

# Evidence for gender responsive actions to prevent and manage **adolescent pregnancy**

Young people's health as a whole-of-society response



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## **Keywords**

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ABORTION, INDUCED

# Abstract

The WHO Regional Office for Europe supports Member States in improving adolescent health by recommending comprehensive, multisectoral and evidence-informed adolescent health approaches; by delineating the critical contribution of the health sector; by fostering actions towards reducing inequalities; and by addressing gender as a key determinant of adolescent health. This publication aims to support this work in the framework of the *European strategy for child and adolescent health and development*, and is part of the WHO Regional Office for Europe contribution to the development of a new policy framework for Europe, *Health 2020*, for which the WHO Regional Office for Europe has been mandated by the 53 Member States.

The publication summarizes current knowledge on what works in preventing and managing adolescent pregnancy. It is part of a series that includes social and emotional

well-being, chronic conditions and disabilities, adolescent pregnancy, HIV/STIs, overweight and obesity, violence, injuries and substance abuse.

The publication assumes the position that young people's health is the responsibility of the whole society, and that interventions need to be gender responsive in order to be successful. It therefore looks at actions at various levels, such as cross-sector policies, families and communities actions, and interventions by health systems and health services. The publication does not prescribe nor recommend any particular course of action, which needs to be informed by the country specific context. It rather provides a basis to stimulate countries to further refine national policies so that they contribute effectively to the health and well-being of young people.

# Acknowledgment

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Many international experts and WHO staff members have contributed to the series **Young people's health as a whole-of-society response**, and we are very grateful for their valuable inputs, support and guidance. The conceptual foundation for this publication was based on the Action

Tool of the European strategy for child and adolescent health and development [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0011/81848/Action\\_Tool.pdf](http://www.euro.who.int/__data/assets/pdf_file/0011/81848/Action_Tool.pdf).

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# Foreword

In May 2011, the World Health Assembly adopted a resolution urging Member States to accelerate the development of policies and plans to address the main determinants of young people's health.

This series of publications, advocating a whole-of-society response to young people's health, and looking at the evidence for gender responsive actions, will be a timely resource for Member States as they implement both the resolution and the European strategy for child and adolescent health and development. The publications clearly show that not only are the health, education, social protection and employment sectors jointly responsible for the health of adolescents, but that effective interventions do exist. Ensuring that adolescents who are pregnant or have children can stay in or return to school, or enacting regulations to limit unhealthy snacks and soft drinks in school cafeterias are examples of policies that are beyond the mandate of health systems and yet generate health. By bringing evidence to the attention of policy-makers, these publications take a practical step toward achieving one of the core aims of the new European policy for health, Health 2020: to promote and strengthen innovative ways of working across sector and agency boundaries for health and well-being.

A common shortcoming of adolescent health programmes across the WHO European Region is that they often look at adolescents as a homogeneous cohort. Far too often programmes are blind to the fact that boys and girls differ in their exposure and vulnerability to health risks and conditions, such as depressive disorders, injuries, substance abuse, eating disorders, sexually transmitted infections, violence and self-inflicted injuries, including suicide. They are affected differently not only by the socioeconomic circumstances of their community and their ethnicity but also by gender norms and values. Research shows this, yet there is insufficient progress in transforming knowledge into policy action. I hope this publication will be a useful tool to facilitate this transformation.

Dr Gauden Galea  
Director  
Division of Noncommunicable Diseases  
and Health Promotion

# Introduction

The WHO Regional Office for Europe supports Member States in improving adolescent health in four main ways: by recommending comprehensive, multisectoral and evidence-informed adolescent health approaches; by delineating and supporting the critical contribution of the health sector, including the leadership role of ministries of health to influence other sectors, such as education, employment and social protection policies; by fostering actions towards reducing inequities in health both within and between countries; and by addressing gender as a key determinant of adolescent health.

By bringing together and coherently interconnecting knowledge and evidence on effective interventions and good practices for the better health, equity and well-being of young people, this publication aims to support this work using the framework of the European strategy for child and adolescent health and development. It is also part of the WHO Regional Office for Europe's contribution to the development of a new policy framework for Europe, Health 2020, for which the WHO Regional Office for Europe has been mandated by the 53 Member States (resolution EUR/RC60/R5).

The publication summarizes current knowledge on what works in preventing and managing adolescent pregnancy. It is part of a series that includes social and emotional well-being, chronic conditions and disabilities, adolescent pregnancy, HIV/STIs, mental health, overweight and obesity, violence, and injuries and substance abuse.

The publication includes two parts. The first part is a summary table of effective interventions and good practices in preventing and managing adolescent pregnancy. The table emphasizes intersectoral governance and accountability for young people's health and development, and takes a whole-of society approach to young people's health. It therefore looks at actions at various levels, such as cross-sector policies, families and communities actions, and interventions by health systems and health services. It demonstrates that health systems in general, and health

ministries in particular, can work proactively with other sectors to identify practical policy options that maximize the positive health effects of other policies on young people's well-being, and minimize any negative effects. Interventions need to be gender responsive in order to be successful; the publication therefore looks at presented practices through a distinct gender perspective.

The second part explains the impact of gender norms, values and discrimination on the health of adolescents relevant the prevention and management of adolescent pregnancy. Through a review of the existing evidence, it looks at why is it important to look at gender as a determinant of adolescence health, what are the main differences between girls and boys in exposure to risk, norms and values and access to services, and what are the different responses from the health sector and the community. It complements the Gender Tool of the European strategy for child and adolescent health and development [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0020/76511/EuroStrat\\_Gender\\_tool.pdf](http://www.euro.who.int/__data/assets/pdf_file/0020/76511/EuroStrat_Gender_tool.pdf). It gives readers a deeper understanding of the gender dimension of actions listed in Part I.

The evidence base of this publication includes a review of existing literature, such as scientific and research articles and books, policy reviews, evaluations, and 'grey' literature. It needs to be emphasized that this is not a comprehensive and systematic review of the evidence in the area of prevention and management of adolescent pregnancy, nor of approaches to support policies and their implementation. The publication does not rank presented interventions and good practices in any priority order, and does not assess them against the strengths of the evidence behind them. The publication does not prescribe nor recommend any particular course of action, which needs to be informed by country specific context. It rather provides a basis to stimulate countries to further refine national policies and strategies so that they contribute effectively to the health and well-being of young people.

## ADOLESCENT PREGNANCY

PRIORITY	CROSS SECTOR ACTIONS		FAMILY & COMMUNITY ACTIONS	HEALTH SYSTEM ACTIONS	HEALTH SERVICES ACTIONS
	HEALTH IN ALL POLICIES	SCHOOL SETTING			
<p><b>Prevent unintended pregnancies among adolescents and ensure appropriate access to safe abortion and childbirth services</b></p>	<p>Formulate and enforce laws and policies to prohibit the marriage of girls before the age of 18 years [13]</p> <p>Ensure that legal, policy and regulatory framework supports the rights of adolescents to age appropriate information, confidentiality and privacy, access to services and commodities, and reinforce the principle of evolving capacities of the child for autonomous decision and informed consent [1, 2, 4, 13]</p> <p>Ensure completion of compulsory education for girls and boys [1, 13]</p> <p>Design sex education programmes that incorporate characteristics of effective programmes<sup>1</sup> and take into account the social and cultural influences on young people sexual behaviours [5, 6, 14]</p> <p>Promote collaboration among sectors and non-profit organizations to ensure free contraceptive services</p> <p>Implement policy to ensure that pregnant and parenting adolescents can stay in and return to school [1, 7, 8, 13]</p> <p>Implement programmes that are specifically designed to focus on most at risk young people [2, 3, 4]</p> <p>Design programmes to improve service learning<sup>2</sup>, vocational training and employment opportunities for youth [5]</p> <p>Improve social support to teenage mothers and young parents, including housing conditions [7]</p>	<p>Implement comprehensive<sup>3</sup> sex education programmes that incorporate characteristics of effective programmes and take into account the social and cultural influences on young people sexual behaviours [5, 6, 9, 10, 14]</p> <p>Implement a combination of educational and contraceptive interventions [10, 13]</p> <p>Complement SRH education with counselling and selected adolescent-friendly SRH services in schools and/or ensure a close collaboration between schools and local health services [8]</p>	<p>Implement interventions to inform and empower girls, in combination with interventions to influence family and community norms, to delay the age of marriage among girls under 18 [13]</p> <p>Implement sex education programmes with multiple components<sup>4</sup> that are based on local needs, send clear, consistent messages about appropriate sexual behaviour, take into account the social and cultural influences on young people sexual behaviours<sup>5</sup> [5, 6], and combine sex education with contraceptive interventions and service use [10, 11, 13]</p> <p>Implement strategies to improve pregnancy outcome among adolescents that involve decision-makers of community at large and in household (i.e. men, “mothers-in-law” [1])</p> <p>Provide information to all pregnant adolescents and community members about the importance of utilizing skilled antenatal and childbirth care [13]</p> <p>Implement comprehensive multicomponent<sup>6</sup> youth development programs [5]</p> <p>Implement parenting programmes with certain characteristics<sup>7</sup> to improve adolescents’ SRH [12]</p> <p>Implement home visiting, parental and psychological support to young families to improve health and welfare outcomes for mother and child [7]</p> <p>Encourage community-based distribution programmes for postpartum and post-abortion contraception to maintain contraceptive use after post-abortion care provided at the clinic [1, 13]</p>	<p>Implement policies to ensure access to contraceptive advice and contraceptive services for adolescents and young people including reduced financial cost of contraceptives [1, 13]</p> <p>Identify and reduce the barriers<sup>8</sup> for (pregnant) adolescents to access services, including safe abortion and post-abortion care services where abortion is legal, and develop youth friendly characteristics of services [1, 5, 13]</p> <p>Ensure appropriate training for all health professionals in contact with adolescents including primary care providers [1]</p> <p>Provide 100% subsidy for maternity care and services for all adolescents and very young adolescents in particular [1]</p>	<p>Involve family planning clinics and other services in school based sex education programmes and outreach activities in schools and the community [5]</p> <p>Provide services that answer the characteristics of youth friendly health services and are linked to activities to promote the use of health services including contraceptive use by young people [11, 13]</p> <p>Provide counselling, medical, social and psychological support for girls with unintended pregnancies with options for continuing or terminating the pregnancy [1]</p> <p>Provide information to all pregnant adolescents and other stakeholders about the importance of utilizing skilled antenatal and childbirth care [13]</p> <p>Promote individualized birth and emergency preparedness in antenatal care strategies for pregnant adolescents<sup>9</sup> [1, 13]</p> <p>Start counselling for breastfeeding and contraception during the antenatal period [1]</p> <p>Ensure adolescents’ access to interventions to reduce mother-to-child transmission of HIV during the antenatal period and delivery<sup>10</sup> [1]</p> <p>Provide adequate social and psychological support<sup>11</sup> to adolescent mothers in particular when family and community environment is inadequate [1]</p> <p>Implement protocols for systematic detection of violence as part of the routine antenatal care, and train health care providers accordingly [1]</p> <p>Ensure access by adolescents to post-abortion care as a life-saving medical intervention, whether or not the abortion or attempted abortion was legal [13]</p> <p>Ensure that those adolescents who have had abortions can obtain post-abortion contraceptive information and services, whether or not the abortion was legal [13]</p> <p>Consider implementing home visits as part of postpartum care to promote and support breastfeeding and contraceptive use [1, 13]</p>

<sup>1</sup> see Annex 1 for characteristics of effective programmes and social and cultural factors that influence young people sexual behaviours

<sup>2</sup> service learning programs have two components: voluntary or unpaid service in the community (e.g., tutoring, working in nursing homes, or helping fix up parks and recreation areas), and structured time for preparation and reflection before, during, and after service (e.g., group discussions, journal writing, or papers) (Kirby, 2007)

<sup>3</sup> comprehensive programs encourage abstinence as the safest choice but also encourage young people who are having sex to always use condoms or other measures of contraception

<sup>4</sup> multicomponent community programmes are founded on broad-based collaborations with various agencies and stakeholders, and combine a range of strategies such as sex education in the classroom, individual counselling and community events

<sup>5</sup> see Annex 1 for characteristics of effective curriculum-based programmes for sex and HIV education, and for social and cultural factors that influence sexual behaviours of young people

<sup>6</sup> such as tutoring, mentoring, small group discussions with caring adults, development activities (including arts, sports, and career planning), referrals to health services (including reproductive health services), and other components

<sup>7</sup> see Annex 2 for recommended characteristics

<sup>8</sup> e.g. cost, working hours, appointment procedures

<sup>9</sup> “Birth Plan” including the place of birth and availability of transportation and costs involved

<sup>10</sup> this is usually in the form of voluntary HIV testing and counselling and should be followed by appropriate treatment, support and care

<sup>11</sup> addressing their social, nutritional and medical needs during pregnancy, labour, delivery and the postpartum period

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# Gender impacts on adolescent health with focus on safe motherhood and safe abortion

*“In order to ensure that women and men of all ages have equal access to opportunities for achieving their full health potential and health equity, the health sector needs to recognize that they differ in terms of both sex and gender. Because of social (gender) and biological (sex) differences, women and men face different health risks, experience different responses from health systems, and their health-seeking behaviour, and health outcomes differ.”*

Source: Strategy for integrating gender analysis and actions into the work of WHO. Geneva, World Health Organization, 2009.

The sexual activity and health of adolescents, in general, is determined by their cultural, environment and socio-economic status, access to education, religion, and ethnic background as well as by their gender. Adolescence is a stage of life when gender role differentiation intensifies. The term gender categorizes different roles of men and women as determined by the society in which they live. A child's sex is determined before birth but gender is learned throughout childhood. Boys and girls receive different messages about the behaviour that is expected of them; messages that certain behaviour is acceptable for boys but not for girls,

and vice versa (Joshi, 2005). Gender perspectives shape the way adolescents view sexuality and play an important role in sexual behaviour, risk-taking attitudes and their use and access to information and services. Also, gender perspectives play a role along with the biological distinction in determining the reproductive health status and reproductive health needs. The purpose of gender analysis is to unearth sex differences and gender inequalities and their impact on specific health problems. Those inequalities often create, maintain and exacerbate exposure to various health risks (WHO, 2007).

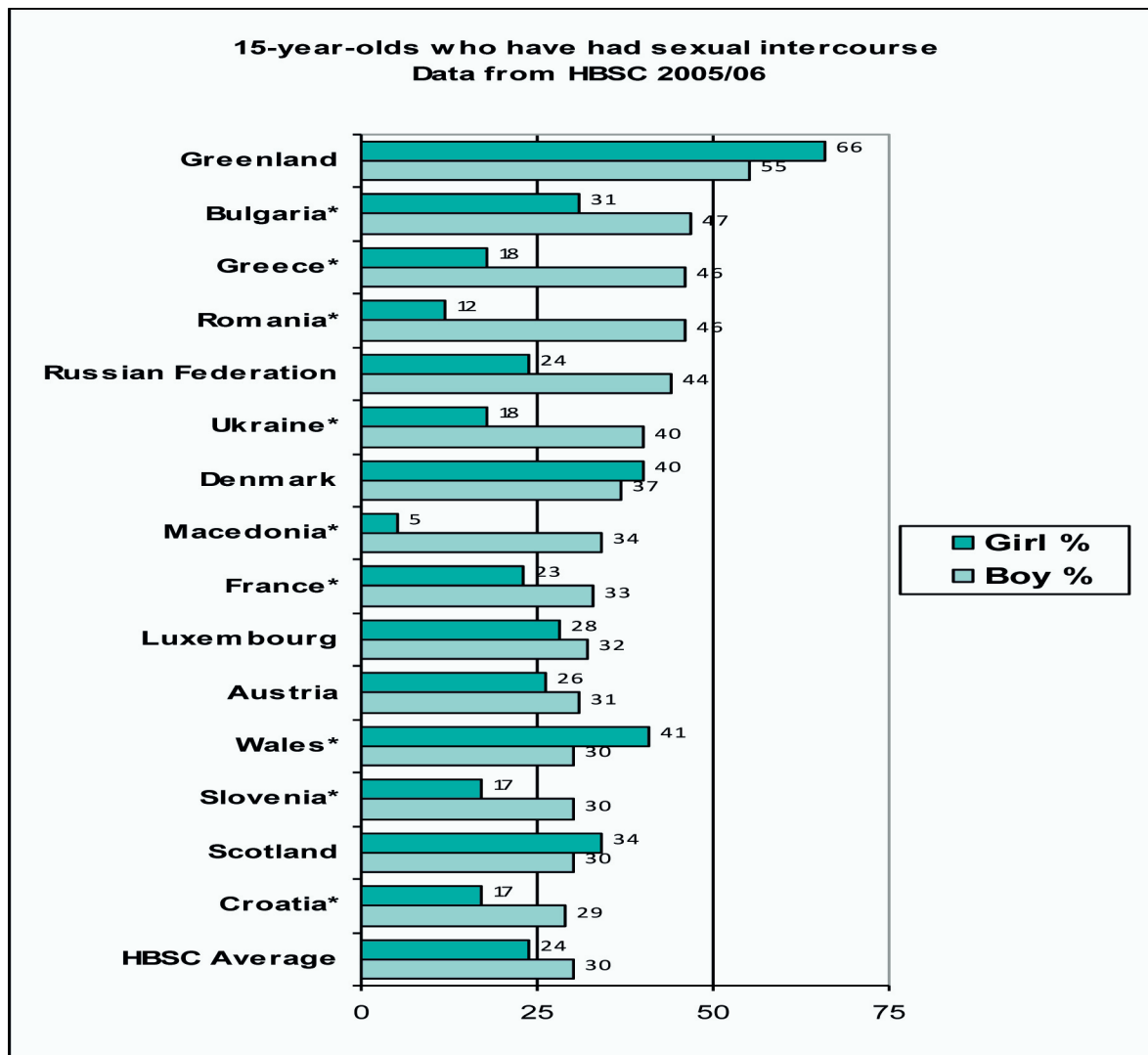
## Safe motherhood and safe abortion among adolescent girls – what do we know?

Several studies have shown that gender roles affect sexual conduct and health-seeking behaviour. Adolescent sexual activity shows a gender difference in many countries and regions. The data from the WHO European Health Behaviour in School-age Children Study (WHO, 2008) showed significant gender differences in sexual conduct among countries. The survey found that at age 15, 24% of girls and 30% of boys report sexual intercourse. Significant gender differences are reported by some countries but such differences should be handled with great caution. In more than half of the HBSC study countries, boys are more likely to report having had sexual intercourse: Bulgaria (47% of boys, 31% of girls),

Russian Federation (44% versus 24%), Greece (46% versus 18%), Ukraine (40% versus 18%), Romania (46% versus 12%) and the former Yugoslav Republic of Macedonia (34% versus 5%) show the largest differences (Fig. 1). Although in general boys are more likely to report sexual intercourse at the age of 15 years, in a few countries this pattern is reversed. This is the case for northern countries like Greenland (66% of girls versus 55% of boys) or Sweden (32% versus 25%). It should be assumed that, at least partially, this reversed pattern reflects the gradual disappearance of the double standard and subsequently more honest answering of sexuality-related questions by both boys and girls.



Fig. 1: 15-year-old boys and girls who have had sexual intercourse



\*indicates a significant gender difference (at  $p < 0.05$ )

During puberty, interest in sex manifests itself and multiple forms of sexual expression may be explored. Sexual behaviour is influenced by gender, the social and cultural environment, risk behaviours, education and beliefs. Sexual behaviour of young people from a migrant background in Europe shows a gender difference that is different from their native peers. In Germany, at the age of 17, 47% of

girls from a migrant background, compared with 34% of German girls, have not yet had sexual contacts, and the corresponding figures among boys are 28% (migrants) and 35% (non-migrants) (BZgA, 2010). The strong gender difference in experience among migrants, which is absent among native German youngsters, is striking. Again, this gender difference in reported experience may well be more

a reflection of cultural norms that are different for girls and boys than a difference in actual behaviour. In the Netherlands, similar differences have been observed (and should probably be similarly explained): among 12-to-18-year-old Turkish and Moroccan boys, 45% and 38% respectively claimed to have sexual experience, against only 11% and 6%, respectively, of their female peers. The comparable percentages for native Dutch youngsters were 20% (boys) and 28% (girls), indicating a reversed pattern compared with the immigrants (De Graaf et al., 2005).

Often sex occurs as a result of abuse or coercion (Avery & Lazdane, 2008). A study conducted in Ireland among both rural and urban adolescents documented that while only a tenth of boys reported that they felt pressured to have full sex, approximately a third of girls reported that they had at some time felt pressured. Moreover, boys manifested a poorer understanding of fertility than girls, with more than half believing that a pregnancy would not occur while a woman was menstruating (Drennan, Hyde and Howlett, 2009). Endeavours designed to improve young people's knowledge of reproductive physiology and the risks they pose to themselves by having sex without a condom need to be improved.

Financial hardship may lead to prostitution and trafficking for sexual exploitation. Key aspects of an adolescent's social environment, such as a positive relationship with family and school, have been shown to protect against unsafe sexual behaviour (WHO, 2002).

Adolescent contraceptive use and prevalence varies across the European Region. Values for contraceptive use ranged from as low as 31.1% in Serbia and Montenegro to as high as 90.2% in the United Kingdom for females, and 32.5% in Lithuania to 92.6% in the United Kingdom for males (Avery & Lazdane 2008). In Switzerland and the United Kingdom youths under the age of 16 are less likely to use contraception than older, sexually active adolescents (Burack 1999; Narring, Wydler and Michaud, 2000; Wellings et al., 2001). Additional factors related to a lesser use of contraception during the first intercourse experience included a casual first relationship and a male partner more than 7 years older than the girl (Burack, 1999).

Data for adolescent contraceptive prevalence (defined as both traditional and non-traditional contraceptive methods) were obtained from fertility surveys. As seen in Table 1, contraceptive prevalence varies significantly between countries from a low of 8.9% in Tajikistan to a high of 76.6% in Ukraine. Reliance on a traditional method as primary contraception is the greatest in Albania, Azerbaijan, Bosnia and Herzegovina, Kazakhstan, Tajikistan and Turkey.

**Table 1** Married or in union women aged 15–19 using contraception. All data are from 2000 with the following exceptions: Albania 2002, Turkey 2003, Kazakhstan 1999 and Kyrgyzstan 1997

Country	% of married or in-union women aged 15–19 using contraception		
	Any method	Modern method	Traditional method
Albania	48.9	2.5	46.4
Armenia	25.5	18	7.5
Azerbaijan	16.1	0.8	15.3
Bosnia and Herzegovina	31.9	7.2	24.6
Kazakhstan	39.2	16	23.2
Kyrgyzstan	29.3	20.5	8.8
Republic of Moldova	42.3	23.8	18.6
Tajikistan	8.9	3.9	5
Turkey	44.3	16.9	27.5
Turkmenistan	26.6	20.9	5.6
Ukraine	76.6	58.4	18.2
Uzbekistan	26.8	22.4	4.5

Source: (Avery & Lazdane 2008)

The low rates of contraception use or reliance on traditional methods may reflect desire for childbearing at the time of marriage in certain countries, the belief that contraception is not required if married or a lack of access to contraception; however, this is difficult to comment on with certainty (Avery and Lazdane, 2008).

A study which aimed at identifying and reporting on cross-national patterns in contraceptive use among sexually active adolescents in 24 countries showed that the adequacy of each contraceptive method depends on many factors, some related to the activity (e.g., type of sexual behaviours, frequency of intercourse, risk of STIs), some related to the person and/or partner (e.g., age, ethnicity, culture, religious beliefs, educational level, family characteristics) (Godeau et al., 2008). More boys than girls reported using a condom at their last intercourse (78.4% vs. 67.9%, respectively), with boys reporting significantly more use of condoms than girls in 12 countries. Overall, no significant differences existed by sex for reporting having used no method of contraception (boys, 13.3%; girls, 13.0%). However, in some countries, the sex gap in non-use of contraceptives was striking. For example, in Ukraine, 33.3% of girls but only 14.5% of boys reported no contraception during their last sexual intercourse. This difference between girls and boys was reversed in Switzerland (2.8% vs. 10.2%, respectively), the Netherlands (1.6% vs. 8.4%, respectively), and England, United Kingdom (11.0% vs. 17.6%, respectively).

Sex differences in contraceptive methods are confirmed by the HBSC survey that shows differences between the sexes in use of condoms and oral contraception by 15-year-old boys and girls at their last sexual intercourse, although wide variations exist between countries (WHO, 2008). Condom use was reported more frequently by boys (with an average of 81% compared with 72% by girls), while girls mentioned oral contraception more often (with an average of 26% compared with 17% among boys). The difference between boys' and girls' answers may well be due to the fact that boys sometimes do not know that the girl is using oral contraception, and even sometimes that girls are not aware that a boy is using a condom.

A study found significant gender differences in 12 countries. Hungary offers a coherent picture with prevalence rates higher in boys than girls for contraceptive pill use as well as for sexual intercourse. Hungarian boys may have sexual intercourse with older girls who are more likely to use contraceptive pills (Godeau et al., 2008).

The general trend in the European Region over the past 20 years is that of declining adolescent pregnancy. More frequent abortions is not likely to account for this decrease in teenage births as the vast majority of countries in Europe have seen minimal change in their abortion rates (Singh and Darroch, 2000). The decrease is likely due to a combination of factors such as increased importance of higher levels of education, improved knowledge of and access to contraception, freedom from pressures of early marriage and childbearing, and the introduction of sexuality education in school (Haldre et al., 2005; Singh and Darroch, 2000).

However, regional variations are present in pregnancy, birth and abortion rates. Pregnancy rates in Europe differ considerably from a low of 12.38 pregnancies per 1000 women aged 15–19 in Italy to a high of 64.73 pregnancies per 1000 in the Russian Federation. Very low pregnancy rates (520) are found in 13 countries primarily from western and central Europe. The notable exception is that of Uzbekistan. High pregnancy rates (70–99) are not seen in any European country, but 10 countries, predominantly in eastern Europe and central Asia, have moderate rates (40–69.9). The only western European country to fall into the moderate rate category is the United Kingdom. The remaining 14 countries have low pregnancy rates (20–39.9). Interestingly, more adolescents chose to terminate their pregnancy, rather than deliver, in the Russian Federation, Sweden, Denmark, Estonia, Finland, France, Iceland, the Netherlands, Norway and Slovenia (Avery and Lazdane, 2008).

Abortion rates also demonstrate wide variation. According to the data available in the WHO Regional Office for Europe, the Russian Federation has the highest rate at 35.28 abortions per 1000 women aged 15–19. Estonia, Hungary, Iceland, Romania, Sweden and the United Kingdom all

have moderate abortion rates (20–34.9). Eleven countries have low abortion rates (10–19.9) and the remaining 22 countries have very low (510) abortion rates (Avery and Lazdane, 2008).

Limitations exist as abortion data is not nearly as complete as birth data and data on specific age groups, especially under 15s, are not readily available in many countries. Belarus, Belgium, the Czech Republic, Denmark, Estonia, Finland, Germany, Hungary, Iceland, Israel, Latvia, the Netherlands, Norway, Slovakia, Slovenia and Sweden all have accurate abortion reporting (Singh and Darroch, 2000). Underreporting from other countries may reflect inaccurate reporting systems, private sector abortions, unsafe abortions, or legal prohibitions. Representative surveys in some countries have shown a much higher abortion incidence reported by women themselves than that reported to the relevant Ministry of Health or national statistics office. Therefore, there is a need for caution in interpreting statistics on abortion, since trends over time or differences between countries often do not reflect reality. Pregnancy rates, the sum of birth and abortion rates, should also be interpreted with caution.

Several countries do not report abortion data to the World Health Organization for 15–19-year-olds. From available data, Greece would have the lowest rate of abortion at 1.01 abortions per 1000 women aged 15–19. The accuracy of the data for Belarus, Malta, Switzerland and Greece is questionable. Malta prohibits abortions and Switzerland provides limited services, and obligatory reporting of abortion is not mandatory in either country (Pinter, 2002).

The asylum population is diverse in many factors that are known to be associated with abortions and teenage birth rates, for example age, countries of origin, socioeconomic status and level of education (Sedgh et al., 2007).

The results of a study focused on quantifying induced abortion and teenage birth indicators among asylum seekers in the Netherlands showed that differences were found between the subgroups by age, region of origin, and length of stay at the reception facilities. Looking at age group and region, 15–19 year olds from WCS Africa and CES Asia had the highest abortion and teenage birth rates. Looking at the length of stay, the groups at highest risk of an abortion and of a teenage birth were asylum seekers with a length of stay less than three months and between three and eight months. Abortion and teenage birth rates decreased with an increasing length of stay. Abortions and teenage births were more common among asylum seekers than among the overall population of The Netherlands. Increased rates were a consequence of subgroups being at high risk. Abortion and teenage birth rates were very high among women who were pregnant on arrival or got pregnant in the first few months after arrival, but decreased as the length of stay increased (Goosen et al., 2009).



# What are the explanations behind gender inequalities in safe motherhood and safe abortion?

Gender issues play an important role in sexual conduct. The society responds in different ways depending on the gender but there is a growing recognition that improvement of the sexual and reproductive health of boys, largely neglected, is crucial for the improvement of that of girls. It is more common for boys to have casual relationships or “one-nightstands” and to have multiple sex partners. This puts them at higher risk of contracting sexually transmitted infections and is very often connected with sexual coercion. A systematic review that analysed 268 qualitative studies of young people’s sexual behaviour revealed how social and cultural forces shape young people’s sexual behaviour and can help explain why information campaigns and condom distribution programmes alone are not effective. The findings suggest that, among other factors, gender stereotypes are crucial in determining social expectations and, in turn, behaviour. All the societies studied had strikingly similar expectations of men’s and women’s behaviour. Men are expected to be highly heterosexually active, and women chaste. Vaginal penetration is perceived to be important in determining masculinity, and marks the transition from boyhood to manhood. Men are expected to seek physical pleasure, but women desiring sex can be branded “loose” or “cheap”. Where romantic love is expected to precede marriage, sex for young women must be linked to romance, and they are expected to be “swept off their feet” into sexual intercourse, in a way that is not logical, planned, or rational. Men, on the other hand, may scheme and plot to obtain sex, for example, by deceiving women into thinking the relationship is a serious one when it is not. Paradoxically, despite the stigmatizing effect for women in carrying condoms or using other contraception, women, not men, are generally considered responsible for pregnancy prevention. These stereotypes lead to refraining from disclosing planned, or rational behaviours in sex practice (i.e. pro-

ducing a condom), and give limited space for young girls to adopt a pro-active attitude in negotiating sex practices within a societal paradigm of femininity and masculinity (Marston C and King E, 2006). It may also (partially) explain gender differences in self-reported sexual behaviours.

Young men’s attitudes towards sex and intimate relationships in general often cause negative health and social consequences (Mladenovic, Donev and Spasovski, 2009). An alarming statistic is that 5% of the female adolescents in this sample reported that they had been raped, or forced to participate in non-consensual sex within an ongoing relationship with a regular partner. There is a need for systemic changes within the field of sexual education and protection from sexually risky behaviour among young adults (Stankovic et al., 2009).

Differences in sexual initiation and conduct also imply that boys and girls are vulnerable at different periods of their life. Gender roles are a dynamic concept and change over time. For instance, in many countries the age disparity in the period of sexual initiation between the two sexes has been decreasing, while in several developed countries there is an inversion in this traditionally expected behaviour. Combined with the probability of a greater number of partners and a prolonged period of premarital sexual activity because of later marriage, all this puts adolescents and young people at risk of unwanted pregnancy, early childbearing and contracting STIs (Mladenovic, Donev and Spasovski, 2009; Singh and Darroch, 2000; Wellings et al., 2006; Wellings et al., 2001).

While several causes for the high prevalence of adverse sexual outcomes are possible, there is no consensus regarding the role of access to information. Some authors

argue that a lack of information does not seem to be the problem. De Irala for example, mentions that research shows that the majority of pregnant teenagers had seen a health care professional and been given contraceptive information in the previous year (de Irala, Urdiain and Lopez, 2008). Other studies however showed adolescent girls commonly face obstacles when seeking medical contraceptive methods, including insufficient knowledge about modern methods, limited access to services (Glasier et al., 2006) and even health-care providers who actively discourage use of such methods by teenagers. Most probably this issue will be dependant on variations among countries.

In the United Kingdom, for example, the country with the highest teenage pregnancy rate in Europe, there are more pregnancies in areas where contraception is more widely distributed. A Spanish national survey on youth and sexuality revealed that 81% of adolescents did not report having a problem with contraceptive availability. While the idea that extensive distribution of contraception guarantees efficient birth control is widely accepted, the reality is more complex. For example, a study conducted in France indicated that the majority of reported unplanned pregnancies occurred among women using birth control. Several Spanish studies have indicated that, among adolescents, the most common reasons for requesting the emergency contraceptive pill are condom rupture and vaginal retention/slippage of the condom. In addition, teenagers who had a pregnancy ending in termination were more likely to have used birth control in the past, including the emergency contraceptive pill (de Irala, Urdiain and Lopez, 2008).

Reasons for initiation of intercourse and contraceptive use during the first intercourse experience also demonstrate gender differences. Love, sexual arousal, curiosity and peer pressure are all factors involved with a decision to initiate intercourse (Avery and Lazdane, 2008). A Norwegian study found that emotional reasons were more important to girls than boys when deciding to first become sexually active (Traeen and Kvaem, 1996). Love was also identified as the most frequent motivation for first intercourse in Croatian girls (Sedlecki, Markovic and Rajic, 2001).

However, an increasing proportion of young people hold the opinion that it is not necessary to be in love with someone in order to have a sexual relationship. Sex on the first date is more frequent and reported by more than one third of women and men aged 16–24, changes in sexual partners are also more frequent. Adolescent sexual behaviour has become more risky over the last decades, but few studies have analysed the reasons for this or dealt with the consequences. Knowledge of what is required in the area of sex education and counselling of male youths is lacking. This adversely affects sex education in schools and interferes with the communication between professionals and young men in youth health centres (Makenzius et al., 2009).

Some studies show that the preferred method of contraception is influenced by boys' and girls' perception of the seriousness of the relationship. The most usual pattern is that, at the start of a relationship, when partners do not yet know each other very well, condoms are used, to be replaced by oral contraception when the relationship becomes more stable. This shift is sometimes felt as a symbolic confirmation of the seriousness of the relationship. Data from surveys in the 1990s in three European countries clearly illustrate this tendency. In Sweden, oral contraception and condoms were used at first sexual intercourse by 13% and 41%, respectively, of 16-to-19-year-olds, whereas at last intercourse 50% had used oral contraception and 24% a condom. In France, among 15-to-19-year-olds at first intercourse, the figures were 15% for the oral contraception and 66.5% for condoms, which changed to 59% and 28%, respectively, at the time of last intercourse. In the United Kingdom, the comparable percentages were 12.5% for oral contraception at first and 67.5% at last intercourse, and 61% for condoms at first and 23% at last intercourse (Darroch et al., 2010). In Germany, 39% used oral contraception at first intercourse, increasing to 79% at last intercourse (BZgA, 2010). In general, the first sexual intercourse, which may occur more or less unexpectedly, is usually a risky one in terms of contraceptive use. The study just mentioned showed that non-use of contraception decreased from 20% at the first to 6.5% at the last intercourse in Sweden, and from 21% to 4% in the United Kingdom. In France, no such

decrease was found between first and last intercourse.

In a British study of 16–18-year-olds, contraceptive use by males at first intercourse was associated with parents who were open about sexuality, discussion of contraception prior to the event and first sexual encounter involving an intimate relationship. Female contraceptive use during first intercourse was related to the age of the girl when she first had sex, communication, lack of prior visits to a contraceptive service provider, unexpected/unplanned intercourse and the degree of comfort in interaction with adolescent males (Stone and Ingham, 2002). One of the most striking gender differences was that often males were excluded from research or programming. Information on contraceptive prevalence was only asked of women and data on HIV/AIDS knowledge were also often only available for women, highlighting once again that male reproductive health is often neglected (Avery and Lazdane, 2008). This is particularly worrying considering that male injection drug users are one of the fastest growing populations becoming infected with HIV in eastern Europe (UNAIDS, 2010). While male adolescents lack appropriate knowledge on sexual health and are at high risk for sexual promiscuity and adverse reproductive health consequences (Burack, 1999; Kapamadzija, Bjelica and Segedi, 2000), services continue to be directed primarily towards females. A recent study conducted in Sweden showed the staff at youth health centres are predominantly women and only around 20% of these centres in Sweden offer counselling to young men whose partner became unintentionally pregnant, despite them also needing support during the abortion decision-making process. Moreover, the risk of involvement in a new unintended pregnancy increased for young males who already faced this problem in the past (Makenzius et al., 2009).

Another recent study conducted in the same country with the aim of gaining a better understanding into the abortion decision-making process showed that teenage girls are often influenced, directly or indirectly, by the attitudes of their partners, family and friends or by social norms, and the extent to which the decision is truly the woman's own is subject to debate. The study also showed that the main

reasons for unplanned pregnancy were an underestimation of pregnancy risk and inconsistent contraceptive use. Pregnancy prevention was perceived as the woman's responsibility. The abortion decision was accompanied by mixed emotions, and was seen as a natural yet difficult choice. Social norms and the negative attitudes of family and friends strongly influenced the decision. Partners and parents were regarded as the most important sources of support. After the abortion, the women felt pressured by contraceptive counsellors to use highly effective contraceptives despite their previous negative experiences or worries about side effects. Swedish teenagers' basic right to decide whether to have an abortion may be limited by societal norms and disapproval of teenage childbearing. Given the perception that women are responsible for contraception, programs need to emphasize that pregnancy prevention is a shared responsibility; greater efforts to include males in prevention practices are needed. Attitudes towards abortion were found to be ambivalent towards pregnancy termination. Nevertheless, becoming a teenage father was considered to be a catastrophe, and several participants said they would try to make a pregnant girlfriend have an abortion or leave her. The paradox became clear later in the discussions, when most boys also agreed that the girl has the unrestricted right to decide about abortion (Ekstrand et al., 2009).

Another study conducted by the same author with the aim of gaining deeper understanding of how teenage males view abortion, adolescent fatherhood, sexual behaviour, and use of contraception, showed that adolescent fatherhood was considered to be a catastrophe and abortion a moral dilemma. Most participants agreed that the unrestricted right to decide on abortion rests upon the girl, but some were frustrated by not having any legal right to influence the decision. Contraceptive failure was viewed as common and mainly due to the influence of alcohol or in relation to unplanned sex. Boys perceived girls as having a greater responsibility in avoiding pregnancy, and they often put a blind trust in the girls' use of hormonal contraceptives or initiation of emergency contraception. Several groups had insufficient knowledge about foetal development and

other aspects of reproduction. Many were unsatisfied with the sex education they had received at school, but still considered it to be an important counterweight to other sources of information concerning sex, such as pornography.

In every group, alcohol was considered one of the most common reasons for increased sexual risk taking. These findings are supported by the results from a 2005 Swedish survey on drugs, in which over 20% of the males reported unprotected intercourse due to alcohol consumption.

The participants had only a limited knowledge of such matters as foetal development. Similar findings were reported in the previously mentioned study of 17-year-old high school girls. This indicates that Swedish teenagers have insufficient knowledge of basic reproductive health and that this issue is not given the priority it deserves in the schools' sex education programs.

Sex education received in school quantitatively varied widely among the participants, but was still considered to be an important counterweight to other sources of information such as pornography. Pornography is one of the most commonly searched for topics on the Internet, where it is easily available to adolescents. Nearly all high school students in a recent study had watched pornography. More males than females were categorized as high consumers (30% versus 2%), and males were also more likely to engage in riskier sexual behaviour. It is of great importance that schools should reclaim their position as a neutral and reliable source of information on sex and sexuality (Ekstrand et al., 2007).

Research on young people's sexual relationships often overlooks subjective experiences and enjoyment. Theoretical approaches premised on the social construction of sexuality emphasize that the subjective experience of sexual relationships may vary considerably by gender. Perceived quality of sexual relationships may be therefore related to gender, background characteristics, circumstances of first intercourse and subsequent sexual history. Interactionists have shown how sexuality is learned primar-

ily from same-sex peers and relatives, whereas feminists highlight systemic power imbalances between genders in heterosexual relationships. Gender differences in expectations of sexual relationships, and in criteria for evaluating them, have been demonstrated in both qualitative and quantitative research (Giordano 2003). A stereotypical example comes from a large survey of Swiss 16–20-year-olds: for females, intimacy and fidelity were very important in sexual relationships, whereas physical pleasure was very important for males (Narring, Wydler and Michaud, 2000). From a social constructionist perspective, other structural factors that shape sexual behaviour might also shape perceptions of sexual experience. These include social class (Henderson et al. 2002; Wellings et al., 2001), ethnicity family structure and mother's age. Their influence would probably operate through the emotional climate and cultural values of the family and neighbourhood (Wight et al., 2008).

A longitudinal study conducted in Scotland and England, United Kingdom, with the aim of examining young people's subjective experiences of heterosexual relationships showed that during the follow-up, of the 42% of youth who reported having had sex, most assessed their first and most recent sexual relationships positively (Wight et al., 2008). Greater proportions of females than males felt pressure at first sexual intercourse (19% vs. 10%), regretted their first time (38% vs. 20%) and did not enjoy their most recent sex (12% vs. 5%). Younger age at first sex was an important correlate of partner pressure and regret at first intercourse (odds ratios, 2.0 each, for those 13 or younger vs. 15–16-year-olds). Negative experiences were associated with less control (e.g., feeling pressure, being drunk or stoned, and not planning sex) and with less intimacy (e.g., sex with a casual partner and less frequent sex). Background social characteristics had limited influence compared with circumstances of first intercourse and subsequent sexual history. The quality of relationships was enhanced by better communication and greater physical intimacy. Older age at first intercourse was strongly associated with better relationship quality. Young women, who first had intercourse at an early age, or in a casual relationship,



were particularly likely to report lower quality outcomes. The contextual factors associated with negative first intercourse experiences—younger age, older partner, casual partner, lack of planning, substance use and pressure (or regret)—may be linked to a lack of control. This is in keeping with Welling and colleagues' concept of limited "sexual competence," which is strongly associated with younger age at first intercourse (Wellings et al., 2001). Similarly, the most important characteristic associated with not enjoying the most recent sex was pressure. In contrast, intimacy appeared to improve quality. Delaying intercourse within a relationship was associated with less pressure at both first and most recent intercourse, and having sex with a boyfriend or girlfriend, rather than a casual partner, was associated with greater enjoyment of most recent sex. Young women appeared particularly vulnerable to the effects of less control and intimacy at first intercourse.

For a vulnerable minority, early sexual experiences were negative. They could be protected by delaying first intercourse, restricting sexual activity to established relationships and learning skills to improve control in sexual encounters. Research is needed to clarify who benefits most (if at all) from population wide approaches to develop assertiveness, negotiation, planning and communication skills to delay premature sexual intercourse, improve control of sexual encounters and help maintain longer term relationships (Wight et al., 2008).

Moving to a different culture often threatens the identity of immigrants, and thus makes acculturation a difficult and stressful process (Fukuyama, 2006). The many changes affecting individuals during this process can strain relations both within and between first- and second-generation immigrants. One of these areas of friction will be analysed in this paper: sexual and reproductive health behaviour, such as contraceptive use and teenage pregnancies, in first- and second-generation immigrants.

A study conducted in the Netherlands with the aim of identifying factors that influence aspects of sexual and reproductive health behaviour, such as contraceptive use and teen-

age pregnancies, among Turkish immigrants showed that problems facing adolescent second generation immigrants differ from problems faced by Dutch youth in their sexual and reproductive health behaviour (Loeber, 2008). Young Turkish women still want to get pregnant much sooner than young Dutch women but there has been a clear trend in recent years towards the postponement of motherhood and greater use of contraception in Turkish teenagers. In 2001 the probability of teenage motherhood was more than six times as high for non-western foreign girls as for native Dutch teenagers, compared to 4.5 times in 2004. There are striking differences between the various generations of non-western girls. The probability of becoming a mother before the age of 20 is almost eight times as high for first generation Turkish women as for their second generation counterparts. The probability of teenage motherhood is only marginally higher for second-generation Turkish and Moroccan girls than for native Dutch girls. The majority of Turkish and Moroccan teenage mothers are 19 years old and married at the moment they give birth to their first child. The decrease in this group is mostly the result of delayed family formation.

On some issues men and women differ greatly. In both the autochthonous Dutch and the immigrant Turkish population, women are more emancipated than men. In some respects, Turkish women are even more emancipated than the Dutch in their opinions about combining work and caring for young children. The reason why this change in attitude in women is so much more pronounced than in men has not been investigated so far. Possibly, women find a greater advantage in adapting to their new surroundings. But emancipation may also represent a threat to male identity. Whatever the reason, this difference complicates inter-gender relationships.

In the second generation, arranged marriages are no longer common, but the partner should be acceptable to the family and therefore have the same ethnic background. Turkish boys still feel responsible for earning the family income. Their brides should be virgins on marriage, remain faithful, be good mothers and fit into the family. They should

have the same ideas as their husbands about religion and the raising of children.

The Turkish girl wants a reciprocal balanced relationship in which she has the same rights and is entitled to the same respect as her husband. She wants an affectionate relationship and a partner with whom she can talk. It is not easy to find the right partner in the Netherlands, because of the differences in opinion. Turkish young men consider Turkish girls born in the Netherlands to be excessively emancipated, whereas Turkish girls find their male counterparts too conservative, not emphatic enough and unreliable. Two-thirds of the immigrants therefore seek their spouse in Turkey. Turkish boys will look for a traditional, modest girl. Turkish girls born in the Netherlands have different considerations. They might more easily find a modern, well-educated partner in Turkey. They could demand a higher dowry or more emancipated conditions, because a permit of residence in the Netherlands is much sought after (van Wieringen, Harmsen and Bruijnzeels, 2002). These discrepancies in characteristics of the future partner are also seen in Turkey between residents of the city and the countryside. Similar dilemmas and relational problems can develop in marriages among people of different backgrounds. Dutch health care providers must fine-tune their advice to the individual and cultural needs of the patient.

Another study conducted in Portugal showed similar patterns. Compared with Portuguese adolescents, African

migrant teens reported initial sexual intercourse at earlier ages, less frequent condom use, and less frequent and less comfortable communications with parents about sexual issues. Gender relationships among African migrants typically are not equitable, with males tending to dominate, with consequences in terms for sexual health. Some girls indicated that getting pregnant young was normative. Previous research has shown that African men make the decision about condom use, often resist use, and sometimes believe that being asked to use a condom indicates infidelity (Matos and Gaspar, 2004; Matos et al., 2008; Muza and Costa, 2002).

Focus groups findings illustrated the cultural and gender aspects that characterize the sexuality of this adolescent group. For example, girls reported more social pressure and social prejudice regarding female sexual behaviour and condom use. Pregnancy during adolescence was one of the themes that some participants considered an important issue. However, teen focus group participants' indicated that the lack of information about contraceptives is less of a problem, and that some female adolescents wish to become a mother for emotional and social reasons. Given that adolescents often experience emotional and interpersonal difficulties, in addition to lacking experience with and of formal sources of information about sexuality, successful interventions should also promote emotional and relational skills (Matos et al., 2008).

# Are policies and programmes that address safe motherhood and safe abortion gender sensitive?

While commitments to SRH through national and international strategies are recognized as implicit facets of sustainable development, adolescents continue to be a population at risk for sexual/reproductive ill health. Although many countries are committed to SRH and either have developed or are developing strategies to promote better reproductive health, adolescents are still very much neglected in terms of data collection, research and programming (Avery and Lazdane, 2008).

Many studies (Kinsman et al., 1998; Paul et al., 2000; Rosenthal et al., 2001) have identified risk factors for early sexual initiation (poor family relationships, peer pressure, low education and socio-economic status), but few have looked at factors involved in first sexual experience (i.e. alcohol, drugs, coercion).

Adolescent pregnancy in general is declining, but discrepancies in rates continue to exist amongst countries. Why certain western countries continue to have high or moderate pregnancy rates despite sex education, youth-orientated services and stable economies remains unclear. There is a need for greater information on contraception amongst adolescents. Data found in the available research were gathered by asking questions in different ways, targeting different age groups, including only those in marriages/committed relationships and focusing primarily on girls and women (Avery and Lazdane, 2008).

In many countries premarital sex is a cultural taboo, but given that 54% of adolescents aged 15–19 in the Czech Republic, 14% in the Republic of Moldova, 22% in Romania, 49% in the Russian Federation, 30% in Ukraine, and 1% in Georgia and Azerbaijan report having premarital sex, attention needs to be paid to this area to insure that unwanted

outcomes are prevented and unmet needs are provided for (Avery and Lazdane, 2008).

The youngest group of adolescents, aged 10–14, as well as the male adolescent population, migrants/refugees, intravenous drug users and individuals of alternate sexual orientation are often neglected and little information exists on their SRH. Such populations access traditional SRH facilities less frequently and are at higher risk of poor reproductive health. Thus, it is of utmost importance to develop programmes and strategies that target alternative means of reaching these groups.

There have also been successes. Best practices and evidence are helping to identify programmes that are effective and beneficial, such as adolescent contraceptive services and school sexuality education (Kirby et al., 1994). Governments throughout Europe are planning and adopting SRH strategies with emphasis on, and inclusion of, adolescents. HIV/AIDS and sexual education is being implemented in countries where it was previously absent. Throughout Europe, reproductive health surveys and various types of research are providing awareness of the status of adolescent SRH. Educational campaigns addressing safe sexual behaviour appear to be working. Over 60% of sexually active 15-year-olds had used a condom at last intercourse in western, central and eastern Europe (Godeau et al., 2008).

Government policy has recognized the importance of making information and services available to young people. In the United Kingdom, for example, the Teenage Pregnancy Strategy (launched in 1999) is a cross government programme which aims to reduce under-18 conceptions and increase the participation of young parents in education, training and work. There has also been a media campaign

called 'The Sex Lottery' aimed at 18-30 year olds, which raises awareness of STIs and stresses the importance of safer sex. However, despite these initiatives, many young people do not receive the sexual health information and services they need. Sex and relationships education in the United Kingdom is currently inadequate for young people's needs, and is criticised for being "too little, too late, and too biological". Furthermore, many family planning services do not involve young men (Davey, 2005).

A study conducted with the aim of studying the availability, feasibility and comparability of reproductive health indicators and to illustrate whether cross-country comparisons are feasible for pinpointing areas of concern and future research showed the following results (Gissler et al., 2008). Health surveys seldom include questions on reproductive and sexual health. The European Health Interview should

include core questions on reproductive and sexual health. Indicators based on routine health and population statistics and registers were available, reliable, and comparable. The only exceptions were the proportion of children born after assisted reproductive technology and age-specific teenage birth rates, which were less commonly available. There were more problems in obtaining comparable information for indicators which are to be taken from health surveys. In many cases the data did not exist at all or was old. The comparability was also affected by the significant variation in data collection methods. Teenage birth rates were not given by one year age-groups, as recommended by RE-PROSTAT, but included all women aged less than 20 years. It remained unclear whether girls aged under 15 years were included in the statistics or not, but this discrepancy can have only a minor effect on country comparisons.



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## Characteristics of effective curriculum-based programmes for sex and HIV education

Developing the curriculum	Content	Implementation
1. Involve multiple people with different backgrounds in theory, research and sex/HIV education.	<b>Curriculum goals and objectives</b> 1. Focus on clear health goals, such as the prevention of STIs and HIV and/or pregnancy.	1. Secure at least minimal support from appropriate authorities, such as ministries of health, school districts or community organizations.
2. Assess relevant needs and assets of target group.	2. Focus narrowly on specific behaviours leading to these health goals (such as abstaining from sex or using condoms or other contraceptives); give clear messages about these behaviours; and address situations that might lead to them and how to avoid them.	2. Select educators with desired characteristics, train them and provide monitoring, supervision and support.
3. Use a logic model approach to develop the curriculum that specifies the health goals, the behaviours affecting those health goals, the risk and protective factors affecting those behaviours, and the activities addressing those risk and protective factors.	3. Address multiple sexual–psychosocial risk and protective factors affecting sexual behaviours (such as knowledge, perceived risks, values, attitudes, perceived norms and self efficacy).	3. If needed, implement activities to recruit and retain youths and overcome barriers to their involvement (for example, publicize the programme, offer food or obtain consent from youths or parents).
4. Design activities consistent with community values and available resources (such as staff time, staff skills, facility space and supplies).	<b>Activities and teaching methods</b> 4. Create a safe social environment in which youths can participate.	4. Implement virtually all activities as designed.
5. Pilot-test the program.	5. Include multiple activities to change each of the targeted risk and protective factors.	
	6. Use instructionally sound teaching methods that actively involve participants, that help participants personalize the information and that are designed to change each group of risk and protective factors. 7. Use activities, instructional methods and behavioural messages that are appropriate to the culture, developmental age and sexual experience of the participants.	
	8. Cover topics in a logical sequence.	

Source: Kirby D, Laris BA, Rollieri L. *The impact of sex and HIV education programs in schools and communities on sexual behaviors among young adults*. Washington, DC, Family Health International, 2006.

## Seven themes on social and cultural factors shaping young people’s sexual behaviour to be taken into account when designing HIV programmes<sup>12</sup>

Theme	Elements	Consequence for the behaviour
<p><b>1. Young people subjectively assess the risks from sexual partners on the basis of whether they are “clean” or “unclean”</b></p>	<p>Studies repeatedly showed that young people assess the disease risk of a potential partner by how well they know their partner socially, their partner’s appearance, or other unreliable indicators. They readily use condoms to protect against disease with “risky” partners. A partner might be judged likely to be ‘clean’ (disease free) or ‘dirty’ based on their behaviour and social position”.</p>	<p>Young people who use condoms in short term, unstable relationships might not use them in longer term relationships. Such young people may however use condoms with “clean” or long-term partners to avoid pregnancy—which could be more of a concern than disease prevention.</p>
<p><b>2. Sexual partners have an important influence on behaviour in general</b></p>	<p>The nature of the partner and the partnership influences not just whether a young person uses a condom but sexual behaviour in general. Individuals might see sex as something that could strengthen a relationship, or as a way to please a partner. If being feminine is thought to require a stable partnership with a man, failed partnerships can damage women’s social position. Violence against women within relationships can be seen as normal, or as being the victim’s fault.</p>	<p>Pregnancy can be sought as a way to keep hold of a boyfriend.</p> <p>Acceptance of partner’ rules in sex practices, difficulties to apply refusal skills</p> <p>Some young people may be reluctant to refuse sex because of fear of physical violence or retribution if they do so.</p> <p>Non-disclosure of violence</p>

Theme	Elements	Consequence for the behaviour
<b>3. Condoms can be stigmatizing and associated with lack of trust</b>	<p>Carrying or buying condoms can imply sexual experience undesirable for women, although sometimes desirable for men. Similarly, asking for condoms can imply inappropriate experience for women.</p> <p>Young people also worry that asking for their partner to use a condom implies that they think their partner is diseased; thus, condom-free intercourse can be seen as a sign of trust.</p>	<p>Condom-free intercourse</p>
<b>4. Gender stereotypes are crucial in determining social expectations and behaviour</b>	<p>Societies have similar expectations of men's and women's behaviour. Men are expected to be highly heterosexually active, and women chaste. Vaginal penetration is perceived to be important in determining masculinity, and marks the transition from boyhood to manhood. Men are expected to seek physical pleasure, but women desiring sex can be branded "loose" or "cheap". Where romantic love is expected to precede marriage, sex for young women must be linked to romance, and they are expected to be "swept off their feet" into sexual intercourse, in a way that is not logical, planned, or rational. Men, on the other hand, may scheme and plot to obtain sex, for example, by deceiving women into thinking the relationship is a serious one when it is not. Paradoxically, despite the stigmatizing effect for women in carrying condoms or using other contraception, women, not men, are generally considered responsible for pregnancy prevention.</p>	<p>Refraining from disclosing planned, or rational behaviours in sex practice (i.e. producing a condom)</p> <p>Limited space for young girls to adopt a pro-active attitude in negotiating sex practices within societal paradigm of femininity and masculinity</p>

<sup>12</sup> Adapted from Marston, C; King, E (2006) Factors that shape young people's sexual behaviour: a systematic review. *The Lancet* vol 368 Nov 4, 2006.

Theme	Elements	Consequence for the behaviour
<p><b>5. There are penalties and rewards for sex from wider society</b></p>	<p>Social rewards and penalties influence behaviour. Complying with gender expectations can raise social status: for men, by having many partners, for women, by chastity or securing a stable, exclusive relationship with a man. While pregnancy outside marriage can be stigmatizing, for some women pregnancy can be an escape route from the parental home. Young people may behave in particular ways through fear of being caught in the act. Sex can also be a way to obtain money and gifts from boyfriends.</p>	<p>Having many partners to raise social status (for men)</p> <p>Pregnancy as escape route from parental home</p> <p>Behaviours considered risky or taboo can become desirable due to the fact that the relation between individual motivations and social expectations is complex</p>
<p><b>6. Reputations and social displays of sexual activity or inactivity are important</b></p>	<p>Reputations are crucial for social control of sexual behaviour. Reputations are linked to displays of chastity for women, or heterosexual activity for men. Women's reputations are damaged by "too many" partners. Even mentioning sex can risk implying sexual experience and damage reputations. Young men's reputations can suffer if they are not seen to push for sexual access and numerous female partners. Young men not having sex with their girlfriends may be accused of being "gay". Some worry they will be unable to achieve penetration, and may even avoid condom use for fear of loss of erection.</p>	<p>Young girls may pretend ignorance of contraceptive methods to preserve reputations.</p> <p>Family members may prevent young people socialising with members of the opposite sex, to protect family and individual reputations.</p> <p>Display of heterosexual activity to maintain young men' reputation, and seek (condom-free) penetrative intercourse</p>



Theme	Elements	Consequence for the behaviour
<p><b>7. Social expectations hamper communication about sex</b></p>	<p>Social pressures mean that women might not wish to mention sex or acknowledge sexual desires, particularly early in a relationship. For instance, women may avoid saying “yes” directly to sexual activity in case they seem inappropriately willing. This makes “no” difficult to interpret.</p> <p>Young people may avoid discussing sex for fear that raising the possibility may lead to loss of face or hurting others’ feelings (through rejection), or damage to reputation (through seeming inappropriately forward). This makes safer sex difficult to plan: if the possibility of sexual intercourse is not acknowledged, contraception is unlikely to be discussed. Young people could also be reluctant to discuss condom use in case it is seen as equivalent to proposing or agreeing to sex.</p>	<p>Young people often avoid speaking openly to partners about sex, instead using deliberate miscommunication and ambiguity. Genuine refusal under these circumstances may be hard to communicate as a result.</p> <p>Difficult to plan safer sex if the possibility of sexual intercourse is not acknowledged</p>

## Recommendations for parenting programmes

- **Focus on parent- as well as adolescent-focused outcomes.** In the challenging adolescent years, parents need support, information, skills and resources in order to function effectively. Particularly important areas include: information about normal adolescent development, facts about specialized topics like HIV and substance use, communication skills, information about local resources, and support for food and shelter to meet basic needs. Special parent populations should be targeted, such as those dealing with special needs, domestic violence, abuse, drugs, trafficking, or incarceration.
- **Specify the assumptions behind working with parents to influence adolescent health.** Think about how activities with parents will result in outcomes in parents and adolescents. Consider the five parenting roles and how they interact.
- **Plan and design interventions carefully.** Base them on appropriate theory, research, knowledge of local culture and customs, and data about local needs. Adapt theoretical and research knowledge, as well as existing curricula, to local circumstances and demographics, including cultural traditions and age of parents and adolescents. Include pre-testing and evaluation to guide next steps.
- **Tap knowledge of local organizations, networks and traditions to reach parents.**  
Use multiple channels of communication. Consider home visits, working with existing institutions such as schools and faith-based organizations, and special efforts to reach men. Be creative and strategic in offering incentives, such as waiving school fees, offering entertainment or buying seeds for farmers.
- **Offer a balance of information, skills, support and resources.** Parents generally need information about normal adolescent development, and often about specific issues such as sexual and reproductive health, but they also need to know how to use this information, where to go for help, and how to balance parenting with the other demands of their lives.
- **Conduct evaluation and share experiences among parenting projects** to build a base of knowledge, to avoid duplication of efforts, and to work towards a common language, and also on practices to be avoided, tapping lessons learned from existing projects in both the developed and developing world.

Source: Helping parents in developing countries improve adolescents health. Geneva, World Health Organization, 2007.





## **All topics in the series**

Young people's health as a whole-of-society response.  
Evidence for gender responsive actions:

**mental health**

**overweight and obesity**

**violence**

**chronic conditions**

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**HIV/AIDS and STIs**

**injuries and substance abuse**

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## World Health Organization Regional Office for Europe

Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark  
Tel.: +45 39 17 17 17. Fax: +45 39 17 18 18. E-mail: [contact@euro.who.int](mailto:contact@euro.who.int)  
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