Numerous definitions of sexual health have been developed over the past few years [1]. Perhaps the best known and most widely accepted of them is the World Health Organization’s (WHO) working definition, which reads as follows:

...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. [2]

Such a definition is important in several respects. First, it draws attention to the aspirational character of sexual health, as a ‘goal that needs to be worked towards’. Second, it stresses the positive aspects of sexual health as a tangible ‘presence’, not simply the absence of difficulties, problems, illness and disease. Third, it links sexual health to human sexuality in all its richness and diversity and to questions of values and rights. People need to be free to develop their sexuality in ways that pleasurable, safe and respectful of others, and in a manner protected by fundamental human rights—to health, to education, to protection and so on.

Using this definition, efforts have been made to develop a framework for operationalizing and promoting sexual health across a variety of settings. The WHO document ‘Developing Sexual Health Programs: A framework for action’ does exactly this [3]. It identifies five key domains in which action must take place if the sexual health of individuals and populations is to be promoted: laws, policies and human rights; education; society and culture; economics and health systems. Promoting sexual health requires coordinated action on a variety of fronts. Health systems have a key role to play in this respect, but action and intervention in this domain alone will not produce the benefits needed. Unless healthy options are safeguarded and promoted through policy and the law; unless people have access to the information, skills and services they need and unless positive attitudes and values are cultivated in relationships, families and the community, health professionals can do little by themselves to promote sexual health. A ‘combination’ approach to sexual health promotion is therefore needed, which sees sexual health for what it is: as a biological, psychological and profoundly social consequence of the ways in which people live their lives.

The different papers that comprise this special issue of \textit{Health Education Research} engage with these concerns in a variety of ways. We have chosen as our focus three major themes: changing sexual practices and cultures; innovation in education concerning sexuality, sex and relationships, and in service provision and gender-based violence (GBV). Our choice of themes was deliberate in that all have the potential to reveal some of the ‘larger forces’ at work influencing sexual health, both individually and collectively. Each theme points to the need to consider sexual health not as an isolated health issue, but as intimately connected...
to the manner in which people (both as individuals and as communities) live. Sometimes the relationships people enter into may be consensual, supportive and health promoting. On other occasions, they may be abusive and damaging. The key to success in sexual health promotion lies in adopting an inclusive and broad-based response which recognizes this variability and its 'social' origins—in the research and theorization we undertake; in advocacy and lobbying and in future policy and programme development.

### Changing sexual practices and cultures

Sexual practices, and the sexual and broader cultures in which they are embedded, reflect and shape the outcomes of sexual health promotion. The first set of four papers included in this special issue of *Health Education Research* contribute new evidence and innovative approaches to strengthen sexual health promotion programmes in support of the development of healthy sexual practices and cultures. Reporting on recent and ongoing activities in settings as diverse as Malawi, Uganda and The Netherlands, as well as reviewing research conducted across countries and settings, these papers individually and jointly illustrate the importance of the collaborative, systematic development of sexual health promotion programmes that bring together the expertise and experiences of a range of stakeholders, including those for whom the programmes are intended. The importance of effective dissemination of sexual health programmes to ensuring the impact of sexual health promotion is often overlooked, and it is exciting to see that gap addressed in multiple papers.

Despite successes in reducing HIV prevalence, young people, in particular young women, aged 15–24 years remain vulnerable to HIV in sub-Saharan Africa [4], and university students may experience particular risk factors, including being away from family and greater exposure to peer pressure in settings of high sexual activity [5]. Jaganath *et al.* [5] adapted a performance-based approach encouraging community dialogue about HIV and AIDS and facilitating the empowerment of people living with HIV. Undertaken at the largest tertiary education institution in Malawi, ‘This is My Story’ brought together drama students and people living with HIV from the local community in an intensive 5-week process of gaining knowledge, breaking down barriers, increasing understanding and promoting empowerment as they developed and delivered the performance. Drawing on interviews conducted 1 year after the project, this study finds that major themes related to trust and risk, equality of people with HIV and the possibility of a full life with HIV were most discussed in the community, with the project seen to contribute to empowering people with HIV and creating a supportive environment [5].

A substantial body of theory and research has accumulated with respect to the development and evaluation of interventions encouraging safe sexual practices among young people [6]. The efficacy of such interventions varies substantially, and Shepherd *et al.* [7] argue that complementing outcome evaluations, insights gleaned from process evaluations may be particularly helpful in increasing understanding regarding why an intervention was successful, or not. Their systematic review synthesizes findings from nine robust randomized controlled outcome evaluations of skills-based behavioural interventions to prevent sexually transmitted infections (STIs) and promote sexual health for young people in schools, which also included an element of process evaluation. The methodological quality of the process evaluations was found to be mixed, with only three studies assigned medium or high scores with respect to the trustworthiness and the usefulness of findings. Reflecting the most commonly addressed processes [7], the review in particular assessed factors potentially associated with the implementation of interventions, and student engagement and intervention acceptability. Positive contributors included good quality teacher training, involvement and motivation of key stakeholders and relevance and appeal of components to young people.
Focusing on ‘Long Live Love’, a proven and widely used sex education programme for secondary vocational school students in The Netherlands, Schutte et al. [8] reported on a study assessing factors associated with programme adoption, implementation and continued use among teachers. Despite being critical to their effectiveness, the successful diffusion of school-based sex education remains under-researched. To address this knowledge gap and increase understanding of the factors that shape adoption, implementation completeness, implementation fidelity and continued use of the program, a comprehensive self-completion survey was conducted to assess teachers’ curriculum-related beliefs, perceptions of the policy and organizational context, use of external information and supports, and socio-demographic characteristics. Curriculum-related beliefs, which encompassed teachers’ attitudes, social norms and self-efficacy with respect to the ‘Long Live Love’ programme, were related to all stages of the diffusion process. Confirming the findings of the review reported by Shepherd et al. [7], this study found that programme implementation (completeness and fidelity) was related to teachers having completed curriculum training [8]. Other contextual factors, including school policy, governing body support and student response also affected implementation and continued use.

Unintended pregnancies affect many young people worldwide, including in sub-Saharan Africa. The ‘Teenage Mothers Project’ is a community intervention that aims to improve the well-being of unmarried teenage mothers in rural Uganda [9]. Leerlooijer and colleagues described how the development of this programme was guided by the Intervention Mapping protocol, which offers guidance for the systematic development of comprehensive evidence-based and theory-informed interventions [10]. The intervention mapping process consisted of six consecutive steps: encompassing a needs assessment, specifying programme objectives, identifying intervention methods and strategies, designing the programme, preparing for implementation and developing an evaluation plan. Experience with the Teenage Mothers Project illustrates how, over a period of more than a decade, intervention mapping undertaken by a planning group enabled the iterative development of an increasingly comprehensive project responding to the needs of the individuals and communities it aims to serve [9]. The participatory approach, involving teenage mothers and community leaders, contributes to the success of a project that evolved to encompass counselling and support groups, and addresses social and economic factors through community awareness raising, education income generation and advocacy.

Innovation in sexuality education and service provision

Five of the papers in this issue provide insight and views on innovation in sexuality education and service provision. Initially, it would seem that these papers focus on populations in their formative years (students and young people). Yet, a deeper examination suggests that an important focus is on societal and structural factors and social change. Three describe research conducted in the African Continent (Kenya, South Africa and Nigeria) and two outline research initiatives in North America.

Maticka-Tyndale et al. [11] reported on an evaluation of a train-the-teachers initiative to deliver HIV prevention in the 11- to 16-year olds in Kenyan schools. The programme pedagogy that was evaluated was informed by social learning theory; and programme components included role modelling, practise of behaviours, and didactic and participatory interventions, among others. The programme itself, originally implemented in one province, demonstrated increases in student knowledge and self-efficacy related to sexual restraint and condom use which, together with greater acceptance of HIV positive students, were subsequently replicated elsewhere in the country. With greater roll-out in other provinces, results were as strong or stronger than those found initially. Significantly, there was little teaching about HIV and AIDS at baseline, but increases in this area improved with time and with the
experience of teachers, suggesting that teachers become more effective over time.

Exploring the understandings of gender that teachers involved in sex education have in relation to pregnancy and HIV infection, De Palma and Francis [12] reported on a qualitative study involving 25 Life Orientation teachers in South Africa. The authors set out to determine how teachers understand gender as a factor influencing the learner’s experiences of sexuality. They recognized that sexuality does not simply involve a physical dimension or desire, but is shaped in the broader ‘socio-political context’. They illuminate aspects of young people’s sexual learning and experiences and the responses of learners in the classroom. The authors make clear that programmes must not maintain gender stereotypes that are disempowering to women, but rather provide roles and social skills that young men and women need to develop healthy, more equal and sexually satisfying emotional and sexual relationships.

In a third paper, from Nigeria, Amaugo et al. [13] undertook a systematic review to examine the efficacy of HIV and sexual health education programmes in improving sexual health outcomes. The review focused on studies involving pre- and post-programme assessments published between 2002 and 2012. The results suggest that school-based education may positively affect Nigerian students’ sexual health knowledge, attitudes and sexual behaviour. Mechanisms for changes in self-efficacy are explained in relation to the health belief model and social cognitive theory.

Gubrium and Shafer [14], in a North American context, and working with young parenting (teenage) mothers, described the development and evaluation of a unique pilot intervention. Their work seeks to explore and demystify stereotypical notions about teenage mothers. Of special interest are the meanings young women ascribe to teenage pregnancy. For the authors, this implies moving beyond any simplistic notion of mechanisms for the prevention of pregnancy. Their findings suggest a movement towards more sex positive approaches and the fuller engagement of participants in future programmes. The authors postulate that a more ‘sensory approach’, with an emphasis on exploring pleasure, desire and sexual entitlement in a non-threatening environment, holds the potential to stimulate ways of thinking about or within relationships in a more healthy way. Employing a sex positive, sensory approach holds the potential to situate sexuality in everyday life and provides transformative health messaging, which does not focus simply on health issues, difficulties and problems.

The final paper in this group focuses on Lesbian, Gay, Bisexual, Transgender and Queer Youth (LGBTQ) experiences in Canada, and is informed by post-modern and feminist perspectives. In this and other settings, gender and sexual minority youth frequently experience discrimination, use injection drugs, experience sexual abuse or have had thoughts of suicide. Using qualitative data, the study examines doctors’ and nurses’ experiences providing services to LGBTQ youth in Canada [15]. The study illustrates how clinical experiences may exacerbate health inequities; and how institutional norms and lack of social and cultural sensitivity reinforce a heteronormative environment in which all young people are assumed to be heterosexual. Structural changes are needed to address the influences that render gender and sexual minority individuals and populations most vulnerable.

Across each of these studies much is said about the importance of context and culture. An analysis of these factors clearly demonstrates that challenges lie in many areas. Context and cultural beliefs have shaped both the experiences of participants and the interventions examined in these studies. The realized outcome of sexuality education and service provision may be quite different depending on morals, religious values, attitudes to human rights, and cultural and historical traditions. Despite this, there exists a range of demonstrably effective approaches and perspectives. Crucially, however, while one particular approach may work in one specific context, it may not be the ultimate solution in all. The challenge for future health education lies in further developing the research base provided by these papers to identify promising approaches of more general utility and worth.
Four of the papers included in this issue focus on the problem of GBV, one of the most pervasive and pernicious public health and human rights violations of our times. Research has shown that one in three women will be beaten, coerced into sex, or otherwise abused or forced to submit to harmful practices (e.g. female genital mutilation [FGM]) in her lifetime [16–18]. As a result, many will experience devastating physical, mental, sexual, reproductive, and perinatal health impacts such as HIV and other STIs, sexual dysfunction, unplanned or unwanted pregnancy, induced abortion, pregnancy loss and low birth weight [18]. The papers included here deepen our understanding of GBV by examining the issue in important under-researched populations, capturing the viewpoints of those who may play a role in its perpetuation or prevention and evaluating strategies designed to address it. One study each is set in Canada; Nigeria; South Sudan, Uganda, Thailand, Liberia and Rwanda; and Australia.

Examining the problem of sexual violence among sexual minority women, Logie et al. [19] adopted a socio-ecological approach to determining what factors, if any, are associated with having experienced lifetime sexual assault. Results from their cross-sectional Internet-based survey of over 400 lesbian, bisexual and queer women living in Toronto, Canada revealed that over two-fifths had been sexually assaulted. A positive history of sexual assault was associated with several negative health outcomes, including higher rates of STIs and depression, and lower self-rated health. The authors argue from their findings that various individual- (self-esteem), social- (social support) and structural- (barriers to care, access to STI testing and sexual stigma) level factors are also associated with having experienced sexual assault, the value of using a socio-ecological framework to underpin community-based interventions to challenge sexual stigma and sexual violence.

Ahanonu and Onyinyechukwu [20] are interested in the issue of FGM, as studied from the perspectives of mothers with girl children in Nigeria, where the practice is widespread. In their study, nurse-administered, semi-structured questionnaires completed with 95 mothers presenting to a primary healthcare centre in Lagos revealed contradictory beliefs about FGM. Although more than half of the mothers thought that the practice of FGM was not beneficial, a substantive minority responded that FGM could aid a woman in being faithful to her husband and deter sexual promiscuity. About one-quarter reported that undergoing FGM does not increase the risk of experiencing gynaecological problems. The authors make clear that such myths and misperceptions about FGM and the lack of awareness of its potentially serious health-related sequelae must be vigorously addressed. They contend that their findings can aid in the development of content for programmes aimed at protecting Nigeria’s girl children by educating about and eradicating FGM—a priority that should be strengthened by all levels of government in Nigeria.

The work of both Gurman et al. [21] and Ollis [22] is focused on evaluating interventions to address GBV. The first of these papers presents qualitative findings from ‘Through Our Eyes’, a participatory video project aimed at reducing GBV by stimulating community dialogue and action in settings affected by conflict. Eighteen focus groups and 76 key informant interviews were held in South Sudan, Uganda, Thailand, Liberia and Rwanda. According to the authors, the project was successful in that, among study participants, GBV was destigmatized, GBV survivors were encouraged to access health and law enforcement services, awareness of women’s rights and gender equity was increased, and attitudinal and behavioural changes related to reporting violence, intimate partner violence and girls’ education were changed [21]. In the second paper, Ollis reported results from a pilot implementation of a primary prevention approach to GBV in four high schools in Melbourne, Australia. The evaluation focused on assessing whether the curriculum materials developed on respectful relationships were useful in assisting teachers in providing learning experiences on GBV for students as well as their potential for increasing understanding of the issue of GBV among students. Feedback from
teachers and students involved in the delivery and receipt of the curriculum was captured using surveys, focus group interviews and written reflections. Analyses of these data were encouraging, revealing that both teachers and students had positive experiences of teaching and learning about GBV [22]. Importantly, both of these studies contribute to our growing understanding of intervention strategies that may be useful for addressing GBV in communities and schools.

Taken together, these papers on GBV begin to address some important gaps in the literature. At present, there is little evidence on the effectiveness of initiatives for use with women having experienced or at risk of experiencing GBV. Until various strategies have been evaluated and those that are efficacious implemented, the negative consequences of GBV will continue to take a toll on women’s health and well-being. Expanding our knowledge of GBV among populations less studied such as lesbian, bisexual and queer women, as well as drawing on useful, but relatively untapped sources of information, can help better shape the development of or improve existing health services, educational programmes and public awareness campaigns.

**Conclusion**

This special issue of *Health Education Research* has aimed to showcase current as well as promising new directions in sexual health promotion research. Together, the papers demonstrate the vibrancy of a field of enquiry whose findings, only two decades ago, rarely figured on the pages of mainstream health education journals. Growing concern over sexual and gender inequality and the advent of HIV changed all this, opening up for scientific debate issues which had hitherto been viewed as ‘private matters’, or ‘specialist subjects’ best considered within the fields of sexology, sexual therapy and sexual medicine. Although enormous progress has been made in a short period of time, much remains to be understood: both with respect to the social meanings and cultural practices that link to sex, sexuality and relationships, and in relation to the programmes and interventions that are most effective in promoting sexual health. When putting together this special issue, we were surprised by the number of high-quality contributions we received. Such was their strength that we will be publishing several of them separately in regular journal issues over the coming months. We hope you enjoy reading both this special issue and these other papers as much as we have while bringing together this special issue of *Health Education Research*.

**Conflict of interest statement**

None declared.

**References**


