Adolescent Sexual and Reproductive Health

Helping Young People to Protect Themselves
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The sexual and reproductive health of young people has increasingly become an issue of public health concern in many countries of the European Region. Lack of information and knowledge is not only a problem in central and eastern Europe, but also in countries such as the United Kingdom, where one of the highest adolescent pregnancy rates in Europe is found.

Investments made into research on how young people experience the process of sexual maturation, what they know about sexuality and what they do to protect themselves from the unwanted risks of sexual experiences is a reflection of the increased awareness of policy-makers and researchers of the importance of studying key issues in this age group, and taking appropriate policy decisions.

Articles in this issue of *Entre Nous* highlight the current sexual behaviour of young people in various European countries, and they clearly show the urgent need for effective programmes of sexual and reproductive health education and information through schools, health services and the mass media. A clear example of this need is in Serbia, where more than a half of all adolescents have sexual intercourse. Of 300 sexually active female 19-year-olds participating in a survey, 42.6% responded that they did not use a contraception method during their intercourse because they "felt that their partner was reliable" and another 24.9% thought that it was unlikely that there would be any consequences. And in Kazakhstan, abortions among girls 15 to 19 years old is on the rise, as reported in a recent survey undertaken by the Kazakhstan School of Public Health. The situation sounds bleak but we are aware of the problems and ongoing research activities will reveal areas where we should target further efforts.

While efforts continue to find a cure for AIDS and complications of other STIs, there are far too many young people across Europe who not only do not know anything about many STIs, fertility regulation or abortion, but are also too afraid to ask. While eastern Europe is faced with the highest increasing incidence of HIV/AIDS in the world, 40% of Russian youths see no risk of acquiring an STI through sexual relations or, even worse, have no idea that there is a risk. Results from a scientific study of young people's sexual health in the Russian Federation presented in this issue of *Entre Nous* are startling. This study clearly demonstrates the need to work with parents to enable them to support their children in the process of growing up and taking responsibility for their health based on reliable information and a relationship of confidence with those adults who mean most to them.

It is also clear that the determinants of sexual and reproductive behaviour of this age group lie in the general development of a given society, and in order to influence young people's behaviour, multsectoral action is required. In recognition of this, Lithuania led the way by hosting an interagency meeting on the health needs of young people. The meeting was organized jointly by the ministries of health, education and social affairs as well as by the State Youth Council. UNDP Lithuania provided the back up and facilitation of this pioneering meeting which resulted in recommendations and a consensus statement published in this issue of *Entre Nous*. The meeting gave high priority to the views of young people themselves, who had conducted research among their peers and showed that they are able to adequately formulate their needs and that they have a clear picture of the kind of interventions which would be most appropriate in responding to their needs. Planning services in cooperation with young people may thus be the best and most effective way forward in tackling issues such as unwanted pregnancy and STIs in adolescents.

We hope that this issue of *Entre Nous* will support colleagues working on these issues with ideas and suggestions and will contribute to the ongoing discussion on how to best invest in the health of young people. As always, we look forward to receiving comments and feedback from our readers.

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Editor
Similar to other central and eastern European countries, there has been an increase in sexual activity among young people in the Republic of Serbia. In a risk behaviour survey conducted in 1999 among 5,385 students from five university centres in Serbia, it was reported that 67.75% of boys and 43.2% of girls had had sexual intercourse during adolescence.

Sexually active adolescent females are at the highest risk for sexually transmitted infections (STIs) and unplanned pregnancies. Physiological, behavioural, socio-economic and cultural factors all contribute to their vulnerability. Therefore, a study of 300 sexually active 19-year-old women in Belgrade, all attending the Youth Advisory Centre of the Mother and Child Health Care Institute of Serbia, was conducted between 1995 and 1997, in order to further analyse the state of reproductive health of adolescent females in Serbia. The study included the adolescents’ opinions about the acceptability of some adolescent sexual and reproductive health interventions and is the only study of adolescents in Serbia that has combined an interview with clinical findings.

Knowledge, attitudes and behaviour in the sphere of sexuality and reproduction were explored in the study group in addition to a clinical evaluation of their reproductive health status, based on gynaecological examinations, Papanicolaou tests, colposcopies and the presence of the most frequent STIs. The results were analysed by descriptive statistics.

Sexual behaviour

The study revealed that the mean age at first intercourse among interviewed female adolescents was 16.9, which is earlier as compared to the results of a similar study conducted in Belgrade between 1982 and 1991 (17.5 years of age). First sexual intercourse was most often experienced at the ages of 16 and 17 (55.7%) and somewhat less frequently in 18 and 19 year olds (34.3%). One out of ten teenage girls, however, had their first sexual intercourse at a very young age (between 13 and 15).

About one third of the girls (31.3%) reported using contraception at their first intercourse, mainly the condom (28.3%).

The reasons for not using any contraception during the first intercourse were: "felt that the partner was reliable" (42.6%), "didn't think there would be any consequences" (24.9%), "first intercourse was an uncontrollable act" (15.8%), "wanted first intercourse to be natural" (8.1%). Less frequent reasons were: partner against the use of contraception (1.9%), girl regarded condoms as unreliable (0.5%), intercourse took place while under the influence of drugs (0.5%) and couldn't explain how it happened (5.7%).

**Motives for first sexual intercourse**

<table>
<thead>
<tr>
<th>Motive</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Contraception</td>
<td>45.7%</td>
</tr>
<tr>
<td>Partner's insistence</td>
<td>23.7%</td>
</tr>
<tr>
<td>Fear of pregnancy</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fear of discomfort</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fear of partner's initiation</td>
<td>0.0%</td>
</tr>
<tr>
<td>Fear of no answer</td>
<td>0.0%</td>
</tr>
<tr>
<td>No motive</td>
<td>0.0%</td>
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</tbody>
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The number of sexual partners during adolescence was most frequently one (36.3%), or under four (78.3%). A smaller proportion of adolescents experienced sexual intercourse with four or five partners (11.5%), and with six to twenty (10.2%).

Reproductive health is additionally endangered by the fact that only a small proportion of adolescent girls in Belgrade use reliable methods of contraception. The method of fertility regulation used for the longest period of time was coitus interruptus (54.3%), followed by condoms (34.3%), oral contraception (10.7%) and spermicides (0.7%).

The main reason why adolescent females in Belgrade do not use reliable birth control methods appears to be a lack of relevant knowledge and the belief that withdrawal is an efficient form of birth control. Although most of the interviewed adolescent females were fairly well informed about contraceptive methods, they did not base practical knowledge about how the contraceptive methods were used. The girls had heard about condoms (99.3%), intrauterine devices (95.7%), oral contraception (95%), spermicides (78.7%), diaphragms (61%), sterilization (38.3%) and postcoital contraception (25.3%). A smaller proportion of the interviewed girls knew how each contraceptive was used: condoms (97.7%), oral contraception (64%), spermicides (47%), intrauterine devices (28%), postcoital contraception (14.3%), diaphragms (6%) and sterilization (5%). Adolescent females also believed that reliable modern contraceptive methods might be harmful to their health. Compared to other contraceptive methods, oral contraception caused the heaviest psychological burden, by inducing fear for their health in 71% of the interviewed girls.

Young people in Belgrade are not sufficiently aware of the fact that not using a condom during sexual intercourse with a new partner puts one at risk of acquiring an STI (see table).

**Use of condoms among young people in Belgrade**

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Regular</td>
<td>55.6%</td>
</tr>
<tr>
<td>Sporadic</td>
<td>27.7%</td>
</tr>
<tr>
<td>Never</td>
<td>19.7%</td>
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</table>

The research results revealed that a lack of knowledge about STIs is the main reason why adolescents do not protect themselves against STIs. The majority of interviewed girls could name only three STIs, most frequently HIV (82.3%), gonorrhoea (75%) and syphilis (72.3%). A smaller number was informed about crabs (5.7%), genital herpes (5.3%), chlamydia trachomatis genital infection (2.7%), trichomoniasis (2.3%), genital warts (2%), hepatitis B (0.7%), genital mycoplasmas (0.3%) and cytomegalovirus infection (0.3%). Only 2.3% knew of no STIs at all.

**Health behaviour**

Young people in Belgrade exhibit poor health-care seeking behaviour. Among the interviewed adolescent females one
out of three (31%) visited a gynaecologist for the first time from one to three years after her first sexual experience. Other girls had their first gynaecological examination in the first six months (43.3%), or between six and twelve months (25.7%) after the initiation of sexual activity.

It is not unusual for young people to seek a gynaecological examination when their reproductive health has already been endangered by: having symptoms of STIs (22%), fear of being pregnant (22%) and having symptoms of pelvic inflammatory disease (PID) (18.3%). The less frequent reasons for the first gynaecological examination among interviewed girls were routine control (19.4%) and the need for contraceptive advice (18.3%).

Unwanted pregnancy during adolescence occurred in one out of six interviewed girls (16%) - 14.4% had had one induced abortion, while 1.6% had two or more induced abortions.

In the majority of those interviewed, no STIs were diagnosed previously to this study, which can not be accepted as an accurate picture of the situation. The only STIs that have been diagnosed were those that could be recognized during a gynaecological examination (genital warts in 2.7% of those interviewed) or those that could be detected by simple diagnostic procedures (trichomoniasis in 2.7%).

Gynaecological disease was previously diagnosed in 24.7% of the interviewed girls; 9.3% of them have been treated for PID.

Clinical findings

All of the girls had normal cervical cytology evaluation results, as analysed by a Pap smear. Colposcopic evaluation was normal in 57.7% of the study group. Cervical ectopy was found in 29.3%, and abnormal findings (mosaicism, acetic-white epithelium, punctations and leukoplakia) were observed in 13% of the girls investigated.

A microbiological evaluation showed: chlamydia trachomatis cervicitis (30.3%), bacterial vaginosis (23.7%); non-specific bacterial vaginitis (10.1%); vulvovaginal candidiasis (10.3%); trichomoniasis (1.7%); mycoplasma hominis and ureaplasma urealyticum genital infections (14.0%).

Social influences

Young people are susceptible to their social surroundings, which directly or indirectly influence their knowledge, attitudes and behaviour in the sphere of sexuality and reproduction.

According to the results of this study, the main sources of knowledge about sex, contraception and STIs were: their peers (57%), parents (22%), the mass media (21.6%), school (10%), their partner (7.7%) and health care workers (1.7%).

In the families of many of the adolescents, no information was provided about conception, pregnancy and childbearing (27.6%), sex (39%), induced abortion (39%) or STIs (48.4%). At the same time, 46.3% of the study group knew that their mothers used induced abortion as a birth control method. Some mothers informed their daughters that they had been using oral contraception or intrauterine devices (27.7%) as well as condoms (8%).

The girls interviewed reported that their parents often knew that their daughters had been sexually active (70.7%), but took a passive position toward that aspect of their child's life (45.7%). Adolescent girls in Serbia usually discuss contraceptive choices with their partner (94%). Most boys want to take responsibility with regard to birth control (86.2%). Still, a great number of partners are reluctant to use a condom (42.3%), usually claiming that sexual fulfilment is reduced (63.8%). A large number of adolescent girls (39%) also have a negative attitude toward condom use, explaining that condoms cause physical disturbances and a decrease in sexual pleasure (74.1%).

Acceptable adolescent reproductive health care strategies

The majority of interviewed adolescent females wanted to improve their knowledge about sex, contraception and STIs (83.3%), usually by having a discussion with health care workers (67%).

According to the opinion of those interviewed, the best ways to popularise contraception among youth were school-based sex educational programmes (51%) and using the mass media to spread information (33.3%).

Better quality of condoms (54%) is important for more extensive condom use, as well as the availability of condom machines (15.6%), advocacy (10.0%), an attractive condom design (7%) and free-of-charge condoms (6.7%).

The research results showed that good contact with health care services depends mostly on the quality of counselling (91.3%). In providing health services, female gynaecologists were preferred in 36.7% of the cases. Other determinants, like the kindness of health care workers, shorter waiting time or the expertise of doctors were of much less importance.

Conclusions

The reproductive health of young people in Serbia is poor, in large part due to a lack of knowledge about sexuality, contraception and STIs. Parents of young people are passive, and school and health care workers are not adequately engaged in these matters. As a result, there are many misconceptions about the harmfulness of modern contraceptive methods, the reliability of coitusinterruptus, and the risk for STI transmission in addition to a large number of unwanted pregnancies (16%) and a high prevalence of STIs (chlamydia trachomatis cervicitis was diagnosed in 30.3% of the those interviewed).

At present, there is only one adolescent sexual and reproductive health programme in Serbia, which will be presented in the next issue of Entre Nous. Young people have shown that they are willing to improve their knowledge about sexuality and human reproduction, but want health care professionals to be the major provider of this information, and they expect them to have the time and patience for them and their problems. Meeting their needs is our challenge.

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The Dutch Council on Youth and Population consists of 15 people from throughout the Netherlands. We are working on the topic of sexual and reproductive health and the rights of young people, both in the Netherlands and in developing countries, and are interested in increasing our cooperation with organizations in eastern Europe.

The Netherlands is seen as a model country with regard to sexual health and the rights of young people. It has the lowest rate of teenage pregnancies in Europe, combined with the lowest abortion rate and the highest acceptance of contraception amongst young people worldwide. Studies show that young Dutch people have adequate knowledge about reproduction, contraception and STIs, including HIV/AIDS, and have a positive attitude towards their sexuality. It is interesting to discuss here why the Dutch have such a low rate of teenage pregnancies.

Open and objective education, which starts with the parents, is the key. If there is an open relationship between parents and children it is easier for young people to talk about contraception, e.g. to ask for the pill or condoms when they want to have sex. Use of contraceptives during first sexual intercourse is high: 85%. Seventy percent of these 85% use condoms and 24% use the pill. On the other hand, there are no standard guidelines for parents so there are significant discrepancies in the way they deal with sex education.

There is also sexual education at schools, which is provided in secondary schools when teenagers are between 12 and 15 years old. Sex education is a part of the curriculum of biology and, since 1993, also of a course called "care". In biology the focus is on anatomy and reproduction but also on functions of sexuality, like pleasure. In "care" puberty, hygiene and emotions are central - you learn to negotiate and communicate about sex. But it all depends greatly on the teacher who is giving the class. Most like to do it, but some do not and there is much flexibility in the programme. At the same time, sex education as a subject is not truly in and of itself really compulsory at schools.

Another aspect of youth and sexuality in the Netherlands is education and information from the media, especially from magazines and television. For many years, there have been campaigns on television to promote safe sex. These campaigns are close to young people's lives and some are quite humorous. There are also programmes on television, in which young people talk with each other about sex. There are many magazines for young people in the Netherlands and they all have a page or two with questions from readers, the majority about sex. The questions are anonymous, so teenagers are free to ask whatever they would like to know. The answers are open and serious and they encourage young people to take informed and responsible choices.

The use of the pill in the Netherlands is very high and is one of the main reasons that the number of teenage pregnancies is so low. The pill is distributed free of cost. If anything does go wrong while having sex and you are afraid that you may be pregnant, you can easily obtained the so-called morning after pill (emergency contraception). If you get pregnant and you decide to have an abortion, you can get legal and free help at one of the Dutch abortion clinics.

Condom use and the availability of condoms are also high. You buy the condoms in drugstores; sometimes you have to ask for them and sometimes you just take them from the shelves. And, very important, it is fully accepted that young people buy condoms. Although they are not too expensive, condom use has, surprisingly, been slightly declining over the last years. At the same time, there has been a recent increase in the number of abortions in the Netherlands, including among teenagers, as well an increase in the incidence of sexually transmitted infections. Another problems are Christian groups who prohibit sex before marriage, which means that in their opinion sex education is not necessary as the children of these parents are not supposed to have sex anyway.

At present, in the Netherlands, the number of teenage pregnancies is highest among immigrant girls. Some reasons are that parents do not talk with their children about sex; relationships between boys and girls are different; immigrants are sometimes not aware of the way to the services for help; and they often watch non-Dutch TV channels and thus miss the bits of education the Dutch youth receive. Hence, educating young immigrants about how to protect their sexual and reproductive health is the big challenge in the Netherlands today as well as for the Dutch Council on Youth and Population. Please contact us if you would like more information about our work.

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A consensus statement on youth-friendly health services was developed at an inter-country consultation of national and international organizations called together by the United Nations Inter Agency Group (UNAIDS, UNDCP, UNDP, UNFPA, UNICEF, WHO) on Young Peoples' Health Development and Protection in Europe and central Asia, 5-8 February 2002, Vilnius, Lithuania.

The consultation was convened to discuss the rights and health needs of young people, their access to youth friendly health services and to identify the next steps for action. The key objectives of the meeting were to identify the main health problems for young people, what they currently receive in terms of health care, and review lessons learned and examples of best practice of the health services they need within the Baltic Sea region.

Participants in the consultation were senior health policy makers and planners, a selected group of young people and representatives of NGOs from Bulgaria, Estonia, Latvia, Lithuania and the Russian Federation (Kaliningrad and Saint Petersburg) and representatives of WHO, UNICEF, UNFPA, UNDP, UNDCP and the UNAIDS Secretariat.

Building on the commitments of the International Conference on Population and Development (ICPD) and of the United Nations General Assembly Special session on HIV/AIDS, the adoption of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the United Nations Convention on the Rights of the Child (CRC), the International Conference on Population and Development (ICPD) and the Declaration on the Guiding Principles of Demand Reduction, under-taken by all the countries in this region, the consultation encouraged governments to increase the access of all young people to a range of health services, which are: based on young people's needs; staffed by motivated, friendly and trained health professionals; delivered through confidential and quality health services; located in safe environments; and planned, implemented, monitored and evaluated with young people playing a key role.

Young people are often seen as the healthiest of all age groups, but recent surveys reveal a generation whose health is under threat. The evidence indicates that the main health threats to young people are poor mental health with high levels of suicide, declining levels of sexual and reproductive health (high levels of sexually transmitted infections and unplanned pregnancy), increasing substance use - in particular, alcohol, illicit drug use (more commonly through injecting) and tobacco - and dramatically increasing rates of HIV/AIDS. In addition to addressing these issues, there is a pressing need to promote healthy growth and development of young people through services that are youth friendly.

The countries in Central and Eastern Europe, the Baltic States and the Central Asian Republics have the fastest growing rate of HIV infections in the world, together with very high levels of injecting drug use and STIs. These threats are mainly affecting young people in the 15-24 age group. There is an urgent need, therefore, to address these issues and to promote the healthy growth and development of young people through services that are youth friendly and integrated within a comprehensive approach. This includes access, and attention to, information and education, using peer education, life skills, support for the participation of young people and the creation of safe and supportive environments.

Participants concurred with the consensus reached at the WHO global consultation on Adolescent Friendly Health Services in March 2001 and international efforts to identify indicators and criteria for assessing quality of youth friendly health services.

The Vilnius consultation agreed on a framework that can be used by countries, as well as by international organizations, for improving, reorienting and expanding existing services and establishing new youth friendly health approaches. The UN agencies agreed to develop a joint work plan to take their work forward in this important area.

Acknowledging the existing good practices in the region, the participants at the consultation urgedly call upon governments to mobilize greater efforts to develop appropriate strategies and designate enhanced resources to address the rights and health needs of young people within their countries. This requires identifying criteria for assessing quality of services, collecting epidemiological data on young peoples’ health by age group and gender, and working with young people, civil society and international agencies to provide youth friendly services. Further, the United Nations General Assembly Special Session on Children, to be held in May 2002, provides a major opportunity to put youth friendly services on the policy agenda.

Promoting the healthy development of young people and responding to their health and other needs is a sound investment that will not only benefit young people, but will also have a positive social and economic influence, benefiting the whole society. Young people at the consultation made a challenge to participants and their respective governments: "State policies, finances, politics and programmes should be dedicated to increased public health... for a healthier tomorrow through the participation of young people."
How might one describe a health promoting school and then how would one evaluate its impact, especially in relation to issues of importance such as sexual and reproductive health in young people? The idea of a health promoting school is relatively new, as is the art and science of measuring their effectiveness. Both are areas of interest for health, education and research specialists; for schools which address the concepts and principles of health promotion are taking on wide fields of activity in a comprehensive and integrated manner. The health promoting school approach presents a challenge to researchers, in defining the evaluation and devising techniques able to cover the components that make up a research and evaluation methodology.

The notion of health promoting schools emerged out of the movement in the 1980s to identify and classify the practices of health promotion. Up to this time, the traditional methods of health education in schools had met with little success, especially in the areas of adolescent sexual activity and the recognisably greater incidents of substance use by young people. Comprehensive and integrated processes were being recognised as more effective tools for health development. WHO led the field in this and the Ottawa Charter of 1986 formally described the fundamentals of modern health promotion. The notion of social settings as places where health promotion practices could be built came from the Ottawa Charter and many other contributions since have established the holistic nature of health and the methods through which comprehensive approaches to the promotion of health can be implemented.

Health promotion is not just another project dealing with a health topic or emergency situation. Health promotion is an exercise in change. The WHO definition of health promotion is that it is a "process of enabling people to take more control over the determinants of their health and through this process, improve their health". Taking this definition to its logical conclusion, it points to initiating social, cultural and political change in the pursuit of good health. When placing this in the context of the schools wishing to introduce health promotion processes, a thorough analysis of the school as a setting would need to be undertaken to identify which changes should be made to make the greatest difference to health. However, schools operate within the wider sector of education, requiring both the sectors of education and health to consider the structural and policy needs for the planning of new approaches to the topic of health within the sectors.

The European Network of Health Promoting Schools (ENHPS) has been developing and supporting country strategies and approaches for the introduction of health promoting school programmes within the European Region. In many instances this has involved a simultaneous top-down and bottom up approach, through the creation of school networks and technical assistance to ministries, and pedagogical and public health institutes. In addition, the programme has been building consensus in methodologies and techniques in the many aspects of health promoting school planning and implementation, including research and evaluation.

In developing an evaluation protocol, it is important to identify exactly what it is that is going to be studied. This of course means also identifying the audience for the results, and here is one of the first challenges. Teachers will want to see the impact of the health promoting school approach in educational terms; health services may want to see results in health terms, donors in terms of their investment, administrators in terms of administration procedures, parents in terms of all round development of their children and of the school their children are taught in and so on. So, does research study health alone? Or education alone? Or health and education? Or health, edu-
SEXYAL AND REPRODUCTIVE HEALTH PROGRAM-

The curriculum from grade one and right through their educational career, the environment of the school and its relationships with the community. Research would be designed to observe the linkage between the taught curriculum and the "hidden curriculum" and indicators would be used to measure the progress made in all fields.

For instance, one element of the programme might include curriculum content on making, keeping or ending relationships. This could be an integrated process, beginning in the lower grades where the understandings of friendship may be the focus. This work would extend its reach to outside the classroom and could be measured in terms of social interactions in on- or off-class situations.

Later, in the adolescent age range, the focus would be more concentrated upon the social, emotional and physical aspects of friendships and relationships. Differing measurement tools might look at levels of interactions within and between the age groups and with adults, levels of conflict, incidents of harassment and bullying, support given by peers and uptake of opportunities to participate in the life of the school. A relationships programme planned for the adolescent age group would, by its nature, be closely linked to the specific reproductive health curriculum content and the feelings and emotions experienced within a relationship which included a sexual element. Here, apart from the biological educational content, relationship skills might be taught and practiced, such as:

- how to say no to having sex;
- how to negotiate having safer sex;
- understanding needs and wants;
- ending relationships and understanding and dealing with feelings of jealousy or rejection;
- Knowing about and explaining one's rights and protecting them.

A well-planned curriculum would take many of these aspects into account and match them with the social and cultural norms of the groups as well as the maturity of the pupils. The environment of a health promoting school would also be used to reinforce the curriculum content in the way the school behaved, institutionally, towards young people. The environment would offer young people opportunities to sharpen the skills and competencies developed in the curriculum, through inviting participation at all levels, from taking responsibility to making decisions. Research would provide a pathway for development by showing how successful the school was in these regards.

The ultimate goal of the health promoting school is the development of young people able to live healthy and fulfilling lives. This can be achieved through educational achievement together with healthy physical and psychosocial development. Health promoting school programmes are able to make a valued contribution to both aspects. Through focused and relevant research, schools are better able to identify what they do that is working and how best they can improve what they do to enhance their practice. The ENPHS is attempting, through the trialing of new ideas in health education, health promotion processes and research, to develop guidance for countries in the European Region. The programme is gathering evidence on the best methods to not only build the healthy development of the next generation, but to show it through effective research and evaluation methods. It is a challenging task, for the kind of research needed is very often new and different. Practitioners, such as researchers, teachers and other educationalists as well as the audience of administrators, donors, politicians and parents, need to be educated into new ways of undertaking and reading the evidence and using it to build effective, sustainable and comprehensive programmes that meet the needs of young people in a modern and changing society.

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- What if a fourteen-year-old girl like yourself became pregnant, would abortion be an option?

- No, no ... or yes, because when you’re only fourteen, you might not be old enough to take good care of a baby. You’re not more than a child yourself!

Issues like teenage pregnancy and abortion may come up when Swedish medical students in the project Kärleksakuten meet with adolescents to talk about sexuality. Kärleksakuten (“ER of Love”) is run by the students themselves, working voluntarily in the Swedish affiliate of the International Federation of Medical Students’ Associations (IFMSA).

For nearly two years, Kärleksakuten has regularly met with groups of young people in the schools and youth clubs of six Swedish cities. The meetings aim to encourage adolescents to reflect on sexual health and norms and feelings associated with being on the way to adulthood. At the same time, medical students get to practice how to talk openly about sensitive issues, sex and love, and to adapt their knowledge to an adequate level for young people.

Offers deepened sex education

Sweden has a relatively long tradition of sexual education in school. Since 1956, sexual education has been mandatory in the school curriculum. However, the time allocated for and the content of the sex education varies significantly from one school to another. Rather than to replace the education provided in school, Kärleksakuten should be seen as a complement that can be called in when additional time for sexual education is needed or when it might be useful for the pupils to talk to somebody from out of the school.

Meeting somebody from the outside often makes it more comfortable for the adolescents to open up and discuss sensitive issues. Medical students are also relatively young, which makes it easier for young people to identify with them and for the medical students to act as role models for the youngsters they meet. Also, the medical students in Kärleksakuten have a great interest in medicine and health and have completed a special course in sexual health education.

Breaking the ice

When somebody contacts Kärleksakuten, it is often because of a theme day coming up in school or due to certain problems seen among the adolescents, for example bullying, sexually transmitted infections (STIs) or teenage pregnancies. Upon discussing with the teacher or youth leader, the medical students (one female and one male student) choose methods and contents suitable for a particular meeting. Key methods are brainstorming and “ice-breaking exercises”, allowing everybody to talk, laugh and to take part in a more open discussion. The adolescents’ own feelings, questions and ideas always steer the discussion, allowing them to reflect on norms, values and attitudes among themselves and in the society.

Common topics are peer pressure (Doesn’t everybody have sex before the age of fifteen?), body image (My greatest dream is to become a model); friendship and love (How can I tell if she’s interested?); gender roles (Aren’t condoms a boy thing? Why do girls always have to wear so much make-up?); “the first time” (How does it feel? Does it hurt? Can I prepare myself?); different sexual orientations (I’ve never been in love with a boy, what if I’m lesbian?); masturbation (Is it harmful to do it too often? I’ve never tried. is something wrong with me?); pornography (Why does it exist? Is this a real picture of sexuality?); and STIs (How can I get protected?). Of course, the adolescents do not open up to ask all of these kinds of questions in a group setting, but
a good way to broach the topics and likewise most youngsters' favourite exercise is anonymous questions written on a piece of paper. Throughout the sessions, the importance of showing one another respect in a sexual relationship and everybody's right to decide over their body is central.

Glittering clitoris
Materials used to catalyse the discussions are pictures of people, articles from today's paper, romantic love poems and popular song texts. Role-plays can be used to illustrate safe sex negotiation and correct condom use (putting the condom on a carrot or a banana). Most adolescents have fairly good knowledge of the anatomy of the male and female genital organs. However, when boys have learnt about erection and masturbation, girls have often been taught the menstrual cycle. Therefore, medical students in Kärleksakuten have made their own model of the female genital organ, a vagina and labia in red felt with a glittering pearl as the clitoris. In this way, Kärleksakuten wants to teach girls to be proud of their sexuality.

National training for medical students
The idea to start Kärleksakuten first came from similar projects run by IFMSA in other countries. With support from the Swedish National Institute for Public Health, in August 2000 students in IFMSA-Sweden arranged a one-week summer course to educate the first students to take part in the project. A large number of students signed up for the course, but the number of participants was for practical reasons limited to 30. Methods for interactive sexual education were adopted from IFMSA and people working professionally with sexual health and education were invited to teach. At the second summer course (August 2001), the now experienced sex-educators in Kärleksakuten did most of the training, while professionals were invited to cover theoretical parts. Local groups are now functioning at all six Swedish medical faculties and they regularly meet at national meetings to develop and evaluate their progress.

Kärleksakuten gets a lot of positive response from the adolescents they meet.

Evaluating a tangible outcome of the teaching is difficult, but a new questionnaire on methods and contents of the meetings has recently been taken into use and the first results will be presented later this year. Furthermore, the National Institute for Public Health recently presented a thorough evaluation of the project as a whole and decided to continue their financial and material support.

Working locally worldwide
Since 1951, IFMSA has been working locally worldwide to educate future doctors in global health issues. Today, the federation has around 80 national member organizations. As an IFMSA-Sweden project, Kärleksakuten is part of a wide network of medical students working with sexual education in many countries. Ghana, Jamaica and Peru are some countries that just recently started similar projects. At the biannual IFMSA general assemblies, medical students from around the globe meet to exchange ideas, discuss methods and to get inspiration for their voluntary work. The Nordic contacts within IFMSA are also well developed and Kärleksakuten collaborates closely with similar projects in Denmark and Norway. Since 1969 IFMSA has been recognized by WHO as the official representative for medical students. IFMSA also organizes medical students exchanges and has activities on public health, refugees and peace and medical education matters.

Filling a gap
Although sexuality is closely related to one's health and well-being, the topic is often neglected in the medical curriculum. The culture that sees sexuality as taboo is therefore also the norm for most future doctors. Until this is changed, Kärleksakuten fills an important gap in the medical curriculum, giving medical students a good chance to learn how to talk openly about sexual matters.

Furthermore, by managing the project the medical students acquire useful skills on project management, leadership and collaboration. Through IFMSA, they also develop contacts and friendships with similar-minded people from around the world!

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The research was conducted among 15-18-year-old girls and boys in 41 schools (grades 10 and 11) in the cities of Dmitrov, Murmansk, Mytishch, Pskov and Taganrog. The objectives of the study were to find out what young people's values, attitudes, knowledge and behaviour are regarding love, health and intimate relationships. The results will be used to extend and improve information, education and medical services for adolescents.

Love, attraction and sexual contacts
As in other European countries, young Russians usually start having superficial relationships with the opposite sex at the age of 15 or 16, but they usually wait until the age of about 17 to have their first sexual contact. By the age of 18 the vast majority (about 80%) have some sexual experience.

Sexual contacts usually occur in love relationships, and not just occasionally. This is particularly the case for girls. 84% of both boys and girls feel that a boy and a girl may have sexual contacts if they are in love. But only 33% of girls feel sexual contacts are acceptable if "you just like each other", whereas 64% of boys think this way.

Only in 15% of the cases, the first sexual contact of a girl takes place just after having met her partner. She has usually known him for 3 to 6 months (28%), or for more than half a year (21%). Only 12% of boys and girls currently have regular sexual contacts, i.e. more than once a month. These tend to be the older girls and boys.

An issue of very serious concern is sexual abuse. Among girls with sexual experience, 24% wanted their first contact later than they had it, and 5.4% were really forced into their first sexual contact.

Sexual health protection
Girls and boys run very high risks of being infected with a sexually transmitted infection (STI), because they are not sufficiently aware of the risk. Of those having sexual contacts, 25% think there is no risk at all and 15% cannot even say whether there is a risk. More than a third (37%) think this risk is very small. Only 3.4% think there is a serious risk! This is because most of them have never really been informed about this. As the risk perception is so incredibly low, young partners do not discuss this issue; only 8% of boys and 13% of girls say they did discuss this with their first partner.

The risk of unwanted pregnancy is also hardly discussed with the first partner (9% of boys and 23% of girls did). Fortunately, at the first contact a condom is often used, although without even talking about it. 57% of the boys and 40% of the girls report that a condom was used. But, taking the answers of the girls, in 42% of the cases no form of contraception was used, and in 13% it was withdrawal (which is highly unreliable).

A striking result is the very limited use of oral contraception ("the pill"). Only 2.2% of girls used this method at their first, and 6.4% at their last sexual contact. In this respect the situation in the Russian Federation differs greatly from that of western Europe, where most sexually active girls are using the pill (often in combination with the condom). This largely explains the huge difference in adolescent pregnancy rates between Russia and western Europe. The problem in Russia is that the pill has a very negative image and it is too expensive, especially for young girls.

A positive result of the survey is the rather high acceptability and appreciation of the condom. Only 18% of boys think condoms reduce sexual pleasure; only 8% think they are "messy to use"; and only 16% associate condom use with sexual promiscuity. Most boys also feel that condoms are reliable, safe for health and morally acceptable. Another positive result is that both boys and girls know that traditional methods of contraception (withdrawal and "safe period") are not reliable.

Information and education
In almost every respect, the level of knowledge and the communication skills on issues related to love and intimate relationships is unacceptably low among Russian adolescents. At the same time, most of them are very eager to learn about these issues.

Various results of the survey point in one and the same direction: young Russians need and want, on the one hand, factual information from people who really know
about these issues (like a doctor), and on the other hand they need and want to discuss their feelings and questions with people close to them, with whom they have an intimate relationship: parents in the first instance, but also a brother or sister, a close friend, or their own boy or girlfriend. This pattern of information and education needs is found everywhere in the developed world. But in Russia these needs are hardly met, although the pattern of sexual maturation and behaviour is very similar to other European countries. Only 19% of girls say their knowledge of sexuality in general is definitely sufficient, 17% say they know everything about contraception, and 32% feel they know enough about STI prevention.

Russian adolescents hardly get factual information from reliable sources. Parents know little about the details of sexuality, STI prevention and contraception, and they do not talk about these issues with their children (only 15% of mothers and 4% of fathers do). For most adolescents it is a big step to go to a doctor just to ask questions about these issues, and so only 23% have received information from this source. Nor at school do most adolescents obtain the information they need: only 7% mentions this source as being important. As a result, adolescents look for books, magazines and journals to find what they need (53%), they get information from television and radio (38%), and they try to find out with their friends (33%) or their own lover (35%). In many cases this only means receiving distorted or false information. This explains to a large extent the so-called "irresponsible" behaviour of adolescents. But adolescents not only need objective and factual information, they also need to discuss their uncertainties, questions, feelings and experiences in an emotionally close and safe environment, because they are involved in a developmental process to adulthood. In this respect as well, they are largely left to themselves, not having their parents to turn to (41% would like to be able to talk to their mother, 14% to a brother or sister, and 11% to their father), and so they rely on their friends.

**Sexual health education at school**

In almost all western European countries sexual health education is fully integrated and 18 (as in other developed countries), but they are not at all prepared for it. Therefore, it is recommended that:

1. Parents be assisted in learning how to communicate with their adolescent children on the issues of evolving feelings of love and attraction, and dealing with sexuality in a mature and responsible manner;

2. Reliable information on STIs, including HIV, and pregnancy prevention be made available to young people through communication channels that they really have access to;

3. Sexual health education be introduced in secondary schools, including both factual information and more emotional issues. This type of education should use interactive methods in order to ensure that it responds to the needs of the pupils and enables them to express themselves;

4. Teachers, being either specialists from outside or preferably school psychologists, be properly trained, both factually and methodologically, on how to deal with these emotional and sensitive issues;

5. Sexual health services (family planning cabinets, or clinics and STI control centres) be made more accessible to young people by creating a "youth-friendly" atmosphere;

6. Modern reliable methods of contraception (particularly "the pill") be brought in reach (also financially) of young people.

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**Being Young and in Love in Russia**

Survey on health and intimate relations among 1000 girls and boys in five Russian cities

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A survey of 601 Kazakh women sheds light on why abortion is a popular form of fertility regulation.

During its ten years of independence Kazakhstan has experienced a major transformation, from democratisation on the one hand to socio-economic deterioration on the other. These changes first and foremost impact on the population’s life expectancy, which leads to the need to improve and ensure the sexual and reproductive health of the population.

Family planning is now an important part of national reproductive health policy, in addition to protecting mother and child health, the safe motherhood initiative, medico-genetic consultation, breastfeeding, the integrated management of child illness and other activities to decrease maternal and infant mortality rates, the number of abortions and increase the number of users of contraception (table 1).

The high number of abortions indicates that one of the major methods of birth rate regulation is still abortion, which is a major cause of maternal mortality. Based on this, the purpose of a recent research project of the Kazakhstan School of Public Health has been to define the main reasons motivating women to turn to abortion as a method of fertility regulation instead of contraception. The focus was on the social and psychological aspects of this problem.

The study took the form of a 76-question survey on reproductive behaviour and health, completed anonymously by 601 Kazakh women aged 19-49. It included 76 different questions. 28.8% of the women were from rural areas, where there is a high level of abortions.

Women’s attitude to abortion

Research results showed that most of the women (93.8%) believed that abortion is a method of fertility regulation and that it should be legal. 50.1% of the women viewed abortion as something positive, if there were reasons to have one. 21.1% of women saw abortion as appropriate only when there was a health risk, while 6.3% of women thought that it was a violation of a child’s right to life. 6.4% of those questioned considered abortion to be a harmful and barbaric act.

Of the surveyed women, 48.8% noted that they had had unwanted pregnancies and 76.4% from them had had an abortion. The main reasons were: 2.3% of women do not want to have children because of their difficult financial position; 16.9% of them because they have little children; 23.3% simply wish to limit the number of children they have, 11.4% because they are not married; 7.1% due to poor living conditions; 8.2% due to difficulties in combining the upbringing of a child with studying or a career; and 6% because of poor health status.

The data show that hard socio-economic conditions is one factor leading to abortion. Women believe that abortion should be available and that it should not depend on their financial situation. 89% of the women noted that abortion is available in the country but another 51% pointed out that it had to be paid for.

During the last five years in Kazakhstan the number of women that had 2 abortions fell from 51.7% to 27.2%; 3 abortions fell from 14.3% to 12.3%; 4 abortions from 8.7% to 5.0%; and 5 or more from 7.9 to 6.7%.

One of the principal ways to reduce the number of abortions is the promotion of contraception. The main method of changing women’s mentality is information and education about modern methods of family planning. The research showed that information about the prevention of unwanted pregnancy in 36.6% of the women was obtained from doctors, through specialised literature (33%), from friends (21.3%), through the mass media (18%), from their mother (11%), from a partner (4.2%), from schoolteachers (6.2%), in institutes (9.2%) and other sources (2.3%).
The data showed that in most cases women do not use contraception because they do not have sufficient knowledge about modern methods of contraception and about their benefits. Due to difficulties during the transition to independence period and the growing number of people living in poverty, for many women modern contraceptive methods are not available. Thus 30.4% of the women noted that for them contraceptive methods were not available due to the high cost.

**Young people’s sexual activities**

One of the current problems for Kazakhstan is the reproductive health care of adolescents and young people. Their level of sexual activity has increased significantly. Research undertaken by Kazakhstan School of Public Health shows that adolescents under the age of 17 as well as 60% of young people in general have experienced sexual activity.

Kazakhstan is now confronted by a serious threat to young people’s health, related to the initiation of sexual activity at an early age compounded by early pregnancy and the resulting high risk of maternal incidence and mortality as compared with older women, and a high incidence of STIs including HIV/AIDS.

According to Ministry of Health data, every tenth childbirth is to a 15-19-year-old girl and the number of abortions among them is 8%. The ratio of delivery to abortion is 1:3. There has also been an increase in the number of abortions among girls who become pregnant for the first time (from 10.9% in 1998 to 13% in 2000). Our school’s research confirms the data: 11.8% of the respondents reported that their pregnancies ended in abortion and among them two-thirds had had a first pregnancy.

Young people have a negative opinion about abortions: 98% of female and 94% of male think that abortion is harmful to one’s health and brings “moral suffering” to young women. 34% of the respondents had contracted gynaecological diseases, and most were unmarried rapidly changing partners.

Adolescents and other young people have problems which are connected with inadequate access to reliable information about safe sex and contraception. Their parents are not ready to provide them with needed information: only 11% of young people noted that their parents informed them about safe sex. Medical specialists and teachers were a principal source of information about safe sex (33-38%). The primary source of information for young people is their friends (38.8%) and other sources (literature and the mass media) – 43%.

As a result, youth lack information about safe sex and modern contraception: 68% of young females and 35.9% of males think that the most effective contraception is the pill; 54% and 25.6%, respectively, – condoms; and 32% and 12.8% the IUD. Unfortunately, 20% of adolescents and youth noted that abortion is their main method of contraception. It is difficult for young people to obtain contraceptives (41% of respondents cited “high prices”).

There is an acute problem with regard to the availability of services in the field of family planning for youth and the satisfaction of sexual and reproductive health needs. Most respondents (87%) noted that they need accessible and reliable information about safe sex, improved medical service, accessible centres and clinics etc. A poignant commentary was that these services should respect young patients.

As adults and experts, we urgently have to review how to improve the reproductive health conditions of adolescents and young people, how to help them to change their minds about their sexual and reproductive behaviour; and how to increase the use of contraceptives among those already sexually active.

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Safe, nutrient-dense foods are essential for foetal and maternal health and allow both a young mother and her infant proper development and the chance for a healthy, productive life.

Adolescent pregnancy has important nutritional implications for the young mother and the foetus. It puts a double burden on her body: both she and the foetus are growing and developing and end up “competing” for essential nutrients, potentially jeopardizing the health of both mother and child. Figure 1 shows that adolescent pregnancy rates are still high in most transition countries relative to western European countries. These data warrant the need to focus on prevention of adolescent pregnancy as well as to help adolescent girls have healthy behaviours, including an adequate diet, when they do become pregnant.

Figure 1: Adolescent pregnancy rates, per 1000 women aged 15-19, 1998

Folic acid helps prevent spontaneous abortion and birth defects such as spina bifida. Calcium is also essential for the pregnant adolescent who is still increasing bone mass. Other micronutrients such as zinc, vitamin A, B6, B12 and D are also needed in sufficient quantities and from bioavailable sources during pregnancy, delivery, and the postpartum period. Other nutrition-related concerns in adolescent pregnancy include:

- Diabetes: gestational diabetes and even mild maternal impaired glucose intolerance increase the risk of insulin resistance, diabetes and obesity in the offspring in later life.
- Hypertensive disorders, a major cause of perinatal mortality and morbidity in adolescent pregnancy;
- Pica, an abnormal craving and ingestion of inappropriate substances potentially resulting in foetal and maternal toxicity; and
- Eating disorders, such as restricting eating and purging behaviours which can result in inadequate gestational weight gain, excessive weight gain and/or decreased nutrient stores.

Once the infant is born, breast milk is by far the best food for the newborn baby (exclusively for 6 months): breast milk is perfectly balanced nutritionally for the baby’s needs and has many benefits such as protecting the infant against common infections. Lactation demands adequate maternal nutrition, particularly in adolescent pregnancy, as there is potential competition between the needs of the adolescent mother for her own development and those for milk production.

Delaying the first pregnancy to adulthood and improving adolescent girls’ nutrition is a critical part of breaking the intergenerational cycle of malnutrition, poverty and poor health. The pregnancy-related benefits of improving adolescent girls’ nutrition include:

- Increased pre-pregnancy weight and body stores of nutrients, thus contributing to improved future pregnancy and lactation outcome, while preserving the mother’s nutritional status and well-being.
- Prevention of obesity before and during pregnancy to minimize associated maternal and child risks.
- Improved iron status to reduce the risk of anaemia in pregnancy, low birth weight, maternal morbidity and mortality, and with increased productivity at work and perhaps linear growth; and
- Improved foetal status, with reduced risk of spontaneous abortion and neural tube defects in the newborn.

Increasing access to safe, nutrient-dense foods, and advising the young mother on her and her child’s nutritional health via antenatal and postpartum services, family and school, can help ensure a healthy pregnancy and brighter prospects for both mother and child.

Tools for improving pregnancy and related services and practices will be presented in future issues of Entre Nous.

References are available from the author.

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This article is part of a broader research project on reproductive health in the European Region. It also presents evidence on the nutritional health of young mothers, further discussed in an upcoming WHO publication entitled “Food and Health in Europe: A New Basis for Action”.
Still no Internal Health Promotion Measures Specifically for Women within Organizations:
The Graz Women’s Health Program Gender Audit

Equal chances on the job have positive effects on the health of women. In 2001, the Graz Women’s Health Center, Austria, conducted a gender health audit within six businesses and non-profit organisations to assess the status of equal rights and health promotion in the workplace for women. The programme was based on the World Health Organization’s Strategic Action Plan for the Health of Women in Europe (2001) and the Glasgow Women’s Health Action Plan.

The results showed that women are still disadvantaged as compared to men and that there are no programmes targeting women in particular.

Spar, a chain of supermarkets; Graz Public Transportation Company (Grazer Verkehrsunternehmen); the Styrian Public Health Insurance Plan (Steirische Gebietskrankenkasse); Steyr Daniele Puch Fahrzeugtechnik, the Styrian Bank, and Caritas, the Catholic welfare organization, participated in an analysis of their organizational culture and of their women-oriented products and services in which way do the businesses and organizations account for the specific needs of their female employees, and do they specifically assess the needs of their customers and clients by gender?

The main results of the employees’ needs audit were:
1. No organization sees the health and well-being of their female employees in the context of the gendered working conditions of women and men.
2. Only the Styrian Public Health Insurance Plan (GKR) has equal rights as an explicit part of their mission statement. Steyr Daniele Puch, however, is undertaking a large number of activities to increase equal chances. They offer some special training programs for women, specifically look for and train female apprentices and have an equal rights project headed by a woman.
3. All organisations offer health promotion activities, however, mostly target women.
4. Organisations with a high proportion of female employees are better at taking women’s needs into account with respect to working hours and return to work after maternity leave.
5. Women are underrepresented in management positions, while catching up on the second and third levels of leadership.

That equal rights promote the health of women employees is still not fully recognized by businesses and organizations, not only to the detriment of their female employees but also to their own disadvantage.

The Graz Women’s Health Program Gender Health Audit was funded by the City of Graz, Office for Women, City Counsellor Tatjana Kolenbeck, the Office for Health, City Counsellor Peter Wenminter, and the Healthy Austria Fund (Fonds Gesundes Österreich).

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Counselling skills training in adolescent sexuality and reproductive health: A facilitator’s guide

The Counselling skills training in adolescent sexuality and reproductive health: A facilitator’s guide is designed to help facilitators to run a 5-day workshop for training counseling skills in adolescent sexuality and reproductive health. It includes six sections. The first describes preparatory activities and the facilities needed for the workshop. The following five sections each provide a model daily program, although some optional sections are suggested at the end, and by including those options and increasing the time devoted to practice, the training can readily be expanded to ten working days. In addition to general topics covered at the beginning and end of the workshop: each day is divided into three sequential sections: (A) Sexuality and Reproductive Health (B) The Psychology of Counselling, and (C) Micro-Communication Skills for Counselling.

The method described in this guide has been used with participants from more than 20 countries throughout the world since 1988, especially developing countries. Their experience and evaluation of the techniques has played a major role in refining it. They work primarily in the youth and health sector with non-governmental organizations, such as those affiliated with the World Assembly of Youth and the International Planned Parenthood Federation, as well as in the public health and related sectors.

For more information, please contact:
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Family and Community Health unit
Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark
Tel: (+45) 3917 1426
Links to websites and online publications on adolescent reproductive health

Supporting the Next Generation of Parents and leaders

http://www.unfpa.org/adolescents/
This link leads to the index page of UNFPA's site on adolescent sexual health and reproductive rights. The sub-headings include: Critical information for making smart choices, providing services that young people want and need, supportive communities, youth participation and leadership, and empowering girls: promoting gender equality. You will also find links to pages with demographics and facts, and international agreements and consensus documents.

A very informative, well designed and easily navigable page. The articles are, however, not dated and I believe most of the material to be at least two years old, though still relevant. The page is well worth a visit.

Women's Empowerment and Reproductive Health: Links Throughout the Life Cycle.

(http://www.unfpa.org/modules/intercenter/index.html)
Here you will find articles such as: Reproductive health and early life changes and Reproductive health education: the mutual relationship. UNFPA's site has many informative articles on adolescent health amongst other topics.

Youth and HIV/AIDS, Can We Avoid a Catastrophe?

http://www.jhuccp.org/pr/12edsum.shtml
Source: Population Reports, Johns Hopkins Center for Communication programs
http://www.jhuccp.org
The page focuses on youth and HIV/AIDS. The main page summarises topics that are expanded through the links to the left.
Topics include: The invisible epidemic, how young people become infected, Why so vulnerable, addressing the epidemic, reaching out, the consequences of inaction, HIV/AIDS: what young people want to know.
This page contains a plethora of information on HIV/AIDS and adolescents. The site mostly deals with sub-Saharan Africa. I did find the hodgepodge of links and PDF files (not noted as PDFs) to be slightly confusing, but the site is extremely informative and up to date.

Advocates for Youth

http://www.advocatesforyouth.org
Advocates for Youth is an organization dedicated to creating programmes and advocating for policies that help young people make informed and responsible decisions about their sexual and reproductive health. The free online publications page is excellent and packed full of HTML, PDF and video downloads. Here you can scroll through topics such as: Advocacy, contraceptive use & sexual behaviour, European approaches, HIV/AIDS & STI prevention, Teen pregnancy and emergency contraception. Recent publication topics include: Life skills approaches to improving youth's sexual and reproductive health, and Adolescent sexual health in Europe and the US - why the difference? This is a great page from a great organization. The site is well maintained, up to date, positive and informative.
Check out Youth HIV, a daughter site of Advocates for Youth. A website created by and for HIV-positive youth and HIV peer educators: www.youthhiv.org

Sex etc: A Website by Teens for Teens

www.sxetc.org
This award-winning site is the online version of Rutgers University's Network for Family Life Education newsletter. The site is youthfully designed, very navigable and informative. It is loaded with personal testimonies of teens and advice and articles on such topics as: Abstinence, AIDS/HIV/STDs, Condoms and birth control, curious about sex? Drugs, alcohol and tobacco, Gay and lesbian teens, Girls and girls, Health and happiness, Love and dating, Pregnancy and parenting, Abortion and adoption, Sex ed, Sound off, and Violence and abuse. There is a chat line for teens and a forum called "Ask the experts", where teens can pose questions directly to professionals. This site is a breath of fresh air in the often stagnant realm of reproductive health education.
Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents

Source: Family Health International
www.fhi.org
An online manual written to “Help service providers and health workers strengthen the reproductive health care and services offered to young women and men.” Published by Family Health International.

Street Kids International

www.streetkids.org
Street Kids International confronts why some children and youth around the world are forced onto the street, and helps them achieve dignity and self-reliance, health and security.
Street Kids International has been in existence since 1988 training street workers, helping and educating approximately 200,000 street kids throughout the Americas, Asia, Africa and eastern Europe, to make informed lifestyle choices and to “build better livelihoods”, through the innovative use of teaching, video and animation. This is an excellently designed website, clear and simple with nice graphics. I am sure it has been a valuable asset to the organization.

Positive.org

http://www.webcom.com/~cps/Home/index.html
“You have the right to complete and honest sex education. Demand information from your school, healthcare provider and parents” quotes this interesting site from teens, for teens. Positive.org gives a quick and easy online tour through some important topics for teens who are sexually active now or just thinking about having sex. “Because we’re tired of people telling us what we can and can’t do. There’s no preaching. No moralizing. Just the facts.”
For a site whose target is teens the design and user interface was certainly not designed with the target market in mind. Many of the external links are no longer active.

United Nations Special Session on Children
8-10 May 2002, New York, NY

As a follow-up to the 1990 World Summit for Children, the UN Special Session on Children will bring together government leaders, NGOs, children’s advocates and young people themselves to improve the way the world views and treats its children.
http://www.ipas.org/new/UNchildren.htm
This announcement is located at IPAS www.ipas.org, an NGO working globally to improve women’s lives through a focus on reproductive health. Also on the same page: Factsheets on children’s and adolescents’ reproductive health containing information on: Maternal health; Implications for children and adolescents. Children, youth and unsafe abortion; HIV/AIDS, The human rights of children and their sexual and reproductive health; Trafficking and girls. These files are in PDF form.

The WHO Headquarters
Department of Child Health and Development (CAH)
www.who.int/child-adolescent-health/
The menu on the left provides a link to a section describing WHO’s main areas of work on adolescent sexual and reproductive health, including a few publications. One key event is the Global Consultation on Child and Adolescent Health and Development, held on 12-13 March 2002, in Stockholm, Sweden. See www.who.int/consultation/child-adolescent/ to read about how WHO and UNICEF will look at how to prevent the almost 11 million deaths of infants and children and more than 1 million adolescents annually.
Entre Nous

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