ENTRE NOUS

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In this issue

Young people and the special skills and approaches needed to provide them with reproductive health information and services are the main focus of this issue of ENTRE NOUS.

In his guest editorial, Professor J.M. Paxman, proposes some lessons that can be learned from the approach to teenage sexuality and fertility taken by certain of the European countries.

Dr Nila Kapor-Stanulovic examines the similarities and differences between the young in various parts of Europe (page 5).

New social, political and economic pressures, she says, are adding to the problems they already face in their personal transition to adulthood.

The Netherlands and Sweden have comparatively low rates of unwanted teenage pregnancy, but are still actively exploring ways of making their information and services for this group more acceptable and effective, report Dr J. Rademakers and Ms A. Nilsson (pages 6-7).

School sex education programmes in Denmark, Finland and Switzerland feature on pages 9-10.

Services intended originally for adults have many built-in drawbacks in young people's eyes. Confidentiality, friendliness and accessibility have made the Brook Advisory Centres in the United Kingdom a model service for this group (page 8). A similar approach is taken in Ireland - where the participation of young people in services has revitalized the Irish Family Planning Association (page 8) - and in Belgium (page 10).

In Spain and Portugal very few young people use contraceptives. The Family Planning Associations in both these countries are making energetic efforts to fill the gap left by a lack of services tailored to their needs (page 10-11). The articles on Yugoslavia and Bulgaria give an indication of the type of problems occurring in Eastern Europe, where sex education and reproductive health services for adolescents are often inadequate and inefficient (page 11). Also in this issue, how UN and non-governmental organizations are working with and for young people (pages 12-14), and peer leadership as an effective approach to adolescent health promotion (page 13).

Diana Gibson

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Cover photo: WHO/Jørgen Schytte
Facts of life for adults

by J.M. Paxman

Andersen's beguiling story The Emperor's New Clothes has many applications. The Emperor and his subjects gullibly accept the master-tailor's line that the elegant new robes are made of a magic, invisible weave. Only when a small boy blurts out that the Emperor has nothing on at all do they admit the reality.

In the past, many people - parents and policy-makers alike - have dealt with the issue of adolescent sexuality in the same, unrealistic way. They have repeatedly ignored the fact that most teenagers are sexually active, and that this is a natural part of human development. Underneath their denial of the facts lie very strong feelings, which in part explain why the discussion of sexuality programmes for adolescents is often accompanied by confusion and confrontation.

Where, when and by whom should teenagers be taught about sexuality? When should they become sexually active? Should those who are already sexually active be given access to contraception? Should they be able to terminate an unwanted pregnancy by an abortion? Is contraception the best way of reducing teenage abortion rates? Should parents be asked for their consent to contraception or abortion? These are just a few of the questions that legislators and policy-makers in Europe have been called upon to answer.

The response of four of the European countries - Sweden, the Netherlands, France, and England and Wales - has been to decide in favour of helping teenagers cope with their sexuality. Much can be learned from their experience and other countries are carefully studying their achievements, not least the United States, where the teenage pregnancy rate is three times that of Western Europe.

In the Netherlands 90% of sexually active teenagers use contraceptives; the teenage birth rate - 14 per 1,000 - and abortion rate - less than 10 per 1,000 - are far and away the lowest among the four countries mentioned. In Sweden almost as many teenagers use contraception as in the Netherlands, and the birth and abortion rates are also very low, although Sweden has the earliest average age for the first sexual experience. In England and Wales 90% of teenagers use contraception but the birth rate is higher, at 45 per 1,000, and the teenage abortion rate is on a par with those of other European countries.

The birth rate in France is similar to that of England and Wales, but contraception use is much lower, at 58%; however, the abortion rate in France is only slightly higher than in Sweden and in England and Wales.

What can be learned from these four countries that might be applied elsewhere? The Swedes were the first, in 1956, to introduce mandatory sex education in schools. But they do not feel that sex education alone is enough. The answer is, no, it is not. The Swedes have insisted that as a matter of public policy, education should be linked directly to services, ranging from contraception to abortion. In all four of the countries mentioned contraceptive services are available for adolescents, either free or at low cost. Elsewhere the debate over contraception for the young is still entangled in polemic. One main worry is that access to contraceptives will act as an incentive to sexual activity. However, research has made it quite clear that it does not: young people become sexually active well before they think of contraception. Nonetheless, adults around the world continue to try to ban contraception for teenagers. One observer notes: "It is as though, to demonstrate their dislike for motorcycles, they have chosen to ban the use of safety helmets!"

Young people have a strong wish to keep their personal sex lives private. In parts of Europe, laws, policies and practice support them in this. In Sweden, for example, doctors are specifically forbidden to inform parents if a teenager asks for contraception. Visit confidential if the young persons asks them to do so, and clinic services are confidential. French policy requires contraceptive services for women under 18 to be strictly confidential. In Britain, after several years of legal wrangling, they are now confidential for people under 16.

Parents do in some settings insist that they want to know what their sons and daughters are doing. What should their role be? The countries mentioned seem to feel that while parents should not be completely excluded, parental consent or notification should not be part of the price that young people pay for obtaining contraception, nor should pregnancy be the price of sexual intercourse.

As to the connection between contraception and abortion, again the Swedes have led the way. The expansion of contraceptive services for teens in the 1970s was part of a concerted campaign to lessen the number of abortions in Sweden. Between 1974 and 1981 the teenage abortion rate in Sweden fell dramatically, by 27%. (Over the same period, the United States rate rose - even more dramatically - by 59%!)

In France and the Netherlands too, the desire to minimize abortions among young women was a major factor in the decision to develop contraceptive services for young people. But this does not mean that there is no place for abortion services for young women. Again, the experience in Sweden, England and Wales, France and the Netherlands indicates that access to abortion services is an important part of the overall approach to reproductive health for teenagers.

Parents, policy-makers and programme managers everywhere can all learn some of the facts of life from the European experience. These are: that teenagers are sexually active; that comprehensive sex education makes a valuable contribution to the lives of teenagers but is not enough by itself; that access to confidential, low-cost contraceptive services is essential to reduce rates of unwanted teenage pregnancy and abortion, but will not wholly eliminate either; and that the need for early, safe abortion services will never altogether disappear.

Now another dimension has been added to teenage sexuality - the AIDS pandemic. Nearly a quarter of those who have AIDS are in their twenties, and probably contracted the virus while still in their teens. Does this mean that the debate over sex education will subside? That comprehensive sex education will be supplanted by single-focus AIDS education? That teenage sexuality patterns will change? That abstinence will become the new vogue?

Will the condom - admittedly less effective as a contraceptive but the frontline measure in preventing the spread of AIDS - become the predominant method for teenagers? Will pregnant teenage girls be screened for HIV? If they test positive, will an abortion be mandatory?

Europe may again provide some of the answers to these questions, which are the new frontiers of teenage sexuality. As with the Emperor, they need new clothes, that is, new responses. We cannot pretend that they are invisible: They are the facts of life.

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Adolescent fertility worldwide

In September 1990, the International Forum on Adolescent Fertility met in Arlington, Virginia, USA under the auspices of the Washington-based Center for Population Options. Forty experts concluded that the world has made only modest progress recently in providing for adolescent reproductive needs.

Young people worldwide are being systematically denied access to reproductive health care and services. The result is that nearly 15 million teenage women between the ages of 15 and 19 give birth every year – 80% of them in the developing world. Adolescent childbearing takes its hardest toll on young women in those countries, because it further limits their already fewer opportunities and exacerbates their precarious health and economic status. In Latin America, 50% of young women give birth by age 20, as do 65% in sub-Saharan Africa, and 54% in Asia.

While exact figures are not available, the evidence suggests that a large percentage of the estimated 200,000 maternal deaths each year due to abortion-related complications occur among young women. The Alan Guttmacher Institute estimates that between 36 and 51 million abortions were performed worldwide in 1987, about 10-20 million of them illegally. Between 10% and 20% of these abortions probably involved adolescent women who, because of their generally limited access to contraceptives, may have even higher rates of abortion than older women.

Restrictive laws and policies are major barriers to adolescent access to reproductive health services. What is needed to improve the situation is a great deal of individual commitment, an intensified battle to change restrictive laws and policies, and financial help from donor agencies for the implementation of adequate services.

UNICEF and WHO join forces for youth

The UNICEF-WHO joint committee on health policy met in Geneva on 28-30 January 1991 to discuss healthy lifestyles for youth. It was agreed that young people’s health is an issue of priority concern to both agencies and that a strong attempt should be made to safeguard their health and wellbeing.

Patterns of behaviour laid down in childhood and adolescence profoundly influence both current and future health and longevity. Therefore, a number of recommendations were put forward for both national and international action to foster health-promoting patterns of behaviour among the young. Some of these ideas were:

- to increase knowledge and understanding among young people of general health, nutrition and safety issues; of the health and social risks of tobacco and substance abuse; and of sexuality and the prevention of pregnancy and sexually transmitted diseases
- to reduce the incidence of early pregnancy, reduce exposure to and contraction of sexually transmitted diseases, and reduce the harmful consequences of early pregnancy, childbearing and sexually transmitted diseases
- to reduce the prevalence of tobacco and substance abuse
- to involve young people in health promotion and development action.

Sex education for parents

Most people would agree that parents are responsible for seeing that their children receive education in sexuality and personal relationships. But are they really equipped to deliver effective education, especially to adolescents?

In a new and unique WHO study to be published shortly, Mary Porter, Karen Akhjem and Danuta Duch contacted nearly 70 professionals from different disciplines active in the field of sex education and advice to parents in 21 European countries. Most of these people believed:

- that children and young people need education about sexuality
- that parents have a responsibility to see to the sex education of their children, either directly through communicating with them in the home or through actively supporting teachers and schools, or both
- and that parents will meet this responsibility more effectively if they receive education, information, resources and support.

Many parents are supportive of sex education for their children, but often do not feel able to take on this role. They either want help or would prefer to delegate their role to teachers or other professionals, whom they see as better equipped.

However, even if teachers offer the best sex education that is possible in schools, the children still learn about sexuality and relationships from their parents, either directly, or indirectly through the model of relationships in the family and the parents’ own attitudes to sexuality.

The authors of the study conclude that it is now time to focus on parents and their needs, and on other sources of sex education in addition to school. More research is needed, they say, to clarify the issues facing parents, and their concerns, fears and hopes. This would form the basis for development, implementation and evaluation of suitable approaches to giving parents all the help and support they may need to become effective sex educators of their children.

(The to obtain a copy of the report, please write to: Sexuality and Family Planning Unit, WHO Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen O, Denmark.)

THE HEALTH OF YOUTH

Facts for action

- There are 1,500 million young people aged between 10 and 24 years in the world today.

- Worldwide, fertility rates for women under 20 are decreasing, as are those for other age groups. Total numbers of births to adolescents, however, are increasing.

- The lower the age of the mother, the greater the risk associated with pregnancy and childbirth, particularly if there is inadequate prenatal care.

- Smoking remains the most important preventable cause of death in developed countries. It is especially important to focus on young people because it is during adolescence that the smoking habit is acquired.

- Abuse of both licit and illicit drugs often has its roots in adolescence and youth, although the problems of chronic use may not be apparent until adulthood.

- Worldwide, consumption of alcoholic drinks by young people and adults has been increasing, and alcohol-related mortality rates are a cause for concern.

- Highest rates for notifiable sexually transmitted diseases are usually observed in the 20-24 year age group, followed by the 15-19 and 25-29 year age groups.

- At least half – up to 2 million – of those infected with HIV are under the age of 25; making AIDS a major concern affecting youth today.

- From WHO fact sheets
Europe's youth: are they all alike?

There are 109 million young people aged 10-24 in Europe, which is a little more than a fifth of the total population. This is below the averages in developing countries, where a much higher proportion of the population is under 24, and also below world estimates, which suggest that about 30% of the global population is aged 10-24.

In comparison with other areas far more European children survive childhood—only 2% die before the age of 20. However, the fact is that fewer and fewer children are being born in Europe. From today's 109 million the number of young people will drop by 2025 to only 88 million youngsters in the same age range.

Some 85% are enrolled in secondary school (83% males and 86% females); this is high in comparison to developing countries, where the figure is between 35% and 45%. School enrolment is the highest for Western Europe (92% for males, 83% for females) and lowest in Eastern Europe (69% for males and 74% for females).

Participation in the labour force by young people aged 15-19 is 45% for males and 36% for females. It is highest in Northern European countries, where on average 50% of the young at this age are employed (54% males, 47% females) and is lower for other parts of Europe: in Eastern Europe, 39% of all youth, in Western Europe 40%, and in Southern Europe 37%.

If these two indicators—school enrolment and employment—are taken together, then clearly Eastern European youth is in a disadvantageous position. Too many of them to not go to secondary schools and too many are without a job. Employment is the most important condition for adequate development of young people leaving school. Unemployment poses all to frequently a disproportionate burden, which can lead to psychological stress and reduced self-esteem, and may be a contributing factor to the abuse of drugs and alcohol.

Getting a job, on the other hand, helps young people to adopt adult roles and responsibilities.

Girls in Europe as a rule do not tend to get married early nor to have children early. The overall percentage of girls aged 15-19 who have ever been married is 5%; in Northern and Western Europe it is 2%, in Eastern Europe 10% and in Southern Europe 7%. Bulgarian girls lead in this: 18% of them get married before reaching their 19th birthday.

The percentage of teenagers giving birth each year is 0% of the total population as a whole, 2% for Western and Northern Europe, but 5% for Eastern Europe, with Bulgaria, where 8% of girls have a baby early in life, again in the lead.

There is no doubt that young people's lives are considerably shaped by the society in which they live and by overall social changes. All the European countries are experiencing social, demographic, technological, scientific and other changes, but some are also undergoing rapid changes in the political, economic, religious and legal spheres. This makes the life of young people more difficult, since they are now faced not only with the problems of their personal transition to adulthood, but also with the changes in the world around them.

Increased psychological stress, limited opportunities and curtailed aspirations are only some of the sad consequences of this.

In many ways young Europeans resemble each other. Like all adolescents, they pass through the same physical and developmental processes, suffer identity crises, are hurt by double standards, fight for their independence and want to be recognized as adults.

The greatest differences between them result from the particular lifestyles adopted by the young in different parts of the European continent. It is well established that adolescence is relatively disease-free and that morbidity and mortality in this group is mainly determined by the patterns of behaviour they adopt. Smoking, alcohol and drug abuse, unprotected sexuality with unwanted pregnancies, sexually transmitted diseases, HIV/AIDS—all these are examples of behaviour-rooted health problems of the young.

There has been a significant decrease in the number of young smokers in Nordic countries but an increase in the Southern countries, especially among the girls. Alcohol and drug abuse are on the increase in almost all of Europe, but sexuality-related problems vary considerably, due largely to society's very different attitudes towards sexuality in young people. While the Nordic countries take a very casual approach to sexuality and have highly effective sex education programmes, the young in Southern Europe are undergoing a long process of fighting for at least partial recognition of their sexuality.

A 17-year-old girl in Denmark will find no problem in admitting she is "on pills", while a 17-year-old in southern Italy will suffer the consequences of an illegal abortion due to her lack of knowledge about contraceptives or her reluctance to contact contraceptive services and many barriers to obtaining a legal— that is safe—abortion. Most of the Eastern countries meanwhile have long ago approved sex education officially, but have not managed to implement it adequately.

Exercise, fitness and adequate nutrition, so important for long-term health, are common in Western Europe but entirely forgotten in the East.

To turn again to similarities, in Europe, as in other developed societies, accidents, suicides and other external causes now constitute the major causes of death in adolescence. These causes are responsible for more than half of all deaths among the young. In Austria and Switzerland, the figure is in fact over 70%.

So are the young people of Europe homogeneous as a group? The common stereotypes of sophisticated West, liberated North, joyful South and eager-for-a-change East imply that they are heterogeneous, but as the figures show one cannot make such generalizations: there may be some regional differences, but at the same time the young in various parts of Europe have many features in common.

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Data for this article are taken from The World's Youth Data Sheet 1990 (see page 15).

European countries are classified into four groups as follow: Northern Europe: Denmark, Finland, Iceland, Ireland, Norway, Sweden, United Kingdom; Western Europe: Austria, Belgium, France, Germany, Luxembourg, Netherlands, Switzerland; Eastern Europe: Bulgaria, Czechoslovakia, Hungary, Poland, Romania; Southern Europe: Albania, Greece, Italy, Malta, Portugal, Spain, Yugoslavia.

Photo Beppe Arvidsson \*Billedhuset
Netherlands

Study of teenagers gives pointers for better sex education

Dutch teenagers have the lowest teenage pregnancy rate in the world, but the Netherlands is still anxious to bring the rate even lower.

Since the Alan Guttmacher Institute’s 1986/1988 international comparative study on teenage pregnancy, the Netherlands has been regarded as an outstanding example in the field of education, prevention of unwanted pregnancies in general, and prevention of teenage pregnancies in particular. In 1980/81 the teenage pregnancy rate in the Netherlands was 14 per 1000 girls aged 15-19, compared with 35 in Sweden, 43 in France, 44 in Canada, 45 in England and Wales and 96 in the United States.

The Guttmacher Institute found three reasons for the low pregnancy and abortion rates in the Netherlands. Most contraceptives are provided by easily accessible general practitioners or by the 36 family planning clinics of the Rutgers Foundation, a private non-profit organization subsidized by the government, and contraceptives are covered by national health insurance. There are open and tolerant attitudes to sexuality in general. And information and education for adolescents is of high quality, both in and out of the school system.

However, teenagers in the Netherlands remain a risk group with respect to unwanted pregnancy, and in 1986 the Ministry of Welfare, Public Health and Culture decided to finance a three-year study on the sexual and contraceptive behaviour of adolescents.

The main part of this study was a comparison between the sexual lifestyles and interaction skills of "good" contraceptors (girls who had gone to a family planning clinic in order to obtain contraceptives) and those of the "ineffective" ones (girls who went to an abortion clinic to have a pregnancy terminated). Also, some 350 adolescent boys and girls filled in a questionnaire on their sexual and contraceptive behaviour, their AIDS prevention behaviour, and the sex education they had received.

The results showed, briefly, that more than 70% of both sexes used effective contraception at first intercourse. Some 40% used condoms, 20% took the pill, and 10% — responding to messages about AIDS — used both. But almost a quarter either used no contraceptive at first intercourse, or an inefficient method such as withdrawal. At the most recent intercourse, 85% had used the pill and/or condoms. Only half had always used a contraceptive. As many as 1 in 10 had made love more than five times without protection.

In the study of the teenage girls — the "good" and "ineffective" contraceptors — the latter group had as a whole taken more risks after the first intercourse. Effective contraception seemed to be a skill structurally present in the girls who had gone to a clinic to obtain protection, whereas for those who went to a clinic for an abortion, ineffective contraception was the rule.

Why was this? It seems that the differences were concentrated in three areas. First came the meaning that sex and contraceptives had for the girls: for the "good" group a contraceptive had a functional meaning — to prevent unwanted pregnancy — whereas for the others it was more a sexual symbol, signifying the readiness to have intercourse.

The second important point was the nature of the contact with the boy-friend: "good" contraceptors were much more active in the "negotiations" about the sexual contact and what was going to happen during it, whereas the abortion clients left the initiative and responsibility more often to their partners — partly because they were less at ease talking about sex.

And thirdly, the "good" contraceptors seemed to learn from earlier sexual contacts about how to control and influence the situation, but with the other group every development in this respect was absent, and for the same reason their contraceptive use remained less consistent over time and susceptible to circumstances.

This study points to certain conclusions about how sex education can be improved so that it not only provides information on contraceptive use but also promotes more competent and responsible behaviour in sexual encounters.

The starting point for the educator should be a thorough understanding of the teenager's point of view and experiences, and not just the passing on of "messages". A display of respect for different sexual lifestyles and freedom of the individual is preferable to a moral standpoint imposed on adolescents. It is important for them to accept their own sexual behaviour in order to behave actively and maturely, but difficult for them to do this if others seem to disapprove of their behaviour.

Adolescents should also learn that in a sexual relationship they are in a position where they should "negotiate". Both partners are equally responsible for what happens, and neither should simply assume a passive role.

And finally, the "dangers of sex" such as unwanted pregnancy, AIDS and sexually transmitted diseases — should be incorporated in a total view of sexuality, instead of being treated separately and in isolation from each other and from their sexual context.

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Photo Bjørn Myrman ©Billedhuset
Sweden

Swedes take the lead in interpersonal relations

Sweden has found that a combination of measures is the best way of tackling a complex subject.

What others may call family planning, we in Sweden call "sexuality and interpersonal relations." But not just to be different. The name change means that we work to prevent unwanted pregnancies, STDs and HIV/AIDS among young people in a new and wider context.

Abortion prevention started in Sweden in 1973 - two years before the new abortion law was passed. The law contained some built-in directives for preventive measures. One of these was the Gotland project - a pilot project on a Baltic island with 55,000 inhabitants. Gotland had a relatively high number of teenage mothers and more abortions than other Swedish counties. The project reduced both problems by two thirds in three years. It taught us important lessons that became the basis of our work with the young today.

This might sound as if we in Sweden once and for all had learned our lessons: This is, of course, is not the case. Old obstacles, once conquered, come to the surface again and new barriers appear.

Sweden had very low teenage abortions and teenage births during the 1970s and early 1980s. But the decreasing trend was halted in 1985, when both rates started to increase again. (In 1990 they decreased once more.) Last year we published a new abortion prevention programme for Sweden where the main message is the need to coordinate education and information on the three main problems related to sexuality: unwanted pregnancies, STDs and HIV/AIDS.

Community information on sexuality is complex. One lesson we learned is that you have to work on three fronts at once. In the first you build up the services and train counsellors (85% of all contraceptive counselling is done by midwives). In the second you train a lot of professional groups in sexuality and interpersonal relations. And in the third you go out with information to the public through schools, youth centres, organizations, the local press and so on. It is the combination of these measures that will be effective.

Another important lesson is that education and information in such personal and emotionally charged issues as sexuality need a method based on person-to-person communication. Pamphlets, films and similar materials may provide a starting point for this but cannot replace the dialogue between people.

One problem is that sometimes youngsters can get assaulted with information provided in an inappropriate and segmented way. One day it's STDs, the next abortion, the third drugs, the fourth violence. But when it come to sexuality, it is important to integrate your materials. Many so-called AIDS educators have talked too much about HIV/AIDS and not even mentioned the risk of having an unwanted pregnancy. As a sex educator you have also got to take the everyday life of young people into account and deal with friendships, work, education, relationships with parents, the future - in other words a "larger context".

All of us with experience of abortion preventive work in Sweden wanted to give deeper support to young people, instead of putting too much money into mass-media campaigns. In recent years, therefore, we have involved politicians more in our work and convinced them of the importance of having good youth clinics.

Today we have about 130 such clinics in Sweden. But it is also important to reach those who don't show up at the clinics, so the staff also work outside - in schools, youth centres, at meetings with parents, and so on. In the clinics they have started to trace young women for chlamydia infections and we can already see a result - in some regions the chlamydia rate has decreased from 20% to 7%.

We also try to respond to the needs of boys and young men by addressing especially teenage boys in our sex education programmes called "Just for Boys". During the last four years we have arranged three-day courses for adult men (teachers, doctors, etc.) with the aim of training them to be good sex educators for young men.

Finally, the liberation of sexuality, not moralizing about it, is an essential ingredient of all sex-related preventive work. Messages such as "don't do it" border on hostility to sex. Could it be that politicians in many countries are more concerned about teenage sexuality than teenage pregnancy? Morality tends to create a world of the good and the bad, the respectable and the disgraceful, just as in times gone by when syphilis was the shameful sign of a dissolve life. But shame never prevented people from making love.

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Photo Jan Håkon Dahlström/Billedhuset
United Kingdom

Brook Advisory Centres: a service young people are confident to use

Brook Advisory Centres was founded in 1964 by Helen Brook, as the first birth control organization prepared to offer contraception to unmarried women. Twenty-seven years on, Brook remains in the forefront of work with young people and, as a national registered charity, provides the only network of youth advisory centres in Britain where young women and men can get confidential help with contraception, pregnancy and sexual and emotional problems.

Brook has always recognized the reluctance felt by many young people to use formal contraceptive services. Experience shows that teenagers are often wary of meeting a family friend or even their own mother among the older clientele of family planning clinics, while the fear of a breach of confidentiality keeps the majority of young people away from the family doctor.

A guarantee of confidentiality, a friendly and informal atmosphere, easy access and flexible appointment systems to accommodate emergencies are key features of Brook Centres. The Centres are located near good public transport but without being so much in the "public eye" that they worry the clientele; sessions are run in the evenings and on Saturday mornings to allow teenagers easy access from school, work and home and — perhaps most importantly — are staffed by those who like young people and enjoy working with them.

Services offered by Brook Centres include contraceptive advice and supplies, including emergency postcoital contraception, pregnancy testing, pregnancy counselling, referral for abortion and counselling for sexual and emotional problems. Information on protection against sexually transmitted infections including HIV is given at all the Centres and clients are encouraged to use their chosen method of contraception together with condoms, which are free on request. A visit to a Brook Centre provides many young people with one of the very few opportunities they have to discuss the risk of HIV transmission in the context of their own sexual history and current relationship, which helps to make HIV/AIDS education more meaningful.

Education in sexual health and relationships is central to the work of Brook both within the Centres and through the work of its Education and Publications Unit, which produces and distributes publications on personal relationships and birth control for use in schools, further education settings and youth groups. Outreach work from the branches into the community has enormous potential in informing young people about the service and reassuring them of a confidential and sympathetic welcome, and liaison with youth and community groups is initiated wherever possible. However, current funding restrictions are forcing some Brook branches to cut back on this valuable area of work.

Brook Advisory Centres has been recognized as developing a model birth control service for young people and receives over 100 calls a week from teenagers seeking the whereabouts of their nearest Centre. Yet Brook only has 19 Centres in seven major towns and fewer than half of Britain's health authorities provide any similar youth advisory service. With the teenage conception rate steadily rising there is an urgent need for an expansion of young people’s services. Brook Advisory Centres has invaluable experience on which to draw, but first health service planners and society as a whole must recognize the benefits of providing young people with the support they need to develop safe, responsible and happy sexual relationships.

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Ireland

Direct involvement of young people

Adolescents work in partnership with the medical staff in Ireland’s first family planning centre for teenagers

Young People and Family Planning is the title of a new report from the Irish Family Planning Association. Based on the Association’s learning experience during the first five years of its adolescent peer-education programme, the report outlines the history and development, as well as the successes and failures, of this unique project.

In the early 1980s, the Association, faced with a spiralling teenage pregnancy and abortion rate coupled with a conservative state that restricted contraceptives and denied proper sex education, launched its own ambitious plan to educate and inform young people.

With help from the International Planned Parenthood Federation and Family Planning International Assistance, the IFPA successfully operated a teen confidential telephone service. The real strength of this project was grounded in the direct involvement at every level of operation and project development of young adults themselves. They were making major decisions on promotion, operation, evaluation and training requirements.

On average, 80% of callers to the telephone service were young men, debunking the myth that family planning organizations can only reach women in the community.

As a result of the active involvement of young, enthusiastic and imaginative volunteers, the group’s work expanded to include the establishment of Ireland’s first "Young People’s Family Planning Centre". There, young volunteers worked in partnership with medical staff. Research has indicated that the presence of young enterprising and active young clients’ fears, as it was a form of non-verbal communication that the centre was a safe place where young people are accepted and respected as equals.

In later years the group became involved in resource production and education talks, and even started writing two regular advice columns in adolescent rock-music magazines. This latter development further undermined the denial of basic information, with open discussion on taboo topics such as puberty, changes, safer sex, sexual preference and contraception.

Not only did active involvement and power-sharing with young people generate new innovative initiatives, but it also regenerated the 21-year-old Family Planning Association itself, with an influx of new ideas and fresh thinking that ensured for the IFPA a new relevance and ability to meet the changing needs of a changing society.

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ENTRE NOUS 17, April 1991
Denmark

Condoms and luck

The Danish Family Planning Association produces a wide range of sex education materials for schoolchildren, teachers, pharmacists and all who work with the young.

Danes enjoy a good joke about sex. Other Europeans admire them for their unruffled and liberal attitude, which Foreningen for Familieplanlægning (FF), the Danish Family Planning Association, puts down to well established equality between the sexes and relaxed religious influences.

Of course young Danes have to learn the sexual ropes like everyone else. The video Sex – A Guide for the Young shows very amusingly that they are by no means immune to embarrassing experiences and myths. But Danish children start learning about sex from their first year in primary school, and no doubt this pays off.

Integrated in ordinary classes, sex education by teachers goes on until the pupils leave school. Now plans are afoot to revise the curriculum, but FF fears that may cause sex to drown in a sea of health education.

Young people are a big issue for FF. The organization provides leaflets, films and demonstration materials such as a box containing every type of contraceptive and a glossy book of full-colour overheads called Growing, Growing on, Grown up. These aids to contraceptive methods and puberty are used mostly by schools. Teachers’ manuals are available for the compulsory, integrated sex education. Local classes can visit FF’s two Copenhagen-area contraceptive clinics. All 14 counties are obliged by law to provide such clinics, but more and more are closing for lack of funds and political support.

In recent years FF has run three big campaigns with the Danish Pharmacists’ Association. The first transformed the pharmacy into an obvious place to go for exact information on contraception. To standardize the information they supplied, all the pharmacies received the same teaching manual.

The second campaign involved children of class 7-10 in a drawing competition: Take Good Care of Your Love. The third, Protect Your Fertility, promoted condoms as a way of preserving one’s ability to have children. All three campaigns aimed mainly at the young.

Videos – including The Test is Positive, an abortion story stressing emotions as well as facts – come with a teachers’ guide and a leaflet for pupils (for videos with English commentary, see page 15).

All Danish schoolchildren aged 14-17 receive a free copy of the quarterly Young magazine, supported by governmental bodies and NGOs. FF contributes a lively page to each issue, on the “first experience”, STDs, incest, early abortion and so on. If the presentation is often light-hearted, nevertheless it must avoid ridiculing sex. It is important to tread a careful line between seriousness and humour.

Sex & health is FF’s twice-yearly magazine for professionals who work with the young, on themes such as sexuality, contraceptives, STD and abortion.

FF staff believe that their Dutch colleagues have been more effective at prevention because of a combination of good sex education and more technical methods, such as IUDs. Failures in Denmark seem to occur because young Danes trust too much to “condoms and luck”.

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Photo Beppe Arvidsson ©/Billedhæset

Finland

Starting young

Finnish schools teach health education throughout the school years. The aim is not only to transmit knowledge but to help young people adopt a health-promoting style of life.

In Finland sex education forms part of health education, performed by teachers, school nurses and school doctors. They teach in small groups and also in individual sessions, using lectures, brochures, videos and campaigns. The National Board of Health and the National Board of Schools give guidance on the courses and send materials to the schools. They have also had direct campaigns for teenagers, sent personally addressed mail, sponsored radio and television programmes, and so on.

Sex education starts when the children are seven. The programme includes information about young people’s development into men and women, sexuality, courtship, sexual behaviour, pregnancy, delivery, abortion and sexually transmitted diseases. The children are advised on how to prevent unwanted pregnancies and venereal diseases. They obtain information about different contraceptive methods, the services available to them and family planning.

Teenagers are always welcome at the municipal family planning centres. Pills and/or condoms are available free of charge.

School sex education has special advantages. It reaches everybody, the whole age group. It can be given gradually throughout the school years, taking into account the young people’s stage of development. It becomes a normal part of school work and of health education, and can reach teenagers before they personally start experimenting with sex.

Teenage pregnancy and abortion rates in Finland are lower than in most countries, even though Finnish teenagers start sexual intercourse just as young as anyone else. This suggests that sex education has been quite successful. There are only two HIV-positive people in Finland under the age of 20. However, condyloma and chlamydial infections are quite common, so there is still a lot to accomplish.

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Spotlight

Work with them, not for them

Sex educator and psychiatrist Dr Pierre-André Michaud of Lausanne, Switzerland was interviewed for Entre Nous by Christopher Lawson

I think it’s true to say that our Canton of Vaud is a leader in Switzerland in terms of sex education and safe-sex campaigns. Vaud has a population of 600,000, 12% of them adolescents aged 11-20. A state-funded private institution called the Pro Familia Medical and Social Centre, with offices in Lausanne, is responsible for sex education, family planning and counselling.

The attitude in our canton is that schools should not be obliged to accept sex-education courses. But after a history of ups and downs we now reach 95% of all pupils. AIDS has certainly been an impetus. Religion, by the way, hasn’t really played a very prominent role.

Pro Familia’s sex-education section has 50-60 staff, none of them full-time. My colleagues and I felt it would not be possible to maintain our enthusiasm if the work turned into something routine. The staff are well known to children and adolescents, and the parents know us too, we think it important to maintain a certain neutrality.

The 10, 12 and 14 year-olds have ‘our hours of sex education in two separate blocks in a school term. We focus on feelings and on exchanging information about the risk of AIDS and STDs. We promote discussion, stressing that sex is something you can talk about.

Vaud had the first committee on school AIDS prevention, set up by the Cantonal Medical Officer in 1987. But the focus should not be on AIDS alone. One should also speak of sex and talk about the fear of risk-taking behaviour in a global, positive way. We need to use multi-channel, consistent messages.

There is a difference in approach between the USA and Switzerland on AIDS: we emphasise not testing, but attitudes and behaviour. We encourage the use of condoms: there are posters in every town. We are trying to get people to talk about it, to live with it, to know what it means to be HIV-positive.

We have also had programmes for homosexuals, drug addicts and prostitutes. In our canton we have developed many programmes for young people and had discussions on AIDS based on their own questions. We had a telephone hotline, pamphlets and brochures. We used different agencies because this gave us different funding possibilities.

At a 1987 exhibition on STDs and AIDS 50,000 free condoms were distributed among the adolescent population! We have a STOP SIDA (STOP AIDS) bus, which toured round rock concerts, state-funded by the Federal Government. We also have a computer programme that enables pupils to ask questions anonymously. And we have six 10-minute videos that make a good introduction to the discussion of everything to do with sex.

Our credo is to work with adolescents, not for them. They have a lot to teach us about the way they see AIDS and sex. We should listen to them and exchange information. We shouldn’t be too demagogic, but of course at the same time we should not let ourselves be manipulated.

Belgium

Aimer Jeunes

What makes a service for young people effective? "The right philosophy adopted by the whole staff", says Dr I. Alptekin of Aimer Jeunes (Young Love), a family planning clinic for young people in Brussels.

At the core of this philosophy, according to Dr Alptekin, are four principles: a friendly welcome to the young client, the chance to get acquainted with the service prior to using it, the investment of time, and demedicalization of the service.

How the client is received is the most important of these, especially on the first occasion. If the first contact with the clinic and staff is not good, then the young person will not come again, and may even be reluctant to try anywhere else.

Whoevers receives the client must know the art of listening – not interrupting, and posing very few questions, so that the client feels that the clinic and staff are there to respond to his or her needs, and not to interrogate.

A friendly welcome also means an understanding attitude, a smile and the appropriate non-verbal communication – sending a message to the young client that he or she is accepted and understood, no matter what the problem is, and without moralizing.

Another feature of a good family planning service for the young is the provision of opportunities for potential clients to get acquainted with the service before a real need for that service arises.

For this reason Aimer Jeunes organizes discussions, individually or in groups, for those who just want to get acquainted with the clinic. The staff accept any topic that comes up. Very little technical information on family planning is provided at these sessions, and never in a formal way. The main message is that the friendly staff are there – ready, willing and able to provide information and help when needed.

The investment of time is also important: there is no limit on the length of an individual session with a client, which simply lasts as long as is necessary.

The demedicalization of the service is expressed in the look of the premises, which makes young people feel at home, in the staff’s dress and behaviour, and in many other features.

Aimer Jeunes is staffed by seven people who share Dr Alptekin’s philosophy. The clients can be of any age or background. Confidentiality is assured. There is a small fee for medical check-ups only.

"We enjoy working with young people", says Dr Alptekin, "and they seem to enjoy coming to us."

(For more information, contact: Dr I. Alptekin, Aimer Jeunes, 48a, rue du Vieux Marché aux Grains, B-1000 Brussels, Belgium.)

Portugal

AFP fills the information gap

Births to Portuguese girls under 20 are gradually declining, but the Portuguese Family Planning Association (AFP) believes that at 9% of all births the figure is still far too high.

In fact, very few young people in Portugal use any kind of contraceptive. In 1988 the government started an educational reform, initially proposing to introduce sex education into the school curriculum. But despite public agreement on this need, the steps taken so far have contradicted the original intentions.

The school programmes hardly refer to sex education matters, except for human reproduction (in natural science) and contraception and prevention of sexually transmitted diseases. But the Portuguese Family Planning Association (AFP) believes that at 9% of all births the figure is still far too high.

In fact, very few young people in Portugal use any kind of contraceptive. In 1988 the government started an educational reform, initially proposing to introduce sex education into the school curriculum. But despite public agreement on this need, the steps taken so far have contradicted the original intentions.

The school programmes hardly refer to sex education matters, except for human reproduction (in natural science) and contraception and prevention of sexually transmitted diseases (in biology). AFP perceives conservative resistance among the reformers themselves. Anti-AIDS campaigners, on the other hand, work in schools, but have had no training in overall sex education.

AFP has publicized these problems and also the lack of services for adolescents. To fill the gaps, it has been organizing courses for teachers, health staff and counsellors, in both sex education and youth counselling.

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skills. APF has also organized workshops on school and out-of-school sex education. AIDS prevention, and the situation with regard to sexual and reproductive rights in Portugal.

Booklets for young readers deal with anatomy, physiology and contraceptive methods. In 1980, a three-year UNFPA-funded project was started in order to produce new sex education materials. The APF regional branches hold meetings for students or parents (in schools), and also in collaboration with professional training centres in several cities – for apprentices. In March 1989 the Lisbon branch started a new project on youth counselling called "Young Wednesdays", including an all-day hotline. In Oporto, the APF branch has since 1986 created several successful counselling centres. Both branches cooperate with drug prevention projects and with the government family planning services.

Work in the media is another APF strategy. In 1989 the Lisbon branch started a twice-monthly radio programme called "Nobody is made of stone". Superson, a music magazine, also invited APF to introduce a new column: "Intimacies".

The provision of training and materials, field work in sex education, cooperation with the health services in organizing services for adolescents, and reproductive rights in Portugal will continue to be the APF priorities well into the beginning of the Nineties.

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Yugoslavia

Why sex education is not effective

Officially introduced many years ago, supported by government and school officials, sex education in Yugoslavia does not seem to be effective. Support for this statement can be found in the extremely lax use of contraceptives among teenagers (although the average age of the first sexual intercourse is about the same as in Western and Northern European countries), in the high number of abortions among adolescent girls, and in survey data indicating that teenagers need additional information on sexual and reproductive matters (80% of all surveyed, aged 15-17, expressed this need).

On the other hand, a survey among teachers in secondary schools revealed that they do not feel comfortable dealing with sexuality issues, and would prefer an outsider, i.e. a doctor or a nurse, to take over this embarrassing job.

 Clearly, part of the problem is a lack of teacher training for this job – and this has never been dealt with adequately. Many attempts have been made to educate educators, but without proper guidance. Teachers were usually exposed to a series of formal presentations on the subject, which increased their knowledge but not their skills.

If teachers don’t do this work, what about others? Unfortunately, reproductive health services for the young are either non-existent in many parts of the country, or are very inadequate, with very little provision for confidentiality, privacy or comfort for the young client.

Although highly qualified medical doctors and nurses are available, they are at a disadvantage in the area of adolescent reproductive health because the curricula of medical schools provide very little information on family planning and nothing at all on the sexual and reproductive health of young people, a field requiring special knowledge and particular skills.

So, while many complain about foolish and irresponsible young people who do not take advantage of having free access to contraceptive services and supplies, but instead risk unprotected sex and frequent abortions, there is still more for society to do than just state officially that the young in Yugoslavia have the right to free access to information and services.

Dr Nila Kapor-Stanulovic

Bulgaria

Early marriage and pregnancy cause problems

In contrast with the young of other European countries, Bulgarian adolescents tend to start their families earlier, to use the most old-fashioned methods of family planning, and to have more abortions than their counterparts elsewhere, claims Dr Elena Kabakchieva of the Medical Academy in Sofia.

Some 40% of all married women in Bulgaria are below 20 years of age (Bulgaria has the lowest marital age at first marriage for women in Europe, at 20.8 years). At the time of the marriage, 41% of the women are pregnant, and Bulgaria has the world's third highest abortion rate.

In an attempt to explain the reasons behind these specific features of Bulgarian youth, Dr Assen Jablensky, President of the Medical Academy, cites the multi-ethnic composition of the Bulgarian population. Approximately one-fifth of the teenage population are Moslems, gypsies and Turks. These groups are known to have very traditional cultural norms, especially with respect to the young girls. They are expected to get married early and keep to the very traditional role of the women – as mother and housewife.

Another reason for early pregnancies and childbirth, says Dr. Jablensky, is very poor knowledge of sex-related topics among the young.

Early marriages, early pregnancies and unprotected sexual relationships among young people are now considered a major medicosocial problem for Bulgaria and the government is ready to introduce a wide range of measures to improve the sexual and reproductive health of adolescents.

(For more information, contact: Dr Assen Jablensky (President) or Dr E. Kabakchieva(Health Education Speacialist), Medical Academy, 15, D. Nesterov, 1431 Sofia, Bulgaria.)
Expanding young people's options

"Our responsibility is no less than ensuring that he options of millions of young people, here and in all countries of the world, are safeguarded and expanded," said UNFP A Executive Director Nafis Sadik in her keynote address at the 10th Anniversary Conference of the Center for Population Options (CPO) in Arlington, Virginia on 24 September 1990.

In her most comprehensive statement to date on youth, Dr. Sadik mapped out UNFP A's strategies on the issue of adolescent fertility.

"I have often argued that better education for young women holds the key to the opening of options and opportunities for a better life. Girls should be brought up with the idea that they have real choices outside their duties as wives, managers of the household and mothers," Dr. Sadik said. "Like many other things, timing is of critical importance. Programmes which advocate delaying marriage and childbirth in favour of education have a special place."

Dr. Sadik added that boys should be given special attention at a time when their attitudes are still at a formative stage. "They should learn to respect other people, including girls and women, and to be responsible for their actions."

Highlighting the health, social, economic and demographic implications of adolescent fertility, Dr. Sadik lamented the lack of knowledge among young people of reproductive health issues, sexuality and responsible parenthood. "The 1984 United Nations International Conference on Population clearly supported the ideas of educating young people to be responsible as well as providing family planning information and services to them," she pointed out.

"However, even if young people have the knowledge, it does not necessarily mean that they will be motivated to act, to change their behaviour," Dr. Sadik said. "Communicators must therefore target appropriate messages to carefully segmented audiences, particularly to those who help shape young people's decisions on fertility."

"Likewise, the service system should be responsible to young people's needs. Health workers should have an empathy for young people as well as a capacity to listen," she added.

Dr. Sadik also called for greater collaboration between United Nations organizations, youth-related NGOs and young people. UNFP A's strategy is "to assist such NGOs in mobilizing young people themselves to articulate their needs, to create public awareness of their concerns, and to mobilize resources."

- by James Chiu, UNFP A Newsletter, Population

Adolescent maternity project launched in Chile

UNFP A has signed an agreement to cooperate with the Government of Chile on a teenage pregnancy project.

The project's aim is to train health personnel and some 200 middle and high-school teachers in reproductive medicine for adolescents. The project will also support university research into adolescent health and fertility.

Teenage pregnancy is very common in Latin America and the Caribbean. Yet institutional experience in this field is scarce and professional training in relevant disciplines has had to be pursued in the United States and Canada.

The World Fertility Survey revealed in the mid-1970s that the proportion of women aged 20-24 years who had given birth to a live baby before reaching 18 years of age in the region's urban areas ranged from 9.4 per cent in Paraguay to 15.7 per cent in Venezuela and 29.1 per cent in Jamaica. In the Santiago metropolitan area, where one third of Chile's population is currently estimated to live, fully one-third of women aged 15-17 have been pregnant at least once. This is according to a study conducted by the University of Chile in 1988.

The pilot plan will be carried out by the Ministry of Health through some 100 health centres, and by the School of Medicine of the University of Chile. (IPS)

- UNFP A Newsletter, Population

Act promptly to cure pubertal problems, doctor warns

Growth and puberty go together: if puberty comes too early or too late, the doctor must act quickly. This was the warning given in January by Dr Niels E. Skakkebaek at a course run by the Danish Medical Women's Association in Copenhagen.

Early puberty usually means puberty which occurs before 9 in girls and before 10 in boys, although there are racial differences. Signs to look out for include fast growth but a short final height, increased pubic hair and sweating, menstruation or nocturnal emissions, and psychological consequences of increased steroid production. In old cases puberty can even be visible in infancy.

Late puberty (after 13 in girls and 14 in boys) shows itself in symptoms such as absence of a growth spurt, absence of pubertal signs, a testis size of less than 3 ml in a 14-year-old, and psychological effects which are due to the lack of an increase in sex steroids. Psychological effects are important to watch for, not only because the children compare themselves uncomfortably with others, but because they often underestimate their symptoms.

A third problem is breasts in boys. Most boys have a little gynaecomasty at the start of puberty but usually it disappears. If not, a boy will suffer dreadfully from self-consciousness, although he can be treated in a matter of months.

In Turner's syndrome (short height), growth hormones should be prescribed early in childhood to promote growth prior to oestrogen treatment, which is begun during the pubertal years.

Diagnostic tests for abnormalities include chromosome analysis, hormone analysis, HCG test, ultrasound and gonad biopsy. But whatever the problem the most important message is: Don't wait.

Boys with a malformed penis should go immediately to the doctor to be treated with testosterone, which works better earlier in puberty.

Intersexual development, where the child's sex is not clear, must also be tackled early if treatment is to be successful.

(For more information, contact: Professor Niels E. Skakkebaek, Department of Growth and Reproduction, Section GR-064, Rigshospitalet, DK-100 Copenhagen, Denmark.)
Adolescent health programme

WHO began working for young people some years ago, at first through projects to improve adolescent reproductive health which were supported by UNFPA. In 1986 the report Young People's Health – a Challenge for Society (WHO Technical Report Series No. 731) pointed out that young people need to contribute actively to their own health and to the health of the community in which they live, especially through primary health care.

In 1990 WHO established its Adolescent Health Programme, thereby recognizing the importance of meeting young people’s special health needs, the consequences of neglecting those needs (for both present and future generations), and the crucial role that young people themselves play in this domain.

The Programme’s main strategy is to develop methods which strengthen young people’s health knowledge and commitment to action and can be applied throughout the world by workers in health, youth, education and other sectors. These methods are highly participatory and focus on the experience of those who use them, which makes them culture-specific.

The needs of adolescents and young people are the starting point for each of the methods, which are as follows:

- the grid approach to planning and prioritizing intersectoral action in countries is used by workshop participants to identify and examine the health reeds and problems of adolescents, and existing services and activities, or to create new approaches;
- the counselling skills training module improves the interpersonal communication skills which are needed to bring about or sustain behaviour change in young people: these skills are especially important for anyone dealing with the sensitive subject of young people’s sexual behaviour;
- the narrative research technique is used to design and carry out behavioural research: it involves young people, who identify their own key experiences related to sexual and reproductive health behaviour;
- the user/system approach to evaluation of services entails matching the perceptions of young people with those of service providers;

- theatre is used to help young people communicate their needs by developing a story line and performing in front of key audiences: this method is also used as a research tool, whereby audience opinion is measured before, during and after performances.

Both governmental and nongovernmental organizations have adopted these methods, often with the direct involvement of young people, which has become an established feature of all aspects of the WHO Programme.

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Peer leadership in adolescent health promotion

Peer leadership programmes have existed in the United States for the last 20 years. Teenagers, recruited and trained to promote adolescent health, have worked as educators, peer counsellors, alternative role models, and programme planners in both school and community settings.

Hundreds such programmes now exist. They range from cross-aged, school-based teaching programmes to volunteer service projects in public housing developments. Not only do they benefit the individuals who are served by these initiatives, but they provide peer leaders themselves with opportunities to examine their own behaviour, learn new skills, and experience the satisfaction of doing something for others.

Peer leadership programmes require a careful recruitment, screening and selection process, to choose applicants from various age groups. They must also provide the peer leaders with adequate direction, preparation and support to ensure programme effectiveness.

The peers should be trained in a number of important skills, including leadership, communication, decision-making, presentation and programme planning. They should study specific content areas such as alcohol and other drugs, sexually transmitted diseases, major causes of accidental injuries, or any other health issues the group will be likely to address.

Properly selected, well prepared peer leaders can play an important role in key areas. As educators they can present lessons to younger children that communicate the importance of healthy behaviour and teach valuable life skills such as personal problem-solving. They can also serve as points of referral to other young people dealing with health-related problems.

Peer leaders can provide volunteer services to the community in any number of areas, ranging from special projects with the elderly to guidance for younger children from their neighbourhood or school. And they can play a critical role in changing the potentially self-destructive rites of passage that exist in many countries throughout the world.

In the United States, for example, two of the major rites of passage from adolescence to adulthood are driving an automobile and beginning to drink alcoholic beverages.

Each of these presents certain independent risks; in combination the potential for problems increases dramatically. Indeed, one of the major causes of adolescent deaths in the United States is drinking-related traffic accidents. If peer leaders can model and encourage alternative behaviour at this critical stage of development, other adolescents may adopt healthier behavioural norms.

While peer programmes offer an exciting and effective approach to adolescent health promotion, anyone interested should be aware of a few cautions. First and foremost, peers should be seen as part of a comprehensive, multi-component programme. Without proper support and referral, teenage leaders will quickly become overwhelmed and eventually ineffective. Secondly, it is always important to remember that a number of the adolescents who join peer programmes come from dysfunctional families themselves. Organizers must therefore develop ways to support these young people in their own personal development and growth.

Peer leadership programmes have proved their effectiveness in promoting healthy behaviour among adolescents.

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World Assembly of Youth

The World Assembly of Youth (WAY) is a nongovernmental international coordinating body of national youth organizations and national youth councils throughout the world. WAY works in close cooperation with UN agencies and government aid agencies, receiving financial support for its activities.

The main means by which WAY seeks to promote good health amongst its constituents is through workshops, conferences, seminars and research which educate and train youth leaders in specific areas of health knowledge and skills. These skills can then be used by the young leaders in their national organizations for the formation of health strategies and programmes.

Most recently, WAY has focused much of its attention on developing training programmes on issues such as AIDS, population and adolescent reproductive health. Statistics show that in today’s world there is a very high percentage of young men and women who are sexually active and tend to have their first sexual encounter at a very early age. For example, in Guatemala City, a survey showed a high proportion of pre-marital sex. First intercourse was reported by males at 15 and by females at 17. Alarming, a large number did not use contraceptives during their first encounter.

Many said that this was because their sexual encounter was unexpected or they believed it was the responsibility of their partner. These findings present a very explosive situation for sexually transmitted diseases (STDs) and AIDS. Some of the information about contraception came from school sex education at the secondary-school level. However, in some countries this may not begin until after the children have already become sexually active, making it rather ineffective. When one looks at the situation in developing countries, where many do not even attend formal education, or drop out at an early age, the result is even more grim.

Therefore, it is imperative that proper and continuous sexual information be available to the young not only in schools and colleges but through private groups, such as youth clubs, and through youth organizations such as WAY. Working on an international level, WAY is able to obtain the resource personnel and materials to establish local or regional programmes, at the same time using the local member organizations to “tailor” the programme so that it is culturally sensitive and sustainable.

WAY conducted an adolescent health survey in 1990 in six African countries in cooperation with WHO’s Adolescent Health Programme. In general, respondents were very shy to talk about issues such as contraception, masturbation and homosexuality. Many were aware of STDs such as syphilis, gonorrhea and AIDS, but were not well aware of the symptoms. Most also knew that early sexual encounters and pregnancy were prevalent, but lacked information on specifics.

WAY has been instrumental in developing training workshops and seminars on adolescent reproductive health and sexuality on all the continents. It has been very active in AIDS programmes as well as in leprosy relief.

WAY believes that only through active participation and education by youth for youth can society achieve its goal of providing the future guardians of the earth with the information they will need to make responsible decisions with respect to family planning, population, contraception, their own health, and most importantly the health of the world.

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League of Red Cross and Red Crescent Societies

Although it is sometimes not thought of as a “youth” organization, the League of Red Cross and Red Crescent Societies has 90 million youth members. Of course, a proportion of these are more passive than active. Nevertheless, even if only half of them are actually involved, with their humanitarian mandate to prevent and alleviate suffering and their roots in impartiality, neutrality and volunteerism, they have a very important contribution to make to developing and strengthening resilience, and to improving the physical, mental and social wellbeing of young people around the globe.

Activities range from holidays for disabled adolescents in Belgium to AIDS education programmes for and with young people in Zambia; from tree planting in Uganda to working with street kids in Colombia; from adolescent reproductive health in Jamaica to food distribution to Mozambican refugees in Malawi; from drug rehabilitation in Italy to promotive and preventive programmes to fight substance abuse in Spain; from community clear-up campaigns by young people in Somalia to youth mobilization for health in the Congo.

Some programmes are naturally more common than others — many young people are involved with disaster preparedness and response activities, with school health education and of course with first aid.

Like other organizations involved with young people and health, the League has learnt many lessons over the years. One of these is the importance of having policy statements which provide a general approach to developing the many and varied activities and programmes with which National Societies are involved.

To this end an important resolution was adopted by the League’s General Assembly in 1989. It emphasised the need for young people to be responsible for defining their own problems and responding to them, rather than simply being a resource for responding to other people’s problems, or having other people decide what needs to be done about their problems.

For example, whose first aid problems do Red Cross youth learn about and how much do they participate in the development of training programmes? Usually it is young people learning how to help deal with the “emergencies” of children and adults, rather than young people learning how to cope with their own emergencies — many of which are of a psychosocial nature.

Adolescent health has not been particularly high on the agendas of most planners and policy maker makers in the past, and there are likely to be increasing factors that will undermine the physical, mental and social wellbeing of young people in the decade ahead. However, if we can ensure that the voice of young people is heard and heeded, if we can continue to focus on the development of human resources, and if we can learn from our past successes and failures, it will be all the more easy to contribute to solving the problems that lie ahead.

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Hormonal contraception for girls

A Task Force of the WHO Special Programme on Research, Development and Research Training in Human Reproduction has evaluated current knowledge on the biomedical aspects of hormonal contraception use by adolescent girls, including safety.

The Task Force concluded that the main side effects and concerns pertaining to hormonal contraceptives when used by adults also applied to adolescents, but that there were extra features specific to adolescent development that warranted attention.

It was also felt that oral contraceptive use should not be deferred in adolescents because of irregular cycles, since it has been shown to regularize bleeding patterns and reduce the occurrence of ovarian cysts. Oral contraceptives are known to reduce the risk and possibly the severity of pelvic inflammatory disease, a benefit that also applies to adolescents. One issue on which information is sparse is the long-term safety of hormonal contraceptives with regard to neoplasia of different sites, since few studies have focused on adolescents.

A strategy will be worked out soon to carry out research in this field. It will be multidisciplinary because of the various cultural, behavioural and biological factors which affect adolescent sexual behaviour and attitudes to contraception.

Study on chlamydia in boys

A separate WHO Task Force is studying the prevalence of chlamydial infection in adolescent boys, beginning with a pilot study in Thailand, Argentina and Chile which uses a new technique to identify the infection from urine samples, rather than the usual method of urethral swabbing, which is painful and also technically difficult. Although the test is not as sensitive as direct culture or immunofluorescence from urethral swabs, it is estimated that in a sexually active adolescent population there should be sufficient numbers of subjects with a symptomatic chlamydial urethritis to produce meaningful results.

Books

AIDS and the young
Less than 10 years after the first cases, AIDS has become everybody’s business and young people are the first to be affected. *L’amour préservé: les jeunes et le SIDA* (1989) (Love Preserved: AIDS and the Young) aims to provoke young people into a stand on principles and on the many unresolved questions. Do adolescents enjoy the risk? What are their values? Why is prevention difficult? Lively presentation, well illustrated. Published by: ISPA, Case postale 870, CH-001 Lausanne, Switzerland. ISBN 2 88183 025 0

Sex education in schools
*The Other Curriculum: European Strategies for School Sex Education* (1989) is the result of an enquiry conducted under IPPF Europe Region auspices. The papers cover theoretical issues, country studies in Belgium, Denmark, Germany, Poland, Turkey and England, the Swedish precedent, and a comparative analysis. Available from IPPF, Regents College, Inner Circle, Regents Park, London NW1 4NS, United Kingdom. Price £ 15/US$ 20. ISBN 0 90483 13 7

Reports

Adolescent childbearing
*Today’s Adolescents, Tomorrow’s Parents: A Portrait of the Americas* by Sasheela Singh and Deirdre Wulf studies high sexual activity and adolescent fertility in 11 countries of Latin and North America and the Caribbean. Why does it occur or not occur? How is it affected by social changes? What are the consequences? Published by: The Alan Guttmacher Institute, 111 Fifth Avenue, New York NY 10003, USA. ISBN 0 939253 19 4

Videos

How it’s done
English versions of three Danish cartoon videos, *Sex – a Guide for the Young, Safe for Life and So That’s How* are available from the State Film Centre. *Sex – a Guide for the Young* is clever, direct and very funny – full “operating instructions” on everything you had to find out the hard way. Good preventive advice. Apply: Statens Filmcenter, Vestergade 27, DK-56 Copenhagen, Denmark

General

Spanish guides to reproductive health
A series of excellent guides on contraceptives, pregnancy, parenthood, abortion, STDs and menopause are now available in Spain. Facts explained clearly with attractive, informative and amusing illustrations. Suitable for all types of reader. From: Instituto de la Mujer, Ministerio de Asuntos Sociales, Almagro 36, SP-8010 Madrid, Spain.
Training opportunities

School-based AIDS education
Israeli educators have been training schoolteachers in El Salvador, Costa Rica, Honduras, Peru and Guatemala, who receive a kit containing comprehensive health education programmes: Explaining AIDS to Children (for 11-15 year-olds) and The Immune System and AIDS (15-18 year-olds). Once trained, the teachers create local committees to fight AIDS by training their colleagues. Other countries on four continents have applied for similar courses. For details write to: Dr Inon Schenker, Director, Jerusalem AIDS Project, POB 7956, Jerusalem 91077, Israel.

Learn from the Indonesian experience
BKKBN, the National Family Planning Coordinating Board of Indonesia, offers the following International Training Programme in Management in 1991: Planning and Managing a National FP Programme (8-17 May); Planning and Managing Family Planning IEC (14-31 August); Women in FP and Development (2-15 October); Planning and Implementing and Information System in support of a National FP Programme (24 November-2 December); and Planning and Managing a National FP Programme (4-17 December). Details from: Programme Coordinator, International Training Programme, BKKBN, Jl MT Haryono, POB 1186, Jakarta, Indonesia. Fax 62-21-819-1555.

Family health workshops, USA
International Health Programs' 1991 training schedule for international health personnel is as follows: FP Programme Management and Supervision (English 9 September-18 October, Spanish on request); Health Care Financing and Financial Management (English 24 June-12 July); IEC Programmes for AIDS Prevention (French 13 May-14 June, English 15 July-16 August, Spanish on request); IEC Programme Management (French 28 October-22 November, Arabic on request); Advanced Training for FP Trainers (French 29 July-23 August); Nutrition in Development (English, Spring); Training for Family Life Education Trainers (French, English, Spanish on request). Individualized programmes can also be arranged. Contact: IHP, 210 High Street, Santa Cruz CA 95060, USA. Fax (408) 458-3659.

Research and management, UK
University of Exeter short courses (7-11 weeks) in 1991 include: Collecting and Analysing FP Data (early May); Programme Management and Evaluation (early May). Four-week attachments between January and June: Providing Family Planning Services, Formulating Research Problem, Needs Assessment, Data Collection, Information Management and Evaluation. Two MA programmes and a three-year PhD programme are also offered. Apply to: The Training Officer, Institute of Population Studies, University of Exeter, Hoopern House, 101 Pennsylvania Road, Exeter, Devon, EX4 6DT, UK.

Adolescent fertility, Hungary
In association with WHO and UNFPA, Debrecen University Medical School in Hungary will hold a course on adolescent fertility for 15 participants with national or regional responsibility on 30 September-18 October 1991. Apply to: Dr István Batár, Debrecen University Medical School, PO Box 37, Debrecen, Hungary 4012.

Management information systems
Management Sciences for Health will run a new course on Management Information Systems Development and Design for Health and Family Planning Organizations in English (17 June-19 July 1991) and French (October 1991). Information from: MSH, 165 Allandale Road, Boston, MA 02130, USA.

Adolescent fertility, USA
The International Center for Population and Family Health will hold a course on adolescent fertility for professional and paraprofessional personnel from developing countries, on 2-27 September 1991. Apply to: Dr André Singleton, International Centre for Population and Family Health, 14130 W. 9th Street, Ziton, IL 60099, USA.

Health legislation and the elderly

Health legislation is not only one of the most effective means of improving the physical, mental and social well-being of the elderly; it is probably the only way of translating the objectives of a specific health policy into practice, by means of legally enforced rights and obligations, administrative instructions and binding budgetary decisions. Yet there are serious disparities and shortcomings in the legislation of the European countries and major delays in adopting the essential texts and taking steps to implement them, not to mention wide inequalities in the budgetary resources allocated to the various services for the elderly.

This work offers a fresh view of the contribution legislation could make to solving these problems, identifying the areas where, although currently absent or inadequate in many European countries, legislation might be particularly useful. The author's forecast of future trends is based on data gathered by the Regional Office for Europe and on his own international experience. This book will therefore be of interest to all those concerned with these problems and in particular to lawyers, politicians and legislators.

Available in French (English version in preparation) from: Distribution and Sales WHO, CH-1211 Geneva 27, Switzerland

Price: 16.50 Swiss francs. ISBN 92 890 2124 1