Guiding documents on SRH and sexuality education

The global community has acknowledged the importance of both positive SRH and access to education for the entire population. Several global and regional documents can be cited. First the Sustainable Development Goals (1):

• 3.7 By 2030, ensure universal access to sexual and reproductive health-care services... (1); and
• 4.7 By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development... (2).

Another key document is the Global Strategy for Women’s and Children’s Health (2), in which the life course and the health system approaches are prominent and integration and collaboration are emphasized.

• Efforts to improve health must be closely linked to those intended to tackle poverty and malnutrition, improve access to education, ensure gender equity and empowerment... (2).

The European Union parliament has formulated Policies for Sexuality Education in the European Union (3):

• Sexuality education lessons should be comprehensive whilst dealing with various subjects (3).

In 2001 the WHO Regional Office for Europe developed the Regional strategy on sexual and reproductive health (4) where two of the objectives are:

• To inform and educate adolescents on all aspects of sexuality and reproduction and assist them in developing the life skills needed to deal with these issues in a satisfactory and responsible manner; and
• To ensure easy access to youth friendly SRH services (4).

Standards for sexuality education in Europe were issued in 2010 (5) and two of the seven characteristics of sexuality education highlight intersectoral collaboration:

• The continuity of sexuality education over time is complemented by its multisectional setting. School-based sexuality education is linked to other sectors by establishing cooperation with partners in and out of school, for example health services and counseling centres (5); and
• Sexuality education establishes a close cooperation with parents and community in order to build a supportive environment... Cooperation with other stakeholders (public and church-based youth work, youth welfare, health services, counseling centres, faith-based groups) in the field of sexuality education is also beneficial (5).

Intersectoral collaboration

Although intersectoral collaboration in SRH involves many stakeholders, the following will mainly focus on the intersection between education and health services, but also mention media, which is increasingly becoming a source of SRH knowledge for adolescents (6-8).

Sexuality education and SRH services in Sweden

Sweden has mandatory school-based sexuality education. It is included in the national curriculum, under the responsibility of every headmaster. Sexuality education begins early and should be delivered on a regular basis. The content and the methods vary however between schools, since no detailed curriculum is available and teacher training does not include sexuality education. Studies have shown that school based sexuality education is a main source of knowledge about sexuality, together with friends and media (8, 9).

In 2008 a virtual Youth clinic UMO.se, was launched (10). The Swedish Government wanted to strengthen gender equality and access to information and support for all adolescents. The web site contains information about SRH, body development, gender roles, relations, lifestyle and gender based violence. It also has a counseling tool where a panel of counselors respond to questions.

Every school has school health services and the school-nurse regularly invites all students for individual health counseling. Lifestyle and health promotion are important ingredients but the school nurses do not have any specific education in SRH and therefore rarely include SRH issues. In the recent years, however, they have become responsible for providing Human Papilloma Virus (HPV) vaccine to all 12-year-old girls and thus have the duty to inform students and parents about the purpose of the vaccine. This has been a challenge for some of the nurses but also an opportunity to raise SRH issues with pupils and parents (11, 12).

In the mid 70s youth centres were created in complement to the school-based sexuality education with the aim to prevent sexually transmitted infections and unwanted pregnancies. The centres could be either freestanding or integrated in other health services. Every clinic must have medical and psychosocial competence; for example midwives and social workers or psychologists. Services are free of charge and around 240 youth centres exist in the country. Girls are the main visitors, but boys increasingly attend, for their own reasons or together with a girl friend (13).

Other European countries have similar models. Finland has one of the best sexuality education programmes in Europe and evidence points towards an association with the re-establishment of mandatory sexuality education and an improvement in SRH outcomes (14). In Estonia, similar success has been reported after introduction of sexuality education and youth-friendly SRH services (15, 16).

Personal experience

Let me share some of my personal experiences. I live in a municipality with around 15 000 inhabitants. I worked in a public Primary Health Care Centre at the antenatal/family planning clinic. We wanted to strengthen access for adolescents to SRH services and therefore set up a youth clinic within the ordinary clinic, but with separate opening hours and drop-in possibility for adolescents. In order to make the clinic attractive to the teenagers we re-decorated the waiting room and the consultation rooms. We contacted the headmaster of the schools, the school nurses and the teachers responsible for sexuality
education. We developed a collaborative approach with the aim to strengthen sexuality education, open the doors to the SRH services and work better in collaboration with the school nurse. In short the programme was structured as follows:

• All students in grade 6 had the opportunity to discuss puberty, sexual development and gender issues with the female midwife or a male volunteer in sex-separated groups.

• In grade 8 all students came to the clinic for a study visit in small groups. We then discussed sexuality and contraception and what services the clinic could offer.

• In grade 9 we visited the school for education and discussions on sexuality and reproduction. Attitudes, values, communication skills and pornography use were issues on the agenda.

• The school nurse was available for individual counseling and could refer to the youth clinic.

The programme has, with some modifications, run successfully for many years and has contributed to an increased satisfaction among the health and education professionals and the lowest rate of unintended pregnancy in the entire county.

Challenges and opportunities

Intersectoral collaboration is a win-win situation, but continued efforts are needed to make it a reality in most European countries. Most professionals appreciate working in collaboration with others (17). There are, however, challenges. The high inflow of migrants to many European countries during the last years challenges sexuality educators, but also health service providers since migrants may be more hesitant to seek care. The public-private divide in both sectors means that many actors and stakeholders are involved, with slightly different priorities and resources. School health services could be more equipped to handle SRH issues. Teachers and health care providers need better education and continued support, preferably in multi-professional groups. NGOs active within the SRH and education field could also be used and media offers a great opportunity. As health care providers and educators we should embrace the opportunity to move intersectoral collaboration forward for the benefit of improved SRH for all in the many countries that comprise Europe.

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References


10. www.UMO.se


