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Promoting reproductive and sexual health

Report of a regional consultative meeting
Beirut, Lebanon, 8–11 December 2003

World Health Organization
Regional Office for the Eastern Mediterranean

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1. Introduction

A Regional Consultative Meeting on Promoting Reproductive and Sexual Health was held in Beirut, Lebanon, from 8 to 11 December 2003. The Meeting was co-sponsored by the WHO Eastern Mediterranean Regional Office in collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS), Inter Country Team for the Middle East and North Africa, Cairo, Egypt. Staff of UNAIDS Inter Country Team for the Middle East and North Africa, the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNWRA), Family Planning Associations in Lebanon and Syria, and International Federation Of Medical Students' Associations (IFMSA) participated. The objectives of the consultative meeting were to:

- Discuss the existing opportunities and challenges in addressing sexual health as a priority component of reproductive health, with specific focus on adolescents and young people, gender and HIV/AIDS related issues in the Region.
- Identify appropriate mechanisms to develop and operationalize the existing and new strategies for sexual health through multi-sectoral collaboration and translate them into action.
- Share information and experiences on existing national programmes, strategies and approaches designed to address sexual health issues in countries of the Region.
- Identify training, programmatic and resource needs to better address sexual health in specific settings.

The consultative meeting was attended by 44 experts from governmental ministries of health, social affairs and education, two United Nations agencies, two national family

planning associations and one international organization. WHO Temporary Advisers came from Bahrain, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, Saudi Arabia, Sudan, Switzerland, Syrian Arab Republic, Tunisia, United Arab Emirates and United Kingdom. In addition, two observers and five staff members from WHO Regional Office for the Eastern Mediterranean participated.

On behalf of His Excellency Mr Sleiman Franjieh, Minister of Public Health, the consultative meeting was inaugurated by Dr Mohammed Ali Kanaan, Chief, Social Health Department, Ministry of Public Health, Lebanon. Dr Kanaan welcomed the participants and expressed his gratitude to the Regional Office for hosting this important activity in Beirut. He raised priority issues that are believed to be required for promoting reproductive and sexual health in the Region. Among these pressing issues, physiological and sexual maturation, sexual dysfunction, gender perspectives of sexuality were highlighted. Dr Kanaan also emphasized the need for considering sexual disabilities, which were increasingly widespread, as a result of the increase in prevalence of noncommunicable diseases in countries of the Region. Therefore, a wider approach for addressing reproductive and sexual health issues is greatly needed instead of the currently maintained "pinhole" view.

Dr M.A. Latiri, WHO Representative, Lebanon, delivered a message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. In his message, Dr Gezairy noted that in view of the high magnitude of maternal and neonatal death in some countries and the limited resources available in the Region, specific focus had been placed on safe-motherhood related programmes, including antenatal, obstetric, postpartum and newborn health care and family planning, as priority components of reproductive health. However, the attainment of health for all in countries still faced challenges where information on major determinants of reproductive morbidity throughout the life span was still inadequate to enable development of a strategic, evidence-based approach to policy formulation. Sexual health was still one of those issues that people found sensitive and embarrassing, which might

prevent them from presenting to their health facilities, and had profound effects on the individual, the family and on community values. Health workers who had received adequate training and skills in human sexuality could help to prevent sexual disorders before they occurred and alleviate much unnecessary suffering among married couples who were in serious trouble today. Unfortunately, most medical schools still did not teach sexual health in order to enable health workers to acquire the required knowledge and skills to address sexual health needs in a scientific manner in the community. It was a reflection of the time-honoured traditional values and beliefs of the Region that the incidence of sexually transmitted diseases remained relatively low. In fact, puberty and sexuality related issues were considered mandatory knowledge, according to Islamic teachings. Indeed, there were numerous references in the Holy Quran and Hadith to human reproduction and conduct in regard to sexual and marital relationships. Sexual behaviour in the early years of Islam was not regarded as a subject of taboo and received due attention, being discussed seriously in relation to Islamic teachings and Muslim lifestyles. However, the gradual decline of the family influence, the proliferation of the nuclear family, rapid urbanization and the manifold increase in exposure to mass media and the internet were now important factors that contributed to major changes in social behaviour and lifestyles in the community, particularly among young people.

Sexual health, he noted, was influenced by a complex web of factors ranging from sexual behaviour and attitudes and societal factors, to biological risk and genetic predisposition. It encompassed the problems of HIV/AIDS and sexually transmitted infections, unintended pregnancy and abortion, infertility and cancer, and sexual dysfunction. Sexual health could also be influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. Addressing sexual health at the individual, family, community or health system level required integrated interventions by trained health providers and an efficient referral system. It also required a legal, policy and regulatory environment where the health rights of all people were upheld.

Dr Gezairy drew the attention of the participants to WHO's work on sexual health. He noted that in order to update the definition of sexual health, identify challenges and opportunities in addressing sexual health, and identify strategies that countries and regions could adopt for the promotion of sexual health in their specific contexts, WHO had convened, in January 2002, a global meeting on challenges in sexual and reproductive health. However, in view of the nature of this issue, there had been early consensus in that meeting that a regional adaptation would be needed to further develop the global outputs from a regional perspective. The social element of sexual health was very important in interpreting the dynamics of sexuality and its relevance to the cultural context. Hidden forms of irresponsible, unhealthy sexual behaviour could be prevented by showing the physical, mental and social consequences of these practices. Such unhealthy practices could be addressed by provision of culturally sensitive, appropriate sexuality education programmes, backed by support from political and religious leaders.

After the adoption of the agenda, the programme was modified to reflect the wish for a continuous working day. The agenda, programme and list of participants are attached as Annexes 1, 2 and 3, respectively. A draft paper on promoting reproductive and sexual health in the Eastern Mediterranean Region is attached as Annex 4.

2. Objectives and methodology

The objectives, mechanisms and expected outcomes of the workshop were presented by Dr Ghada Hafez, Adviser, Gender and Women Development. Dr Hafez drew attention to the overarching issues and challenges towards the development of strategic directions that needed to be set for promoting reproductive and sexual health in the Eastern Mediterranean Region, and to the specific area of sexual health, which was still among the most sensitive and embarrassing topics that people bring to their health facilities and have profound effects on the individual, family and community values.

In her instructions to the participants, Dr Hafez advised that a regional adaptation of sexual health related issues would be needed to further development the global outputs from a regional perspective. In order to serve the needs of the public health community in the Region, the major conclusions of the gathering would attempt to indicate culturally appropriate future directions to be taken by the Regional Office, in collaboration with Member States, the concerned UN agencies and international and nongovernmental organizations.

The consultative meeting was divided into technical presentations, country presentations and group work. Temporary advisers participating in the activity would be asked to suggest areas where the Regional Office's technical support would assist in identifying culturally sensitive, action-oriented approaches to promote reproductive and sexual health, bearing in mind the existing situation, opportunities and challenges that enable or overcome operationalizing them in countries of the Region. In addition, all groups would be asked to reflect their inputs in formal presentations and make applications of their recommendations appropriate for country and community interventions. The work of the groups was planned to be presented and discussed at the end

of the third day. The last day would be allocated for a plenary discussion that summarized the input of experts participating in the activity in order to reach a consensus on major conclusions and future directions that underlined in this consultation.

At the end of her presentation, Dr Hafez reminded the participants of the expected results of this activity, which were as follows.

- To have exchanged lessons learned on different approaches and methodologies for promoting and addressing sexual health in the Region

- Based on this new knowledge, to have identified the capacity building needs and required guidance to operationalize appropriate strategic guidelines to better address sexual health in the prevailing socio-cultural context

- To have identified opportunities for closer collaboration between UN agencies and potential partners working on sexual health

- To have built consensus on future steps to promote the agreed upon strategic directions in sexual health in the Region.

3. Technical presentations

3.1 Overview on reproductive and sexual health programmes in the Eastern Mediterranean Region

Dr Ramez Mahaini, Regional Adviser, Women's and Reproductive Health, WHO/EMRO

In view of the high magnitude of maternal and neonatal death in some countries and the limited resources available in the Region, specific focus has been addressed to safe-motherhood related programmes, including antenatal, obstetric, postpartum and newborn health and family planning. However, the attainment of health for all in countries of the Region still faces challenges where information on major determinants of reproductive morbidity throughout the lifespan remains inadequate to enable developing a strategic, evidence-based approach to policy formulation. Sexual health is one of these issues that is influenced by a complex web of factors ranging from sexual knowledge, attitudes, practices and societal factors, to biological risk and genetic predisposition. It encompasses the problems of physical, emotional and social disorders resulting from ignorance of biosexual development in puberty, sexual malpractices of adolescents and young people, long-standing illnesses and violence. These can also lead in its turn to numerous health hazards and illnesses such as emotional and psychosocial disorders; unintended pregnancy and abortion; sexual dysfunctions; infertility; sexually transmitted infections including HIV/AIDS and sometimes cancer.

Unfortunately, in local traditional communities, there is often delay in offering appropriate, sensible and culturally sensitive information to young people that help them understand the biosexual changes they undergo and, consequently, enable them to behave in a responsible manner as agents of change in their communities. In such situations, parents frequently claim

embarrassment or ignorance about the so-called "sensitive issues" and usually shift the responsibility to the school. Teachers often neglect to talk to their students about these topics, and chapters on human reproduction in school curricula are often classified as "self-learning lessons", or are delivered in a theoretical manner that does not link theory with reality. As a result, the remaining alternative sources of information are, unfortunately, left to peer groups, uncensored publications, video-tapes, internet websites and satellite channels and last, but not least, the street. In such situations, young people are not empowered with the necessary skills and knowledge to lead a safe and healthy life and are not prepared to take up their future roles in marriage, reproduction and family formation.

In advanced ages, sexual dysfunctions become more prevalent and may result from physical, mental or social factors. The prevalence of noncommunicable diseases, such as cardio-vascular disorders, diabetes and cancer, is rapidly increasing in countries of the Region. The negative effect of noncommunicable diseases on sexual health is well known as they can result directly or indirectly in the development of sexual dysfunction, anxiety, depression and violence. Consequently, the individual's close relationships may suffer and tension may build up in the family as a whole.

Fortunately, there are numerous references in the Holy Quran and *hadith* about human reproduction and roles of conduct in regard to safe and healthy sexual and marital relationships. In the early stages of Islam, sexual behaviour was not regarded as taboo and received due attention as it was seriously discussed in relation to Islamic teachings and lifestyles. However, rapid urbanization, changes in living patterns and outside work activities have strained supportive family mechanisms and contributed to gradual decline of the family influence. Consequently, members of the family become widely exposed to the market and materialistic values that contribute to major changes in social behaviour and lifestyles in the community, particularly among young people. In a few countries, situation analyses have shown the inadequacy of conventional health systems in meeting the sexual health

needs of the people. There is also insufficient awareness among health care providers of the psychological, biological and social aspects of the needed sexual health services. Research based on scientific approaches would generate reliable information, which in turn would help identify and prioritize areas of action.

Dr Mahaini gave examples of the work of WHO Regional Office for the Eastern Mediterranean in several facets of reproductive and sexual health. One of these examples was the Pan-Arab Project for Family Health, which is executed by the League of Arab States, in collaboration with the Regional Office along-with other concerned agencies, made significant progress in up-dating our database on reproductive and family health related issues. The project was initiated in the year 2000, and is planned to be implemented in 10 Member States. Some of these countries have already conducted this project, including: Djibouti, Syrian Arab Republic, Tunisia and Yemen. Meanwhile, Lebanon, Libyan Arab Jamahiriya and Morocco have signed project agreements and are expected to implement projects in 2003–2004. Somalia and Sudan have also lately shown interest in undertaking similar project surveys.

In response to the resolution (EM/RC43/R.11) on protection and promotion of adolescent health and development, and in order to bridge the information gap between adolescents and their parents and other concerned partners, a set of regional manuals on health education for adolescents were developed by the Regional Office in collaboration with IOMS and ISESCO. The materials were designed to address three priority target groups, including: parents, teachers, mass media and health workers; adolescent girls; and adolescent boys. The manuals elaborate major areas of concern in adolescent health and development, with specific focus on reproductive and sexual health using culturally acceptable approaches, which are supported by well-known experts in Islamic science. These manuals have already been used as reference materials for developing health education for adolescents by Member States, as well as, some interested partners including the Arab Regional Office for the World Organization for the Scout

Movement. The manuals are currently being translated into English in order to allow for their wider use within and outside the Region.

Addressing sexual health at the individual, family and community levels, as well as in national health care systems, requires integrated interventions by trained health providers and a functioning referral system. It also requires a supportive legal, policy and regulatory environment.

Addressing sexual health also requires understanding and appreciation of sexuality, gender roles and scientific, evidence-based approaches in designing and providing the needed services. Understanding sexuality and its impact on individual and family practices, standards and human reproduction presents a number of challenges as well as opportunities for improving sexual and reproductive health care services and interventions.

Mr Oussama Tawil, Team Leader, Intercountry Team for the Middle East and North Africa

The situation of HIV/AIDS prevalence in the Region varies from country to country. Although the Eastern Mediterranean is generally considered a low prevalence region, with a rate of around 0.3%, the trend of contracting new infection is increasing in the Region. The predominant route of transmission is through heterosexual relations, with a resultant rise of incidence in young people and women. This rising trend is the consequence of unprecedented behaviour changes evident in the younger population resorting to unhealthy sexual behaviours, including pre-marital sex. The situation is further complicated by certain situations in the Region such as mass migrations, conflict and wars, gender inequalities, and low socioeconomic and education status. The evolving pattern of drug abuse, limited access to HIV and STD related information and means of prevention and the tension between protective local and global culture are all adding to this dilemma.

There are various gaps in the existing response to preventing

HIV/AIDS in the countries of the Region. Notable among these are lack of information and education on HIV/AIDS and STD for young people, health services are yet to adapt to face the new emerging challenges, limited coverage and follow-up of HIV/AIDS prevention by national programmes, nongovernmental organizations, and in school and the workplace and absence of a systematic approach to HIV/AIDS and STD prevention, care and support in emergency and post-conflict settings.

Key strategies that can have and effective outcome for HIV/AIDS prevention includes targeting young people, high risk and vulnerable groups, putting in place blood safety and infection control measures, offering voluntary counselling and testing, management of STD and increasing access to care and psychosocial support for people living with HIV/AIDS. The core package of HIV/AIDS prevention should include participation of young people in needs assessment and programme development, involvement of parents, schoolteachers and community leaders, adapting messages to specific situations and sub-groups, advocating for abstinence and delaying age of first sexual intercourse and employing methods for imparting sex education in schools.

Certain opportunities exist in responding to this growing menace in the Region. These include mobilization of decision-makers in countries and an endorsement of the Millennium Development Goals (MDGs), recognition of risk factors across countries, access to anti-retroviral drugs, although access and prices are still considerably limited and involvement of other sectors, civil society mobilization, media and people living with HIV/AIDS. However, certain challenges still remain and warrant generating greater dialogue with religious leaders, decision-makers and the media on sexual health, including reducing taboo and stigmatization. There is also a need to evaluate the effectiveness of the existing HIV/AIDS prevention programmes in addressing sexual health, and further integration of HIV/AIDS prevention strategies and messages within reproductive and sexual health programmes in the Region. To address these challenges it is suggested that efforts are made to link HIV with reproductive and sexual

health in planning with national AIDS programmes, civil society and HIV/AIDS focal points in other sectors (i.e. education, youth and sport, labour) and in bridging between HIV and reproductive and sexual health interventions for young people, gender and vulnerable group, reviewing and analysing lessons learned about sexual health within AIDS programmes and building an inter-agency working group on young people and HIV/AIDS.

3.2 Sex education in promoting reproductive and sexual health

Dr M. H. Khayat, Senior Policy Adviser, WHO/EMRO

The workshop participants were particularly attentive to a 70-minute television interview with Dr M.H. Khayat, Senior Policy Adviser, WHO/EMRO, which was recorded on video by Al-Jazeera station. The interview focused on priority issues in sex education for adolescents and young people, and underlined appropriate methodologies for raising the awareness of the parents and their children about these issues in line with the religious values and sociocultural norms prevailing in countries of the Region.

In the interview, Dr Khayat stated that the concepts of sex education and sexual health are not new, but have become priority issues in recent years due to the increasing exposure of young people to the media and the Internet. Sex education is in fact focused on means and norms through which we can convey necessary information about bio-sexual maturation and sexuality to the public in a culturally-sensitive manner that respects the age, gender and social environment of the audience population. For example, the child does not regard his or her sex organs with any specific sensitivity, in comparison to other organs. Nonetheless, the older people, including the parents, usually interpret the growing interest of children while they grow up with their sex organs and sexual issues with specific concern, a matter that could be wrongly perceived by children as they do not find a clear justification for such concern. When the parents have adequate knowledge on these issues, they can deal with such situations in scientific

and appropriate ways. Dr Khayat elaborated on means and ways for answering common questions usually asked by children during their stages of life. When a child asks, for instance, why the breast of his mother is different from that of his father, the answer could simply be because the mother needs to breast-feed her infants, but not the father. For more complicated issues, such as those related to pregnancy and childbirth, it might be advisable to provide necessary information to the child by giving examples that refer to certain parts of plants, such as flowers and seeds, to answer questions. In this case, flowers are used to refer to sex organs, and seeds to newborn children. In older ages, Islamic teachings indicate that children must be taught how to purify their bodies in preparation for the prayer, and must be given the information required to know why they purify themselves, and in what cases and when they must do this. Several sexual related issues are also mentioned in the Quran, and should be clarified to children in an appropriate manner. It is recommended to use the plant kingdom to explain such issues for children. Meanwhile, the animal, and then, the human body can be referred to in case of the older children and adolescents. It is also preferable that the mother provides sex education for her daughters, while the father talks about these issues with his sons.

Dr Khayat pointed out that sex education, which aims at enabling children and adolescents to avoid sexual hazards and sexual practices outside the marriage institution, and prepare them to behave in a responsible manner to protect their bodies and health, is a religious duty and must be provided to children. Dr Khayat also emphasized the role of the media, particularly the satellite television channels that are very popular among young people, in dealing with sex education and sexual health issues in a scientific and responsible manner that respects religious teachings.

After the video presentation, the door was opened for discussing issues raised in the video interview presentation, and copies of the videotape were distributed to the audience.

3.3 Promoting reproductive and sexual health in the Eastern Mediterranean Region

Dr Faysal Al-Kak, Lecturer, American University of Beirut

Sexual health is considered to be an essential part of reproductive health. It has come to encompass aspects of enjoyment, pleasure, enrichment, freedom from shame and guilt, enhancing love and communication and raise individual and social responsibility. Sexual health with its evolving understanding represents a public health challenge due to several aspects. These aspects include the HIV/AIDS pandemic, biological and social impact of STDs and ethical challenges, in addition to aspects of assisted reproductive technology, sexual dysfunction and sexual violence.

Sexuality and sexual health may be very difficult to discuss in certain areas of the world, including the Region, and there are widely ranging views and beliefs around it, but it is compelling an essentially cultural understanding of sexual health be promoted.

Sexual health promotion demands special considerations namely the sociocultural norms and religious values prevailing in countries of the Region. Traditions, family values and the political and religious institutions are also important determinants that should be considered while addressing reproductive and sexual health related issues. Therefore, strategies for promoting reproductive and sexual health must give special attention to factors related to laws and policies, national capacity building for providing the required services in scientifically appropriate and culturally sensitive packages, support from religious leaders, integration into school and university curricula, research and information provision, with special focus on young people and vulnerable populations.

3.4 Socio-cultural dimensions of reproductive and sexual health in countries of the Region: opportunities and challenges

Dr Ahmed Ragab, Associate Professor, Al-Azhar University

The concept of reproductive health and reproductive choice and rights has been evolved over years. Reproductive health strategies are built around a core belief that women as full, thinking, feeling personalities, shaped by the particular social, economic, and cultural conditions in which each of them lives, are central to their own reproduction. Consequently, health policies and programmes cannot treat reproduction as mere mechanics, as isolated biological events of conception and birth; rather they must treat it as a lifelong process inextricably linked to the status and roles of women in their homes and societies.

The concepts of 'autonomy'' and 'choice' which are pivotal in international population debates, are influenced by social and cultural factors that vary widely, even within a region or country. An increasing body of social and anthropological studies shows that Islam is interpreted differently in different countries and by different social groups. Religion is not the only factor that determines social outcomes, although it is very important. Traditions, customs and geographical differences are other factors. Moreover, the Islamic texts are flexible and could be adapted for all places and all times. Furthermore, some of the current theologians tend to quote from the classics, even in old medical opinions whose error has been brought to light and which have since been superseded by various other more scientifically grounded ideas. These factors could explain some of the gaps between Islamic ideology, as expressed by the Quran and *hadith*, and the practices, which are based on customs and traditions and were misinterpreted as Islamic.

From the Islamic point of view, two different positions on reproductive choice may be taken: the more traditional one gives women little freedom to make decisions that bear on reproduction; the second argues that constraints on reproductive choice that exist in some Muslim countries are

not inherently Islamic, and that the egalitarian elements in the sacred texts should be the guide to a reinterpretation of the doctrine that would be fully compatible with ideas of human rights and reproductive choice.

Contraception rights in Islam have been discussed in detail in many publications (see the work of Omran, 1992). The majority of those authors indicate that Islam gives the women absolute right for contraception. However, there is a diversity of opinion regarding the permanent methods of contraception (surgical sterilization). Regarding abortion, there is consensus among the theologians that abortion after 120 days is not allowed except to save a mother's life. However, there is no unified position among Muslim scholars on abortion before 120 days. All the schools agree that Islam gives women a right to abortion when their lives are in danger because of high-risk pregnancy. Some schools also agree on the right for early abortion in certain health, social, mental and economic situations. There is a clear indication of the need to revise and unify the Islamic laws regarding abortion in the context of the recent advances in medicine and technology.

Regarding sexuality, Islam gives women the right to sexual health by discouraging all that was believed to be harmful, such as anal intercourse and sex during menstruation. Islam also gives women the right to proper sex education and provides women the right to sexual enjoyment. However, all these rights should not be practised outside marriage. Accordingly, from Islamic perspectives, reproductive health implies the ability of women and men to live from birth to death with reproductive choice, and with dignity, and to be reasonably free of reproductive health diseases and risks. In addition, it refers to the ability of a married couple to enjoy marital sex without fear of infection, unwanted pregnancy, or coercion; to regulate fertility without risk of unpleasant or dangerous side effects; to go safely through pregnancy and childbirth; and to bear and to raise healthy children.

3.5 Reproductive and sexual health in formal and non-formal settings

Dr Abdel Halim Joukhader, Regional Adviser, Health Education, WHO/EMRO

Sexual and reproductive health education is central to the healthy development and well being of children and young people. Parents are often silent and school curricula are ambivalent on this issue. Islam considers sexual education obligatory knowledge that parents must teach their children so as to acquire moral responsibility. Adolescents and young people are being exposed to the intensive influences of media programmes with sexual overtones through the mass media, satellite television, internet and the sex industry. Despite the efforts of many countries to incorporate reproductive health education into the school curriculum and extracurricular programmes, there is heavy emphasis on content of knowledge at the expense of developing health life-based skills. To be effective, sexual and reproductive health education should be reflected in national health policy within a health promotion framework. School health provides a good entry point in conjunction with curricular and extracurricular activities. Critical success factors in school-based approaches are intensive evidence-based advocacy; striking a balance of knowledge, attitudes and health-based life skills; utilizing a variety of interactive teaching methods; starting the programme prior to the onset of risk behaviour and availing enough time to acquire and develop the required skills; coordinating with other programmes and linking to consistent strategies; providing adequate training and professional development of all concerned staff; ensuring relevance to reality and developmental stages of young people; and, above all, participation and active involvement of students, parents, teachers and health providers. Out-of-school activities should address young people and children wherever they are, as well as parents and community workers. Vulnerable groups must not be overlooked. Modern information and communication technology should be used to reach target groups, both young and old, including the creation of websites and hotlines. Adequate training should be provided to all people involved in these activities. Community resources and private sector participation should be tapped to ensure sustainability.

4. Country presentations

4.1 Egypt

Egypt is faced with a population explosion with a high population growth rate and high rates of urban migration. This mal-distribution of population has resulted in economic constraints and is influencing the stability and progress of Egyptian society and affecting the quality of life of the people. Key strategies to address this issue cover a variety of aspects of the human life including reproductive health and family planning, child health, increasing the literacy rate, care for adolescents and youth, women's empowerment, population redistribution, protection of environment and supporting research activities. The adolescent and youth care strategy addresses the major challenges including shift of the population composition towards younger age group, high rate of early marriages, unplanned pregnancies and sexual abuse of young people. The goal is empowering young people to make informed decisions and choices regarding their sexual and reproductive well-being. This is planned to be achieved through increasing the access of young people to information and quality reproductive health care services and reducing gender-related barriers affecting the sexual and reproductive health and rights of young women. A cornerstone of these strategies is building partnerships and alliances with parents, teachers, religious leaders, nongovernmental organizations and other institutions.

4.2 Islamic Republic of Iran

The Islamic Republic of Iran is one of the most populous countries of the Region; its current population stands at 65 million. Health care in Iran is delivered through levels of care including the primary health care (PHC) network, which was

established in 1985. Through its extensive PHC network the country has been able to put in place effective reproductive health interventions including formation of fertility committees, integration of family planning services within PHC, creating awareness in the general public through the mass media, conducting research in the area of reproductive health and building community partnerships. Due to these efforts the country has been able to achieve a contraceptive prevalence rate (CPR) of 60% and an annual birth rate of 1.2. Other measures include initiatives for gender equality and women's empowerment aimed at protecting the rights of girls and women and addressing gender-based violence. However, new issues are emerging that require more focused attention. Among these are cultural barriers to family planning measures in some parts of the country, population ageing and the need for adolescent reproductive health education and for male participation in reproductive health issues faced at the community level. The government has been very keen to take steps towards addressing these issues through puberty health assessments in schools, offering voluntary counselling and testing for HIV/AIDS prevention, provision of free condoms, conducting information, education and communication (IEC) interventions for youth and children in the schools, integration of reproductive health issues and population concepts in the school curricula and strengthening the capacity of service providers.

4.3 Lebanon

Lebanon is currently implementing a reproductive and sexual health current country project for the period 2002–2006. The project covers a wide variety of programmes focusing on IEC, school curricula, peer education and making inputs in other regional projects endeavouring to make reproductive and sexual health as an integral component of these projects. Through the project interventions certain milestone activities have been achieved. The most significant among these are development of reproductive health care guidelines and protocols, development of communication and social

mobilization material and awareness activities in the schools and at community level. Though the project is faced with some impediments in implementing peer education, devising a national reproductive health strategy and incorporating reproductive and sexual health in the school curricula, operational research is being planned to address these issues in the future.

4.4 Sudan

Sudan is the largest country in Africa, with a population of around 33 million and an annual growth rate of 2.6. The life expectancy (52.5 for males, 55.5 for females) at birth is still low as compared to other countries of the Region. The total fertility rate (TFR) is still very high (5.9 births per woman) and the maternal mortality and infant mortality rates stand at 509 deaths per 100 000 live births and 67 deaths per 1000 live births, respectively. Although 86% of deliveries are conducted at home, Sudan has an established midwifery network where both community and nurse midwives are available for conducting deliveries. Political support is now available for safe motherhood through a declaration endorsed by all state health ministers in 2001 in which they pledged to provide a skilled birth attendant to every village equipped with midwifery kits. Reproductive health has been identified as a priority area in Sudan and the core package comprises safe motherhood, referrals of complicated pregnancies, abortions and other serious cases, management of STDs, prevention of HIV/AIDS, family planning and infertility management, and mass awareness raising through IEC and the media about harmful practices such as female genital mutilation (FGM). HIV/AIDS has high prevalence in Sudan. The government has developed a comprehensive plan of action for prevention of HIV/AIDS encompassing measures like blood safety, protected sex, research, programme management and mass awareness. Through its commitment to attain the MDGs, Sudan has been implementing the Making Pregnancy Safer Initiative which aims at promoting and protecting maternal and neonatal health through improvement of accessibility,

availability, affordability and acceptability of the quality of essential package of maternal and perinatal care. The package offered through this initiative not only includes emergency obstetric care and emergency management obstetric care, but also has a strong communication, advocacy and social mobilization component. Particular emphasis is put on raising awareness about female genital mutilation, for which the government endorsed a plan of action for elimination in 2001.

4.5 Tunisia

A steady and sustained improvement has been noticed in the reproductive health care delivery services in Tunisia. This has been achieved through a three-pronged approach: increasing the literacy rate, especially among women; making available a legal framework for reproductive health measures and political support; and effective mobilization of civil society. The legal framework includes measures attracting the general public that promote good reproductive health practices. Notable among these include family allowance and reduced tax for families having fewer children, establishment of presidential awards, legalization of abortion and issuance of permits for selling contraceptives. An institutional framework exists which has many tiers, called councils, facilitating the implementation of reproductive health programmes and interventions. Support from religious leaders and civil society is provided through this framework. An extensive network of static and mobile services is available offering family planning and reproductive health care services to the general public. Mass awareness is carried out through trained staff and media. Regular sessions are held for both men and women at the community level. These measures have helped the country to achieve a decrease in the crude birth rate from 50 in 1956 to 61.7 in 2000 and growth rate from 3 in 1966 to 1.1 in 2000. The current CPR stands at 65%. The achievement is partly attributable to the steady increase in the percentage of GNP spent on health services, particularly reproductive health services.

5. Group work

The group work was divided into three separate sessions, which would culminate in highlighting strategies for promoting reproductive and sexual health in the Region. The three distinct tasks included:

- Discussing the use of the background paper as a normative resource for promoting sexual health in the Region.

- Identifying the required strategies for promoting reproductive and sexual health at the country level, with special attention to mechanisms suitable for delivery in the appropriate key settings: public health and education sectors, the media and nongovernmental organizations.

- Determining the opportunities and challenges in the religious values and socio-cultural and traditional norms prevailing in the Eastern Mediterranean Region.

The groups used certain tools to accomplish these tasks, including strengths, weaknesses, opportunities and threats (SWOT) analysis, problem tree and fish bone diagram. The groups identified various critical issues to be considered in devising strategies for reproductive and sexual health interventions. Focus was made on creating opportunities for building capacities among the concerned service providers, as well as among political, religious and community leaders. Integration of sexual health in the relevant existing programmes was considered to be a key strategy that countries and concerned organizations should employ. Effective legislation and policy directions were considered important to abrogate harmful practices like female genital mutilation. Strengthening institutional capacities focusing on health, information, media and research, both in the governmental and nongovernmental sectors and strengthening capabilities of community leaders, focusing on

religious partners, parents, teachers and health care providers were also considered to be important strategic directions. This would warrant developing and designing a relevant sexual health package to be delivered in priority sectors with particular focus on health, education, religion and media. Promoting networking with identified stakeholders and target groups at all stages of assessment, planning, implementation, monitoring and evaluation at national, regional, and international level is required to give a much-needed boost to the sexual health programmes.

It was reiterated that sexual health, as a component of reproductive health, should be incorporated within a larger health policy framework such as national multisectoral framework for health promotion, which accommodates life cycle and supportive approaches. It was envisaged that sexual health should be considered a fundamental right and an integral component of reproductive health.

School health was considered as an appropriate entry point for sexual and reproductive health interventions. In view of the increasing role of media and its impact on everyday life, special attention should be given to developing the skill of deconstructing commercial media messages and understanding the underlying ideologies used to promote unhealthy products and harmful practices such as smoking, alcoholism, violence, sexual permissiveness, etc. Religion was considered to be another available opportunity for promoting reproductive and sexual health in the community.

The Regional Office and its Member States were requested to work for building capacities at the country level and endeavour to integrate sexual health in relevant existing programmes by strengthening multisectoral partnerships. Therefore, establishing a regional technical task force of experts for guidance in sexual health strategic issues was considered to be a priority.

6. Conclusions

- Sexual health is an integral component of reproductive health and should receive due attention in view of its central role in the well-being and development of individuals throughout the life cycle, especially in adolescence.

- Sexuality, sexual health and sex education need to be considered as high priority areas on the human development agenda of countries of the Region. In most countries of the Region, sexual health is still regarded as a sensitive issue, and is not adequately addressed by parents, teachers and health professionals. Further efforts are needed to provide responsive, user-friendly services.

- Some countries of the Region have already implemented peer education activities and have provided counselling and hotline services. These activities have proven to be popular and effective among youth.

- Sexual health as a component of reproductive health should be incorporated within a larger health policy framework such as national multisectoral framework for health promotion, which accommodates life cycle and supportive settings approaches. School health is considered an appropriate entry point for reproductive and sexual health.

- Promotion of reproductive and sexual health contributes to the elimination of traditional practices that adversely affect the health and well being of women and children such as gender based-violence and female genital mutilation.

- Concerted efforts of national, regional and international parties are needed to promote sexual health.

- Investing in relevant existing programmes utilizes opportunities available in existing relevant programmes

involving governments, civil society and the private sector such as national AIDS programmes, reproductive and adolescent health and school health.

- Children, adolescents and adults lack adequate knowledge and skills regarding their sexual health. Adolescents in particular lack information and skills to cope with their sexual maturation when most needed; parents are virtually silent and school curricula are ambivalent on this issue.

- Prevailing silence about sexuality, sexual health and sex education in countries of the Region is to a great extent due to social factors and misconceptions rather than to authentic religious teachings.

- Religion provides a good basis for the promotion of sexual health. Religious scholars can play an effective role in supporting efforts directed to promote sexual health.

- Responsibility for sex education lies with parents, teachers, health professionals and religious scholars; however, their roles should be strengthened. Islam considers sexual education, as personally obligatory knowledge that parents must impart to their children before the onset of puberty so as to acquire moral responsibility.

- Despite numerous efforts undertaken in the area of reproductive health research, there is a need to further strengthen national capacity to plan and implement behavioural and operational research in sexual health.

- In many countries of the Region, target groups, especially adolescents, need to be further involved in the planning, implementation and evaluation of programmes related to their health. The existing reproductive health services are still insensitive to the needs of young people.

- Modern information and communication technologies and mass media play an increasing role in the life of people, particularly adolescents, and represent a major source of information.

7. Recommendations

Member States

1. Develop national policies and strategies to promote sexual health through its integration within existing relevant programmes such as: reproductive and adolescent health, prevention and control of HIV/AIDS, school health, mental health, healthy lifestyles and nutrition, drawing upon successful experiences, best practices and lessons learned.

2. Address sexual health issues in existing reproductive and sexual health related programmes and activities and ensure a multi-disciplinary approach. Appropriate structures should be established to strengthen and consolidate multisectoral coordination mechanisms so as to ensure wider coverage of sexual health services and rational utilization of available resources.

3. Build and strengthen partnership with civil society, especially nongovernmental organizations and the private sector, in order to consolidate efforts in promoting sexual health and securing programme sustainability through resource mobilization and community alliances.

4. Ensure that reproductive and sexual health programmes contribute effectively to the elimination of traditional practices that adversely affect the health and well being of women and children and avail adequate quality services for the management of affected people.

5. Intensify evidence-based advocacy targeting legislators, decision-makers and community leaders in order to mobilize support for programme implementation and strengthen community participation.

6. Develop necessary interventions to underscore the role and duties of parents and family members in promoting sexual health and empower them to improve child–parent

communication.

7. Take active measures to ensure that sexual health education, information and life skills are effectively integrated and operationalized within school curricula and classroom activities, as well as extracurricular and out-of-school programmes and activities in different settings.

8. Integrate sexual health into pre-service education of different categories of health professionals and other relevant service providers and workers involved in reproductive and sexual health, and strengthen continuing education for all staff.

9. Involve the target groups, especially young people, in all stages of programme development, monitoring and evaluation to ensure relevance, responsiveness and ownership of programme activities.

10. Modern information and communication technologies and mass media should be used more effectively to reach target groups, wherever they are, including the creation of websites and hotlines. Attention should be given to developing skills in deconstructing commercial media messages and understanding the underlying ideologies used to promote unhealthy products and harmful practices such as smoking, alcoholism, violence and sexual permissiveness.

11. Conduct research to assess sexual health of different target groups so as to better respond to their real needs.

WHO/EMRO and other concerned organizations

12. Further encourage national efforts to formulate and implement national policies and related strategies through provision of the required technical support and mobilization of resources.

13. Establish a task force with selected experts from the Region to review, recommend, guide and backstop reproductive and sexual health programmes as necessary.

14. Facilitate further exchange of experiences, information, research findings and success stories in reproductive and sexual health

among countries of the Region.

Annex 1

AGENDA

1. Inaugural session
2. Welcome and opening remarks
3. Introduction of participants, election of Chair and Rapporteur
4. Adoption of the Agenda
5. Objectives, mechanics and expected outcomes of the meeting
6. Overview on reproductive and sexual health programmes in the Region
7. Video presentation: sex education for promoting reproductive and sexual health
8. Background paper on promoting reproductive and sexual health in the Region
9. Socio-cultural dimensions of reproductive and sexual health in countries of the Region: opportunities and challenges
10. Reproductive and sexual health education in formal and non-formal settings
11. Country presentations of existing national programmes, strategies and approaches designed to address sexual health issues: Egypt, Islamic Republic of Iran, Lebanon, Sudan and Tunisia
12. Working sessions in three groups to:
    - Discuss the use of the background paper as normative source for promoting sexual health in the Region
    - Identify the required strategies for promoting reproductive and sexual health at the country level, with special attention to the mechanisms suitable for delivery in the appropriate key settings: the health and education governmental sectors, the media and non-governmental organizations
    - Determine opportunities and challenges in the religious values and socio-cultural and traditional norms in the Region
13. Group presentations and plenary discussion
14. Major conclusions and future directions
15. Closing session

Annex 2

Programme

Monday, 8 December 2003

8:30– 9:00	Registration
9:00–10:30	Inaugural session
10:30–11:00	Introduction of participants Election of Chair and Rapporteur Adoption of the agenda
11:00–11:30	Objectives, mechanisms and expected outcomes of the meeting/Dr Ghada Hafez
11:30–13:30	Overview on reproductive and sexual health programmes in the Eastern Mediterranean Region/Dr Ramez Mahaini, Mr Oussama Tawil
13:30–15:20	Video presentation: sex education for promoting reproductive and sexual health/Dr M. Haytham Al-Khayat
15:20–16:00	Plenary discussion
16:00–16:40	Background paper on promoting reproductive and sexual health in the Region/Dr Faysal Al-Kak
16:40–17:00	Socio-cultural dimensions of reproductive and sexual health in countries of the Region: opportunities and challenges/Dr Ahmed Raghab
17:00–17:30	Plenary discussion

Tuesday, 9 December 2003

9:00–9:40	Reproductive and sexual health education in formal and non-formal settings/Dr Abdul Halim Joukhadar
9:40–11:00	Country presentations of existing national programmes, strategies and approaches designed to address sexual health issues: Egypt Islamic Republic of Iran Lebanon Sudan Tunisia
11:00–11:45	Plenary discussion
11:45–12:00	Briefing for group work sessions

12:00–17:00	Work sessions in three groups to:
	A: Discuss the use of the background paper as normative source for promoting sexual health in the Region
	B: Identify the required strategies for promoting reproductive and sexual health at the country level, with special attention to the mechanisms suitable for delivery in the appropriate key settings: the health and education governmental sectors, the media and non-governmental organizations
	C: Determine opportunities and challenges in the religious values and socio-cultural and traditional standards and norms prevailing in the Eastern Mediterranean Region

Wednesday, 10 December 2003

9:00–15:30*	Group work (continued)
15:30–17:30	Group presentations and plenary discussion

Thursday, 11 December 2003

9:00–11:00	Plenary discussion
11:00–12:00	Plenary session: major conclusions and future directions
12:00–12:30	Closing session

Annex 3

List of participants

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Annex 4

Draft background paper on reproductive and sexual health in the Eastern Mediterranean Region

1. OVERVIEW OF PUBLIC HEALTH CHALLENGES

1.1 Reproductive and sexual health as public health challenge

Countries of the Eastern Mediterranean Region belong to the category of states undergoing rapid epidemiological transition. This transition poses clear and present challenges that are directly related to public health field, lifestyle matters, youth and women's health concerns, and health sector reform demands. The health indicators identified in the Arab Human Development Report as a reflection of the public health challenges revealed that life expectancy at birth ranges from 45 years in countries like Somalia and Djibouti to 75 years in United Arab Emirates, with women having an average of 2.5–3.5 years more than men. The burden of ill health and disability takes more than 9 years from the expected age in around one-third of the Arab countries. This affects women more than men due to several health problems including reproductive morbidity, subjecting women to spend more years in disability [1].

The incidence of noncommunicable diseases shows a remarkable rise, with circulatory diseases and cancers being major causes of adult deaths. At the same time, infectious conditions, like diarrhoea and acute respiratory infection are still major causes of morbidity and mortality among the poor and underprivileged communities in places like Yemen, Morocco, and rural areas in Egypt [2]. Regarding reproductive health (RH), several health problems continue to pose danger to women's well being in countries. Some of the most serious RH conditions are high maternal and perinatal mortality, high fertility, and increasing incidence of sexually transmitted infections (STIs) and HIV/AIDS. The UNICEF/UNFPA/ WHO revised maternal mortality estimates showed that a total of 161 000 maternal deaths took place in countries of the Region in 1995, representing 31 per cent of the global burden

[3]. Total fertility rates (TFR) are still high irrespective of the economic conditions of these countries, and the rates of STIs and HIV/AIDS though low are showing a remarkable interval increase. Other RH elements like menopause, adolescence, reproductive tract infections, reproductive tract cancers, harmful practices, and congenital genetic disorders are emerging now as priority issues in the Region. [4]

On the other hand, countries of the Region have large gender gaps in the fields of education and social participation. Despite the considerable variation of these countries in terms of their economic and social status, they often share similar cultural constraints that hamper adequate approach of reproductive health issues. Despite remarkable improvements in social sectors, various health problems continue to threaten women's health in this area [2].

A promising attempt trying to address reproductive health of women within a medical and psychosocial frame came from the International Conference on Population Development (ICPD) held in Cairo in 1994. The ICPD recommendations and Programme of Action broadened the classical approach of Mother and Child Health and Family Planning to a RH one including Sexual Health (SH). Being carried further in the following international meetings (Beijing, ICPD+5, and others), this widened approach addressed several levels (strategy, policy, services, IEC and advocacy) within primary health care and public health settings. In this regard, the WHO committed itself to several objectives including country assistance to develop strategies to integrate RH services in the national health care system, strengthen existing services and further develop accessible, equitable, and quality services. In addition, WHO works to initiate cost-effective interventions, promote healthy reproductive practices, and advocate for rights-based approach to RH.

1.2 Critical issues in understanding reproductive and sexual health

Since the launching of ICPD recommendations and programme of action, the reproductive health approach is being implemented in various countries of the world

including countries of the Region. Though this approach is potentially successful, it is of paramount importance that it has to be sensitive to specific situations where women find themselves in these countries [5]. This implies a need for cautious supervision from developing countries to allow RH concept to be of use to women in different contexts, especially when addressing female sexuality. As RH approach remains one of the main entry points to introducing and pushing further the sexuality issue in this Region, it is compelling for this approach to take into consideration several aspects that contribute to understanding and promoting sexuality. These aspects include men's role in understanding reproductive and sexual health of women and the power imbalance between men and women [6], which could reflect the extent of sexuality expression and experiences. The second aspect is related to better knowledge of women's experiences and perceptions of their RH and reproductive morbidity in relation to sexuality and SH within the cultural context, and the third is related to high fertility being desired by many families and communities as a source of power. High fertility though considered by western perspectives and literature as a population problem, in the cultures of the Region it is an expression of sexuality to the extent where people boast about it. All these considerations should be addressed within a culture-specific perspective when attempting to address sexuality and other related concepts. This urges us to realize that some key concepts that are used may be differently interpreted in different cultures. The concept of consensual sex is also emerging from the RH approach with healthy sexuality [7], and as being part of the sexual rights. This poses a "problematic" when it comes to the question of whether every sexual act should be consented to, and how this can be applied to marriages in relation to husband/wife choice where consent is not ensured in many cases [5]. Other similar issues include premarital sex, gender identities and orientation, and not having children. It is argued that in order to prepare the grounds to deal smoothly with sexuality issue, it is advised to begin addressing issues related to sexual violence and sexual abuse of children that are common in some cultures [7].

1.3 Reproductive health status

The Eastern Mediterranean Region includes high-income, medium-income and low-income countries. This variation extends to include health and social indicators including RH ones. Despite marked improvement in population and some health indicators in this Region [1,2], many serious problems are still pondering mainly high maternal mortality, high fertility, reproductive morbidity and the burden of sexually transmitted infections (STIs) including HIV/AIDS. According to data reported by countries in 2001, the average maternal mortality ratio (MMR) in the Region was estimated as high as 367:100 000 live births [3]. However, wide disparities in maternal and neonatal mortality exist between countries of the Region. For example, countries like Kuwait, Qatar and United Arab Emirates have drastically dropped their MMR to Northern European ranges. Other countries like Egypt, Morocco and the Syrian Arab Republic have made considerable achievements, but unfortunately countries such as Afghanistan, Djibouti, Sudan and Yemen and have among the highest MMR in the world [3]. The most prominent causes of maternal mortality are postpartum bleeding, puerperal infection, and pre-eclampsia, bleeding being responsible for one fourth of deaths. Maternal morbidity on the other hand, complicates the life of around 10 million women a year in Arab countries, adding to the burden of disease of those women and negatively affecting their experiences of sexuality. Another issue closely related to maternal mortality is unsafe abortion. Though legally restricted in most countries of the Region, and often a very sensitive issue to discuss, approximately 8% of maternal deaths in the Region are due to unsafe abortion. However, available data do not discriminate between induced and spontaneous abortion, thus affecting accuracy of estimates [2]. It is noteworthy that an estimate of voluntary interruption of pregnancy in cases of unwanted pregnancy can be indicative of the dynamics of sexuality within the socio-cultural context of the Region.

In the face of such worrisome indicators, the WHO Regional Office for the Eastern Mediterranean (WHO/EMRO) had initially adopted the Safe Motherhood Initiative as a priority

and later the Making Pregnancy Safer strategy, supported by multiple activities in various countries that led to the improvement of maternal health indicators. Several projects on data use, total quality management and research have been carried out and other operational projects have been executed jointly between WHO and UNFPA, UNICEF, League of Arab States, IPPF and other concerned international agencies.

Regarding total fertility rates, though they have dropped dramatically in most countries of the Region (6.2% in 1980 to 3.5% in 1998), they remain high compared to international average (2.7%). In general, Arab countries can be placed into 3 categories: low fertility rate countries (2.2% in Lebanon and Tunisia); countries in transition where the total fertility rate (TFR) ranges from 3%–5%, such as in Algeria, Egypt, Libyan Arab Jamahiriya, Morocco and Syrian Arab Republic; and, lastly, countries with high total fertility rates. This pattern of fertility relates to the understanding and experiences of sexuality and sexual health in terms of accessing and utilizing tools and skills that help control the reproductive destiny. In this regard, contraceptive prevalence rates (CPR) of modern family planning methods remain low in most countries of the Region due to either a lack of access or a lack of demand for family planning services. Unmet needs as an assessment of the gap between birth control use and women's desire to space and control their pregnancies are still remarkable in the Region, ranging from 16% in Egypt and Morocco to 39% in Yemen [2]. The reasons for unmet needs are related to sociocultural and traditional factors, the coverage and quality of the provided services and lack of public awareness, among others.

Another crucial issue is reproductive morbidity, mainly attributable to reproductive tract infections, cancers and prolapse. Studies conducted in the Region (Jordan, Lebanon) have shown that women are burdened by reproductive ill health at an early reproductive age [8]. In Egypt, a study conducted in rural areas showed that around 85% of women had one or more reproductive tract infections, and more than half had genital prolapse [9]. These conditions burden reproductive and sexual health of women and drastically

affect their sexuality perceptions and experiences, especially that women believe that these conditions (vaginal discharge and pelvic relaxation) are "normal" and expected for their age and "lot in life". This belief is an important notion to keep in mind, as a sociocultural indicator, as we are discussing the issue of sexuality. In a study conducted in a rural community in Lebanon, in contrast to Egypt, the prevalence of reproductive tract infections was around 10% and genital prolapse 50% [10]. According to some studies [11, 12], women in developing countries seek help late for reproductive tract infections, a behaviour that could allow the infection to ascend the reproductive tract and cause more harmful consequences.

Looking at patterns of prevalence, the impact of STIs and adolescent reproductive health problems are likely to increase in the near future. Although the estimated prevalence rates of STI and HIV/AIDS are relatively low in the Region, a rapid increase in AIDS cases is being reported [1,2]. The sector representing adolescents increased in the Region from 57.5 million in 1970 to 120.3 million in 2000, constituting around 23.4% of the population [13]. This growing adolescent population faced with socioeconomic restrictions is having difficulty accessing RH information and services especially that, sexuality expressions are culturally critical in the majority of countries. This is more pressing in the case of unmarried adolescents. High teenage fertility as a result of early marriage leads to about 900 000 babies born every year to teenage mothers [2].

Provision of care for safe motherhood, family planning, and reproductive tract infections continue to be most delivered and utilized as compared to other components of RH. This gives a lower priority to sexuality and sexual health in policy planning and service provision. At the same time growing international interest in sexuality and sexual health led to several international initiatives, led by WHO and other agencies. World governments, including those in the Region, responded to these initiatives by partial or relative adoption of certain principles and plans of action that tackle sexuality matters. This has been propitious in bringing about certain changes in many areas, mainly RSH and population.

2. SEXUAL HEALTH

2.1 Review of definitions and concepts

In the Eastern Mediterranean Region, definitions and concepts of sexuality and sexual health emanate usually from the religious explanations appearing in the holy texts, *sura*, and as interpreted by religious scholars and sociologists. These concepts emphasize the importance of pleasure, eroticism, emotional attachment, mutual satisfaction, respect, safe sex, freedom from coercion, and procreation. In fact, they are in unison with those developed by the Pan American Health Organization and WHO in May 2000, and carried further in the global technical meetings in WHO later, and during the Informal Consultation on Promoting Sexual Health in the Region. The Regional Office is closely working with headquarters and countries to ensure that the regional perspectives in sexuality and sexual health are well addressed within the global revision of sexual health currently taking place.

In case of countries of the Region, sexuality and sexual health are addressed within the context of marriage that necessitates different vocabulary and phrasing (married couple instead of partners, husband instead of father of the child, and so on). The other debatable issue is related to sexual identity and its connotation, especially when it comes to cases of homosexuality (penalized by the law). Looking through religious and traditional perspectives shaping the daily life of most people in the Region, procreation is at the core of sexuality, and along with sexual satisfaction, both are integrated in sexual activity and heterosexual orientation. Researchers in the Region tend to agree that the 'body' is a cultural construction, and consequently sexuality is as well [14]. So, in stating definitions and understandings, a careful and meticulous approach has to be maintained.

It is worth mentioning that during the global consultations on sexuality held in WHO headquarters in 2001, most of the above-mentioned debatable points were raised by EMRO representatives. As these definitions are still operational,

comments here will be restricted to statements that contrast with the present concepts when available.

Sex: "Sex refers to the sum of biological characteristics that define the spectrum of humans as females and males".

Sexuality: "Sexuality refers to a core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, emotional attachment/love, and reproduction".

Gender: "Gender is understood as the 'social kind' attributed to each sex based on set of cultural values, attitudes, roles, practices, and characteristics resulting from sex. Gender norms are deeply internalized and are closely linked to power relations between both men and women".

Sexual activity: "Sexual activity is a behavioural expression of one's sexuality where the erotic component of sexuality is most evident". This activity should be confined to the marriage relationship.

Sexual practice: "Sexual practice is a pattern of sexual activity that is exhibited by an individual or a community with enough consistency to be expected as behaviour". Again, any form of sexual behaviour outside legal relations is denied and condemned.

Safer sex: "Safer sex is a term used to specify sexual practices and behaviours that reduce the risk of contracting and transmitting STIs, especially HIV". This practice is encouraged by all National AIDS Programme Managers in Member States, first by encouraging abstinence, and second by reinforcing the benefits of safer sex practices.

Responsible sexual behaviour: "is expressed at individual, interpersonal and community levels. It is characterized by autonomy, mutuality, honesty, respectfulness, consent, pursuit of pleasure and wellness". This behaviour is highly recommended and encouraged as it captures the core of sexuality and sexual health, within the context of marriage.

2.2 Status of sexual health within primary health care

Following ICPD recommendations and understandings, sexual health (SH) was introduced as an integral component of RH and health in general. Despite variegated reservations of most governments in the Region and private sector organizations on certain aspects of SH, it is for the first time that the issue of SH is brought to open debate. As a result, policy-makers, health care providers, program managers, community leaders, and researchers are now studying and debating aspects of sexuality and SH in terms of policy planning, service provision, promotion of and advocacy for sex education, like the case of Lebanon and other countries of the Region.

More recently, a meeting to describe sexual health and plan its promotion was held by EMRO in Cairo, 2001 [15]. A critical situation analysis was undertaken raising issues related to the specificities of the Region character that ought to be respected. Notions of sexuality understanding by local people, human rights-based approach, and Region-specific definitions are essential elements to consider in formulating a strategy on SH. Premarital sex, access to information, East versus West ideological gaps, sexual abuse and violence, and gender expression are all critical issues that should be wisely addressed. This is happening at a time, where health care systems are suffering from limited resources, and are undergoing drastic reforms to help respond to peoples' needs and expectations in penal codes, health services, counselling and information provision, especially for women, youth, and rural areas.

Following ICPD, RH was to a certain extent adopted and implemented by governments through RH programs depending on the sociocultural and health settings of each country. Because of existing problems and worrisome indicators in maternal and women's health in general in most countries of the Region [1], maternal and child health and family planning were the main focus within RH component of primary health services. Although sexuality and sexual health are both core issues in unplanned pregnancies, STIs, infertility,

and others, yet they were not adequately placed within the RH package. Notions of sexuality can slightly surface in relation to STIs and infertility, and the clinical approach within primary health care services lacked this perspective. At the same time, the sociocultural environment of countries of the Region does not favour the integration of sexuality in RH services. There is another important issue that affects also the status of SH within PHC, which are the training and the skills of providers who are inadequately exposed and insufficiently trained in issues related to sexuality and sexual health.

Looking at the prevalence of sexuality outcomes in the Region, around 12 million people in the Region suffer from STIs [2]. However, these relatively low rates may be attributed to the sociocultural values that are intolerant of sexual relations outside marriage, and also to under-reporting of actual cases. Under-reporting may be related to several reasons, such as: social and cultural factors, absence of health information system, mechanism of reporting and collection and medical confidentiality. The prevalence of syphilis is also low in countries of the Region, with the highest prevalent rates was reported around 1.5 % in Jordan and Morocco [2].

In the current primary health care system, specialized STI clinics are either few or absent. Besides the suggested reasons for under-reporting, key informants (physicians of different specialties) believe that it is either a low prevalence country or STI cases are usually self-treated. Some gynaecologists admit treating infertility cases secondary to sexually transmitted infections. However, no laboratory or precise statistical data are available.

In Lebanon, data on HIV cases reveal that around 15% of the most declared cases report a history of previous or concomitant STIs infection (most commonly non-specific urethritis). A national knowledge, attitude, behaviour and practices (KABP) study completed in May 1996 revealed that 5.6% of the sexually active males report at least one episode of STIs over past year prior to the interview [16]. According to a national AIDS programme (NAP) study on “Prevalence of Sexually Transmitted Infections in Women Attending

Obs/Gynaecology Clinics in Lebanon" [17], chlamydia and candida were the most prevalent, and gonorrhoea, syphilis, and HIV had zero prevalence. Chlamydia and candida are more likely to be prevalent among younger age groups and divorced females. Chlamydia was also more prevalent among working women. Though these studies reflect low prevalence rates, they are believed to be not representative. In Egypt, unpublished data show that gonorrhoea is the most common, being higher in men than women, but more symptomatic in women [14]. There is a need for gender-sensitive large studies of clients presenting to different specialized clinics to further understand STIs in relation to life style and gender relations. Besides, KABP studies on STIs will help primary prevention interventions. In the absence of population-based studies or statistics on the prevalence of STIs, there is also a real need to improve service statistics and personnel capabilities regarding STIs in order to expand the coverage and improve the quality of these services.

With respect to HIV/AIDS, the number of reported AIDS cases has increased remarkably in the past 7 years throughout the Region. Adult HIV prevalence is estimated to be between 0.005% and 0.18%. This prevalence rate may be underestimated due to unreliable surveillance [2]. Nonetheless, NAP and NGOs in various countries of the Region have intensified their efforts in terms of information provision, campaigns, advocacy, and outreach activities to help prevention and control of this condition.

2.3 Sexual and reproductive health of youth

Over the past few decades, young people between ages 10 and 24 emerged as the world's largest population sector, representing alone 34.4% of the population in the Region [13]. Youth is considered to be a healthy category, yet they are more exposed to high-risk behaviours that lead to a lot of preventable morbidity, especially as there is shortage of both information and the required services in the Region. Youth reproductive and sexual health is continuum with myriad interactions of the biological (pubertal changes, growth and biosexual development disorders), emotional (mental health),

reproductive and sexual, lifestyle, and the social (marriage and family). It is affected to a large extent by several factors including, family, school, community, and government policy. Though an enormous portion of the regional population, youth suffer from marginalization and neglect as far as their sexuality and sexual health is concerned. They are negatively influenced by lack of specialized services, lack of timely and optimal information, social restrictions and taboo stigmas, lack of confidentiality and privacy, lack of proper counseling, fear of side effects, and economic constraints. In specific, youth suffer from unmet needs in family planning, even when they are married.

In a compilation of studies, carried by the American University of Beirut and supported by UNFPA in 2003, concerning adolescent RSH in the Arab countries, a wide range of needs were identified including information, services, counseling, and others. All this is happening at a time where globalization and western values are permeating the life styles of our youth. Supportive evidence for these observations comes from a recent survey of Lebanese university students showing that students exhibit, in their values, characteristics of modern, or post-modern, rather than traditional society [18]. Evidence from several studies on youth health and in specific RH, reveal that Lebanese youth are exposed to high-risk cluster practices like unsafe sexual practices that expose them to consequences like unplanned pregnancy, STIs, and abortion. This is happening in the face of almost total absence of any kind of national plans for information provision and counseling, with a pressing need for reproductive and sexual health (RSH) information [19–23]. These practices also include substance abuse, poor nutrition, and lack of exercise, peer pressure, and lack of social support.

As far as exposure of youth to formal sex education in the formal sector, it is limited to basic issues in biological sciences and animal reproduction. A strategic vision to a curricular reform that integrates sexuality and sexual health as a basic track in daily life remains absent in most countries of the Region. A more in-depth exposure to sex education comes from many NGOs working in the Region, particularly family

planning associations, carrying many activities related to RH information provision for youth through several projects: youth in their military service, university students, health workers, and other community or political groups (such as youth revolutionary union in the Syrian Arab Republic).

Although current selected services are supposed to serve all age groups concerned, there are no specific considerations meeting youth needs, especially reproductive health needs. Taking the example of Lebanon, regular reports from the Ministry of Public Health in Lebanon indicate that beneficiaries in the 15–24 year age group constitute 20% of the total clients [24]. This represents a marked improvement in attracting youth to utilize available services, as compared to previous years. Unfortunately, there is no substantial information on the health-seeking behaviour of youth. Besides, the official Ministry reports do not reveal the type of services utilized by youth, although it is believed that pregnancy care, menstrual disorders and non-specific perineal discomfort are the most common services. In exceptional situations, youth may be discretely provided with birth control pills and condoms from certain health outlets, and in an unofficial manner, or sometimes through the activities of the national AIDS programme in case of condoms. At non-occasional times, youth can still and do have an access to private clinics for services related to sexual health and its outcomes. Again, this is done in a very discrete way.

Youth need to be provided with apt and opportune RH information in both formal and informal sectors using modern means of communication like peer-peer counselling.

2.4 Ongoing programmes

Concerned with adolescents, the Regional Office in consultation with Member States and concerned UN agencies has identified several areas within a programme of work [13]. This programme aims to support countries at several levels to reduce morbidity and promote psychosocial development of children and adolescents. Health education materials were produced by EMRO in collaboration with IOMS and ISESCO.

As well, The Regional Office participated in developing a RH skills manual with Arab Regional Office of the World Organization of Scouts and UNFPA. A number of national efforts in countries like Bahrain, Islamic Republic of Iran, Oman, Morocco and Syrian Arab Republic to develop research in adolescent health have been supported by EMRO. More recently, adolescent health is increasingly being advocated for through the Pan-Arab Project for Family Health (PAP-FAM), which is planned to be implemented in 12 Arab countries. Currently, EMRO is developing a strategy towards evidence-based, systemic planning for adolescent health, pushing further the successful activities for policy formation and research.

On the other hand, the initiation of AIDS programmes supported by WHO was a main entry point to the propagation of issues related to certain aspects of SH, mainly sex behaviour. The national AIDS programmes (NAPs) continue to play an active role in STIs/HIV/AIDS monitoring and prevention through information provision. This role entails coordination with various stakeholders to address this problem at several levels: sex education, sexual health service provision, policy level, and advocacy. This has led to the launching of many awareness campaigns focusing mainly on safe sex practices and abstinence in a culturally sensitive way, knowing the notorious resistance of national and community leaders to matters related to sex education and sexual relations. Many of the traditional groups strongly argue that sex education can lead to increased risk of premarital sex, though this was not found to be not necessary.

In Egypt, an AIDS hotline service was founded in 1996, offering counselling, services and referrals, and material provision to callers. A report evaluating the activity of this hotline underlined the growing awareness among people about HIV/AIDS, but also urged more counselling, as sexuality and AIDS education need to become a higher priority.

On the other hand, family planning associations in Lebanon and the Syrian Arab Republic have been actively involved in

programmed activities related to RSH. The ongoing project of "RH for University Students" involves RSH information provision to university students, peer leaders, and to youth forum. There is also the 24 hours "hotline service" mainly responding to sex information needs, complaints and advice, in addition to yearly camps or retreats for youth where RH issues are discussed and debated by peer-peer education in the presence of specialists and educators.

Youth peer-counsellor training programmes have been initiated in several countries like the Palestinian Authority [25]. In partnership with UNAIDS, youth programs were established in several countries of the Region, including Jordan and the Syrian Arab Republic.

3. DETERMINANTS OF SEXUALITY

The Eastern Mediterranean Region includes the vast majority of the Arab countries and its population is mostly Muslim. Historically, these countries have traditionally adopted religiously dominated traditions in issues related to sexuality and sexual health. Islam remains the basis and the dynamic force of the Arab family. Today, there is no Arab country (except Lebanon) where constitution does not mention Islam as a state religion. The laws on the status of the family in the countries of the Region (except Tunisia) are directly inspired by the Islamic jurisdiction that dictates all matters related to marriage, sexual behaviour, and sexual health. Besides Islam, the traditions and cultural heritage still dictate many practices and social habits and shape the daily life of people in the Region. Being an area that had blended several civilizations and religions, the Eastern Mediterranean Region continues to fuel debates. Sexuality represents a theme that is attracting mixed and heated debates. Early and ongoing tense debates continue between modernists and traditionalists on issues of sexuality. These debates were enriched by contributions from the academics, theologians, and feminist groups, being initially rooted in the historic works of Al-Ghazali describing the integration of sexual instinct into the social order, and continuing with contemporary scholars exploring sexuality and its ramifications into social and religious constructions as

will be overviewed in this paper.

3.1 Religion's view of sexuality

In essence, tradition constitutes a solid and permanent element in the formation of the Arab–Muslim personality, by resting on revelation as an eternal and extra-temporal message. So, tradition remains an essential requirement to the understanding of the cultural and the historical views and discourses, as the whole Arab–Muslim cultural system is centred on the need to identify, analyse, and understand this tradition [26]. Within this perspective, the Islamic view of love and sexuality, combining pleasure and responsibility, removes any guilt from both sexes [26]. Sexuality is considered merely to be a particular case of an absolutely universal divine was installed into the individual, where the Quran holds that the relationship of men and women is one of equality, mutuality, and cordiality [27]. Islam recognizes the sex drives and active sexuality of both men and women and acknowledges their right to fulfil it, however in a legitimate way within the institution of marriage. In this regard, marital copulation is based on the right of sexual fulfilment and does not need the justification of reproduction, as fertility control is permitted (28 Musallam, in Pinar, p 756).

Nevertheless, the diversity of the social did not lend itself to a similarity of status but affirmed a total dominion of man over woman leading to a hierarchical married life. Marriage gives concrete form to the order of existence and gives sexuality a new significance, as this marriage is a relationship of complimentarily. This is clearly affirmed by the Quranic view of sexuality as being total and totalizing, where the cosmic and the sociological, the psychological and the social rest on the union of the sexes implying that sexuality is creation and procreation. So the Quranic exercise of sexuality assumes an infinite majesty, and the sexual function is in itself a sacred function [26].

Looking at sexuality with respect to gender relations, Islam affirms that male sexuality is stronger and pressing as compared to female one. Men need to satisfy their sexual

desires, and it is their duty to satisfy their women's desires, and the later have to meet men's sexual demands, as initially stressed by the prophet and other Islamic scholars. In fact, this Islamic recognition of the right of women to get sexually satisfied should be practised within marriage [29], which should be consented by both men and women as a precondition. Accordingly, "forced marriages" represent a harsh violation of the basic premise of marriage as mentioned in Quran. This recognition, according to Fatmeh Mernissi, considers male-female relationship in Islam to be highly sexual, and that women are considered to have sexual power over men, which needs to be controlled by veiling [30]. Though female sexuality within the confines of marriage has been well recognized in Islam, some authors present a critical 'problematic'' of sexuality within marriage as being liable to abuse under the pressures of certain traditional practices [31,32]. On the other hand, it is strongly believed that the marriage institution in Islam is meant to strengthen women and the couple within a relationship of equality and respect (33 Sabeq in Hind Khattab, p 12).

In the same context of understanding sexuality in relation to gender rights, *shari'a* states equal punishment to both men and women in cases of adultery, but some civil laws in some countries contradict *shari'a*, favouring more tolerance to pre and extra-marital relations of men.

The elaborative discussions of Ziba Mir-Hosseini in which sexuality and gender inequality is maintained in *fiqh*-based (jurisprudence) literature, is worth noting. Mir-Hossieni identified traditionalist, neo-traditionalist, and modernist discourses, through which progression occurs from the most sexually candid and opposed to gender equality (traditionalist), to the least sexually candid and supportive of gender equality (modernist)[34].

Human understanding of Islam is flexible and continues to be interpreted according to the perceptions and stands of the above-mentioned discourses. This will generate a lot of practices that might be alien to true spirit of Islam [35].

3.2 Historical discourse

In pre-Islamic Arabia, and among the varied nomadic and Bedouin communities, some women used to experience a kind of sexual autonomy manifested in certain aspects like having open love affairs, enjoying their sexual life without full sexual relations, and having several husbands. With the rise of Islam, and within early Islamic societies, there was a predominant mercantile spirit influencing the daily lives and habits of those societies. Women continued to have some sort of power in voluntarily negotiating marriage contracts, where the condition for monogamy and right to divorce were stated in these contracts. Since then there was a slow decline in these "rights" until the Abbasid period, where women were subjected to greater oppression. Women image was constructed around being a housewife, passive, through her restraint, modesty, submission, and compliance [36]. During the era of Muslim conquests, women-including wives- and children were taken as captives and sold. This led to the creation of a flourishing female slave market encouraging polygamy and concubinage, being more preferred as no restricting legal rights was made on men.

In medieval Islamic societies, available literature on manners, morals, and medicine authored mostly by males, sexual relations were arranged in conformity to the principles of social and political hierarchy. This understanding of sexual relations gave sexuality different interpretations and meanings. In this regard, sexuality was defined in relation to the penetrative in a sexual act, and sexual role was fully identified with the social hierarchy. Thus, sex as penetration occurs between a dominant adult man and a subordinate social inferior (wife, concubine, prostitute, slave). In her analysis of a Mamluki literature, Aliya Saidi argues that despite this historic acceptance of different types of sexuality, polygamy was largely unaccepted and resulted in women's mental illnesses [37].

Often, sexual dominion reflects and proves social dominion, a formula that explains gender roles and sexual roles in medieval Muslim societies. Homosexual relations are sinful

but not demeaning of social powers [38].

In the modern period, most of the countries of the Region were under mandate by the colonial powers at that time (France and United Kingdom) that facilitated the initiation of the democratization process of women and girls. It is argued that the colonial and post-colonial discourses framed the Arab women in two images: the sexualized other, and the servant submissive housewife. So in both the colonial and the post-colonial era, women subordination was formed around the bipolarity of veiled controlled sexuality and the sexualized other [39]. Drawing on the case of Tunisia, women were used by the French mandate as means of accomplishing the civilization mission, and by the nationalist as symbols of Arab Muslim cultural authenticity. According to Mervat Hatem [40], the earliest discourse examining women's role in the Arab society came through the modernist-nationalist approach facing the colonial era. This discourse though defended religion against orientalists' attacks, had led to the adoption of new rights for women according to western definitions. These western influences are considered by nationalists as "bad influences", while at the same time those same nationalists who were using women for anti-colonial reasons are blaming colonial influences instead of examining their own, under the cause of defending religion. In fact, Arab women quest for issues of democratization, rights and dignity is at the heart of cultural and religious heritage of Islam, and not a legacy of western civilization [30].

Attempts of women to express their rights and manifest their sexuality were perceived as a rejection to societal norms. These attempts were faced by refusal from domestic spaces and families. Women trying to "walk out" from their houses and roles into the public space of men made them vulnerable to attack. The issue of female singers and dancers represent to a great extent the construction of those females around indecency and prostitution. In Egypt, and despite the continued distinction over the years between various performers as dancers or singers, publicly or in private halls, women continue to suffer from stereotyping and stigmatization [41]. In the Middle East region, women were

subject to contradictory roles imposed by nationalist movements arising during the independence days and the foundation of nation-states. In one track, they were encouraged to engage in political and social arenas, but on another track, they were held as the mothers bearing the newly constructed nations [27]. This was meant to control women's sexuality by assigning them to reproduction and nation maintenance [27]. It is strongly argued nowadays that nationalist and Islamist discourses guard change [42], and controls women's sexuality [27].

3.3 Cultural interpretation

In countries of the Region, Islam represents one of the major—if not the major—components of cultural life and practices. Muslim societies have a diversity of traditions and practices drawing from the two other monotheistic religions, pre-Islamic Arabia, and the traditions of communities that were conquered by Islam. Despite this mosaic that makes it very difficult to delineate precisely what is intrinsic to Islam in shaping sexual behaviour [27], Islam remains the strongest culture forming the cultural identity of this Region. It emphasizes the acknowledgement and expression of sexuality within marriage context, without diminishing women's respect and integrity. This understanding has led to several manifestations like segregation of sexes at schools, veiling, and restriction of females from occupying public spaces. At times, these manifestations are exaggerated by the influence of traditional and community practices, in addition to existing problems of illiteracy, poverty, and lack of development in some communities. In other cases, the type and nature of the state and the political regime also affects and imposes certain cultural practices related to people dynamics, cultural production, freedom of expression in matters related to sexuality debated and discussions. Yet, in other communities where globalization, media hype, and dynamic interactions exist, more open and candid debates related to sexuality understanding, service integration, and relative expression in terms of civil society activity on the issues of rights, gender-based violence, and female participation in public life, cultural discourses regarding sexuality are more vibrant. It is not an

easy task to stigmatize the different communities in the Region with one label of sexuality understanding, though it behoves us to understand the various displays of intrinsic and extrinsic images of sexuality affected by western mores, post-modern attitudes, and traditional factors. This compels policy makers to better understanding of the importance of improving women conditions within their families and at work, in addition to ensure just and righteous approach to women's issues as human issues. A shred of this process is being visible in certain countries in relation to political rights and civil society activities.

Understanding gender is an essential tool of examining the cultural aspect of the Region. Within the economic, political, and social changes happening over the past two centuries, gender roles continue to strongly affect sexual relation. Despite the degree of diversity of legal codes and their application in countries, and despite the positive impact of all reforms on women's position and feminists' movements, the Arab region ranks very low in terms of Gender Empowerment Measure, illiteracy, and participation in political and labour forces [1]. The roots of this gender inequality lie in tools and mechanisms used to control women's bodies and sexuality.

Modernization efforts happening in the Middle East countries had placed women's status in a central place, aiming at improving gender equality in various aspects. Examining several essays on women's status from the ME [40,43], modernization reforms had selectively benefited certain classes women (upper and/or dominant race), and restriction and loss of power for other classes and minority women. In Egypt for example, the new laws on rape did nothing to discourage rape, and in addition, became a commodity for privileged women able to access and pay legal expenses [44].

Concerning cultural understanding and experiences of sexuality and sexual behaviour, Islam distinguishes between lawful and unlawful sexual relations, and lawful relation demarcates the taboos, violation of which constitutes the capital sin. Sexual relations outside marriage or concubinage is culpable, and premarital sex relations are condemned.

Homosexuality incurs the strongest condemnations. In specific, male homosexuality stands for all the perversions and constitutes in a sense the depravity of the depravities. Female homosexuality is equally condemned; however, it is treated with relative indulgence equals to that of autoeroticism, bestiality and necrophilia [26]. Husein Tapnic argues that in countries like Turkey, Egypt, and Morocco, men who are penetrative in a sexual relations with other men are not considered homosexual, but rather hyper-masculine [45], or in the case of Morocco functional bisexuals, as they substitute men for their women [46]. Participation in homosexual acts is much more preferred to issues of affection and equality in sexual partners. Equality in sexual relations, whether homosexual or heterosexual, undermines the "hyper-masculine" order.

Recently, modern and "post-modern" discourses are arguing that there is no inherent link between patriarchy and Islamic ideals, and is even challenging the hegemonic orthodoxy of Islamic interpretation, thus moving forward the debates on sexuality, sexual behaviour and gender issues.

Taking the example of Lebanon, large-scale societal change was brought about by a multitude of factors. Among these, three trends may be particularly worth noting. First, mean age at first marriage in Lebanon (30.9 years for males and 27.5 years for females) has risen to be the highest in the Arab region and one of the highest in the world [47], thus widening the bio-social gap and increasing the tendency for premarital sexual behaviour. Second, massive emigration occurred with war with an estimated cumulative total of about one-third of the population emigrating during the war years. Many of these war emigrants are now returning to the country, bringing with them new ideas, attitudes and behaviours acquired abroad. Supporting this statement, a recent survey of entering university students found that those who had lived abroad for one year or more differed significantly from those who had not with regard to many health behaviours including having ever had sexual intercourse [20]. Finally, the dizzying speed of the worldwide waves of modernization and globalization also may have led to a rapid shift in norms and

values of adolescents towards a more liberal orientation within a fairly conservative society. Similar situations can be found in countries like Egypt, Morocco, and others to a certain extent. In Morocco, the domain of sexuality is contested due to close and dynamic interactions of discrepancies between Islamic doctrine and its application, the ongoing change in relations between sexes, socioeconomic transformations, and competing claims for legitimacy and authenticity [48]. This change has been creating a lot of problems as governmental, societal, and religious authorities are not accompanying or trying to deal with its emanating consequences. In these countries, a problematic situation is expanding towards a total crisis; a crisis in the relations of the Arab with him/herself, and with religious/social norms. This cultural context embodies the sexual and the religious crisis, both reflecting an anomic situation where perception and practice of sexuality is taking different types, shaking the existing beliefs forged by religion and society.

Today, globalization and human sexual rights have unleashed images of sexual diversities, and encouraged formation of specific sexual subcultures in large cities like Cairo, Beirut, and Istanbul [49]. Despite the utmost rejection of homosexuals by societies and families, and their criminalization by law and harassment by authorities, some of them are working to assert their status within the society. In Lebanon an anonymous organization, the Gay and Lesbian Organization in Lebanon, (GLOL) is displaying itself on the net. On the other hand, many others in the Middle East have sought asylum in the west as refugees from official persecution.

In the Arab World, homosexual sex is not new, but homosexuality and sex identity questioning are troublesome issues. In countries like Jordan, Lebanon, Palestine and Syrian Aran Republic, societies are caught up in a process of change and emulating the West. Debates on gender identity and sexuality are heating up, the last being in Lebanon with an attempt to introduce civil marriage. In Lebanon, there is a slow shift from patriarchal model to a “nuclear” family model. A whole debate is just beginning on issues of sexuality, civil marriage, cohabitation and premarital sex. Tolerance of these

issues seems to be increasing, but traditionalists are not ready or willing to succumb to all efforts to liberate sexuality from religious authority. Traditionalist argues for the sex frontier laid down by God in religious revelations, and to the sacredness given to sexuality and sex relations within marriage context. If this is broken and unlawful things happen, then many unprecedented consequences will occur that will be detrimental to the health of the individual as well as the society. According to traditionalists, the prevalence of AIDS and HIV cases, STIs, abortions, weakening marriage relations, and adultery, are all potential consequences. At the same time, sexual mores of the West are persistently permeating almost all echelons of life of the Arab-Muslim societies in varying degrees (liberalization tends various types of youth clubs, media images, and internet).

The problematization of sexuality has never been more striking. The intricacies and the myriad interplay of all these dimensions and factors seem to wave a long and diverse clash of sexualities, where nobody appears to be a winner and where the government is not taking any firm actions. Arab societies continue to witness "honour killings" and at the time conceal premarital sex, abortions, undercover restoration of virginity (hymenoplasty) and out-of-wedlock sex affairs.

4. ISSUES AND CONCERNS

It has been briefly described in this background paper that in view of the existing socio-cultural reservations in countries of the Region on the issue of sexuality, this issue of sexuality remains improperly understood and placed, if not nearly eliminated from the public health agenda. The global burden of HIV/AIDS has urged most governments of the Region to respond to the international agenda to address HIV/AIDS as a sexual and social health problem with several dimensions. This arising agenda allowed sexual health issues to go up the public health agenda, a change though encouraging, yet was only restricted specific topics (awareness and information provision) without concurrent address of sexuality as a whole. This relative gain amidst the ongoing crisis between the social and the religious, the rules and the players, the traditional and

the post-modern discourses, had led to further complication of sexuality and sexual health concerns. As a result, sexuality with its psychosocial issues was not thoroughly examined, thus rendering the approach to women's health incomplete. This has left most of gender- related practices and perceptions almost untackled.

4.1 Honour killing

This is related to the killing of a woman by a family member, usually the father, husband or brother, for engaging in, or being suspected of engaging in sexual practices before or outside marriage. Hundreds of women are killed every year in various countries for suspected sexual relations. It is quite difficult to estimate the overall or annual toll of honour-killings. In a presentation on penal code [50], Sherifa Zuhur reported worrisome data on from several Arab countries. An Egyptian report based on 1995 statistics counted 52 honour killings (out of 819 murders), while in Yemen more than 400 women were reported killed for honour in 1997, and 461 honour killings were reported in Pakistan in 2002. Some sources mention about 5000 per year, but this is probably a low estimate. In Jordan, Rana Husseini reported that one third of the nation's homicides are honour-killings, frequently committed by minors since they may be released at age 18 without a criminal record. The average sentence served in Jordan is seven and a half months for an honour killing. The same sort of premeditated selection by family assemblies takes place in Turkey, and in other countries. According to Sharif Kanaana [51], honor killing "stems from the patriarchal and party-liner society's interest in maintaining strict control over designated familial power structures". Honour killing is not a means to control sexual power or behaviour, but to control fertility or reproductive power, as argued by Kanaana. The discourse on gender and the discourse on virginity in Arab culture are both intricately intertwined. Virginity is a crucial aspect of the production of femaleness in the Arab culture, where the hymen assumes the functions of marking virginity and delineating female body [52]. Examination of honour killing in Jordan, Palestine, and Lebanon confirmed that gender-based violence cannot be divorced from the larger

context of women's status and women's rights. Unfortunately, the legal system plays an important role in perpetuating the issue of honour killing by considering women the vessels that contain and protect society's morals and constitute the sole perpetrators of any moral digressions [53]. At the same time many Arab Codes show sympathy for the father, brother, and husband by allowing them exemptions from or reductions in penalty [52]. The legal system remains an embodiment of social and cultural construct in issues related to women's sexuality. Remarkable efforts undertaken by civil society groups and NGOs, namely Al-Badeel Coalition and the Women's Center for Legal Aid and Counseling, in addition to other activists operating in Palestine and Jordan, did affect advocacy, awareness, and media coverage regarding honour killing.

4.2 Female genital mutilation (FGM)

FGM is considered to be one of the most seriously harmful practices in the Region, causing irreversible damage to girls and women. FGM is mainly practiced in Djibouti, Egypt, Somalia, Sudan and Yemen. The Demographic and Health Survey report for Egypt indicates that 97% of women in Egypt had FGM [54], mainly in rural areas and with lesser education. Meanwhile, its prevalence was reported at 89% in Sudan, 98% in Djibouti, almost all girls aged 6–10 in Somalia, and 23% in Yemen. Despite the well known fact about the dangers and hazards affecting the reproductive and general health of girls/women, and despite the humongous efforts by many local and international agencies, namely WHO, and building on governmental policies and procedures like signing on international agreements of child rights and CEDAW, this practice continues and women morbidity burden continues to agonize more lives and more families.

4.3 Gender-based violence

Besides the well established violence acts against women in the Region, "Honour crimes or crimes of passion" and FGM, domestic violence related to substance abuse (*khat*) in Yemen was reported [2]. Other forms of domestic violence including

verbal, physical, and rape do exist in the Region. Several NGOs working in Lebanon, Palestine, Jordan, and Egypt, raising awareness and advocating on issues of violence, are quiet active. These organizations, in collaboration with the governments, offer shelter, advice, counselling, and coping skills to abused women. In the Islamic Republic off Iran for example, fighting violence against women had been integrated into the mental health programs at the primary health level [55].

4.4 Abortion

Precise and exact figures on incidence of abortion are hard to find in the Region. However, according to World Bank reports [2], the estimated incidence of unsafe abortion in northern Africa and western Asia is around 130 and 110 in 1000 live births, respectively. Several reports from Egypt indicated that mortality resulting from unsafe abortion ranges from 3-194 per 100 000 live births. In general, there is an estimated maternal deaths of 8% related to unsafe abortions in the Arab region, being lower than figures from other developing countries. In most countries of the Region, abortion is legally restricted except for Tunisia [2].

4.5 Sexuality services

Despite the emphasis of ICPD and the following congresses on the importance of sexuality and sexual health, the availability of this service continues to be very marginalized or neglected within the reproductive health package in various countries. In fact, sexual health services are confined to family planning at large and in part to prevention and management of STIs and HIV/AIDS, due to global initiatives and alarming increase of HIV/AIDS prevalence in the Region. An optimal outlet for such services is family planning association clinics that continue as long-standing services within reproductive health setting. Nevertheless, social taboos regarding sexuality continue to hinder proper integration of sexuality within these services, despite its demand by family planning clients [56]. The marginalization of sexuality and sexual health services extends to pre-service and in-service training of health care

providers, who are inadequately exposed to these issues. This situation can contribute to lack or sub-optimal provision of sexual health, and thus leaving women, youth and other categories in the community with unmet needs [57]. Regarding the other service, sex education, review of literature related to the issue of sex education show that there is an urgent need for sex promotion and raising awareness. In a workshop co-organized by UNFPA, UNAIDS and AUB, held in June 2003, at the American University of Beirut, and after reviewing close to 40 articles in the Region, several gaps in sex education and information, need for counselling and advise, and sexuality services were identified in various countries, in the formal and informal sectors. This is also revealed by several studies [19, 21, 22] showing lack of sexual education and knowledge. In the absence of gradual and proper planning for sex education and raising awareness, sexuality is constructed mainly through social and traditional determinants [58].

5. SEXUAL PROBLEMS

Notwithstanding the fact that several sexual issues and problems might arise from the lack of sexuality education and proper advocacy, there is worrisome absence of consideration of this matter, at the government level principally, and at the community level in the Region. The mere attention is mainly focused around HIV/AIDS as part of keeping up with the global agenda and funding. In order to appreciate the scope of sexuality, it is imperative that relevant parties look at the various dimensions, the physical, psychological, social, gender, and skills. The burden of problems related to sexuality and sexual health should be seen through this multi-dimensional perspective, and not merely STIs and family planning.

5.1 Outcome of sexual behaviour

Sexuality is expressed within a multidimensional setting, in an environment free of coercion, and in a socioculturally sensitive approach. At times, and in the absence of those enabling factors, negative consequences can result from certain

irresponsible sexual behaviour (see definition of responsible sexual behaviour under II). These consequences impose transient and permanent damages to reproductive, mental, and psychological health. Serious problems such as unplanned pregnancy, forced marriages, STIs, loss of virginity, abortion, and gender-based violence are not uncommon in countries of the Region. Often, these problems are "socially" and "culturally" related and dictated, where an act of premarital sex can lead to first, loss of virginity, second possibility of unplanned pregnancy, which can lead to either forced early marriage, or to abortion and repair of the hymen (hymenoplasty). This is accompanied by grave emotional and social distress on the side of the girl, the couple, and their families, mainly the girl's family. This simplistic, every day type of story reflects the rigid construction of sexuality within traditional and social discourses. Despite the relative increase in tolerance to sexuality expression in certain communities in the Region. This construction will continue to dominate sexuality understanding and expression in different ways. For example, abortion is strictly prohibited in all Arab-Muslim countries except Tunisia. As a result, abortion usually takes place in silence and at times under non-skilled attendance leading to serious morbidity and mortality, in addition to emotional and social consequences. Other outcomes will continue to lull with under-reporting, inadequate services, and absent education and counselling.

Another important issue closely related to sexual behaviours is premarital sex. Premarital sex presents itself in the Region with cultural, social, and health aspects. Its exact prevalence remains unknown, though attitudes towards it may be more tolerant. As premarital sex is happening, there is almost absent sex education and information through official and scientific channels. In Lebanon, a survey about attitudes of university students showed that close to 60% of males and 40% of females are not against premarital sex [23]. Another survey on sex practices in high school students in Beirut found that 30% of males and 2% of females had had at least one sexual encounter; a condom was used in 70% of these encounters [14]. A survey on lifestyle risks conducted on entering students to the AUB found out that 24% of those

students had engaged in a sexual activity [20]. Within this existing sexual behaviour, students had expressed compelling need for sex education, and through professional sources, because of a serious lack of sex information [21]. In Palestine, women admit that sex education is absent mainly because of absence of sex education at schools [59].

5.2 Sexual dysfunction

The issue of sexual dysfunction through life-cycle remains under-estimated. Many of its confounding factors like reproductive tract infections (RTIs) are not well perceived by couples as affecting their sexual well-being. Clinical observation suggest that women consider many of their reproductive dysfunction to be an expected and "normal" finding due to age, work, parity, and other social conditions. The Giza study in Egypt clearly demonstrates such observations [60, 61].

5.3 Sexually-transmitted infections, including HIV/AIDS

Despite the current low prevalence of sexually-transmitted infections, including HIV/AIDS, the pattern of increase remains worrisome calling for holistic and collective approach to this problem. This approach should involve all sectors: Governmental, private, NGOs, and community leaders in order to advocate and raise awareness, and to situate proper sexuality services within existing primary health care facilities.

6. SUGGESTED STRATEGIES FOR PROMOTING REPRODUCTIVE AND SEXUAL HEALTH IN THE EASTERN MEDITERRANEAN REGION

6.1 Research

Recently, available literature from this Region indicates a gradual increase in the amount of research embarking on a holistic approach to reproductive health. However, available research on issues of sexuality and sexual health is dearth due to overwhelming and discouraging sociocultural circumstances. Compiled research on reproductive and sexual health from the Region [62] and by UNFPA initiative

identified several unmet needs including sex education, scope of sexual health services, capacity building of providers, raising awareness and counselling, and many others. Most importantly, there is a beginning of a realization that sexuality is integral to the overall understanding of reproductive and youth health. This realization is inviting more research initiatives and interests, like the "sexuality initiative" led by the Reproductive Health Working Group (a regional group housed in the American University of Beirut), and is calling for theme-specific and action-oriented research to understand better issues like determinants of sexual behaviour, perception and understanding of sexual health, models of sex education, clinical services, curricula and training, policy and law reform, and reduction/elimination of gender-based violence practices (FGM, honour killing).

6.2 Modalities of sex education

Though the need for sexuality education is evident from research and supported by various groups (academics, NGOs, UN agencies), there is a general agreement that it is either absent or very superficial (basic biology knowledge) in the current systems of formal education. Unfortunately, these existing educational programs are not competent to meet the demands of the evolving social dynamics and globalization effect rendering sexuality education a pressing issue. It is compelling to conduct a wide sector approach towards formulating sex education programmes encompassing life-cycle approach, gender perspective, social and cultural attitudes, in addition to the health components [59]. This programme should be offered by trained professionals and supported by other relevant resources. It is of paramount importance to implement a whole sex education package that works and is sustainable. Examining the example of sex education attempt from Lebanon is not very encouraging. A sex education package was developed under the government supervision (Ministry of Education) and guided by values that are inherent in the Lebanese society. This package was mainstreamed in the curricula across various school grades. However, and under pressure from religious and traditional factions, the material on sexuality was eliminated by a

presidential decree from the 7th grade curricula and assigned to the secondary school level without any regard to academic considerations. As a result, sex education stumbled at first walks as its track lines into the puzzles of the Lebanese society and similarly the other Arab-Moslem societies. Among the pieces of the puzzle are: civil marriage polemic, women's rights, and violence against women, child abuse, and many others. In the nature of the polemic between the various opponents and proponents of sexuality education, two opposing approaches can be identified: one is trying to understand the existing findings and behaviours and manage them accordingly, while the other elected to resort to its educational and cultural conceptions as the proper channel of dealing with these manifestations [63].

6.3 Laws and policy regulations

Family law, referred to as personal status law, was the main focus of attention towards legal transformation of women's status in countries of the Region. As additional reforms are required for this law, it is evident that other laws like the penal or criminal codes allow the family and the state to constrain women as reproductive and sexual beings. From the tribal era to Islam, legal codes authorized control of women and their bodies. Most recently, legal modernization sought to transfer authority over women from their extended families to their husbands and only in certain cases to women, themselves as individuals. Despite certain improvements regarding certain aspects in the penal codes like "crimes of passion" instead of "honour killing" in Jordan, punishment of the rapist, and the right of women to seek divorce in Egypt are all achievements of a long struggle by NGOs and the civil society. Main strategies that should be used to promote sexuality ought to ensure women's rights as individuals, like being able to contract and register one's own marriage, right to seek divorce, or ensure justice for rape or sexual abuse for oneself or one's daughter [50]. Apart from that, there are no clear and concrete laws or policies that facilitate or regulate sexuality promotion amidst no clear distinction between traditional, tribal, Islamic, and civil laws. Attention and intervention should focus on issues such as rape, adultery,

honour killings, battery and wife-beating, murder, abortion, infanticide, sex trafficking, sexual abuse, incest, prostitution, homosexuality and trans-sexuality that are penalized differently in different countries, but similarly discriminating against women. Other forms of violence against women, like domestic violence, FGM and marital rape were not criminalized. Other problems like political rape or sexual battery on prisoners require attention beyond the wording of the penal codes [50].

6.4 Training of professionals

Promotion of sexuality rests to a great extent on reproductive health care providers, as physicians, midwives, nurses, and socio-medical workers. Review of international literature shows that medical and paramedical students and residents are slightly exposed to issues of sexuality and sexual health as compared to other core topics. In a study conducted in Lebanon [57], obstetricians and gynaecologists reported low contribution of their specialty to their skill in sexuality and sexual health management, and they demanded various forms of training and capacity building in terms of seminars, congresses, publications, and curricula change to accommodate more sexuality and sexual health topics. In Egypt, a similar study is being conducted with initial data suggesting difficulties facing physicians in sexuality management [64]. In Lebanon too, inadequate training of school-teachers on sex education material contributed to the lack of success of this attempt. In Palestine, some training was conducted on RSH to youth club leaders [65] and to health care providers by NGOs, and currently UNFPA is conducting training of school-teachers on a population and development package including RSH. It is essential to continue working with those categories of professionals at pre-training, post-training, and on-the-job-training to ensure their contribution to reproductive and sexual health promotion.

6.5 Health care and services

Despite the growing need for sexual health services and information, most RH services in countries of the Region lack

a strategy on sexual health that governs its service delivery. This is crucial as more people are raising issues related to sexual health and demanding clarifications and answers. Again, this lack of sexual health care is related to the overall discourse discussed through this report. Nonetheless, careful introduction of sexuality issues within integrated reproductive health services accompanied by training of professional can be a promising intervention to promote sexual health within existing health care systems and services. In countries of the Region, reproductive health services continue to be the most appropriate entry point for sexual health promotion.

6.6 Adolescent health

Efforts should add to the strategic priorities identified by EMRO and addressed towards adoption of a regional strategy, preparation of advocacy documents, establishing a sex disaggregated national surveillance system, training health professionals and monitoring services and ensuring collaboration with concerned agencies for this sake.

6.7 A new role for men

The role of men in RH is well recognized. Realization of this role is highly warranted. Men are expected to participate in RH events, encourage health-seeking behaviour of women, collaborate in eliminating gender discrimination, and violence against women as well as other harmful practices. In patriarchal societies like those in the Region, men affect maternal health, fertility control, access and use of health services, and sexual health. It is crucial to involve men in a multi-level process of information provision, policy planning, and partnership in all aspects of reproductive and sexual health.

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