuality and Disability. 2005;23(2):51–63.

51. Gavin L, MacKay AP, Brown K, Harrier S, Ventura SJ, Kann L, et al.; United States Centers for Disease Control and Prevention (CDC). Sexual and reproductive health of persons aged 10–24 years – United States, 2002–2007. MMWR Surveill Summ. 2009:58(6):1–58.

52. Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL, editors. Through the patient's eyes: understanding and promoting patient-centered care. San Francisco: Jossey-Bass Inc; 1993.

53. Girls, women and sexuality education – the link to achieving the MDGs. Geneva: United Nations Human Rights, Office of the High Commissioner (http://www.un.org/en/events/women/iwd/2011/pdfs/Infonote_Women_and_the_right_to_sexual_education.pdf, accessed 9 March 2015).

54. Good practices in legislation on "harmful practices" against women. Report of an expert group meeting organized by the United Nations Division for the Advancement of Women and the United Nations Economic Commission for Africa, Addis Ababa, Ethiopia, 26–29 May 2009 (http://www.un.org/womenwatch/daw/egm/vaw_legislation_2009/Report%20EGM%20harmful%20practices.pdf, accessed 28 January 2015).

55. Gott M, Galena E, Hinchliff S, Elford H. Opening a can of worms: GP and practice nurse barriers to talking about sexual health in primary care. Fam Pract. 2004;21:528–36.

56. Guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization: 2011 (http://www.who.int/immunization/hpv/target/preventing_early_pregnancy_and_poor_reproductive_outcomes_who_2006.pdf?ua=1, accessed 28 January 2015).

57. Guyatt GH, Oxman AD, Akl EA, Kunz R, Vist G, Brozek J, et al. GRADE guidelines: 1. Introduction – GRADE evidence profiles and summary of findings tables. J Clin Epidemiol. 2011;64(4):383–94. doi:10.1016/j.jclinepi.2010.04.026.

58. Guyatt GH, Oxman AD, Kunz R, Brozek J, Alonso-Coello P, Rind D, et al. GRADE guidelines: 6. Rating the quality of evidence – imprecision. J Clin Epidemiol. 2011;64(4):1283–93. doi:10.1016/j.jclinepi.2011.01.012.

59. Guyatt GH, Oxman AD, Kunz R, Woodcock J, Brozek J, Helfand M, et al.; GRADE Working Group. GRADE guidelines: 7. Rating the quality of evidence – inconsistency. J Clin Epidemiol. 2011;64(12):1294–302. doi:10.1016/j.jclinepi.2011.03.017.

60. Guyatt GH, Oxman AD, Kunz R, Woodcock J, Brozek J, Helfand M, et al.; GRADE Working Group. GRADE guidelines: 8. Rating the quality of evidence – indirectness. J Clin Epidemiol. 2011;64(12):1303–10. doi:10.1016/j.jclinepi.2011.04.014.

61. Guyatt GH, Oxman AD, Kunz R, Falck-Ytter Y, Vist GE, Liberati A, et al; GRADE Working Group. Going from evidence to recommendations. BMJ. 2008;336(7652):1049–51. doi:10.1136/bmj.39493.646875.AE.

62. Guyatt GH, Oxman AD, Montori V, Vist G, Kunz R, Brozek J, et al. GRADE guidelines: 5. Rating the quality of evidence – publication bias. J Clin Epidemiol. 2011;64(12):1277–82. doi:10.1016/j.jclinepi.2011.01.011.

63. Guyatt GH, Oxman AD, Vist G, Kunz R, Brozek J, Alonso-Coello P, et al. GRADE guidelines: 4. Rating the quality of evidence – study limitations (risk of bias). J Clin Epidemiol. 2011;64(4):407–15. doi:10.1016/j.jclinepi.2010.07.017.

64. Guyatt GH, Oxman AD, Vist GE, Kunz R, Falck-Ytter Y, Alonso-Coello P, et al.; GRADE Working Group. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ. 2008;26;336(7650):924–6. doi:10.1136/bmj.39489.470347.AD.

65. Harries J, Stinson I, Orner P. Health care providers' attitudes towards termination of pregnancy: a qualitative study in South Africa. BMC Public Health. 2009;9:296. doi:10.1186/1471-2458-9-296.

66. Hartigan P. The importance of gender in defining and improving quality of care: some conceptual issues. Health Policy Plan. 2001;16 Suppl 1:7–12.

67. Hassan Z and Wahsheh M. Knowledge and attitudes of Jordanian nurses towards patients with HIV/AIDS: findings from a nationwide survey. Issues Ment Health Nurs. 2011;32(12):774–84. doi:10.3109/01612840.2011.610562.

68. Hatcher A. Patient and provider perspectives on addressing intimate partner violence in Johannesburg antenatal clinics. In: Children and AIDS. Compendium of abstracts presented at the 17th ICASA. Cape Town: International Conference on AIDS and Sexually Transmitted Infections in Africa; 2013:111.

69. Hatzichristou D, Rosen R, Derogatis L, Low WY, Meuleman E, Sadovsky, et al. Clinical evaluation and symptom scales in men and women with sexual dysfunction. In: Montorsi F, Basson R, Adaikan G, Becher E, Clayton F, Guilano S, et al. Sexual medicine: Sexual dysfunctions in men and women. 3rd International Consultation on Sexual Medicine, Paris. International Consultation on Urological Diseases (ICUD) and International Society for Sexual Medicine (ISSM); 2010 (http://www.icud.info/PDFs/SEXUAL-MEDICINE-2010.pdf, accessed 28 January 2015).

70. Hawkes S, Hart G. Men's sexual health matters: promoting reproductive health in an international context. Trop Med Int Health. 2000;5(7):A37–44.

71. Hawkes S. Sexual health: a post-2015 palimpsest in global health? Lancet Glob Health. 2014;2(7):e377–8. doi:10.1016/S2214-109X(14)70036-1.

72. Health workers for change: a manual to improve quality of care. Geneva: UWDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) and Women's Health Project; 2005.

73. Hinchliff S, Gott M, Galena E. 'I daresay I might find it embarrassing': general practitioners' perspectives on discussing sexual health issues with lesbian and gay patients. Health Soc Care Community. 2005;13:345–53.

74. Hines DA. Predictors of sexual coercion against women and men: A multilevel, multinational study of university students. Arch Sex Behav. 2007;36:403–22.

75. Hull T, Hilber AM, Cherisch M, Bagnol B, Prohmmo A, Smit JA, et al. Prevalence, motivations, and adverse effects of vaginal practices in Africa and Asia: findings from a multicountry household survey. J Womens Health (Larchmt). 2011;20(7):1097–109. doi:10.1089/jwh.2010.2281.

76. International guidelines on HIV/AIDS and human rights. Consolidated version. Geneva: Office of the United Nations High Commissioner for Human Rights (OHCHR) and the Joint United Nations Programme of HIV/AIDS (UNAIDS); 2006 (http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf, accessed 28 January 2015).

77. Isaacs J, Creinin M. Miscommunication between healthcare providers and patients may result in unplanned pregnancies. Contraception. 2003;68:373–76.

78. Jaccard J, Levitz N. Counseling adolescents about contraception: towards the development of an evidence-based protocol for contraceptive counselors. J Adolesc Health. 2013;52(4 Suppl):S6-13. doi:10.1016/j.jadohealth.2013.01.018.

79. Jackson G. Prediction of coronary artery disease by erectile function status – evidence-based data. Sex Med Review. 2013;1(2):104–7.

80. James NJ, Gillies PA, Bignell CJ. Evaluation of a randomized controlled tiral of HIV and sexually transmitted disease prevention in a genitourinary medicine clinic setting. AIDS 1998;12:1235-42.

81. Jemmott L, Jemmott J, O'Leary A. Effects on sexual risk behavior and STI rate of brief HIV/STI prevention interventions for African American women in primary care settings. Am J Public Health. 2007;97:1034–40.

82. Jewkes R, Abrahams N, Mvo Z. Why do nurses abuse patients? Reflections from South African obstetric services. Soc Sci Med. 1998;47(11):1781–95.

83. Johnson CA. Off the map: How HIV/AIDS programming is failing same-sex practising people in Africa. New York (NY): International Gay and Lesbian Human Rights Commission; 2007 (http://iglhrc.org/sites/default/files/6-1.pdf, accessed 28 January 2015).

84. Kalichman SC, Cain D, Eaton L, Jooste S, Simbayi LC. Randomized clinical trial of brief risk reduction counselling for sexually transmitted infection clinic patients in Cape Town, South Africa. AM J Public Health 2011:101:e9-17.

85. Kamb M, Fishbein M, Douglas JM Jr, Rhodes F, Rogers J, Bolan G, et al. Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases: a randomized controlled trial. Project RESPECT Study Group. JAMA. 1998;280(13):1161–67.

86. Kambou S, Magar V, Hora G, Mukherjee A. Power, pleasure, pain, and shame: assimilating gender and sexuality into community-centred reproductive health and HIV prevention programmes in India. Global Public Health. 2007:2(2):155–68.

87. Krebs LU. Sexual assessment: research and clinical. Nurs Clin North Am. 2007 Dec;42(4):515–29.

88. Lamont J; Society of Obstetricians and Gynaecologists of Canada. Female sexual health consensus guidelines. J Obstet Gynaecol Can. 2012;34(8):769–83.

89. Langston AM, Rosario L, Westhoff CL. Structured contraceptive counselling-a randomized controlled trial. Patient Educ Couns 2010;81:362–7.

90. Lee JT, Yen HW. Randomized controlled evaluation of a theory-based postpartum sexual health education programme. Journal of Advanced Nursing 2007 60(4), 389–401.

91. Lipp A. A review of termination of pregnancy: prevalent health care professional attitudes and ways of influencing them. J Clin Nurs. 2008;17(13):1683–8.

92. Logan C. Homophobia? No, homoprejudice. J Homosex. 1996;31(3):31–53.

93. Lombardi E. Enhancing transgender health care. Am J Public Health. 2001;91(6):869–72.

94. Magnani R, Karim A, Weiss L, Bond KC, Lemba M, Morgan GT. Reproductive health risk and protective factors among youth in Lusaka, Zambia. J Adolesc Health. 2002;30(1):76–86.

95. Marrazzo J, Thomas KI, Ringwood K. A behavioural intervention to reduce persistence of bacterial vaginosis among women who report sex with women: results of a randomized trial. Sex Transm Infect. 2011;87(5):399–405. doi:10.1136/sti.2011.049213.

96. Mburu G, Hodgson I, Teltschik A, Ram M, Haamujompa C, Bajpai D et al. Rights-based services for adolescents livning with HIV: adolescent self-efficacy and implications for health systems in Zambia. Reprod Health Matters. 2013;21(41):176–85. doi:10.1016/S0968-8080(13)41701-9.

97. McCabe M Althof C, Assalian P, Chevret-Measson M, Leiblum S, Simonelli C, Wylie K. Psychological and interpersonal dimensions of sexual function and dysfunction. J Sex Med. 2010;7(1 Pt 2):327–36. doi:10.1111/j.1743-6109.2009.01618.x.

98. McKelvey R, Webb J, Baldassar L, Robinson S, Riley, G. Sex knowledge and sexual attitudes among medical and nursing students. Aust N Z J Psychiatry. 1999;(33):260–6.

99. Mead N and Bower P. Patient-centeredness: a conceptual framework and review of the empirical literature. Soc Sci Med. 2000:51:1087–110.

100. Metcalf CA, Douglas JM Jr, Malotte CK, Cross H, Dillon BA, Paul SM, et al. Relative efficacy of prevention counselling with rapis and standard HIV testing: a randomized, controlled trial (RESPECT-2). Sex Transm Dis 2005;32:130–8.

101. Meyer IH. Prejudice, social stress and mental health in lesbian, gay and bisexual populations: conceptual issues and research evidence. Psychol Bull. 2003;129(5):674–97.

102. Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. Contraception 2011;83:274-80.

103. Mitchell EMH, Trueman KA, Gabriel MC, Fine A, Manentsa N. Accelerating the pace of progress in South Africa: an evaluation of the impact of values clarification workshops on termination of pregnancy access in Limpopo Province. Johannesburg, South Africa: Ipas; 2004.

104. Mohapatra S and Mohanty M. Abuse and activity limitation: a study on domestic violence against disabled women in Orissa, India. A research report of a project funded by the Oxfam India Trust. Bhubaneswar, India: Swabhinam; 2005.

105. Montejo AL, Llorca G, Izquierdo JA, Rico-Villademoros F. Incidence of sexual dysfunction associated with antidepressant agents: a prospective multicenter study of 1022 outpatients. Spanish Working Group for the Study of Psychotropic-Related Sexual Dysfunction. J Clin Psych. 2001;62 Suppl 3:10–21.

106. Neff JA, Gaskil SP, Prihoda TJ, Weiner RV, Rydel KB. Continuing medical education versus clinic-based STD and HIV education interventions for primary care service providers: replication and extension. AIDS Education and Prevention. 1998;10(5):417–32.

107. Neumann M, O'Donnell L, Doval A, Schillinger J, Blank S, Ortiz-Rios E, Garcia T, O'Donnell C. Effectiveness of the VOICES/VOCES sexually transmitted disease/human immunodeficiency virus prevention intervention when administered by health department staff: does it work in the "real world"? Sex Transm Dis. 2011 Feb;38(2):133–9. doi:10.1097/OLQ.0b013e3181f0c051.

108. Orr DP, Langedelf CD, Katz BP, Caine VA. Behavioral intervention to increase condom use among high-risk female adolescents. J Pediatr. 1996:128:288–95.

109. Owusu-Edusei K Jr, Chesson H, Gift T, Tao G, Mahajan R, Ocfemia M, Kent C. The estimated direct medical cost of selected sexually transmitted infections in the United States, 2008. Sex Transm Dis. 2013;40(3):197–201. doi:10.1097/OLQ.0b013e318285c6d2.

110. Parish SJ and Clayton AH. Sexual medicine education: review and commentary. J Sex Med. 2007;4(2):259–67.

111. Park E, Norris E, Bober S. Sexual health communication during cancer care: barriers and recommendations. Cancer J. 2009 Jan-Feb;15(1):74–7. doi:10.1097/PPO.0b013e31819587dc.

112. Parker R. Sexuality, health and human rights. Am J Public Health. 2007;97(6):972–3.

113. Pastuszak AW, Badhiwala N, Lipshultz LI, Khera M. Depression is correlated with the psychological and physical aspects of sexual function. Int J Impot Res. 2013;25(5):194–9. doi:10.1038/ijir.2013.4.

114. Patterson TL, Mausbach B, Lozada R, Staines-Orozco H, Semple SJ, Fraga-Vallejo M, et al. Efficacy of a brief behavioral intervention to promote condom use among female sex workers in Tijuana and Ciudad Juarez, Mexico. Am J Public Health. 2008;98(11):2051–7. doi:10.2105/AJPH.2007.130096.

115. Pittman P, Hartigan P. Gender inequity: an issue for quality assessment researchers and managers. Health Care Women Int. 1996;17(5):469–86.

116. Proude E, D'Este C, Ward JE. Randomized trial in family practice of a brief intervention to reduce STI risk in young adults. Family Practice. 2004;21(5):537–44.

117. Reese JB, Porter LS, Somers TJ, Keefe FJ. Pilot feasibility study of a telephone-based couples intervention for physical intimacy and sexual concerns in colorectal cancer. J Sex Marital Ther. 2012;38(5):402–17. doi:10.1080/0092623X.2011.606886.

118. Resolution A/RES/44/25. Convention on the Rights of the Child. New York (NY): United Nations General Assembly; 20 November 1989 (http://www.un.org/documents/ga/res/44/a44r025.htm, accessed 28 January 2015).

119. Resolution A/RES/21/2200. International Covenant on Economic, Social and Cultural Rights. New York (NY): United Nations General Assembly; 16 December 1966 (http://www.un-documents.net/a21r2200.htm, accessed 28 January 2015).

120. Richardson JL, Milam J, McCutchan A, Stoyanoff S, Bolan R, Weiss J, et al. Effect of brief safer-sex counselling by medical providers to HIV-1 seropositive patients: a multi-clinic assessment. AIDS. 2004;18:1179–86.

121. Rogers C, editor. L'approche centrée sur la personne. (Anthology of texts presented by Kirschenbaum H and Hendersen VL). Lausanne: Editions Randin; 2001.

122. Rogow D, Haberland N, Del Valle A, Lee N, Osakue G, Sa Z, et al. Integrating gender and rights into sexuality education: field reports on using It's All One. Reprod Health Matters. 2013;21(41):154–66. doi:10.1016/S0968-8080(13)41699-3.

123. Rosser BR, Hartfield LA, Miner MH, Ghiselli ME, Lee BR, Welles SL. Effects off a behavioural intervention to reduce serodiscordant unsafe sex among HIV positive men who have sex with men: the Positive Connections randomized controlled trial study. J Behav Med. 2010;33:147–58.

124. Ryan C, Huebner D, Diaz RM, Sanchez J. Family rejection as a predictor of negative health outcomes in white and latino lesbian, gay, and bisexual young adults. Pediatrics. 2009;123(1):346–52. doi:10.1542/peds.2007-3524.

125. Sargent C and Bascope G. Ways of knowing about birth in three cultures. Med Anthropol Q. 1996;10(2):213–36.

126. Schmidt CE, Bestmann B, Kuchler T, Longo WE, Kremer B. Ten-year historic cohort of quality of life and sexuality in patients with rectal cancer. Dis Colon Rectum. 2005;48(3):483–92.

127. Shlay J, Mayhugh B, Foster M, Maravi M, Baron A, Douglas J. Initiating contraception in sexually transmitted disease clinic setting: A randomized trial. Am J Obstet Gynecol. 2003 189:473-81.

128. Simbayi LC, Kalichman SC, Skinner D, Jooste S, Cain D, Mathit V, et al. Theory-based HIV risk reduction counseling for sexually transmitted infection clinic patients in Cape Town, South Africa. Sex Transm Dis. 2004;31(12):727–33.

129. Siu G, Bakeera-Kitaka S, Kennedy CE, Dhabangi A, Kambugu A. HIV serostatus disclosure and lived experiences of adolescents at the Transition Clinic of the Infectious Diseases Clinic in Kampala, Uganda: a qualitative study. AIDS Care. 2012;24(5):606–11. doi:10.1080/09540121.2011.630346.

130. Smith PB, Weinman ML, Parrilli J. The role of condom motivation education in the reduction of new and reinfection rates of sexually transmitted diseases among inner-city female adolescents. Patient Educ Couns. 1997:31:77-81.

131. Standards for sexuality education in Europe: a framework for policy makers, educational and health authorities and specialists. Cologne: Federal Centre for Health Education (BZgA) and WHO Regional Office for Europe; 2010 (http://www.bzga-whocc.de/pdf.php?id=061a863a0fdf28218e4fe9e1b3f463b3, accessed 28 January 2015).

132. Stead ML, Brown JM, Fallowfield L, Selby P. Lack of communication between healthcare professionals and women with ovarian cancer about sexual issues. Br J Cancer. 2003;88(5):666–71.

133. Stefan C, van der Merwe PL. Treating adolescents in South Africa: time for adolescent medicine units? S Afr Med J. 2008;98(3):184–5.

134. Stewart M, Brown J, Weston W, McWhinney I, McWilliam C, Freeman T. Patient-centered medicine: transforming the clinical method. London: Sage Publications; 1995.

135. Surlis S and Hyde A. HIV-positive patients' experiences of stigma during hospitalisation. J Assoc Nurses AIDS Care. 2001;12(6):68–77. doi:10.1016/S1055–3290(06)60185–4.

136. Tepper M. Providing comprehensive sexual health care in spinal cord injury rehabilitation: implementation and evaluation of a new curriculum for health care professionals. Sexuality and Disability. 1997;15(3):131–65.

137. The Voluntary HIV-1 Counseling and Testing Efficacy Study Group. Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomised trial. Lancet. 2000;356(9224):103–12. doi:http://dx.doi.org/10.1016/S0140-6736(00)02446-6.

138. Thrun M, Cook PF, Bradley-Springer LA, Gardner L, Marks G, Wright J, et al. Improved prevention counseling by HIV care providers in a multisite, clinic-based intervention: Positive STEPs. AIDS Educ Prev. 2009;21(1):55-66. doi:10.1521/aeap.2009.21.1.55.

139. Troussier T. Les conduites à risque de l'adolescente. Réalité en gynécologie obstétrique. 2011;155:18–20 (in French).

140. Troussier T, Tourette-Turgis T. La qualité de la vie sexuelle et affective favorise la prévention chez les personnes vivant avec le VIH. Revue Européenne de Sexologie. 2006;3:165–75 (in French).

141. Troussier T, Benghozi P, Ganem M. High-risk sexual behaviours. In: Sultan C. (ed) Pediatric Adrenal Disease. Evidence-based clinical practice. Second edition. Basel: Karger. 2012;22:1–23.

142. Turner C, Ku L, Rogers M, Lindberg LD, Pleck JH, Sonenstein FL. Adolescent sexual behavior, drug use, and violence: increased reporting with computer survey technology. Science. 1998;280(5365):867–73.

143. van Reeuwijk M, Nahar P. The importance of a positive approach to sexuality in sexual health programmes for unmarried adolescents in Bangladesh. Reprod Health Matters. 2013;21(41):69–77. doi:10.1016/S0968-8080(13)41694-4.

144. Villaroman-Bautista V, Roldan AT, Basco M. A comparison of use patterns, the health care process and the effectiveness of four prenatal health services in a provincial community of the Philippines. Maternal Nutrition and Health Care Program report no. 9. Washington (DC): International Center for Research on Women; 1990.

145. Vlassoff C, Fonn S Health Workers for Change as a health systems management and development tool. Health Policy Plan. 2001;16 Suppl 1:47–52.

146. Walker B, Harrington D. Effects of staff training on staff knowledge and attitudes about sexuality. Educational Gerontology. 2002;28(8):639–54.

147. Warner L, Klausner JD, Rietmeijer CA, Malotte CK, O'Donnell L, Margolis AD, et al. Effect of a brief video intervention on incident infection among patients attending sexually transmitted disease clinics. PLoS Med. 2008;5(6):e135. doi:10.1371/journal.pmed.0050135.

148. Welbourn A. Stepping Stones: a training package in HIV/AIDS, communication and relationship skills. London: Strategies for Hope; 1995.

149. Wenger NS, Linn LS, Epstein M, Shapiro MF. Reduction of high-risk sexual behaviour among heterosexual undergoing HIV antibody testing: a randomized clinical trial. American journal of public health. 1991;81(12):1580–5.WHO Handbook for Guideline Development. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/10665/75146/1/9789241548441_eng.pdf, accessed 28 January 2015).

150. Young ME, Nosek MA, Howland C, Chanpong G, Rintala DH. Prevalence of abuse of women with physical disabilities. Arch Phys Med Rehabil. 1997;78(12 Suppl 5):S34–38.

7.2 FINDINGS USED IN THE EVIDENCE

- Baldwin DS. Depression and sexual dysfunction. Br Med Bull. 2001;57:81–99.
- Boekeloo B, Schamus LA, Simmens SJ, Cheng TL, O'Connor K, D'Angelo LJ. A STD/HIV prevention trial among adolescents in managed care. Pediatrics. 1999;103(1):107–15.
- Bowman MA, Russell NK, Boekeloo BO, Rafi IZ, Rabin DL. The effect of educational preparation on physician performance with a sexually transmitted disease-simulated patient. Arch Intern Med. 1992;152:1823–8.
- Carey MP, Senn TE, Vanable PA, Coury-Doniger P, Urban MA. Brief and intensive behavioral interventions to promote sexual risk reduction among STD clinic patients: results from a randomized controlled trial. AIDS Behav. 2010;14(3):504–17. doi:10.1007/s10461-009-9587-1.
- Cohen DA, Dent C, MacKinnon D, Hahn G. Condoms for men, not women. Results of brief promotion programs. Sex Transm Dis. 1992;19(5):245–51.
- Dodge W, BlueSpruce J, Grothaus L, Rebolledo V, McAfee TA, Carey JW, et al. Enhancing primary care HIV prevention: a comprehensive clinical intervention. Am J Prev Med. 2001;20(3):177–83.
- Feldblum PJ, Hatzell T, van Damme K, Nasution M, Rasamindrakotroka A, Grey TW. Results of a randomized trial of male condom promotion among Madagascar sex workers. Sex Transm Infect. 2005;81:166–72. doi:10.1136/sti.2004.010074.
- Jemmott L, Jemmott J, O'Leary A. Effects on sexual risk behavior and STI rate of brief HIV/STI prevention interventions for African American women in primary care settings. Am J Public Health. 2007;97:1034–40.
- Kamb M, Fishbein M, Douglas JM Jr, Rhodes F, Rogers J, Bolan G, et al. Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases: a randomized controlled trial. Project RESPECT Study Group. JAMA. 1998;280(13):1161–7.

- Marrazzo J, Thomas KI, Ringwood K. A behavioural intervention to reduce persistence of bacterial vaginosis among women who report sex with women: results of a randomized trial. Sex Transm Infect. 2011;87(5):399–405. doi:10.1136/sti.2011.049213.

- Neumann M, O'Donnell L, Doval A, Schillinger J, Blank S, Ortiz-Rios E, et al. Effectiveness of the VOICES/VOCES sexually transmitted disease/human immunodeficiency virus prevention intervention when administered by health department staff: does it work in the "real world"? Sex Transm Dis. 2011;38(2):133–9. doi:10.1097/OLQ.0b013e3181f0c051.

- Patterson TL, Mausbach B, Lozada R, Staines-Orozco H, Semple SJ, Fraga-Vallejo M, et al. Efficacy of a brief behavioral intervention to promote condom use among female sex workers in Tijuana and Ciudad Juarez, Mexico. Am J Public Health. 2008;98(11):2051–7. doi:10.2105/AJPH.2007.130096.

- Thrun M, Cook PF, Bradley-Springer LA, Gardner L, Marks G, Wright J, et al. Improved prevention counseling by HIV care providers in a multisite, clinic-based intervention: Positive STEPs. AIDS Educ Prev. 2009 Feb;21(1):55–66. doi:10.1521/aeap.2009.21.1.55.

- Warner L, Klausner JD, Rietmeijer CA, Malotte CK, O'Donnell L, Margolis AD, et al. Effect of a brief video intervention on incident infection among patients attending sexually transmitted disease clinics. PLoS Med. 2008;5(6):e135. doi:10.1371/journal.pmed.0050135.

ANNEXES

ANNEX 1
PARTICIPANTS IN THE GUIDELINE DEVELOPMENT PROCESS

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ANNEX 2
PICO QUESTIONS AND OUTCOMES FRAMEWORK

PICO refers to four elements that should be in a question governing a systematic search of the evidence: population, intervention, comparator and outcomes. The following three PICO questions were identified by the Guideline Development Group as the basis for the systematic review. Each question includes outcomes that were identified and scores rated for each.

PICO 1: Is brief sexuality-related counselling (BSC) as applied to adolescents and adults more effective than the usual standard of care in preventing/addressing:

1.1 sexual difficulties, sexual disease, sexual distress, sexual concerns and sexual misconceptions

1.2 STIs and HIV

1.3 unintended pregnancy and abortion

1.4 sexual violence

1.5 harmful practices

1.6 knowledge increase

OUTCOME	RATING (1–9)
HIV =/> 6–12 months follow-up	8.5
Sexual difficulties, disease, distress, concerns, misconceptions, stigma	8.4
Sexually transmitted infections (STIs) =/> 6–12 months follow-up	8.4
Unintended pregnancy/abortion =/> 6–12 months follow-up	8.3
Sexual violence =/> 6–12 months follow-up	7.8
Relationship difficulties, relationship abuse, relationship dissatisfaction	7.7
Knowledge =/> 6–12 months follow-up	6.9
Harmful practices (e.g. female genital mutilation)	5.9

PICO 2: Is BSC as applied to adolescents and adults more effective and encouraging of sexual well-being than no intervention?

OUTCOME	RATING (1–9)
Increased safety (condom use, contraceptive use, reduced number of sexual partners)	8.2
Use of preventative services (STI testing, HIV testing, contraceptive demand, vaccinations)	8.2
Increased satisfaction	8.1
Better self-regulation	7.7
Feeling understood or accepted	7.6
Increased connectedness (feeling of being accepted by those around i.e. family, school, peers)	7.6
Increased autonomy	7.6
Higher self-esteem	7.4

PICO 3: Which elements of (sensitization/training) programmes for primary health-care providers increase knowledge and skills on sexuality counselling/communication? (sensitive issues to consider include: abortion, gender-based violence, sexual dysfunction, sexual health, erectile dysfunction, pleasure, fantasies, sexual orientation, gender identity, same sex desire, sexual desire, female genital mutilation).

OUTCOME	RATING (1–9)
Knowledge	7.8
Objective-measured	7.5
Self-reported	7.4
Comfort in addressing sexuality-related issues, promotion of sexual pleasure	8.6
Attitude towards sexual health risk assessment	8.4
Improved patient interaction skills (asking about sexual risk-taking, providing confidentiality, addressing barriers/sensitive issues)	8.6
Objective-measured	8.4
Self-reported	7.5
Use of education techniques (use of written materials for the patient, referral to relevant online resources, ensuring patient understands issue, etc.)	7.6
Frequency of STI diagnosis (self-reported)	7.3

ANNEX 3
LINKS TO FULL REVIEWS AND EVIDENCE TABLES

POPULATION, INTERVENTION, COMPARATOR AND OUTCOMES (PICO) QUESTIONS	OUTCOME MEASURE(S)	STUDIES
PICO 1	STI/HIV	Marrazzo 2011 (95): n=89; Feldblum 2005 (47): n=1000; Patterson 2008 (114): n=924; Cohen 1991 (31): n=192; Cohen 1992 (32): n=903; Warner 2008 (147): n=38,635; Kamb 1998 (85): n=5,758; Metcalf 2005 (100): n=3,297; Orr 1996 (108): n=209; Neumann 2011 (107): n=3,365; James 1998 (80): n=492; Boekeloo 1999 (17): n=219 adolescents; Smith 1997 (130): n=205 adolescents
	Unintended pregnancies	Boekeloo 1999 (17): n=219 adolescents
	Sexual concerns	Boekeloo 1999 (17): n=219 adolescents; Wenger 1992 (149): n=435; Bryan 1996 (22): n=198 adolescents; Orr 1996 (108): n=209
PICO 2	Self-esteem	Bryan 1996 (22): n=198 adolescents
	Efficacy	Bryan 1996 (22): n=198 adolescents; Richardson 2004 (120): n=585; Patterson 2008 (114): n=924; Fisher 2006 (48): n=497, Jemmot 2007 (81): n=564, Kalichman 2011 (84): n=617; Kamb 1998 (85): n=5,758, Rosser 1990 (123): n=159; Langston 2010 (89): n=186; Marrazzo 2012 (95): n=89; Carey 2010 (24): n=1,483; Miller 2011 (102): n=906; Lee 2007 (90): n=166; Proude 2004 (116): n=156; Shlay 2003 (127): n=877; Neumann 2011 (107): n=3,365
PICO 3	Knowledge, attitudes, skills	Neff 1998 (106): n=423; Fronek 2005 (50): n=89; Bowman 1992 (20): n=232; Thrun 2009 (138): n=182; Dodge 2001 (41): n=1,042; Dreisbach 2011 (42): n=110; Walker 2002 (146): n=125; Bluespruce 2001 (15): n=49; Tepper 1997 (136): n=18
	Use of materials	Boekeloo 1999 (17): n=19; Bowman 1992 (20): n=232; Dodge 2001 (41): n=1,042.

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