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Reproductive health behaviour of young Europeans

Volume 2: the role of education and information

Osmo Kontula

Directorate General III – Social Cohesion

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Foreword

The Council of Europe has a long tradition of producing population studies and the work of the European Population Committee contributes to the understanding of the relationship between social policy and demographic issues in Europe. The findings of this work are published in the series "Population studies". Topics covered recently include migration flows, national minorities, demographic changes and the labour market, the ageing of European populations and the demographic consequences of economic transition. These publications provide essential background information for implementing the Council of Europe's strategy for social cohesion : an integrated policy approach aimed at combating poverty and social exclusion through promoting access to social rights in areas such as employment, health, social protection, housing, education and social services. The population studies series is accessible through the Internet at the following website : http ://www.coe.int/population.

This is the second volume of a report that examines the reproductive health behaviour of young Europeans. While the first publication (Population studies No. 42) focused on contraceptive practices and sexual and reproductive behaviour, this report studies the role of education and information, explaining how health promotion by institutions and programmes can influence reproductive health. The author argues that reproductive health can be promoted effectively through national reproductive health strategies, provided there is an adequate provision of sexual and reproductive health infrastructure, knowledge, contraceptive means, services and treatment.

I should like to take this opportunity to thank the author, Osmo Kontula, for his work, which has resulted in the comprehensive and thorough study contained in this volume. My sincere thanks go also to the European Population Committee whose careful discussion of successive drafts has guaranteed the high quality of the final result.

Alexander Vladychenko
Director General ad interim of Social Cohesion

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Executive summary

The aim of the report is to provide a general approach to reproductive health in Europe taking into account the educational background at the individual level, and programmes and institutions that provide education and information on the reproductive health issues. The most important task is to increase understanding on how health promotion via education and information (including sex education) can make a difference to reproductive health.

Education has many-sided consequences and impacts on individual values and lifestyles. It can change life goals as well as social roles and aspirations. The data presented here give evidence that due to educational aspirations even sexual initiation will often take place at an older age. Highly educated people postpone their sexual initiation and steady relations in order to meet the other aims in their lives. As a consequence, they marry older and they also give birth to their first child older than their peers. To sum up, education frequently has an impact on values and lifestyles that have implications on social and sexual interaction. The highly educated have at least moderate means and resources to control their lives. They also have better knowledge and skills to engage in rewarding couple relationships. Educated women are consistently better able to negotiate sexual matters with their partners. Higher education provides tools for improved and satisfied interaction with the partner, as well as resources to avoid sexual health hazards.

In some eastern European countries since the political transition young people have had more freedom but not enough resources, including sexual knowledge, to conduct responsible and enlightened sexual actions. Especially women from disadvantaged backgrounds have problems in gaining access to contraception. As a result, sexual health hazards increased in the 1990s in eastern European countries. On the other hand, for some teenagers, early childbearing can be a means to acquire status and social identity that they could not otherwise obtain in their society.

Higher education provides cognitive and attitudinal tools for empowerment and decision-making skills at the individual level. Knowledge promotes use of modern contraceptives and means to control fertility and postpone early marriages. Also almost everywhere in Europe higher school enrolment has correlated with a higher prevalence of contraception and with a sharp decline in teenage fertility. There is also some evidence that highly educated young women are more prone to have abortion if they get pregnant.

In most European countries training of sexual health service providers is not sufficient. This has implications on the quality of sexual counselling. Counsellors may provide poor information, for example negative perceptions on contraceptives. This has been the case especially in the Russian Federation. These perceptions are more based on emotions than knowledge. They have generated distrust of hormonal contraception and even condoms and labelled them unnatural and hazardous. In eastern Europe knowledge of contraceptive methods and the menstrual cycle has been found to be sketchy - traditional methods are better understood. In addition, when contraceptive provision is irregular and prices high, it is easy to understand why for instance the teenage pregnancy rate is high. In the Russian Federation two-thirds of all pregnancies have been unwanted. Usually they end up in abortion.

In European surveys educational level and sexual initiation have correlated. Graduates have had their sexual initiation later than early school-leavers. The highly educated have also been found to be more active in using contraceptives. In New Encounter Module (NEM) surveys respondents with a higher level of education, both men and women, have a higher average age at their first experience of sexual intercourse. The difference in average ages according to the educational background is even more than two years. The highly educated also have a twice as high incidence in the use of contraceptives for their first sexual intercourse than the less educated.

Highly educated women postpone their pregnancies in all seven western European countries studied compared to women with a lower level of education. There were three types of countries. In the first type (France, Norway) the postponing effect on pregnancies was limited only to the age group under 30. In the age group 25-29 the proportion of women with a higher level of education was only a half of that level among lower educated women. At 30 and over these differences in pregnancies by educational level disappeared in this type.

In the second type of country (Italy, Greece, Finland) the postponing effect was still clearly perceivable in the age group 30-34 (Greece, Finland) or in the age group 35-39 (Italy). In the age group 25-29 the proportion of pregnancies among higher educated women was less than half that observable among less educated women. In Finland almost half of better-educated women had not yet been pregnant before 35. In Greece and Italy the motivation to have a child among highly educated women was roughly 10 percentage points lower (80-95% vs. 90-95%) than among less educated women.

In the third type of country (Spain, Switzerland) educational background seemed to make a permanent difference in the decision to have a child. Firstly, the postponing effect was much bigger in the age group 25-29. The

proportion of pregnancies among highly educated women was almost only a quarter compared to the figure among lower educated women. By the numbers one could predict that around 30% of highly educated women in Spain and Switzerland would never have a child. Among lower educated women this proportion was only around 10%. Highly educated women were more career oriented than other women who, on the contrary, were more family oriented.

Four case studies were conducted in Bulgaria, Finland, the Russian Federation, and the United Kingdom. The state of art in reproductive health was best in Finland. Thanks to a high incidence in the use of modern contraceptives (90%) the rates of abortions, teenage pregnancies and sexually transmitted infections (STIs) and HIV infections were low. In the UK modern contraceptives were also advantaged (70%) but the aforementioned rates were several times higher than in Finland. In the Russian Federation the rate of use of modern contraceptives was around 50% and in Bulgaria only 25%. Not surprisingly, these low rates had serious implications on reproductive health. In both countries abortion and teenage pregnancy rates were very high and in the Russian Federation the rates of STIs and HIV infections were at a record level.

All four countries had conducted national efforts to improve reproductive health. The outcome of these activities was unsatisfactory when there was not public support to promote sexual and reproductive health. When the sexual issues were labelled taboo in the society, and when there were major interest groups lobbying against reproductive health programmes, contraceptives and sex education, the existing programmes usually failed to make any real difference to the national and regional reproductive health. This was highly marked in the Russian Federation and to a somewhat lesser extent also in Bulgaria and the UK. Favourable and tolerant public attitudes in Finland on sexual issues have been found to have a very important impact on professional motivation and qualifications in the treatment of sexual issues and disorders in social and health care. Promotion of tolerant public opinion on sexuality is the first and perhaps also the most important activity to be carried out in order to be successful in promoting reproductive health. Tolerant public sexual attitudes also generate a very favourable impact to carry out comprehensive sex education, both nationally and locally.

Another crucial component in the promotion of reproductive health was the training of those who have a professional interest in sexual issues and sexology. This training was very well advanced in Finland, and thanks to the Teenage Pregnancy Strategy, it was also improving promisingly in the UK. There had been some training activities also in Bulgaria and the Russian Federation, but basically, in both countries the professional motivation and

expertise was still very low in reproductive health issues. These countries were considerably dependent on foreign aid for professional training and for the provision of contraceptives. Unrealistic myths and fears of contraceptives still prevailed and a lot of necessary information was missing. As a consequence, especially the population with a lower economic and social status faced a lot of sexual risks and reproductive health disorders. These consequences could be prevented by the systematic sexual and social policies that promote reproductive health and give rise to the use of modern contraceptives.

Reproductive health can be promoted effectively via national reproductive health strategies that can empower young people to successfully face their first sexual experiences. In many European countries there is still a need to build up the sexual and reproductive health infrastructure. Provision of knowledge, contraceptives and services, including treatment, is insufficient or even almost nonexistent.

Very often unwanted pregnancies and sexual health hazards have to do with social inequalities and poverty among teenagers. Young women need realistic options to gain social status, other than teenage motherhood. There is a serious need to increase school enrolment and motivation in education especially among young women living in poverty. Education provides cognitive and other resources that help to gain better control of one's life.

Young people everywhere in Europe need knowledge and information on reproductive health; knowledge on the options and risks in their sexual actions, and correct perceptions on contraception. Secondly they also need motivation to act on this information in order to avoid the existing risks. Thirdly they need skills as to how to act effectively according to the acquired information.

Sex education that is linked to access to contraceptive services is the most important tool to promote reproductive health among teenagers in Europe. General attitudes on sexual issues in society have very crucial implications on the way the promotion of reproductive health information and sex education is carried out in each society. There is a need for adequate dissemination of sexual information through a range of channels; basic education does not meet this aim. In societies where sexual issues are limited only to the private sphere, sex education is often opposed with the argument that it may seduce young persons to be sexually active too young. Based on several reviews of the behavioural impact of sex education this argument is unfounded. On the contrary, sex education can have a decisive positive impact on reproductive health. Some existing educational programmes have been evaluated with the aim of defining the best practice in sexual health promotion.

1. Introduction

The European Population Committee (CAHP) took a decision on 7 December 2001, to draw up a study on the activity "Reproductive health behaviour of young Europeans : trends and implications". In the first year of the project (2002) two reports were drafted and accepted : "Trends in Teenage Sexual Behaviour, Pregnancies, Sexually Transmitted Infections and HIV Infections in Europe" (Author Osmo Kontula) and "Contraceptive Practices and use of Abortion among Adolescents and Young Adults in Europe" (Authors Nathalie Bajos and Agnès Guillaume). These reports were published in 2003 under No. 42 of the Population Studies of the Council of Europe.

Education and information are among the key determinants of healthy reproductive behaviour. As was suggested by the previous studies under this activity, reproductive behaviour varies to a significant degree according to the level of educational attainment. However, an in-depth analysis was not made due to time constraints and lack of data accessibility. To gain more knowledge on these issues a new CAHP project was launched. The title of the study is "Reproductive health in Europe : the role of education and information".

The first part of the current study will address this issue and further elaborate on the interrelations of education and reproductive behaviour, focusing on pregnancies and contraceptive behaviour at the individual level. Some issues of STIs and HIV infections will be surveyed as well. Secondary analysis of existing micro-datasets of NEM and Baltic datasets will be carried out, as well as a more detailed analysis of the existing literature and theoretical explanations. Although the focus of the report is on adolescents, the aim of the current study is to extend the study to include all age groups, in order to obtain a balanced overview and allow comparison.

A second part of the study will consist of four country case studies in collaboration with national Family Planning Associations (FPAs) to analyse the institutional and policy frameworks of reproductive health education and information and its implications on reproductive health. The case study countries are Bulgaria, Finland, the Russian Federation and the United Kingdom.

It should be noted that the topic of this project has been endorsed by various intergovernmental organisations and conferences, such as the International Conference on Population and Development of the United Nations (ICPD, Cairo, 1994) and the Regional Population Meeting, organised by the United Nations Economic Commission for Europe, the Government of Hungary and the United Nations Population Fund in Budapest (1998).

The aim of the report is to provide a general approach to reproductive health in Europe taking into account educational background at the individual level, and programmes and institutions that provide education and information on reproductive health issues. Education and information is placed into a more general framework that can give understanding of the different state of educational impacts on reproductive health in different European countries. The most important task is to increase understanding of how health promotion via education and information (including sex education) can make a difference to reproductive health.

2. Sexual and reproductive health

Sexuality is an essential characteristic of every human being and is individually fundamentally determined by our sex. The concept of sexuality is very broad and multidimensional. The World Health Organisation (WHO) gave their updated definition on sexuality in January 2002: "Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors".

Sexuality includes the basic need for human affection, touch and intimacy, as consciously and unconsciously expressed through one's feelings, thoughts and behaviour. Sexuality may be the origin for happiness and satisfaction on the one hand, but in cases of sexual dysfunction it may cause frustration and suffering. Therefore, sexual health promotion should be integrated into the routine health care process.

Concepts of sexual health and reproductive health are rather novel in their international application. The World Health Organisation (WHO) applied them in some of their documents for the first time in the 1970s and 1980s. The concept of reproductive health has been applied with the aim of focusing more attention on female health issues, especially in the developing world. The meaning of reproductive health was extended to include health problems and rights related to sexuality. Lottes (2000) argues that women wanted to promote the concept of reproductive health in order to get more prestige on family planning. The new concept took into account female individual needs and views and was a renewed approach compared to the previous one that mainly emphasised the issues related to overpopulation.

The WHO definition of reproductive health was adopted, and expanded, in the Programme of Action developed at the International Conference on Population and Development (ICPD) held in Cairo in 1994, and at the International Conference on Women, also sponsored by the United Nations, which was held in Beijing in 1995. In the new approach, agreed upon by 184 governments, sexual health is considered a vital part of a person's physical and psychological well-being. This was the first time that an international document explicitly acknowledged the importance of sexuality in people's lives.

The full definition reads : "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."

In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems.

The World Health Organisation (WHO) has proposed a list of national and global reproductive health indicators, including :

- total fertility rate,
- contraceptive prevalence rate,
- maternal mortality ratio,
- percentage of women attended at least once during pregnancy by skilled health personnel for reasons related to pregnancy,
- percentage of births attended by skilled health personnel,
- number of facilities with functioning basic essential obstetric care per 500 000 population,
- number of facilities with functioning comprehensive essential obstetric care per 500 000 population,
- perinatal mortality rate,
- percentage of life births of low birth weight,

- positive syphilis serology prevalence in young pregnant women attending for prenatal care,
- percentage of women of reproductive age screened for haemoglobin levels who are anaemic,
- percentage of obstetric and gynaecology admissions owing to abortion,
- reported prevalence of women with female genital cutting (mutilation),
- percentage of women of reproductive age at risk of pregnancy who report trying for a pregnancy for two years or more,
- reported incidence of urethritis in men (aged 15-49), and HIV prevalence in pregnant women.

Men's reproductive health needs include sexuality, protection against sexually transmitted infections, infertility prevention and management, and fertility regulation. Protection against prostatic hypertrophy and prostatic cancer is another concern.

Reproduction and reproductive health are limited approaches to sexual issues. Just as only a very small part of sexual interaction nowadays takes place for the purpose of reproduction. The dissociation of the act of sex from reproduction appears to be a purposeful act of nature aimed at increasing the pair bond. Sex was meant by nature for its own sake, not just as a tool for reproduction. That is why there was a need to apply a broader concept to the sexuality health field.

Sexual health represents a new thematic area of work for the WHO and other United Nations health promotion organisations. While sexual health has been implicitly understood to be part of the reproductive health agenda, the emergence of HIV/Aids, of sexual and gender-based violence and of the extent of sexual dysfunction (to name just some of the developments over the past two decades), has highlighted the need to now focus more explicitly on sexuality and the promotion of sexual health.

Reproductive health is a sub concept of sexual health. In addition to reproductive health, sexual health covers the capability and the opportunity for erotic and sexual interaction that gives rise to satisfaction. A definition of sexual health should include the following components:

- the ability to enjoy mutually fulfilling sexual relationships;
- freedom from sexual abuse, coercion, or harassment;
- safety from sexually transmitted diseases; and
- success in achieving or preventing pregnancy.

Sexual health is not just a major health issue ; it is also a development issue, and a human rights issue. Moreover, sexual satisfaction is a necessary condition for sexual health.

Sexual health is influenced by a complex web of factors ranging from sexual behaviour and attitudes and societal factors, to biological risk and genetic predisposition. It encompasses the problems of HIV and STIs/RTIs, unintended pregnancy and abortion, infertility and cancer resulting from STIs, and sexual dysfunction. Sexual health can also be influenced by mental health, acute and chronic illnesses, and violence. Addressing sexual health at the individual, family, community or health system level requires integrated interventions by trained health providers and a functioning referral system. It also requires a legal, policy and regulatory environment where the sexual rights of all people are upheld (Cook et al., 2003).

International consensus documents have played a critical role in defining sexual and reproductive rights, and in outlining the actions that governments should take to promote and protect these rights.

Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. Adequate sexual rights are a necessary condition for the satisfactory realisation of sexuality and sexual health (Girard, 2003).

WHO's 2002 Technical Consultation provides a non-exhaustive list of what sexual rights cover. These include the right of all persons, free of coercion, discrimination and violence, to :

- the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services ;
- seek, receive and impart information in relation to sexuality ;
- sexuality education ;
- respect for bodily integrity ;
- choice of partner ;
- decide to be sexually active or not ;
- consensual sexual relations ;
- consensual marriage ;
- decide whether or not, and when to have children ; and
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

In this report reproductive health is treated mainly only from the viewpoint of unwanted pregnancies and their relation to the use of modern contraceptives.

Modern contraceptives include here hormonal contraceptives (e.g. oral contraceptives), IUDs, and condoms. Properly used these contraceptives are reliable enough to prevent unwanted pregnancies. Traditional methods (not contraceptives) are withdrawal and the rhythm method. Other unwanted consequences of sexual intercourse are STIs and HIV infections. These sexual health issues will be discussed in relation to fertility issues.

3. Trends in sexual and reproductive health in Europe

National sex surveys conducted in Europe in the late 1980s and in the 1990s show that teenage sexual initiation has been in transition during recent years (Kontula, 2003). This transition started first in the Nordic countries and secondly in most other western European countries. The mean age of women at first intercourse decreased after the 1960s by two to three years in all western European countries. Since the 1980s this age has been rather stable. However, in the first part of the 1990s there has been some decrease in the mean age at first intercourse. A similar transition has started in Eastern Europe one generation (twenty to thirty years) later. There is not any evidence that the HIV epidemic and related prevention campaigns had any impact on the age of sexual initiation in Europe (Bozon and Kontula, 1998). Mean ages at first intercourse are 17-18 years for men and women in western and central Europe, and 20 years for women in some eastern European countries. In southern and eastern Europe a double sexual standard prevails: women were expected to have fewer sexual experiences before marriage than men.

In most western European countries the age at first sexual intercourse was almost completely unrelated to marriage. In eastern European countries they were much more interlinked. Women had sexual initiation older, they married younger and they gave birth to the first child five years younger than in the West. The issue of contraception thus takes a different aspect across Europe, in terms of both younger people's access to it and its purposes (prevents any pregnancy with a given partner, defers birth of the first child, spaces births, prevents further childbearing) (Bajos and Guillaume, 2003).

Teenage birth rates were three to four times higher in eastern Europe than in the West. The highest rates were in the late 1990s 50 per 1 000 and the lowest 5-6 per 1 000 in Europe. In most countries birth rates had decreased in the 1990s, but there were also countries where these rates had been rather stable at a high level. All these transformations reflect young people's changing attitude to the family and sexuality, higher educational achievement among young women, a rise in the latter's labour force participation rate and the striking spread of modern contraceptive methods.

More precisely, the drop in fertility over the past few decades stems from the use of modern contraceptive methods in northern and western European countries, whereas in eastern Europe it was due mainly to the use of abortion, which, moreover, preceded the spread of modern contraception in these countries. Differences between eastern and western Europe for contraception and abortion have tended to diminish over time and reveal the historical influence of the socio-political context. However differences between western and eastern European countries remain high as regards contraceptive provision and practices, abortion, and ill-health and mortality due to unsafe abortion (Bajos and Guillaume, 2003).

In countries where teenage access to contraception is easiest and most legitimate, young people use more protection against unplanned pregnancies. Contraceptive coverage remains inadequate in many eastern countries and considerable disparities in the use of medical contraception are still observed as compared to western countries. Contraceptive methods are much less available in eastern countries where the medical staff is not always trained to deliver them. Women from these countries more often use the so-called "natural methods" and condoms.

In countries where access to abortion is most restrictive or where abortions are practised in unsafe conditions, the resulting ill health and mortality are highest. Although abortion practice has decreased in all European countries, abortion remains more prevalent in eastern countries, especially among the age group 20-24. In eight eastern European countries and Italy the proportion of abortions for women aged 20-24 is between 2.5 and four times higher than for those aged 15-19, whereas in other countries the differences are less marked.

These data underlined difficulties in access to contraception, particularly medical contraception, but also revealed differences in the meaning of abortion across European countries. It varies from country to country, depending on how long it has existed and on the access to medical contraception. In countries where the latter is widespread, abortion tends to be used to counteract failure of medical contraception, whereas it is regarded more as a contraceptive method in countries where modern contraception is not widely used and where women have long used abortion to regulate their fertility. The higher prevalence of abortion in certain social status groups reflects first and foremost a greater exposure to the "risk" of unplanned pregnancy that is associated with problems in gaining access to contraception. These problems are encountered above all by women from disadvantaged backgrounds. Disadvantaged environments do not, however, necessarily predetermine the grounds for using abortion. For some, a socially premature pregnancy may burden their chances

of educational success or employment; for others, it will on the contrary be a means of acquiring status and social identity through childbearing.

Estimations on trends in teenage STIs were unsatisfactory due to a lot of missing data around Europe. Information on teenage HIV infections was more reliable. Until the mid-1990s the STIs problem was much less widespread in the transition countries than in western Europe, but the situation has since reversed. In most western European countries rates of syphilis and gonorrhoea had decreased since the early 1980s. In the late 1990s there was some increase. In eastern Europe rates of STIs had increased in the first part of the 1990s but there had been major decreases in the second part of the 1990s. In the Russian Federation STIs were still on the increase in the late 1990s. The incidence (for example gonorrhoea 600 per 100 000) was 100 times higher than in Nordic countries. HIV infection has also been 100 times more prevalent in eastern Europe than in western and central Europe. In several eastern European countries there had been a heavy increase in 1999 and 2000. In the Russian Federation the rate was 124 per 1 million in 2001. This was largely due to an increasing number of IV-drug addicts among young men (Kontula, 2003).

In western Europe decreasing trends in teenage pregnancies and STIs were due to the secularisation of sex and liberalisation of attitudes. They made possible the distribution of relevant information on sexual issues, sex education and related public health services. HIV prevention campaigns in the 1980s were very important in providing the young generation with the knowledge and skills that they needed in order to protect themselves from health hazards. After the transition in eastern Europe in the early 1990s the new generation was freer to make their personal choices but usually without the knowledge and means to protect them.

In the late 1990s European teenagers and young adults have been sexually somewhat more active than before. Thanks to reliable contraceptives and an increase in the level of education, teenage pregnancies have been decreasing at the same time. In eastern Europe syphilis and gonorrhoea have also been better controlled than before. In some countries there has lately been some increase in teenage pregnancies and STIs. This is related to the decreasing use of condoms.

In the late 1990s public sex education and HIV prevention campaigns were less active than ten years before. Attitudes to condoms have been less enthusiastic than some years ago. This has caused dramatic consequences especially in the Russian Federation, where the rates of teenage STIs and HIV infections have been 100 times higher than in western Europe, and still in the late 1990s, and early 2000, they were increasing heavily. Public opinion has not been supportive of proper sex education, and poverty has brought increasing numbers of drug addicts to the streets. Due to insufficient investments

in the public health sector teenagers and young adults have not been equipped to face these risky situations. That has led to serious disorders in sexual and reproductive health among teenagers and young adults in the Russian Federation.

4. Previous studies of the educational impacts on reproductive health

Specific training in sexual issues, namely sex education, became truly internationally recognised only in the 1920s. In Germany it was the sex reform movement of the 1920s, which became the spearhead of sex education. The advocates of sex reform came from the radical left wing of the women's movement, the political left, from science and the medical profession, and from the homosexual movement. They were all convinced that it was better to regulate the sexual conduct of humans than to suppress it. They questioned the churches' monopoly of interpretation over questions of sexual ethics (Sauerteig, 1999).

Although the principal aims of the sex reform movement were to provide its adherents with instruction about birth control, to supply contraceptive devices and to fight against the ban on abortion, it did discuss important aspects of sex education as well : education towards a fulfilling sex life for both partners, but especially for the woman. From the mid-1920s, a number of marriage guides promoted eroticism in marriage. There were also advice columns in various journals of the sex reform movement in which sexologists answered questions. The sex reform movement believed that a more fulfilled sex life in marriage would produce a better marriage and healthier children (Sauerteig, 1999).

Contemporary promotion of sexual health and prevention of unwanted pregnancies or STIs owes much to the educational approach that was implemented in the 1920s in Germany and also paralleled in the United States. From the beginning this work was grounded on the belief that human behaviour can be regulated with proper cognitive tools and that the aim of health promotion is not only to avoid health hazards but also to promote well-being and the quality of sexual relationships.

Not only specific sex education, but also basic education or training, has found to provide very important impacts on sexual and reproductive health at the individual level. Before moving to European studies in the field, some main findings from the relevant studies conducted in the developing world are presented here.

Education has been a very important determinant of teenagers' sexual activities in the developing world according to the demographic and health surveys that have been conducted worldwide in the 1990s (World Population

Monitoring, 2002). The prevailing pattern is one of later sexual initiation among women with higher educational attainment. Since a large proportion of women initiate their sexual activity within marriage, this association is partly explained by the postponement of marriage among better-educated women. In general, the largest differentials among educational groups are observed between women with primary education and women with secondary education. In eleven of the twenty-eight countries examined, the proportion of women with secondary education sexually active by the age of 18 was only one-half the corresponding proportion for women with primary education.

These differentials were even more outstanding between young women with secondary education and women with no education at all. In Zimbabwe the percentage of sexually active women under 18 was 78% with no education but only 25% with secondary education. In the Dominican Republic these figures were 80% and 23%, and in Niger 87% and 26%, respectively. One crucial explanatory factor behind these major differences in sexual activities is the significantly higher age at first marriage among educated women.

The association between higher education and later sexual initiation, however, is not observed among men in the developing world. In most countries examined, young men with secondary education are as likely or more likely to be sexually active by the age of 18 than men with a lower educational attainment. Based on this, education does not play as important a role for young men as young women in the developing countries.

In addition to sexual activities as such, there is a major difference in female fertility rates in various educational categories. Education provides knowledge, increases exposure to information and media, builds skills for gainful employment, increases female participation in family decision-making, and raises the opportunity costs of women's time. The empowerment and autonomy of women transforms reproductive behaviour, mainly through women's ability to control their own fertility. Education is also a major underlying factor of age at first marriage and contraceptive use – two important proximate determinants of fertility. Even a few years of formal education makes a difference: in most countries, women with primary education have fewer children than uneducated women.

The average total fertility rate for developing countries was, in the late 1990s, 2.7 children less for women with secondary or higher education than for women with no education, and this differential was not related to the overall level of fertility. The difference between total fertility of women with no schooling and women with at least secondary education varied from 0.1 children in Indonesia and Jordan to four children or more per women in Bahrain, Burkina Faso, Cape Verde, Oman and the United Arab Emirates.

In the first part of the project "Reproductive health behaviour of young Europeans : trends and implications" Bajos and Guillaume (2003) presented some findings of the relationship between education and social background and pregnancy rate and contraception in Europe. They report that higher school enrolment was linked to a sharp decline in teenage fertility in most East European countries. They presented the case that there is a strong correlation between pregnancy rate and level of education for women aged 15-19 : the greater the percentage of women with no education, the higher the pregnancy rate ; similarly, the greater the proportion of women with primary or secondary education, the lower the level of pregnancy. These differences imply that women from disadvantaged backgrounds may have problems with the use of contraception. The differences could also be due to the greater tendency of disadvantaged young women to continue with the pregnancy if contraception has failed.

Factors that play an important role in explaining recent international trends include the greater importance ascribed to educational achievement, the increased motivation among young people to delay pregnancy and childbearing in order to achieve higher education levels and to gain job skills before forming a family, as well as the improvements in knowledge of and access to the means of preventing unplanned pregnancy (Singh and Darroch, 2000). There is lower motivation to avoid pregnancy among teenagers who have lower educational and job aspirations and expectations, among those who are not doing as well in school and among those in poor and single-parent families.

Whatever the country studied (Bajos and Guillaume 2003), the more education the women had, the more often they had used protection during their first intercourse. Such data undoubtedly reflect the greater problems in gaining access to contraception encountered by women from the most socially disadvantaged backgrounds and possibly also a lesser social capacity to control their lives in general and reproductive matters in particular. Disadvantage has been characterised by such factors as living in poverty ; being poorly educated ; having poorly educated parents ; being raised in a single-parent family or in an economically struggling neighbourhood ; and lacking educational and job opportunities.

Being disadvantaged is associated with an early age at first intercourse, less reliance on or poor use of contraceptives, and lower motivation to avoid, or ambivalence about, having a child. Once pregnant, disadvantaged adolescents are less likely than other adolescents to have an abortion, and more likely to have a child and have a premarital birth (Singh et al. 2001).

Bajos and Guillaume (2003) found that, overall, the higher the prevalence of contraception, the lower prevalence that of abortion. Women with the most

education in the 15-19 age group were more likely to have an abortion in the event of an unplanned pregnancy than those with the least education. The correlation between the abortion ratio and the proportion of women with primary or secondary education is 0.43 (p=0.08). The more education women have, the more they will reject unplanned pregnancies : this finding agrees with a similar finding in numerous studies according to which women with high social and cultural capital will postpone parenthood, which may be felt to be a barrier to achievement of their educational or occupational plans (Bankole, 1999 ; Singh, Darroch et al., 2001).

Do young mothers bring their schooling to an early end because maternity prevents them from continuing their education, or do they become mothers because they are already failing at school ? For some women, socially premature childbearing represents a means of acquiring status and social identity, which they have had little opportunity to acquire otherwise (Bajos and Guillaume, 2003).

Early sexual initiation may be related to a preference for concentrating on the union and raising a family rather than focusing on a career. The future graduates have an attitude and a lifestyle in which sexual initiation is not a priority, at least during secondary education. On the other hand, early school-leavers are in a position to take independent decisions and initiatives much earlier, free from parental control and from the constraints of school (Kontula, 2003).

These findings have been replicated in Moldova (Serbanescu et al., 1998) where young women with low socioeconomic status and with less years of schooling were more likely to be sexually experienced at the given age. In addition, in the Armenian demographic and health survey conducted in 2000 (Armenia Demographic..., 2001) the median ages of both first marriage and first intercourse increased steadily with increasing education. The impact of education seems to be similarly valid in eastern Europe as in western Europe.

In most western and eastern European countries teenage pregnancies have been declining in the 1990s. Altogether, one can argue that it is an increase in school enrolment among young women living in poverty and the spread of contraception, which underlies the fall in teenage pregnancies observed in Europe over the past few decades (Bajos and Guillaume, 2003 ; Kontula, 2003). The contextual and other explanatory aspects of these trends will be handled more closely in the latter part of this report.

It is important to notice that knowledge of contraceptive methods and the menstrual cycle is still sketchy among many adolescents not only in eastern Europe, but also in western Europe. Representations of contraceptive methods are often marked by a strong distrust of hormonal contraception, which is perceived as unnatural and potentially hazardous. These socially

constructed representations reflect the socio-historical background to the spread of medical contraception in eastern Europe. Information campaigns cannot in themselves alter such representations, whose social anchoring extends well beyond information alone (Bajos and Guillaume, 2003).

Based on the previous studies in the field, information, especially at school, and contraceptive provision are often lacking in eastern European countries. The choice of method is limited and their cost high (sometimes higher than that of an abortion) and supply is often irregular and inadequate (Kovacs, 1999). The training of service providers (doctors and non-doctors) is not sufficient to provide counselling and high-quality medical treatment, which explains why some women have a negative perception of contraception and contributes to unsatisfactory conditions of use.

Gynaecologists in the Czech Republic and the Russian Federation explain the persistence of high abortion rates by the lack of sex education, failure to use contraceptives or use of traditional methods, which women prefer and which are better understood than modern methods (Visser, Uzel et al., 1993).

The decision whether to continue or terminate a pregnancy seems to depend largely on young women's living conditions. Young women in eastern European countries with the most education will more often terminate an unplanned pregnancy in order to be able to complete their education or gain occupational experience before starting a family (Bankole, Singh et al., 1999).

One of the determinants for the increasing or exceptionally high trends in reproductive health disorders in eastern Europe is the fact that the awareness of STIs and HIV infections is rather poor. In Georgia only 81% of men and 60% of women reported having heard of syphilis and gonorrhoea. In Georgia only 15% of women knew of chlamydia and a similar proportion recognised herpes. In the youth population aged 15-19 in Tajikistan and Albania only slightly over half reported having heard of HIV/Aids. In Tajikistan over half did not know how to protect themselves from getting HIV/Aids. Almost half of the youth in Kazakhstan reported no knowledge of STI symptoms (Eramova and Toskin, 2001). Without knowledge there are no means to prevent sexual health disorders.

In a study in Romania (Alexandrescu and Tuchendria, 1999) almost three-quarters of 17-29 year old students had positive attitudes to the protection offered by condoms. But even if oral contraceptives were safe for adolescents and young people, only one-third of them considered the pill to be highly effective. Also, almost one-third of students agreed with the statement that withdrawal was an effective method of contraception. These figures reveal that the promotion of reproductive health is, at best, just about to begin in Romania.

Young people who are socially and economically most disadvantaged are also at the highest risk of HIV infection. Lack of education, poor general health, untreated STIs, sex-for-survival interactions, economically driven migration, labour and sexual exploitation exacerbate the vulnerabilities of young people who live in poverty (World Population..., 2002). In eastern Europe several countries have experienced rising unemployment, increases in poverty, the disintegration of social networks and severe budget cuts in the health and social sectors, all of which are having a devastating impact on the health of their populations (WHO Regional..., 2001).

5. The role of education on reproductive health behaviour in European sex surveys

One aim of this report is to conduct a study on the macro and contextual level of the interrelations of education and reproductive behaviour. Awareness raising and education, targeting both women and men, are effective ways of achieving change and sustainable improvements in reproductive health. In this chapter a number of European surveys will be used in studying the relationships between the educational level and sexual and reproductive behaviour.

Some western European results on the relationship between education and sexual conduct were presented in a study "Sexual Initiation and Gender in Europe: A Cross-cultural Analysis of Trends in the Twentieth Century" that was authored by Michel Bozon and Osmo Kontula (Bozon and Kontula, 1998). The study was based on twelve European national sex surveys that were carried out between 1989 and 1993.

The education level clearly correlated with the age of sexual initiation (Figures 1 and 2). All over Europe, male and female graduates had their sexual initiation later than early school-leavers. The gap between the proportions of early school-leavers and graduates who had intercourse before 18 was more marked (20% difference or more) in Finland, Greece (Athens), Great Britain and among Dutch and German women. The difference is smaller in France, Norway and among Dutch and German men. Portugal was the only country where graduates did not behave differently from non-graduates, whether male or female.

Figure 1 – Proportions of men (under 39) who had their first sexual intercourse before the age of 18 ; by level of education

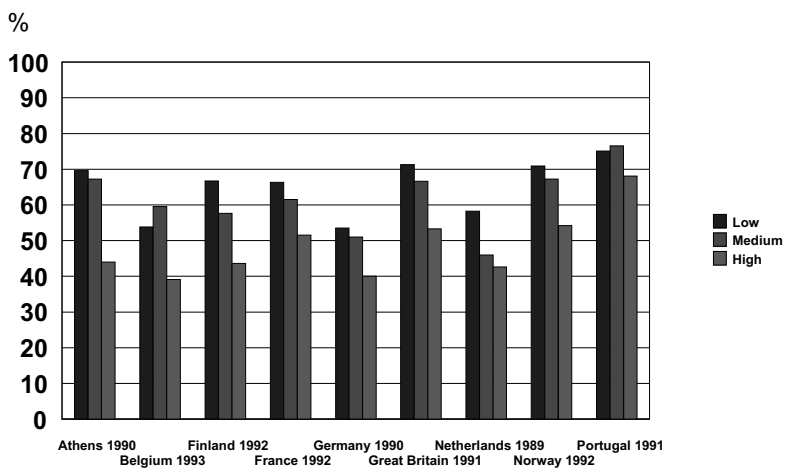
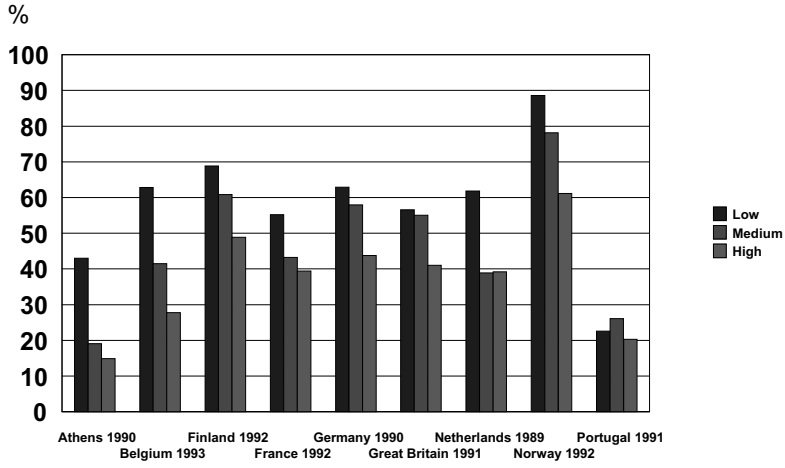
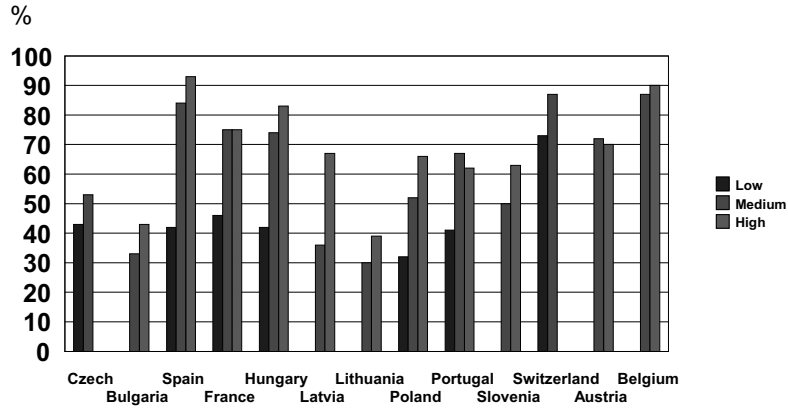


Figure 2 – Proportions of women (under 39) who had their first sexual intercourse before the age of 18 ; by level of education



In several countries, poorly educated women initiate their sexual intercourse much younger than their male counterparts. In these cases, early sexual initiation may be related to a preference for union and raising a family rather than a career.

Figure 3 – Prevalence of contraceptive use at first intercourse by women's level of education (women 20-24)



Bajos & Guillaume 2003

The prolonged dependence that a longer stay in the academic universe implies may delay the appropriation of attributes of independence, such as sexual initiation. In spite of the probable availability of partners of the other sex in the school environment, the future graduates have an attitude and a lifestyle in which sexual initiation is not a priority, at least during secondary education. Early school-leavers, on the contrary, are in a position to take independent decisions and initiatives much earlier, free from parental control and from the constraints of school (Bozon and Kontula, 1998 ; Kontula and Haavio-Mannila, 1995).

In the 1990s a number of family and fertility surveys (FFS) were conducted in Europe. Bajos and Guillaume (2003) have presented how the use of contraceptives was related to women's level of education in the 20-24 age group in thirteen countries (Figure 3). In some cases comparisons have been difficult due to different educational systems. In five cases the criteria of low education could not be applied, and in two cases the criteria of high education was not available.

On average, highly educated women have been more active in using contraceptives during first intercourse. The impact of high education on the use of contraception has been very remarkable in Spain, France, Hungary, Latvia and Poland. In Austria and Belgium the differences were nonexistent.. The use of contraception during first intercourse is important also in the respect that there has been found to be a strong continuation tendency in the use of contraceptives at first intercourse and at the following intercourse.

In 2003 the United Nation's Population Fund and Population Reference Bureau (UNFPA) published Country Profiles for Population and Reproductive

Health (Country Profiles..., 2003). These profiles include information on the modern contraceptive prevalence rate for women 15-49 with lower and higher education in central and eastern Europe. This information was available in the following countries :

Table 1 – Modern Contraceptive Prevalence Rate (%) for Women 15-49

	No Education/Primary	Highest Level of Education
Armenia	13.2	35.3
Azerbaijan	10.3	24.2
Bosnia and Herzegovina	12.0	18.6
Czech Republic	34.9	44.5
Georgia	8.4	28.4
Moldova	40.9	56.5
Romania	13.8	50.1
Serbia and Montenegro	21.5	45.8
Turkey	27.9	52.7
Ukraine	28.6	46.6

In these ten countries education does have a difference in the use of modern contraceptives. Women with a high level of education use contraceptives much more frequently. In most countries the modern contraceptive prevalence rate is two or three times higher among women with the highest level of education compared to those with primary education. Only in Moldova and the Czech Republic was the difference smaller presumably due to the higher rate of contraceptive use in those countries. As a whole, these figures show a very low contraceptive prevalence rate in eastern European countries. If the rate is very low in the country, the higher level of education cannot solve the deficit alone. The society has to also provide a more specified infrastructure and services in order to successfully promote even the minimum standard of reproductive health.

The most important entities of data sets available for the study were the national surveys "The New Encounter Module (NEM) for following-up HIV/Aids prevention in general population surveys". The project was funded by the EU 'Europe against Aids' programme. These surveys provide the latest national trend information on sexual behaviour and use of contraceptives in these countries. The coordinator of the project is Michel Hubert in Brussels.

The aim of the project was to follow up (1) the way HIV/Aids prevention is or is not taken into account in new relationships and (2) key indicators of sexual behaviour and HIV/Aids prevention. The approach was not centred on the individual exclusively but also on the characteristics of the relationship. Special interest

was laid on last new encounters (last new partner) with sexual partner. Surveys were based on a common questionnaire: "Sexual Behaviour and Risks of HIV Infection in Europe". The target population has been the general population in each country. It was strongly recommended to build probability samples.

The following national NEM surveys were conducted in western Europe in the late 1990s (in Spain in the early 2000s) in the age group of 18-49 years (country, year of data collection, number of respondents, response rate):

Norway	1997	(N=3723)	37.2 %
England	1998	(N=2935)	77.9 %
Germany	1998	(N=2583)	68.7 %
France	1998	(N=1614)	75.9 %
Portugal	1999	(N=1000)	86.0 %
Switzerland	1997	(N=2777)	68.9 %
Spain	2001	(N=2935)	69.9 %
Italy	1998	(N=2603)	80.9 %
Greece	1998	(N=2000)	84.1 %

The lower response rate in Norway is due to the mailed data collection technique. This technique was not applied in the other countries concerned. They conducted either face-to-face surveys or telephone surveys. A copy of each survey data was centralised in Brussels. The educational level was divided into four categories in the NEM surveys: 1. Third level, 2. Second stage, 3. First stage, and 4. Less.

The average age for first sexual intercourse correlated roughly with the respondents' educational level as in the previous European surveys (Bozon and Kontula, 1998). The higher the level of education, the higher is also the average age at first sexual intercourse (Figures 4 and 5). This finding holds for both sexes. The most outstanding difference was among women in Italy and England where the average age at intercourse was two years higher among the third level education group compared to less educated women. Among Greek men this difference was as much as three years. In other countries the similar difference was one year or somewhat less.

Figure 4 – Average age at first sexual intercourse. Men by level of education (age group 20-39)

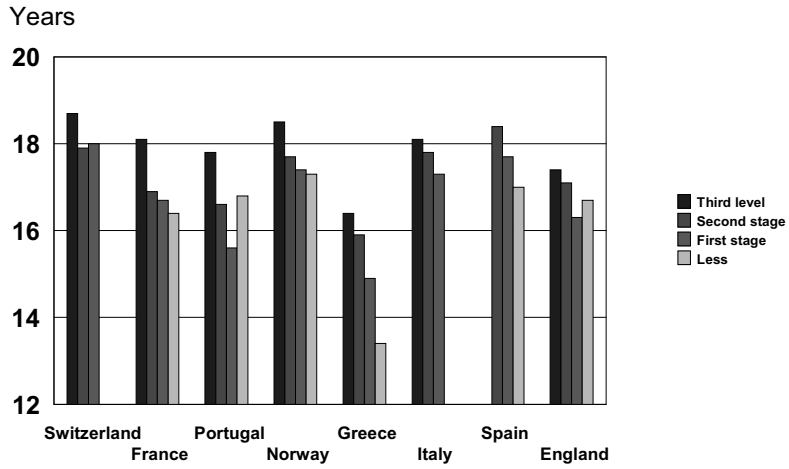
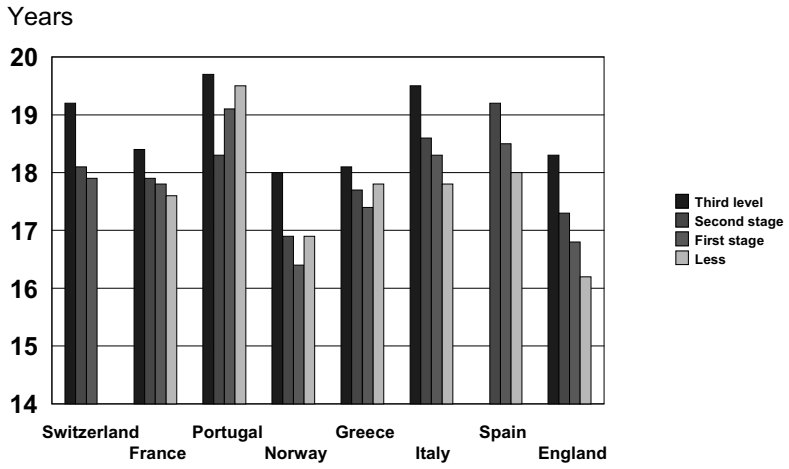


Figure 5 – Average age at first sexual intercourse. Women by level of education (age group 20-39)



In Italy, England and Switzerland the level of education was more interlinked with the average age at first intercourse among women than men. In France, Portugal and Greece education correlated more to age at first intercourse among men.

In six NEM surveys (Italy, Greece, Norway, Switzerland, Spain, and France) data was available to study relationship between level of education and pregnancy. This revealed interesting differences in the prevalence of pregnancies by six age groups and four educational groups. In some cases the less than first stage education category had to be left out due to the low number of respondents. In Spain the third level education category was missing in data. In Switzerland the age group 44-49 had to be skipped because the number of respondents in that age group was too low.

There are three types of countries. In the first type education has had a postponing effect on pregnancies in the age groups under 30, but the impact was almost nonexistent in those age groups of over 30. To this type belonged Norway and France (Figures 6 and 7). In the age group 25-29 the proportion of women who had been pregnant was only half among the women with the third level of education compared to women with only first stage education. Highly educated women usually postponed their motherhood as long as they were active in their studies. Later in life around 80% of them in Norway and around 85% in France had had a child. This is only a few percentage points lower than among women with lower education. In these countries high education does not seem to decrease female motivation to found a family and to have children.

Figure 6 – Proportion of women who have been pregnant by level of education in Norway

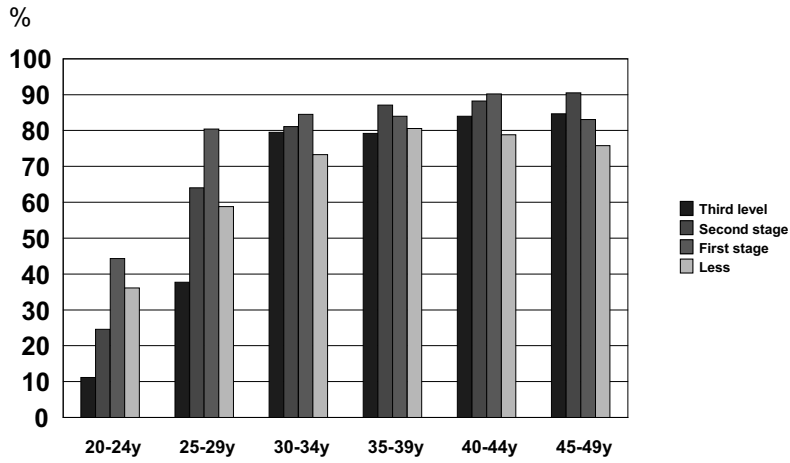


Figure 7 – Proportion of women who have been pregnant by level of education in France

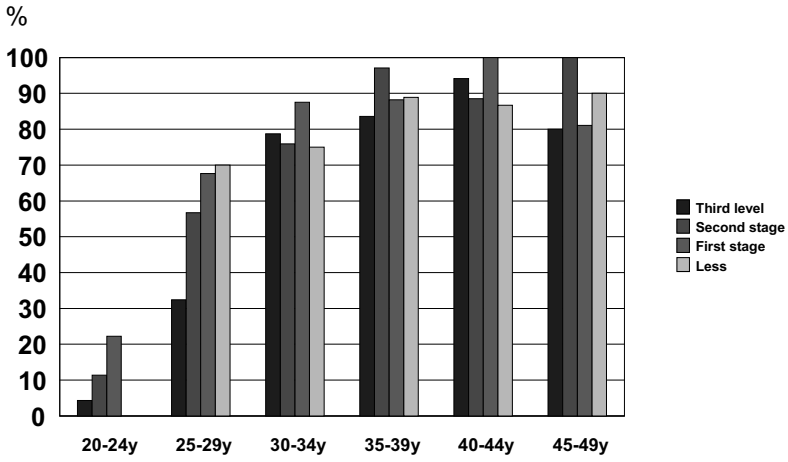
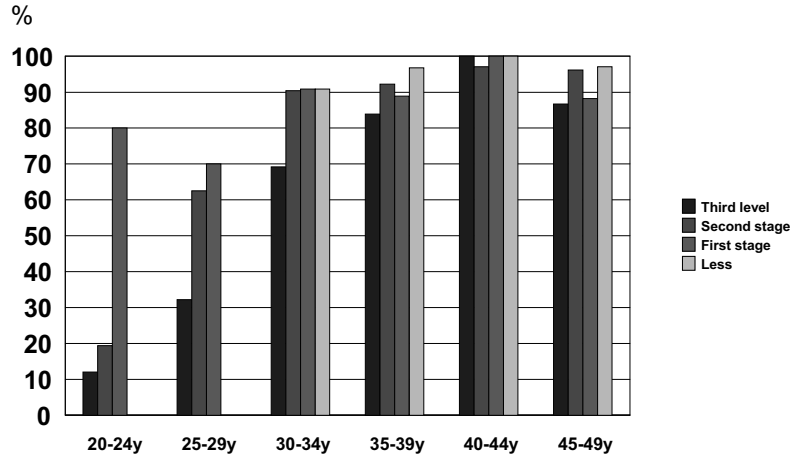


Figure 8 – Proportion of women who have been pregnant by level of education in Greece



The second type constitutes countries (Greece and Italy, Figures 8 and 9) where high education has had a more longstanding postponing effect on pregnancies. In Greece, women with third level education had an even lower proportion of pregnancies in the age group 30-34 and in Italy this postponing effect lasted till the age group 35-39. In the age group 25-29 the postponing power was two times or somewhat more. Most of the women in the third level educational category gave birth to their child at over 30, usually at 30-34. Around 80% of better-educated

women in Italy and around 85% in Greece had at least one child later in their life. For less educated women these proportions were around 88% and 95%, respectively. Among better-educated women the motivation to have a child was roughly 10 percentage points lower compared to lower educated women.

Figure 9 – Proportion of women who have been pregnant by level of education in Italy

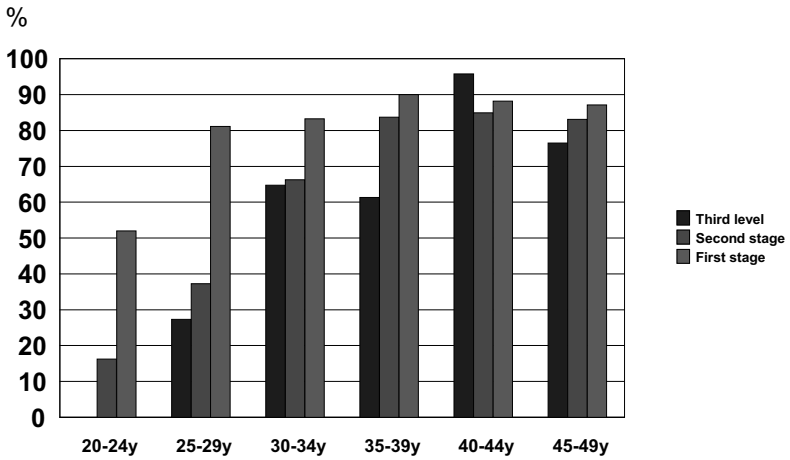
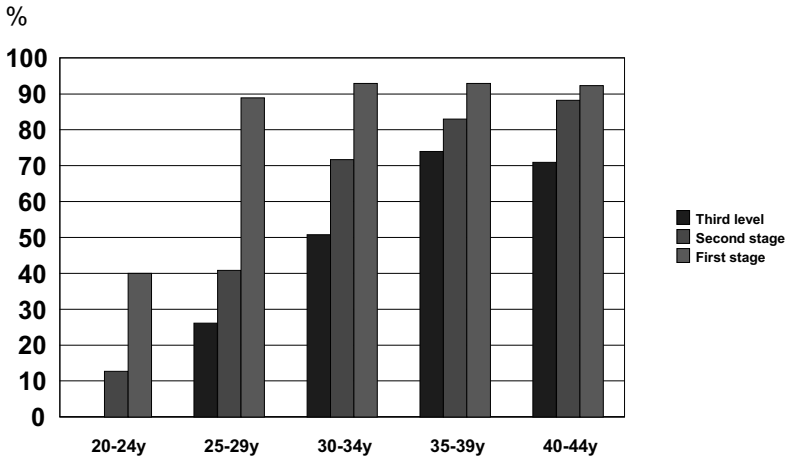
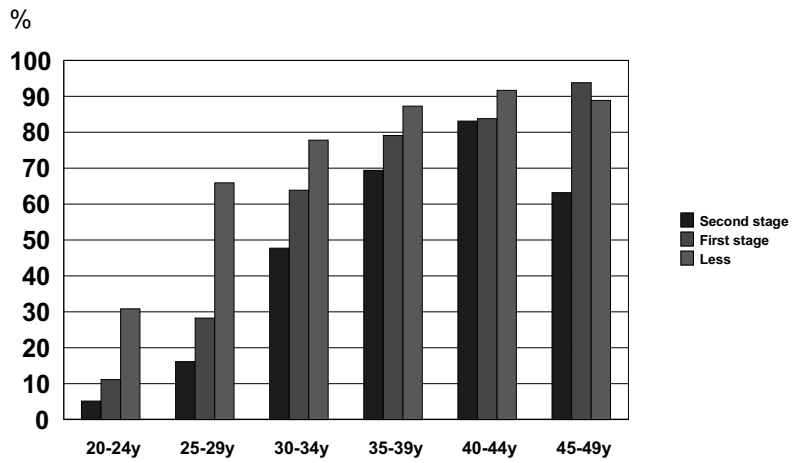


Figure 10 – Proportion of women who have been pregnant by level of education in Switzerland



To the third type of countries belonged Switzerland and Spain (Figures 10 and 11). In this type higher education seemed not only to have the postponing effect on pregnancies but also made a permanent difference in the motivation to have a child. First of all, the postponing effect was much bigger in the age group 25-29 making close to four times the difference between the categories of higher and lower education. Interest in motherhood was very low during the time of their study years. Motivation to have a child in the 30-34 age group was still much lower than for example in France and Norway. These figures could predict that around 30% of women in Spain and Switzerland with higher education will never have a child. Among lower educated women this proportion was only around 10%. Having a second look at these figures, it seems to be possible that Italy could move to this type in the future. Founding a family is not very tempting to women in the countries where gender equality, including the division of home work, is not very well advanced.

Figure 11 – Proportion of women who have been pregnant by level of education in Spain



The motivation to have an abortion did not vary much according to the level of education in Italy and in Norway (Figure 12). In France and Switzerland higher educated women had ended their last pregnancy to abortion somewhat more often than less educated women. In Greece this difference was more remarkable. Highly educated women in Greece were more motivated to have an abortion if they became pregnant.

Figure 12 – Last pregnancy ended in abortion; women by level of education

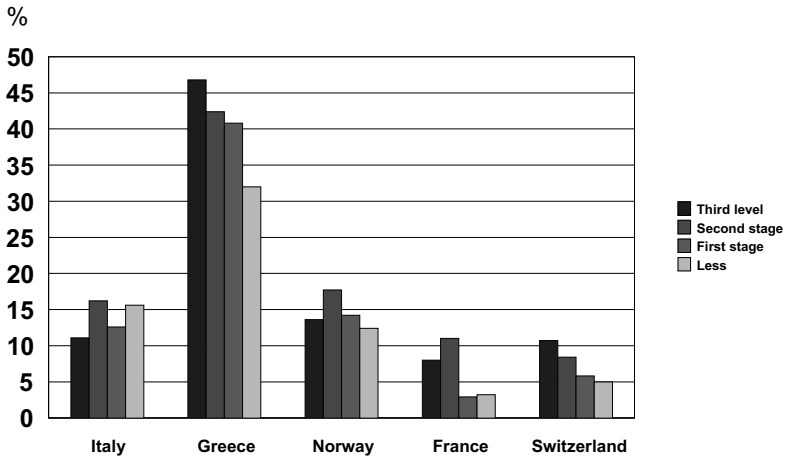
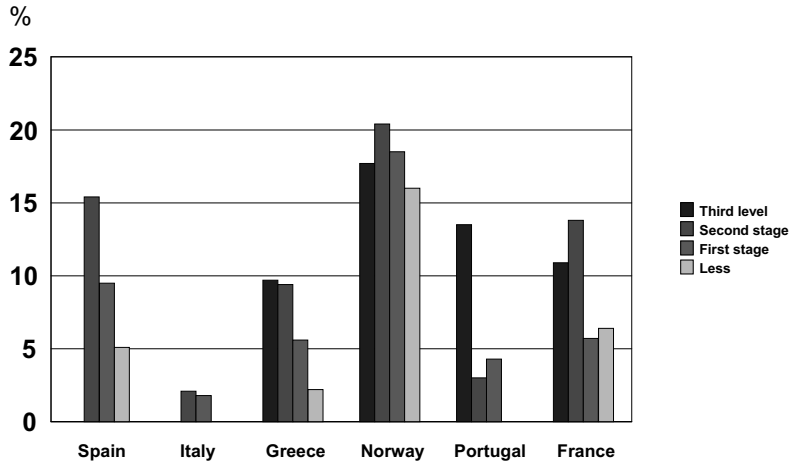


Figure 13 – Two or more sexual partners over the last 12 months; women by level of education



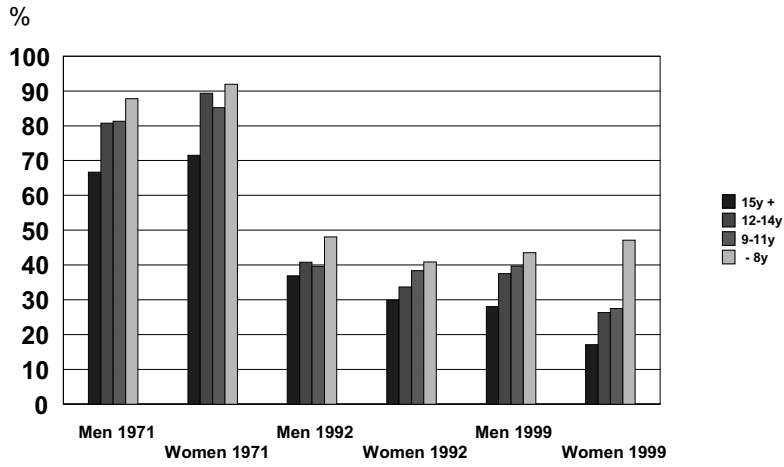
In six NEM surveys it was possible to study the relationship between the attained educational level and the number of sexual partners over the last year among women (Figure 13). In Italy and Norway education was not related to the number of sexual partners over the last twelve months. Altogether, the proportion of women with two or more partners over the year was very low in Italy. In Spain, Portugal, France, and somewhat also in Greece highly educated women more often than less educated women had engaged in more than one sexual relationship over the last twelve months. This difference can

be partly due to their more liberal sexual lifestyle, but also to their more advanced social and economic resources to meet potential partners.

A second data set that will be used for this report is a study "FINSEX study and the related sex surveys in the Baltic area" that has been authored by Osmo Kontula and Elina Haavio-Mannila (Kontula and Haavio-Mannila, 1995 ; Haavio-Mannila and Kontula, 2001 ; Haavio-Mannila and Kontula, 2003). The study covers national follow-up sex surveys in Finland : 1971 (N=2188), 1992 (N=2250), and 1999 (N=1496) ; one local sex survey in St. Petersburg 1996 (N=2085) ; and a national survey in Estonia 2000 (N=1031). The age group varies from 18-54 years to 18-81 years.

The number of years in schooling does make a difference to reproductive behaviour according to the follow-up surveys (1971, 1992, and 1999) in Finland (Figure 14). In each survey, the lower the number of years in schooling, the higher the proportion of respondents who did not use any contraception during their first sexual intercourse. This finding holds both to men and women. In the most recent survey (1999) this difference is most outstanding among women : the incidence of use of contraception was almost twice as high for those who had at least fifteen years of schooling compared to the others.

Figure 14 – No contraception at first intercourse by years of education in Finland 1971, 1992, 1999 (age group 30-49)



In Estonia education had less of a role in relation to sexual initiation (Figure 15). Men who had completed the matricular examination had used contraceptives in their first sexual intercourse somewhat more often than other men. Among Estonian women these differences were much smaller. On the

whole, the proportion of non-contraceptive users in first intercourse was several times higher in Estonia than in Finland. Even education could not make a difference : this implies that the other indicators (sex education, sexual health services) or cultural aspects (attitudes on sexual issues in society) are more crucial in determining reproductive health behaviour.

Figure 15 – No contraception at first sexual intercourse by level of education (age group 18-49)

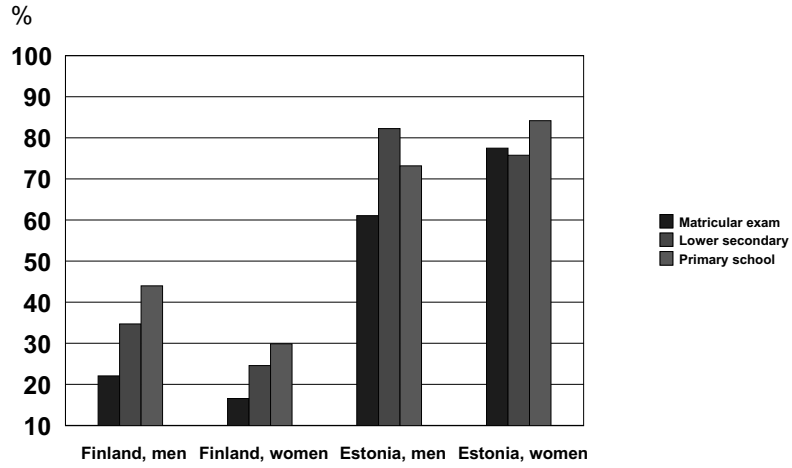
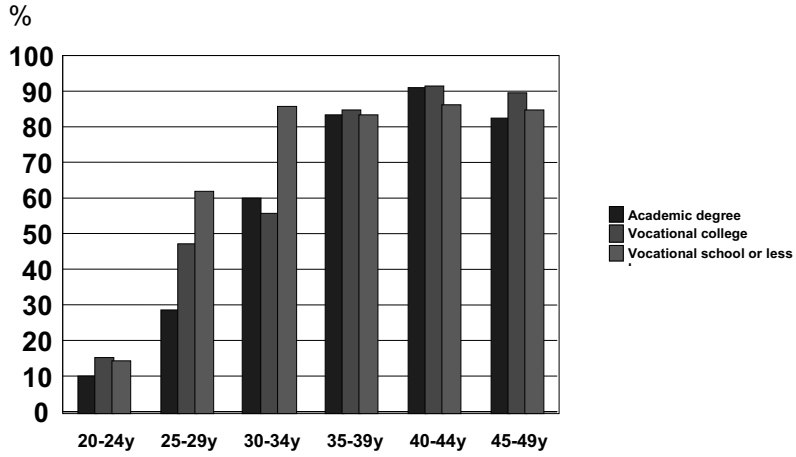


Figure 16 – Proportion of women who have been pregnant by level of education in Finland



Education has a postponing effect on pregnancies also in Finland (Figure 16). Looking back to NEM surveys this effect resembles the second type of countries where the postponing effect lasted longer but did not stay on along the whole life course. Here three educational categories were a bit different to those in the NEM surveys. They were based on vocational training until academic degree level.

Low vocational education does not seem to have an impact on pregnancies under the age of 25. The proportions of pregnancies in the age group 20-24 are very low. In this respect Finland is different to the countries studied in the NEM surveys. The explanation to this difference may lay in the fact that the lower educated women in Finland usually also continue their studies in this age category.

Compared to Norway women in Finland postponed their pregnancies for a longer time. This difference was very notable in the age group 30-34 where still almost half of the educated women have not become pregnant. On the contrary, women with lower vocational training had already reached the final proportion (85%) that got pregnant in their lifetime. In the next age group, 35-39, women with academic degrees reached the very same level.

Here some other exercises were made to study on what other ways the level of education was related or correlated to other sexual issues measured in these surveys. Indeed, high education correlated statistically significantly to several attitudinal and behavioural components of sexual issues in Finland, Estonia and St. Petersburg. In each region and for both genders high education correlated to higher frequency of masturbation, and to higher age at first sexual intercourse. Respondents with high education were also more approving of access to free abortion in each region.

In Finland, high education was significantly correlated to liberal sexual attitudes. These include approval of sex without love, considering homosexuality as a private matter that society should not regulate in any way, approval of extramarital relationships for men and women, and considering pornography very sexually stimulating. Highly educated men and women in Finland were also sexually more active. They more often practised oral and manual sex, and extramarital relationships, and they more often desired a higher number of intercourses in their relationship than what had actually occurred. High education was also correlated to more prevalent love experiences, to happiness of a marriage or of a couple relationship, and to higher self-esteem or higher sexual attractiveness.

As a whole, higher education among men and women in Finland, and partly also in Estonia and St. Petersburg, was significantly correlated to more prevalent love, sexual liberalism, and to an active sex life. Even though highly

educated people often postponed their sexual initiation and engagement to steady sexual relationships to a later period of their life, compared to those with lower education, their motivation to a variety of sexual issues became more prevalent later in life. These people often want to follow-up the latest trends in sexual knowledge and sexual patterns and to get credit as good lovers. In some cases they were more prone even to take sexual risks.

In 1999, the Russian Centre for Public Opinion and Market Research and Centres for Disease Control and Prevention (USA) conducted the Russian Women's Reproductive Health Survey (CDC survey) in Ivanovo, Yekaterinburg and Perm. The number of 15 to 44-year-old respondents totalled 6 004. Similar surveys had been previously conducted in these locations in 1996.

In each location, almost two-thirds of pregnancies (59% to 69%) were said to be unwanted. Among women with two or more living children, as many as 84% to 89% were unwanted. On the other hand, only between 4% and 10% of unwanted pregnancies led to a live birth. Unwanted pregnancies were usually terminated by abortion.

Over the three years between surveys there was a marked increase in knowledge of contraceptive methods. Almost all respondents were familiar with condoms, oral contraceptives, and the IUD. The improvements in knowledge may have been partly attributable to efforts of the Women's Reproductive Health Project. Contractors developed several brochures that were distributed to project clinics, as well as more widely throughout the country through the Russian Family Planning Association. In addition, the mass media campaign included articles distributed through a regional newspaper network, a syndicated column ('Ask Dr. Olga') that appeared in regional newspapers, and a series of television and radio spots on family planning.

The survey results indicate that women from all three sites reported greatly increased exposure to family planning information, with 66% to 73% of women reporting having seen family planning information on television in the previous six months. At each site about 60% reported seeing printed material about family planning.

The prevalence of modern contraceptive methods ranged between 49% and 58%. Overall contraceptive prevalence was 42%-52% among women with no living children and generally exceeded 70% among those with any living children. The IUD was the most widely used contraceptive method (23%-28%) in union in each of the three locations. The only other commonly used modern methods were condoms (13%-17%), and oral contraceptives (5%-10%). Periodic abstinence was used by 9%-14% of married respondents. The unmet need for contraception was 25%-29%.

Contraceptive use among women in union was strongly correlated with educational attainment (Table 2). Only about one-half of women who had not completed secondary schooling were using contraception, far below the prevalence among better-educated women. The greatest differences between women of different educational levels were in the use of oral contraceptive and periodic abstinence, both of which increased with education at all sites. The use of the IUD increased with education in Ivanovo and Perm.

Table 2 – Percentage distributions of current contraceptive method, by educational level, women in union 1999. Russia Women's Reproductive Health survey

Current contraceptive method	Ivanovo			Yekaterinburg			Perm		
	<Comp. Sec.	Comp. Sec.	>Comp. Sec.	<Comp. Sec.	Comp. Sec.	>Comp. Sec.	<Comp. Sec.	Comp. Sec.	>Comp. Sec.
Using any method	49.8	75.1	82.8	52.2	73.3	82.3	55.9	68.5	77.9
Using modern method	32.9	54.5	63.2	43.4	55.9	63.1	38.3	48.8	53.1
IUD	12.9	30.9	31.5	21.9	23.8	23.5	15.9	24.3	22.5
Condoms	12.2	11.8	21.6	13.5	16.4	18.5	16.6	15.8	18.0
Oral contraceptives	4.3	8.1	7.1	6.0	7.9	13.2	1.8	5.7	5.3
Other	3.5	3.7	3.0	2.0	7.8	7.9	4.0	3.0	2.3
Using traditional method	16.9	20.6	19.6	8.8	17.4	19.2	17.6	19.7	24.8
Periodic abstinence	2.5	9.8	11.6	6.6	13.6	16.1	12.7	13.3	17.2
Withdrawal	14.4	10.8	8.0	2.2	3.8	3.1	4.9	6.4	7.6
Using no method	50.2	24.9	17.2	47.8	26.7	17.7	44.1	31.5	22.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of respondents	89	860	346	47	815	391	77	852	326

<Complete Secondary, Complete Secondary, >Complete Secondary
Source : Russian Centre for Public Opinion and Market Research, March 2000

According to the 1999 survey, knowledge of gonorrhoea and syphilis appeared to be nearly universal. The conditions known by the fewest respondents were human papilloma virus (19%-36%), genital herpes (29%-54%), genital ulcers (36%-47%), and chlamydia (27%-52%).

6. Case studies on reproductive health in Europe

Data on the current situation with respect to the integration of sexual and reproductive health issues in education and information policies, programmes, curricula and campaigns is mostly lacking, thus the second part of the study focuses on obtaining an overview of the institutional framework and activities of reproductive health promotion, education and information. Awareness raising and education targeting both women and men is an effective way to achieve change and sustainable improvements in reproductive health.

Within the time and budgetary constraints of the project, it will not be possible to have this information on all countries. Therefore it was decided to carry out four country case studies with due regional differentiation, in close collaboration with national FPAs, to analyse the institutional and policy frameworks of reproductive health education and information. The most important task is to increase understanding on how health promotion via education and information (including sex education) can make a difference to reproductive health.

In collaboration with Eef Wuyts from the IPPF European Network (EN) the four case countries selected were Finland, the United Kingdom, the Russian Federation and Bulgaria. Some of the information has been gathered in collaboration with the national FPAs. The key persons providing information were Inga Grebesheva (Russia), Margaret McGovern (UK) and Radosveta Stamenkova and Dessislava Georgieva (Bulgaria). In Finland I have collected all the information. An important part of the Bulgarian case study is based on a report by Stamenkova and Georgieva (2003).

There were some good arguments for selecting these four case countries. Finland was selected to represent a northern European model how to successfully promote sexual and reproductive health. According to the indicators that were presented in previous reports (Kontula, 2003, Bajos and Guillaume, 2003) Finland was among other Nordic countries with low levels of teenage births and abortions, with high frequency of use of contraceptives, and low prevalence of STIs and HIV infections. A question was raised: how Finland did it, and what it could do better?

The United Kingdom (UK) was elected to represent a western society that has exceptionally high rates of teenage births (as high as in the Russian Federation) and abortions, and high prevalence of gonorrhoea and a rather high number of teenage HIV infections. The UK was an exceptional country also in the respect that in the 1990s teenage births did not significantly decrease in the UK as they did in almost all other European countries. What could explain this unfortunate development?

The Russian Federation was elected due to its poor sexual health situation. Teenage HIV infections have speeded up more than anywhere else and were at a record level in 2001. At the same time teenage STIs have also been increasing heavily. Teenage births have had a declining trend, but the rate is still three times higher than in most western European countries, and the rate of teenage abortions is the highest in Europe. What kind of determinants might have contributed to this regrettable development?

Bulgaria was elected to represent an eastern European country with a different sexual health situation than in the Russian Federation, but on the other

hand, with many sexual health challenges to be faced. Rates of teenage births and abortions have been exceptionally high in Bulgaria even though these trends have been declining since the early 1990s. At the same time the HIV infection rate has been very low. How has Bulgaria succeeded in keeping HIV in control in conditions that are in many ways complicated ?

Because the basic aim of this report is to provide information on the possible impacts of education on reproductive health, it is good to keep in mind that participation to education varies very much in these four case study countries. The percentage of 18-year-old females who continue their education (ISCED levels 1 to 6) is, according to Eurostat, 92% in Finland, 56% in the UK, and 50% in Bulgaria. For males these figures are 85%, 54%, and 46%, respectively. A comparable figure from the Russian Federation is missing. However, in the Monee project, youth enrolments in secondary and tertiary education were equal (almost 50%) in Bulgaria and the Russian Federation. The transition in central and eastern European countries has increased the drop out rate from basic schooling. In 1997, only 88% of Russian and 80% of Bulgarian graduates finished their basic schooling.

In the International Social Survey Programme respondents in Bulgaria and the Russian Federation thought that it was more essential to know the right people than to have a good education. In the UK respondents considered good education more essential than knowing the right people (Unicef, 2000).

In 1998, teenage pregnancy rates (births and abortions) were seventy-seven per thousand women aged 15-19 in the Russian Federation and Bulgaria. In the UK this rate was fifty-four and in Finland twenty-six. In the UK and Bulgaria 40% of pregnancies ended in abortion. In Finland this proportion was 50% and in the Russian Federation 55% (Unicef, 2000). The total abortion rate per thousand women in the age group 15-44 in 2001 was 8.8 in Finland, 16.7 in the UK, 42.2 in Bulgaria, and 52.1 in the Russian Federation.

6.1 Bulgaria

In Bulgaria the population is around 8 million. Bulgaria began its fertility transition with early and nearly universal marriage. In 1982 the mean age for first marriage for women was 21.3 years, the lowest in Europe. In 2001, it had risen to 24.8 years. In a European perspective women still marry young. The total fertility rate dropped from 2.30 in 1974 to 1.23 in 2001. At the same time, cohabitation prior to marriage became a dominant mode of behaviour.

The fertility rate per thousand women aged 15 to 19 years was the highest in Europe, reaching 84.1 in 1982 before declining to 45.1 in 1997. The acceptance of premarital sex was seen as normal in the early 1990s by 80%

of boys and 42% of girls in high school. The double standard still exists as a result of traditional influences (Vassilev, 1999).

Since the 1980s there are no legal restrictions for couples, married or not, to make the decision when and how many children to have. Some attempts in this direction have been carried out in the media. At the end of 2001 the national radio network Darik conducted a campaign under the slogan "Let's have more children" aiming to decrease condom usage. Another example is the series of activities of the Moon Movement in Bulgaria, and some other pro-life oriented NGOs. The public feedback on these campaigns has not been very positive.

At the start of the 1990s, women married early and almost universally and quickly had a first child, but reproductive activity also came to an equally early end. Even as late as 1995, a significant proportion of women reported reliance on traditional contraceptive methods or they did not use contraceptives at all. Limited choice of fertility-control methods plus an early end to childbearing resulted in frequent recourse to induced abortion (Carlson and Lamb, 2001).

Bulgarian abortion legislation could be classified as among the most liberal. It protects the woman's right to abortion while allowing her to make choices with the safeguard of confidentiality. The new legislation, implemented in 1992, also provides contraceptive counselling and prescriptions for contraceptives. The fee is considered a tax because it does not cover actual costs.

Abortion is legal and free for women older than 35. For the rest the fee is approximately $50 (average monthly salary is $150). Young women up to the age of 18 can perform an abortion only with the written consent of one of their parents. Main contraceptives are available in pharmacies and can be obtained with a prescription from a gynaecologist. There is no need for parental consent for provision of any contraception for persons under 18. Abortion is nowadays more and more often perceived as a reproductive right, not as a contraceptive method.

As of 1995 approximately half of all registered pregnancies were terminated. Abortions continue to exceed births. The impact of political and economic events in the early 1990s produced a sharp rise in the abortion rate. In 1992, this rate was 67.5 and in 2001 it had dropped to 42.2.

The continuing dominance of abortion as the major method of fertility regulation is the result of several converging factors. With its close ties to the former Soviet Union, the Bulgarian Government was relying on Soviet social and medical policy favouring abortion over imported western contraceptives. While it was official policy to make the pill available, its adoption was

discouraged. Side effects of modern contraceptives were purposely exaggerated in the media (Vassilev, 1999).

After 1989 the Ministry of Health and other state institutions showed a fresh interest in family planning as a means of providing alternatives to reliance on abortion. IUDs were designed, produced, and distributed. Cooperative production of condoms was arranged with a Singapore company. Pills could be obtained through pharmacies privatised in 1991. However, the cost of modern contraceptives gradually rose to international levels, out of reach for wider utilisation. Within this context international assistance was requested and provided (Vassilev, 1999).

The social and political tensions that followed the demise of the communist regime in 1989 impeded the development of new ideas and actions in the area of family planning. The Bulgarian Family Planning Association (BFPA) succeeded the Society for Planned Parenthood and Family Development (SPPFD), continuing the IPPF affiliation. The Bulgarian Family Planning and Sexual Health Association (BFPA) was registered as an NGO at the end of 1992. Twelve BFPA clinics opened between 1993 and 1996 in selected areas of the country. They were staffed by medical personnel who conduct examinations, prescribe, and dispense contraceptives.

Unfortunately these clinics did not get much public notice; in the 2000 reproductive health survey only 10% of respondents indicated that they knew of clinics. Less than 3% had ever visited such a clinic or centre themselves. Women younger than 25 had visited the clinics most actively (Carlson and Lamb, 2001).

The BFPA is running nationwide family planning and sexuality education programmes and various initiatives. The BFPA in its outlets and in national family planning programmes in university hospitals provides free of charge or subsidised contraceptives – oral, IUDs and condoms. Supplies are obtained through IPPF and offered to clients at approximately 10% of market prices. The BFPA also has a campaign with the aim of overcoming myths and fears that relate to condoms. The slogan of the campaign is "Do not use excuses, use condoms". Condoms are distributed through a network of health and youth-oriented NGOs and the regional unit of hygiene inspectorate.

The BFPA introduced the concept for youth friendly services in the mid-1990s. The concern for anonymity and confidentiality has been found to be relevant for young people who often travel to bigger cities to ask for sexual health services. In those areas where the BFPA is not active, the government invited women's organisations to organise counselling centres and make referrals to obstetricians/gynaecologists whose prescriptions (with referrals) can be filled at local pharmacies at the same low subsidised prices as at the BFPA clinics.

The first organised programme of sexuality education was added to the school curriculum in 1985. For students in the fifth grade, the subject was included as part of lessons on natural history. For eighth graders, sexuality education became part of the biology lessons. The focus was on the anatomy and physiology of the reproductive system.

The attitudes to sexuality education in the communist era were rooted in a tradition of patriarchal and authoritarian human relations. The prescribed task of the authorities was to repress adolescent sexuality and maintain institutional control over personal behaviour. The justification for this approach was to reduce the high rates of abortion. Human sexuality was considered in moralistic and medical terms. Deviant behaviour was subject to sanctions. Until 1989, the official communist press abstained from publishing material on sexuality except for pronatalist purposes and for government documents (Vassilev, 1999).

After 1989 barriers to sexuality education began to crumble. Sexual phenomena were discussed in the context of biology, a compulsory school subject. Courses were introduced into medical school curricula. In March 1992 several Modus members formed the Council for Sexual and Family Health. It developed sexuality education programmes for university and postgraduate students of pedagogy, psychology, and medicine as well as workshops and training courses for other specialists (Vassilev, 1999).

Because Bulgaria represented a highly motivated population with an unmet need for contraceptive services, several groups began expanding family planning clinics and services in the 1990s. Organisations involved included women's associations, the Ministry of Health, and a non-governmental organisation, the BFPA, with links to the international family planning movement (Carlson and Lamb, 2001).

In 1995 began the EU Phare Programme's Family Planning Project. The project goal was to lay down the basis of a national policy for reproductive and sexual health, and prevention of unwanted pregnancy and sexually transmitted infections. The project was implemented by the Ministry of Health, the Bulgarian Family Planning Association, women's organisations, the WHO Regional Office for Europe, and the International Planned Parenthood Federation.

In order to achieve their goals, a large-scale training programme for health professionals was started, a mass media campaign initiated and a clinical management information system developed. National standards were designed for education and training of health professionals. Five hundred health and other professionals were trained in reproductive health and information, education and communication through short training courses. Medical students in all universities and colleges received new postgraduate

training of at least sixty hours in reproductive health. Thirty family planning information centres were established throughout the country within the clinics of BFPA and in women's NGO clubs. These were provided with materials and audio-visual equipment.

In 2001, the National Health Strategy "Better health, better future for Bulgaria" for the period 2001-10 was adopted by the Council of Ministers. Reproductive health is included in three of the five key areas of this strategy. The plan of action under the National Programme on reproductive health has eight chapters, and adolescents are the main focus of chapter one. There are several goals in this chapter and the first one is : "Improving the informational level, knowledge and attitudes of the adolescents in order to create life-skills for responsible sexual and reproductive behaviour."

The main concrete step towards achieving this goal is to introduce as obligatory sexual and reproductive health education in the school curriculum by the end of 2004. Until now sexuality education was not part of the school curriculum in Bulgaria. Partially it is included in the health education lectures in the secondary schools. The health education classes per se are not regularly held. A comprehensive educational package for 12 to 18-year-olds is under testing. It includes a manual for teachers, student's notebook and a special edition for parents. The main motive is to facilitate the introduction of sexuality and health education in official school curriculum. Institutions providing financial support are the institutions on which rely the majority of NGOs in the country : UN structures (UNAIDS, UNFPA, Unicef, WHO), EU structures, OSF, Cooperative Netherlands foundations, CIDA etc.

UNFPA and WHO are funding a national five-year project "Strengthening the national reproductive health programme" executed by the Ministry of Health and selected NGOs (BFPA, Schools promoting health association etc.). The programme is working in several main directions :

- Elaboration of a comprehensive national strategy and plan of action on sexual and reproductive health
- Health professionals' capacity building in order to assure the quality of reproductive health services provided
- National research on infertility
- Development and introduction of a sexual health programme in the school curriculum
- Further development and improvement of peer education in the field of sexual and reproductive health in and out of school
- Increasing the informational level of the general population on sexual and reproductive health issues
- Establishment of a well functioning system for contraceptive supply.

Bulgaria is still a country with a low incidence of HIV/Aids. In 2002, there were only forty-three new HIV infections (rate 5.5). The total number of HIV cases is 402. The guiding principle to combat Aids has been contraception and public information campaigns. A number of projects for sex education at schools have been developed including the project "Health Promoting Schools". A National Committee for the Prevention of Aids and STIs of the Council of Ministers has been established.

School dropouts are a special risk group to face unwanted pregnancies and STIs and HIV infections. There is a direct correlation between the dropouts and poverty. By estimation yearly the school dropouts are from 22 000 up to 33 000. Major part of those children is Roma. 14.7% of children in first to third grade are Roma. In fourth to eighth grade they are 8.2%, ending with the incredibly small figure of 0.9% for after the eighth grade. Teenage pregnancies and early marriages are popular mostly among some ethnic communities (Roma and Turkish). The social role of women in those communities is perceived mainly in the career of mother and wife.

In 1998-2001 the BFPA carried out an EU financed project "Contraceptive and health choices for the marginalised Roma people of Bulgaria". It was the first community based, Roma targeted reproductive-health-oriented macro-project in central and eastern Europe.

There are no recent nationwide studies of the relationship between education and reproductive health. Actually the UNFPA and Unicef are funding a KAB survey. The results will be presented to the general public at the end of 2003.

According to some studies openness in sexual issues is proceeding very slowly in Bulgaria. In qualitative interviews among teenagers sex seemed an illegitimate subject to talk about either with their parents or at school. Also, talking about sex with a member of the opposite sex was close to taboo. Respondents commonly stated that they were ashamed to talk about sex with their parents. If such discussions took place within the family, they were usually in the form of a monologue on the side of the parents (Vassilava and Komarova, 2000).

6.2 Finland

In Finland the population is 5.2 million. Total fertility rate is 1.73. Finland and other Nordic countries are among the leading countries in both the realisation and promotion of adolescents' sexual health and sexual rights. It is not purely by chance that the trends of different indicators of adolescent sexual health (e.g., induced abortions, HIV transmissions) are favourable in Nordic countries. According to a study done in 1993 by the International Planned

Parenthood Federation (IPPF) regional office of Europe (Vilar 1994), sex education was most easily available in Finland, Sweden, Denmark and Norway.

The work done in Finland to promote sexual health during the last few decades has been successful in many respects. The rate of unwanted pregnancies decreased rapidly from the high rates of the early 1970s and the low level has maintained. The main reason for the decrease in teenage pregnancies in the 1980s is the fact that physicians more readily began to prescribe the new and improved pill to young girls. Sexually transmitted diseases are under control and young people are assured of adequate sex education. Gender equality has improved on matters related to sex and people have better possibilities to deal with and get help with their sexual problems. Finland has created its own youth culture, which emphasises responsible sexual behaviour. The widespread use of condoms in Finland (the second biggest user in the world after Japan) has contributed to keeping Aids incidences low. In 2002, there were only 130 new HIV infections (rate 25.1). Teenage HIV infections have been rare.

At the end of the 1980s the Advisory Committee for Health Education appointed by the Government wanted to give an impetus to public discussion about the connections between sexuality and health, and commissioned a group of experts to make an "Eroticism and Health" report, that was published in April 1989. The report contains research-based data on the impact of sexuality on health, a description of Finnish sexual culture, and an outlook for eroticism presenting ways to sexual health and well-being. The report indeed aroused broad and heated debate in homes, workplaces and other places. In the media the report was spotlighted everywhere from news to leaders, columns, drawings, causeries, interviews, reportage and letters to the editor. Foreign media also showed an interest in the issue when the proposal for enriching the relationships between couples by a "sex holiday" was publicised out of context before the report itself was completed.

The task of the Ministry of Social Affairs and Health is to plan the strategy for sexual health and to decide on the grants for health education. The operational side of the promotion of sexual health was delegated to the National Research and Development Centre for Welfare and Health (Stakes). Various bodies can also apply for financial support for the implementation of their projects intended to promote sexual health. Projects that are aimed to promote sex education for adolescents, sexual counselling within health care services and family planning services are prioritised (Nurmi, 2000).

The Ministry of Social Affairs and Health has organised a number of national sexuality seminars implemented in collaboration with the Stakes. In the 1990s their themes have covered Finnish sexuality, male sexuality, middle age and sexuality, long-term illness, disability and sexuality, adolescents and

sex, and "sexuality today – where are we heading?" The Stakes has coordinated "Family planning 2000" a cooperation project on family planning and sex education that has been carried out in several locations of the country. One of the outcomes of this project has been "fertility festivals" that have been held annually in different cities around the country with the aim to give a boost on local sex education efforts (Nurmi, 2000).

As part of family planning policy, since 1987 the Ministry of Social Affairs and Health has annually mailed a sexual education leaflet "Sexteen" to all young persons reaching the age of 16 in the country. The leaflet includes information about dating, human relationships, sexuality, family planning, sexual orientations, and STIs/HIV infections. A sample condom and clear instructions how to use it are also included. There is a separate letter to parents dealing with adolescent sexuality. The leaflet is updated every second year. The reception of the leaflet and the young people's opinions on it and its development, has been studied twice. The feedback has been positive.

In the army all young men are provided with sex education. In collaboration with the Finnish army, an educational booklet dealing with contraception and family life is distributed to all Finnish men on completion of their military service. Girls are more active in visiting youth clinics but boys are equally active in making calls to sexual health helplines and more active than girls to send their questions via the Internet.

The mass media has had a great impact as a promoter of sex education. Especially boys consider magazines and television as an important source of information on sex. The mass media has taken a moderate and objective approach when reporting on new contraception technology. Health and female journals write about sexual issues on a continuing basis.

In 2001, the number of abortions in Finland was 8.8 abortions per thousand women aged 15 to 49 years. In the age group 15-19 the abortion rate was 15.4 per thousand. It has been the lowest in 1994 (10.7 per thousand). Teenage birth rate is 10 per thousand. According to the notifications; just over 70% of abortion patients had been using some form of contraceptive method when they became pregnant. About 17% reported that they had been using a 'safe' method (sterilisation, pill, hormone-releasing or other IUD).

For the most recent sexual intercourse 31% of 18 to 54-year-old women used contraceptive pills to prevent a pregnancy. A condom was used by 28% and an IUD by 24%. Traditional methods were reported only by 8% of women and 5% did not use any method (Haavio-Mannila and Kontula, 2001). According to the school health survey among 17-year-old girls 50% had used the pill during their last intercourse. Among 16-year-olds this figure was 40% and among 15-year-olds 33%. A condom was used by 42%, 49%,

and 51%, respectively. Among teenagers only around 10% did not use any contraception for their most recent sexual intercourse (Liinamo, 2000).

Contraception services are available to all young people at municipal health centres. Some health centres provide the first contraceptive free of charge (condoms or pill). Usually the pill had been given free for half a year, but on social grounds it can be given for much longer. School health care supplements the services provided by municipal family planning clinics. According to surveys, its significance in promoting young people's knowledge of contraceptives has been most essential, especially in reaching girls.

Health centres, school health care, maternity clinics and hospitals as well as the private sector and organisations employ personnel specialised in contraceptive counselling and abortion. Their skills in giving sex counselling have been enhanced through further education. More than half of all women (57%) obtain contraception from public health services ; the others receive it from private doctors. Most young women under the age of 25 use public health services.

The attitudes in Finland towards sexuality and sex education are very positive. Schools, social and welfare services, the church and the media provide sex education. Sex education in schools is offered as part of the curricula. In the field of health care, sex education concentrates on contraception and pregnancy as well as the prevention and treatment of sexually transmitted diseases. Information is given as a part of health counselling of public health centres ; family planning clinics and school health care. Also in congregations, sex education is a part of youth work and sexuality is discussed in confirmation schools. In schools, sex education is mainly provided by teachers (physical education, biology, home economics) and the school nurse. One of the strengths has been the cooperation between the teaching and health authorities in sex education. Both pupils and parents consider the sex education given in schools important and necessary. The basic aim in education provided to young people is not to forbid sex but to reduce the health risks involved and give them the means to make informed choices (Lähdesmäki and Peltonen, 2000).

Kontula (1997) collected information from teachers (N=412) around the country from seventh to ninth grade in the 1995-1996 school year. Sex education had been included in some form in the curricula of almost all (94%) schools. It had been provided comprehensively (according to several criteria) in seventh grade in about one-third of the schools, in eighth grade in 60% of the schools and in ninth grade in three-quarters of the schools. There were large differences among schools. According to the replies, sex education in the seventh grade was most often in connection with hygiene or pupil counselling. In eighth grade, sex education was most generally included in health

education, and in ninth grade in the curricula of biology, family education, and also quite often in religion.

According to Kontula (1997) those teachers who provide sex education in the upper level consider the most important goals of sex education : teaching responsibility, giving correct factual information and encouraging a natural attitude towards sexuality. The goal classified as least important was teaching abstinence. The teachers wanted to avoid moralising and interfering with the choices of pupils. They did not want to give too many warnings about sex. Neither did they want to encourage sexual activities.

To evaluate the knowledge of various aspects of sexual health, and to provide teachers with a basis and new material for sexuality education, a nationwide quiz of sexual health knowledge was performed (Kontula et al., 2001) in the form of a quiz among eighth grade students (mean age 14.8 years). It was carried out nationally in spring 2000 through schools. All 817 lower secondary stage schools were invited to participate, and finally 401 schools returned the papers. Altogether 30 241 girls and boys, 47% of that age group in Finland, filled in a questionnaire that consisted of eighty sexual health knowledge questions, each with four alternatives, of which one should be marked as the right one. Based on the study, a report with specific suggestions for improving sexuality education was sent to all schools in Finland.

In follow-up studies of adolescents' sexual knowledge three types of sexual health campaigns have been found to have a positive impact on their knowledge. The first was the sexual information leaflet (including condom) that the Ministry of Social Affairs and Health sends annually via mail to everybody who has their sixteenth birthday that year. A second was a nationwide quiz of sexual health knowledge among eighth grade students that was organised in 2000. The third was fertility festivals that have been organised annually in different cities with the aim of boosting local sex education and the level of sexual knowledge among adolescents.

There was a major improvement in sexual knowledge among teenagers from the 1970s till the 1990s. This increase in knowledge has resulted from a combination of influences. These include the general development of open discussion on sexuality related issues ; the mass information campaigns conducted by the social and health care sectors ; the work of school health care experts ; and the development of curricula, and contents and methods of sex education in schools. Various non-governmental organisations working for sexual equality or sexual health promotion have been able to make their voices heard in public debate and in networks of co-operation, and thus, in promotion of sexual information and knowledge (Liinamo, 2000).

Recently, there has been some increase in the rate of abortions performed among young women - on the other hand teenage births have remained at the same level for the last six years. In the 1990s local authorities reduced funding for preventive health care services, such as birth control and family planning services and school health care. The sex education provided in schools was likewise undergoing a major change. According to various studies it created many needs to reconsider the sex education provided in schools.

Lately, there has been a positive improvement in sex education. A next step will be taken in 2004 when health education (including sex education) will return as a compulsory subject of instruction in the senior grades of school. The number of school health personnel is now also higher than ever before.

The IPPF member organisation in Finland is the Family Federation of Finland (Väestöliitto). The welfare of families and improvement of sexual health have been important aims of the Family Federation of Finland since its founding in 1941. It can be considered a pioneer in sex education in Finland. As early as the 1940s, there were public lectures about contraceptive techniques. In 1947, a marriage clinic was founded in Helsinki, and by the 1950s eight more towns had their own clinics. Clinics gave contraceptive counselling to people who intended to get married or were recently married.

The Family Federation of Finland was the first to start mail order sales of condoms in Finland, and later started the VL-Marketing company to take care of contraceptive devices' sales. Due to effective press campaigns as well as outside advertising, everyone became aware of condoms. Over the years, hundreds of thousands of family education material such as pamphlets and books have been distributed throughout Finland. Since 1985 the Family Federation of Finland has also been involved in overseas development projects in the field of sexual and reproductive health.

In 1988 Väestöliitto founded the Open House, a youth counselling service, also providing similar counselling to young people free of charge and without an appointment. Open House personnel provide sexuality education for schoolchildren and students. Sex education is given in schools, but groups can also visit the clinic. In 1991, the Family Federation of Finland's Family Planning Clinic in Helsinki started its services, and in 1996 its name was changed to the Sexual Health Clinic. Sexual counselling is an essential service of the Sexual Health Clinic. The clinic's phone service is free of charge and operates four days a week. Counselling is also given via e-mail and web-pages.

In the late 1990s, research on sexual health and sexology became an important part of the Population Research Institute's (Department of Family Federation of Finland) activities. In 1997, a FINSEX-study, which follows up Finnish sexuality and sex culture, became part of the work of the institute.

Comparisons are made among sexuality research in Finland, among neighbouring countries, other European countries, and developing countries, as well as with sexuality research done by international organisations.

6.3 The Russian Federation

In traditional Soviet society individual values had a low priority or were even condemned, and any emphasis on pleasure in life was frowned upon. Love and sexuality were officially disregarded and taboo subjects. Today, Russian society is going through a fundamental process of re-orientation.

Early and universal marriage has always been typical of the Russian Federation. According to statistics the average age of first marriage is 21.8 for women and 24.4 for men. In a European comparison these ages are exceptionally low. Childbearing typically followed within a year of marriage. In the Russian Federation total fertility rates decreased from 2.54 per woman in 1960 to 1.89 in 1980 and 1990, and to 1.23 in 2001.

From the beginning of the 1980s fertility regulation in the Soviet Union was determined by parallel processes: broad provision of early abortion; continuation of the fight against clandestine abortion; localised attempts to make modern contraceptives available; the continuation of official efforts to limit the widespread availability of modern contraceptives; and the commercialisation of abortion services. By de facto prohibiting oral contraceptives while gradually extending the grounds for and the availability of abortion, the Soviet public health system developed a model of fertility regulation, which relied primarily on low cost abortions (Popov and David, 1999).

The abortion rates have been declining in the 1990s. The abortion induced rate was ninety-five per thousand women of 15-49 years of age in 1992 and fifty-two in 2001. Among teenagers (15-19) the abortion rate was sixty-seven in 1992 and thirty-five in 2001. That is still very high. The abortion rate in the Russian Federation has fallen 45% from 1992 to 2001. It will continue to fall as contraceptives become more accepted. However, the use of modern contraceptives has remained rather low. In 2001, 16% of women in fertile age used an IUD and 8% oral contraception (Popov and David, 1999; RFPA, 2003).

The Russian Federation's demographic crisis has contributed to demands that steps should be taken to reverse the declining population trend. For every ten births in the Russian Federation, there are still nearly thirteen abortions. This is why the Russian Federation has recently increased its restrictions on abortion for the first time in nearly half a century. After the first twelve weeks of pregnancy abortion is going to be much more limited than before.

Abortion has been a method of fertility regulation available to every woman, a symbol of personal freedom in a society in which the state tried to control

all aspects of life. By the 1990s, the abortion was "perceived as a routine, although certainly unpleasant, medical procedure, comparable, say, to the removal of a tooth". Abortion rates and ratios were higher than anywhere else in the world. The cost of abortion varies greatly across the Russian Federation, ranging from free to very expensive. Most women choose private clinics where the standard on hygiene is rigorous and the standard of care is much more humane ; however, women must pay for these services, and the average cost of an abortion is US$230 (Women of the world, 2000).

Vikhlayeva and Nikolaeva (1996) conducted a study among women immediately after their abortion. Only 15% of the urban and 13% of the rural women had received contraceptive counselling before their sexual debut. After the first deliveries or abortions, this figure rose to 45% and 36% respectively.

In 1988 the Ministry of Health legalised commercial abortions. Fees could be charged by physicians who had a legal private practice, in private clinics and in commercial sections of state hospitals. Such privatisation constituted legalisation of already existing illegal and paralegal commercial abortion services. The average charge was fifty rubles for early abortion and 100 rubles for later abortion, representing 25-50% of a woman's average monthly income at the time. With the low salaries paid to physicians, the profit to be made performing abortions still acts as a strong disincentive to providing contraceptive counselling.

The view favouring abortion was enhanced by an ultra-cautious attitude toward modern contraceptives. They were perceived as something unnatural and labelled harmful by physicians who never mentioned their advantages. Few women persisted in following the difficult and expensive path of finding efficient and personally acceptable contraceptives. Official figures showed that in 1988 contraceptive supplies met only 25% of demand (Popov and David, 1999).

There were also more general reasons. The authorities feared that widespread availability of the pill might lead to a greater decline in the birth rate. Furthermore, any switch from an abortion strategy to one of effective contraception would mean a substantial extension of women's rights, replacing state control over reproductive behaviour with self-determined control. In this scenario the role of the physician would be reduced to a technician-consultant. That amount of potential autonomy went against the paramount principles of the Soviet regime and past patriarchal experience (Popov and David, 1999).

At the beginning of the 1990s low dosage pills began to be imported from Germany and the Netherlands. These efforts had limited influence on the

medical profession or on the media that associated the pill with declines in morality and a rise in promiscuity in the West. The authorities and the medical profession did all they could to discredit new contraceptive methods and prevent their widespread use. In contrast to this, abortion seemed comparatively harmless and convenient.

There are some sites where use of modern contraceptives has been measured to be quite high. In surveys conducted in Ivanovo Oblast and the cities of Perm and Yekaterinburg, the contraceptive prevalence rate among women in registered and unregistered marriages ranged from 69% in Perm to 78% in Ivanovo. Modern method use exceeded traditional methods by 3:1 or higher. Reliance on traditional methods was 14-18%. Use of condoms, the pill, and periodic abstinence increased with education (1999 Russia Women's..., 2000). According to sociological data, approximately 50% of women aged 15-25 used some form of contraception the first time they had intercourse, 17-30% reported having used condoms (Chervyakov and Kon, 1998).

As of 1999, oral contraceptives were not produced in the Russian Federation. International donors had extended their programmes to more than fourteen regions, working with women's consultation centres of maternity houses. Although the pill no longer requires a prescription and attitudes toward low-dosage hormonal methods have become more positive, supplies in the private sector continue to be irregular and expensive. Misperceptions, even among motivated physicians, suggest a continuing need for postgraduate courses and the integration of family planning into the medical school curriculum (Popov and David, 1999).

Russians have made significant strides in increasing contraception and reducing abortion through their Federal Family Planning Programme, which increased threefold the number of family planning clinics between 1991 and 1997. Since the late 1980s the use of IUDs and hormonal contraceptives has roughly doubled. During this time, the abortion rate declined by half. Unfortunately, there was a growing resistance to both abortion and family planning programmes in the Russian Federation in the 1990s. This has been due partly to the fear that family planning will decrease the fertility rate.

In 1994-1997 the federal programme "Family Planning" was implemented in the Russian Federation. The Russian Family Planning Association (RFPA) has participated in its implementation, focusing on information provision (IEC for specialists, and population). The federal programme has initiated the elaboration and adoption of local family planning programmes in more than fifty regions of the Russian Federation.

In the frame of these programmes federal and local new state family planning centres were established, and already created centres were strengthened. Also information provision of specialists and the population was improved, likewise the access of socially not protected groups of population (young people, women with low income and other) was improved and they started to receive contraceptives free of charge. Federal and local programmes had a great effect : during three years of implementation abortion rates dropped down by 30%. However opposition activities lead to the termination of financing for the federal family planning programme and the cutting down on a number of local programmes.

After the termination of the federal programme in the Russian Federation there were no state purchases of contraceptives, which worsened the situation for the provision of the socially less protected groups of the population with free contraceptives. Some regions are purchasing contraceptives using local budgets funds, and disseminating them between certain groups of citizens for free. All types of modern contraception can be bought in all drugstores.

The availability of contraceptives is not reliable, as it depends upon budget resources, legislation, taxation, and foreign manufacturers. The Ministry of Health purchases approximately 13-17 types of oral contraceptives, which covers the demand of only 3-5% of women in the Russian Federation. Compared to the monthly minimum wage (US$3.00 in 2000), the cost of contraception is very high. Oral contraceptives cost about US$80-100 per year (Women of the world, 2000).

In 2000 the Board of Ministry of Health, Ministry of Education and Ministry of Labour and Social Development adopted the "Conception on reproductive health care and plan of action to implement it", where the importance of education of the population, including young people on reproductive health care issues is indicated.

Reproductive behaviour continues to be a derisive topic among large segments of the Russian population. In 1997, the Moscow city authorities discontinued an advertising campaign on television, billboards and buses that sought to arrest the spread of Aids by promoting the use of condoms (Popov and David, 1999).

At the end of 1991 the Russian Family Planning Association (RFPA) was organised with support from the International Planned Parenthood Federation (IPPF) and the Russian Government. Accepted for IPPF membership in 1993, it has more than fifty branches throughout the country. The RFPA established a training centre for medical professionals, organised seminars for physicians, nurses, and teachers, and developed three youth centres

focusing on the needs of adolescents. With Ministry of Health and international donor support, the RFPA publishes its own medical journal, translations of IPPF texts, and popular booklets. The RFPA seeks to facilitate the dissemination of information, better marketing of contraceptives, and improved quality of abortion services, while encouraging men to assume greater responsibility for pregnancy prevention.

The RFPA, its forty-eight regional branches, RFPA youth centres and state centres provide information on sexuality, education and counselling. Services are provided free of charge. State centres are financed by the government. The RFPA, its branches and youth centres mostly use project funds and, to a minor extent, the funds of local authorities.

Anonymous and confident sexual health services are provided by three youth centres, established by the RFPA, and also by state youth centres, which act under the support of the health care system, social services and youth committees. But a number of such services for youth are not sufficient; those centres cannot provide all the requested confidential and anonymous services to young people.

If an unwanted pregnancy occurs, adolescents often decide to have an abortion, but not because of economic reasons. Adolescents do not use contraceptives not only because they rely on abortion, but also because of the lack of a sex education system. Adolescents are not aware about contraception and the number of services providing counselling on contraceptives.

The Ministry of Education dispatched in 1996 to 30 000 schools a package of five alternative sex education programmes it had developed on its own. A storm of protest ensued, led by vocal pro-life activists who complained to the Duma's National Security Committee about western ideological subversion of Russian children. Some Russian Orthodox priests told their parishioners that all bad things in western life are rooted in sex education, and that western governments are trying to ban it. They argued also that the Russian Government, at the instigation of the "Sexological Industrial Complex", was acting against its own best interests (Popov and David, 1999).

Strong opposition was voiced by "Communist die-hards" who still cling to the Soviet policy of vigorous suppression of public sexuality. The argument was made that western capitalists introduced pornography and immorality into the Russian Federation and that sex education was a means to increasing both. Some mental health specialists attacked sex education as likely to lead to psychological pathologies. The result of this agitation was that the Attorney-General's office declared the Ministry of Education sex education effort "illegal". Meanwhile the communist faction of the Duma reduced the federal family planning budget by more than half (Popov and David, 1999).

There is still no official sex education system in the Russian Federation. Nevertheless these activities are undertaken by local Departments of Education together with the RFPA and its regional branches. The RFPA has elaborated "Conception of sex education" programme and manuals for those who work with adolescents entitled "Fundamentals on family planning and healthy lifestyles" and forwarded it to all forty-eight regional branches. Information concerning youth sexuality is available in youth centres, the number of which is not sufficient at all, and in state family planning centres. Many of these centres have special departments for adolescents (the number of state family planning centres is about 500).

Russian schools have not been ready to carry out sex education. Three-quarters of teachers were convinced that form teachers (those who are primarily responsible for social and moral education) should discuss issues of gender and sexual relations with their students. However, 65% of teachers report having never done this, and another 15% had done it only once or twice. This is due to the fact that only 11.5% of teachers said they were well prepared for such a task ; 85% were in favour of special courses on the fundamentals of sexology as part of teacher training (Chervyakov and Kon, 2000).

According to the 1993 survey findings among teenagers, only 19% of 16-year-olds reported having received special classes, lectures or seminars on sex education. In 1995, the comparable figure was about 10%, and in 1997 it was 22%. (Chervyakov and Kon, 2000.) Parents themselves rarely initiate talks on sexuality with their children. When it comes to having sex, boys tend to allow themselves much more freedom than they allow the girls. As many as 49% of boys strongly agree with the statement that boys should have more freedom than girls in this respect, but only 13% of girls agree with this. Almost two-thirds of girls strongly disagree with this traditional inequality and double standard (Dmitrieva et al., 2002).

In the 1997 survey, respondents were asked the question : 'In your opinion, do you have enough or not enough knowledge about sex ?' In the seventh grade, 21% of boys and 12% of girls said they knew enough about sex. And in the ninth grade, 34% of male and 27% of female respondents considered that they knew enough about sex. At the same time, only 12% of the teachers considered themselves well prepared to answer students' and parents' questions about sexuality. Moreover, only one in three parents gave a clear positive response to the question about whether they thought they have enough knowledge about sex (Chervyakov and Kon, 2000).

In surveys among 14 to 17-year-old teenagers in Astrakhan, Smolensk and Ulianovsk (Grebesheva et al., 1996) only 40-46% reported that they were informed of pregnancy ("I know and understand this issue"). The knowledge on safe sex was roughly equally as low. Less than one-fifth of respondents

had sufficient knowledge on sexually transmitted diseases. Only one-third of girls knew and understood contraceptive methods and how to become pregnant, and a quarter of girls knew of sexual intercourse. With such a low level of sexual knowledge it is easy to understand why teenage pregnancy and STI rates are so high in the Russian Federation.

Half of the boys had discussed protection against unwanted pregnancy and sexually transmitted diseases with their sexual partner. 70% of girls reported having discussed with their partner pregnancy prevention and about half had discussed STIs. The overwhelming majority (95%) of teenagers had a positive attitude towards the idea of setting up special sex education programmes. The most convenient age to receive sex education was assessed to be 13-14 years. Girls were also hoping for individual discussions with specialists (family planning centre, women's counselling bureau) on sexual issues. (Grebesheva et al., 1996.)

Teachers would like to offer a detailed treatment of anatomy, physiology and ethics, whereas students have more interest in practical issues. Of all the topics proposed in a sex education course for both boys and girls, the greatest preference was information on STIs and HIV prevention. Problems of sexual harassment, including rape and unwanted sex, were the second most significant for girls. Boys did not show as much interest in these issues. They worried much more about how to improve their sexual potency and performance. Girls were far more interested than boys in conception, the development of the human foetus and childbirth. Boys had a much higher interest than girls in sexual techniques that could enable them to receive more pleasure from sex (Chervyakov and Kon, 2000).

Russian public opinion is in favour of sex education. In all national public opinion polls conducted since 1989, the vast majority of adults – between 60 and 90% depending upon age and social background – have strongly supported the idea that there would be a systematic sex education in schools. Only from 3 to 20% were against it (Chervyakov and Kon, 2000).

In 1999, the Ministry of Health ordered that sex education should be provided in the health clinics for children under seventeen. Some schools also undergo sex education lectures in some regions, where they want this activity to be done. These activities are undertaken mostly by specialists, trained in the frame of RFPA projects, and by those who have been trained on the TOT (Training of Trainers) system. Among those specialists there are gynaecologists, paediatricians, nurses, teachers, social workers, psychologists. Many regions are conducting lectures on sex education using "Fundamentals on family planning and healthy lifestyles" (IEC) that has been elaborated by the RFPA. The RFPA receives numerous requests from regions looking for more IEC material. However, less than 5% of

adolescents report having received sex education from schools, and less than 5% from medical professionals (Women of the world, 2000 ; Hilber, 2001).

The Russian Federation has budgeted about $38 million in 2003 for the fight against HIV/Aids, and the World Bank is lending Moscow another $150 million to support the effort. According to the Russian Open Society Institute about 1.2 million people have HIV in the newly independent former Soviet states, and more than 90% of them were infected via injected drugs. There were 50 401 new HIV infections (rate 350.6) in 2002. The Russian Health Ministry has said that new HIV infections dropped by half in 2002 compared with 2001, mainly because of a scarcity of heroin due to the war in Afghanistan. Another possible reason for the decrease is that HIV is beginning to saturate the addict population. In some provinces, including Samara and Irkutsk, up to 8% of 15 to 25-year-old Russians have HIV.

Chervyakov and Kon (1998) list the issues that inhibit effective Aids prevention in the Russian Federation. They call the first point cultural. There is absence of a tradition of safe sex and prejudices against using condoms. On the other hand, the open discussion on sexual problems is lacking. The second factor is educational : there is widespread ignorance about issues relating to sexual healthcare, even among physicians. The third factor is organisational. Social problems are approached with a bureaucratic-administrative approach : instead of educating people there are attempts to implement heavier control tools. In the Duma even the law on reproductive rights was voted down. As a result of a huge public moral scandal, the so-called Unesco project on sex education for Russian schools was cancelled. Chervyakov and Kon even argue that the words "safe sex" became virtually taboo.

According to the RFPA Russian society has recently been more tolerant on sexual issues than in the 1990s. The orthodox church has maintained its criticism of sex education but the Ministry of Health and the Ministry of Social Affairs recognise the problems that are related to sexuality. The mass media is no longer attacking sex education in the way it did in the 1990s.

6.4 United Kingdom

British culture shows a marked ambivalence to teenage sexuality and young people receive very mixed messages about sex. Teenagers are raised in a culture that is highly sexualised, but at the same time is very reserved when it comes to talking to them about sex, which leads to confusion, misinformation and mistakes.

The sexual health of teenagers in the UK is poor compared to other western European countries. Britain still has the highest rate of teenage pregnancy in western Europe (as high as in the Russian Federation) ; twice that of

Germany, three times that of France and six times that of the Netherlands. Rates of sexually transmitted infections are on the increase amongst teenagers, with a third of all women diagnosed with chlamydia at genitourinary medicine clinics in 2001 being under twenty years of age. In the past decade chlamydia has risen by more than 100%, while cases of HIV and Aids are growing by almost ten per cent a year. Syphilis infections have risen in ten years even by 870% and gonorrhoea by 100%. In three years the HIV rate has doubled. In 2002, the number of new HIV infections was 6 025 and the rate was 101.0 per million. This is the second highest in western Europe after Portugal and four times higher than in Finland. One of the reasons for this trend is that six out of ten 16 to 24-year-olds say they use condoms only sometimes or never.

The UK has the highest teenage birth (29 per thousand) and abortion rates (16.7 per thousand) in western Europe. Among teenagers the abortion rate is 18.6 per thousand. Levels of teenage sexual activity cannott explain the difference between the UK and other western European countries, because they are very similar. Major differences can be seen in attitudes and use of contraception, societal attitudes to teenage sexual activity and motivation to delay parenthood. Contributing factors in countries with low or falling teenage pregnancy rates include strengthening economies, provision of good school sex and relationship education, confidential and accessible contraceptive services and improving family communication about sex.

According to the national survey, which was conducted in Britain in 1999-2001 (Wellings et al., 2001), some sexual health indicators were in good progress. The proportion of women reporting first intercourse before the age of 16 increased up to, but not after, the mid-1990s. There has been a sustained increase in condom use and a decline in the proportion of men and women reporting no contraceptive use during their first intercourse with decreasing age of those interviewed. Early age for first intercourse was significantly associated with pregnancy under the age of 18, but not with occurrence of STIs. Low educational attainment was associated with motherhood before 18, but not abortion. Motherhood before the age of 18 was reported by 6% of young (16-24 years) female respondents. Both sexual activity and childbearing before twenty are less common among foreign-born adolescents and among non-white adolescents than among native-born and white adolescents (Singh et al., 2001).

Research in the UK shows that there is a great variation among adolescents in their motivation to prevent pregnancy and in their ambivalence about having a child during their adolescent years. There is lower motivation and greater ambivalence (as well as a more positive attitude toward having a baby) among teenagers who have lower educational and job aspirations and

expectations, among those who are not doing as well in school and among those in poor and single-parent families (Darroch et al., 2001).

Non-use of contraception during first intercourse was around 30% among those who left school at sixteen without qualifications. Among those who left school at seventeen or older this proportion was less than 10%. A quarter of young women were already using oral contraception at first intercourse. Three-quarters of young respondents had used a condom for their first intercourse. This is a very high proportion in European comparison (Wellings et al., 2001).

Young people who leave school later, with qualifications, are less likely to have early intercourse, more likely to use contraception at first sex, be sexually competent, and (for women) less likely to become pregnant if they have sex. Family disruption and lower parental socioeconomic status are associated with early sexual experience and pregnancy when younger than 18 years, but effect is weaker. 29% of sexually active young women in the study, who left school at age 16 with no qualifications, had a child at age 17 years or younger. (Wellings et al., 2001)

Most teenage pregnancies are unplanned in the UK. One follow-up survey of teenage parents suggests that about three out of four teenage mothers had not planned their pregnancy, although only one in four had been using contraception around the time of conception. Half had been having unprotected sex for three months or less when they became pregnant.

Some reasons for unplanned pregnancies are misinformation and difficulties with condoms. In a survey among teenagers (Burack, 1999) 52% of boys reported that they would feel embarrassed buying condoms in shops and 32% would be afraid of being clumsy when using a condom. Almost a fifth of boys and girls believed that using the contraceptive pill can help prevent getting HIV infection. As many thought that one cannot get pregnant when having sexual intercourse for the first time.

Teenage parents are often adversely affected by their situation. They are less likely to finish their education and find a job, and more likely to live in poverty. Their children have an increased risk of poor health and are more likely to become teenage parents themselves, so repeating the cycle. However, other follow-up surveys suggest that it is the practical and emotional difficulties such as poor housing and lack of educational opportunities, which lead to unhappiness and regret, rather than the fact of having a child. Good family and social support is important.

The risk of becoming a teenage parent is intimately linked to social exclusion and is highest amongst those who have grown up in poverty or disadvantaged communities, have poor educational achievements and low expecta-

tions of employment. Conception rates amongst teenagers in the most deprived areas of England are up to six times higher than those in the most affluent areas. These teenage girls are or had been in care, had emotional difficulties in childhood or adolescence, and had a mother who had herself given birth as a teenager.

Girls under sixteen can give consent to an abortion if all the doctors concerned agree that the girl has sufficient maturity and understanding to appreciate what is involved. But in practice, most doctors require the consent of a parent or other responsible adult before the operation is performed. Nearly four in ten of all teenage pregnancies end in abortion. Over half of conceptions in the under-16s are terminated.

The sex education elements of the National Curriculum Science Order are mandatory for all pupils of primary and secondary school age (not in Scotland). These cover anatomy, puberty, and biological aspects of sexual reproduction and the use of hormones to control and promote fertility. Secondary schools are required to provide a sexual and relationship education (SRE) programme, which includes (as a minimum) information about STIs and HIV/Aids. Parents have the right to withdraw their child from all or part of SRE provided outside National Curriculum Science. SRE should be "given in such a manner as to encourage those pupils to have due regard to moral considerations and the value of family life". A 1994 survey found that 94% of parents and 95% of young people supported school-based sex and relationship education (Research to inform..., 2000).

Unfortunately, school sex education can have a number of weaknesses. Teachers with little, if any, special training are often expected to teach sex education in large and mixed-gender groups, causing embarrassment on both sides. Perhaps because of this, there is a lot of emphasis on the biological aspects of sex, particularly the female reproductive system, and little on sex within the context of loving relationships or information about forms of contraception.

If a teacher learns that a pupil under sixteen is sexually active they should encourage the young person to talk with a parent or carer, ensure that any child protection issue is addressed and provide adequate information about confidential sexual health advice and treatment services.

There are several determinants and assumptions that explain or can probably explain the high rate of teenage pregnancies in the UK compared to the neighbouring countries. Teenage unplanned pregnancies may occur because of lack of information about contraceptive usage and emergency contraception, embarrassment about discussing contraception with a partner and unplanned sexual intercourse. Unwillingness to discuss contraception with a

doctor and fears about confidentiality if they do so are important risk factors to unwanted pregnancies. One study found that 75% of under 16s and nearly 50% of 16-19 year olds using family planning or pregnancy counselling services thought that the doctors would tell their parents that they had been to see them and why.

Truancy, low academic achievement, and poor sex education have been argued to be the factors implicated in the high rate of teenage pregnancy in Britain. Teenagers have the opportunity to leave school at sixteen and get a low paid job. They take on adult roles earlier than their European counterparts. Young women who leave school are disproportionately likely to become pregnant, to have multiple pregnancies, and to experience poverty and welfare dependency. Female adolescents who lack confidence in their own abilities and future prospects often see little to lose from their pregnancy and childbearing (Rhode, 1993).

In 1999, the government published its Teenage Pregnancy Strategy for England. The main aims of the national strategy are to : 1) reduce the rate of teenage conceptions, with the target of halving conceptions in the under 18s by 2010, with an interim reduction of 15% by 2004 ; 2) set a firmly established downward trend in the under 16 conception rates by 2010 ; 3) increase the participation of teenage parents in education and work, to reduce their risk of long term social exclusion.

The strategy draws from the best available international research evidence. It works through multi-agency partnerships of health, education, social services and the voluntary sector at national and local level targeting groups most at risk. The Teenage Pregnancy Strategy is the first cross government strategy to tackle very high rates of teenage pregnancy, the highest in western Europe. It provides young people with the facts about teenage pregnancy and parenthood, advice on how to deal with peer pressure to have sex, and looks at ways of improving information about sex and contraception.

The strategy is a multi-faceted approach which includes helping young people resist pressure to have early sex through improved sex and relationship education, increasing uptake of contraceptive advice through the development of easily accessible youth friendly advice services and support for parents in talking to their children about sex and relationship issues.

The action plan involves a national campaign among all sectors, coordination of national and local action, better prevention (including education and access to contraception) and better support for pregnant teenagers and teenage parents. Implementation is overseen by the new Teenage Pregnancy Unit. It was set up in 1999 and is based within the Department of Health, but co-funded by the Departments for Education and Skills ; Office of Deputy

Prime Minister; Work and Pensions and the Home Office, who have joint responsibility for the strategy's implementation. A network of local teenage pregnancy co-coordinators is in place, covering every top-tier local authority in England. Within local teenage pregnancy strategies, all local areas have signed up to under eighteen conception rate reduction targets of between 40%-60% by 2010 to underpin delivery of the national target (Government Response..., 2002).

Educational policy is set by the Department for Education and Social Skills (DfESS) who have produced guidance on sex and relationships education (SRE) for schools. New SRE guidance was established as a priority in the Teenage Pregnancy Action Plan launched in 1999. The new guidance emphasises the need for more effective SRE, which is firmly rooted within the Personal, Social and Health Education (PSHE) and Citizenship Frameworks and is supported by the National Healthy Schools Standard (NHSS). It is recognised within the SRE guidance, PSHE and Citizenship frameworks and the NHSS that education plays an important role in promoting better health and emotional well-being for all children and young people.

According to government response to the first annual report of the Independent Advisory Group on Teenage Pregnancy (2002) research clearly shows that effective sex and relationship education (SRE), linked to provision of good quality advice and contraceptive services for young people, is key to reducing teenage pregnancy rates. In their opinion, effective SRE should equip young people with the skills to take responsibility for their sexual behaviour, including dealing with pressure to have early sex. It should ensure that young people know where they can access further confidential advice. SRE will be taught through compulsory science lessons and during other specific lessons.

A national advertising campaign aimed at young people began in October 2000, focusing on the themes of choices and taking control and responsibility around relationships and sexual behaviour, including resisting peer pressure. Evaluation has shown that 78% of 13-17 year olds recognise the campaign materials. In addition to advertising in teenage magazines and radio, the campaign has produced ambient materials, including postcards and posters. They also support a free national helpline, Sexwise, provide advice to young people and, where appropriate, refer them for further professional advice. Since the Strategy launch, there has been a 22% increase in the number of clinic sessions for young people. Young people can also access the website, www.ruthinking.co.uk which includes general information and details of local services for young people. Around 6 000 different users access this site each month.

Contraceptive advice and supplies are available free of charge to all residents, although local decisions are made on which methods will be provided. It is not possible to prescribe condoms but many services provide them free of charge.

In the United Kingdom, youth-oriented sexual health services are often delivered from venues other than health care settings that are accessible and acceptable to young people, such as youth centres, town halls, schools and fitness clubs. Although they vary in their approach, such services offer contraceptive information, advice and products, and many provide specialised counselling services. The number of UK sexual health services for young people has increased steadily over the past decade (Stone and Ingham, 2003).

Many young people initiate sexual intercourse but start to think about and obtain adequate protection only afterwards. An audit at the London-based Brook Advisory Centres found that almost one-half of first-time clients younger than sixteen obtained a pregnancy test or emergency contraceptives. Among the attendees at young people's sexual health services 61% of the sample had used a sexual health service only after having had intercourse for the first time (Stone and Ingham, 2003).

Having had unplanned or unexpected sex, embarrassment or fear, and concern about confidentiality and about being too young were common barriers among women who had delayed using a service, especially among those younger than 16. Lack of knowledge regarding the location or availability of services was frequently mentioned by both men and women (Stone and Ingham, 2003).

Sex and relationship education is most effective when linked to sexual health services. Young people can be unsure how to obtain contraception and find it difficult to access current services, which are often not geared to their needs. The provision on school premises of advice services for young people, staffed by health professionals and counsellors, can ensure that teenagers seek confidential advice about whatever concerns them including sex, relationships and contraception. However, the debate seems to have focused on whether school nurses should provide emergency contraception rather than how to best meet the health needs of young people. The great advantage of providing advice services in school is that barriers to access are minimal and the reason for seeking a consultation need not be obvious. The current patchy provision, where good practice is dependent on the commitment of individual teachers, should be replaced by guaranteed access for all pupils to comprehensive SRE.

The government plan to reduce the teenage pregnancy level involves raising awareness through targeted campaigns on radio, print and online media;

improved access to contraceptive methods and sex education; and support to help young women get jobs, training or education. To date, there has been a 9% reduction over three years. It reflects an enormous amount of work and commitment at a local level towards helping young people make safe choices and supporting teenage parents to improve the quality of life for them and their children.

The reduction of teenage pregnancy rates remains a government priority. However, there is a vociferous minority that opposes abortion, sex education in schools and services to under-16s. As a result, the government has a tendency to be nervous about these issues.

The United Kingdom Family Planning Association provides information for the public and professionals via its helplines and information materials. The FPA has a series of leaflets that are funded by the Department of Health. A training pack - The Fairy - helps teachers who are new to sex education. The community based project The Speakeasy works with parents to enable them to talk to their children about sex.

Every year the FPA runs two national awareness campaigns via the media and health professionals. Contraceptive Awareness Week 2002 focused on raising awareness of the 13 different methods of contraception available in the UK. A national survey was conducted to establish the level of awareness of the range of contraceptive choice and the understanding of emergency contraception amongst the general population. Sexual Health Week 2002 focused on rising rates of sexually transmitted infections and the need for long-term government investing in genitourinary medicine services. Both awareness weeks are aimed at the public and health professionals, and use colorful campaign materials to deliver sexual health messages.

The sexual health and HIV strategy was published for consultation on 27 July 2001. The strategy indicates a long-term commitment to modernise and improve sexual health services. After numerous consultations the strategy received widespread support on its proposals and its aims to: 1) Reduce the transmission of HIV and STIs; 2) Reduce the prevalence of undiagnosed HIV and STIs; 3) Reduce unintended pregnancy rates; 4) Improve health and social care for people living with HIV; and 5) Reduce the stigma associated with HIV and STIs.

In response to the consultation, a 27- point action plan was developed, which was published on 24 June 2002. It provided a framework for delivery and set out detailed milestones and plans as to how interventions will be delivered. It also addressed key concerns raised in consultation.

7. Conclusions

7.1 Determinants of reproductive health

According to a number of indicators the state of art in reproductive health varies very much around Europe. The variation in the rates of teenage births and abortions can be ten times from the lowest to the highest and in teenage STIs and HIV infections this variation can be even a hundred times (Kontula, 2003). Such a huge variation in reproductive health is due to several determinants that also vary from one country to another. Here are summarised some theoretical explanations and determinants of sexual and reproductive health. The role of education and information is interlinked with other factors.

The key concept to study differences and improvements in sexual and reproductive health in Europe is a modernisation process. Hoffmann-Nowotny and Fux (2001) assume that on the structural side the conditions of modernity imply diminishing constraints and an increase in behavioural options. The cultural counterparts are increasing individualism, and a certain loss of the traditions that have governed demographic trends for a long period. Modernisation is marked firstly by a partial loosening of structural and cultural ties. The reduced social control offers individuals increasing degrees of freedom. On the other hand, they are forced to individual self-interpretations.

As societies become more modern, the emphasis people place on higher-order needs will increase. They seek self-expression and will focus on their own well-being and on actions they perceive as giving meaning to their lives (Van de Kaa, 2001).

Modernization has adapted relationships and sexual behaviour patterns. Loosening social control has given more freedom to select romantic and sexual partners and has provided the opportunity to postpone marriage. The modernisation process has also supplied young people with the knowledge how to behave and interact responsible and has provided them with sexual health services. Individuals have taken care of themselves. Looking at sexual health indicators during the last twenty years, the transition in sexual initiation towards a younger age has not increased sexual health hazards ; on the contrary, teenage pregnancies and STIs have decreased around Europe during this transition (Kontula, 2003). In each European culture, it has taken at least one generation to learn how to behave responsibly in sexual issues. Variation in the timing of this individualisation process in different regions of Europe explains a high proportion of the difference in the reproductive health status among the societies.

In the European region, modernisation dispersed from North to South. The Protestant Nordic countries were the forerunners, followed by the western European countries. Supported by social-democratic regimes, which explicitly

intended to provide equal opportunities for all individuals, the spread of ideologies based on democracy, equality and participation developed rapidly with comparatively few structural and cultural restrictions. Major consequences related to this trajectory are the early participation of women in universal education and in the employment sector, openness and tolerance regarding different behaviour (including the acceptance of contraception, abortion and divorce) (Hoffmann-Nowotny and Fux, 2001). Due to this process the status of reproductive health has improved earlier in Nordic countries compared to other European countries.

In the Mediterranean area as well as in eastern Europe, modernisation was hampered either by cultural (e.g. Catholicism, Orthodoxy) or by structural restrictions (e.g. the socioeconomic conditions in the former communist countries). In the central and eastern European countries the propensity of people to marry is much higher and they tend to marry at comparatively earlier ages for traditional reasons. Secondly: the economic conditions in the former socialist countries were comparatively bad. For a comparatively larger segment of women, employment was an economic necessity as well as being normatively expected. The combination of work and family obligations was for women more of a burden than a real matter of choice. (Hoffmann-Nowotny and Fux, 2001.) The population in these countries gained, one or two generations later, an individual freedom to learn how to act responsibly and how to keep oneself safe. This process was hampered by the limitations in the flow of knowledge and by poor sexual health services. The tradition of early marriage was still powerful in inducing early births.

Among the reasons to postpone the engagement to sexual relationship are the higher standards and expectations towards the potential partner. The concept of pure relationship (Giddens, 1992) implies that emotional aspects of the relationship have taken monopoly over the traditional expectations. The young may postpone entering into relationships until they are at least moderately certain to get their expectations fulfilled. Becker's theory about the diminishing gains from marriage highlights the important role of highly educated women in the postponement process. Life comes to be less constrained by traditions and customs and thus more susceptible to individualised action orientations, but it has to be fitted into the standardised and bureaucratised life patterns defined by the state.

In succeeding to improve their sexual and reproductive health individuals need to have resources.

With Cliquet et al (1992), one can differentiate between biological resources such as age and sex, economic resources such as income and assets, sociocultural resources such as educational status, nationality, political/religious affiliation and socio-psychological resources such as socialisation, self-

perception, social integration, or locus of control. In this study focus has been mainly limited to cognitive resources that have been promoted by basic training and specific education in sexual issues.

The results of this study show that higher education has a postponing effect on the initiation of sexual experiences and on getting pregnant. Well-educated women in the upper and middle classes will attempt to benefit from their human capital investments. An increasing number of them will either reject motherhood or postpone fewer births into later life-stages (Hoffmann-Nowotny and Fux, 2001). These women have resources to control their life and to carry out their desires and professional aims.

Missing resources have found to be important determinants of a number of problems in reproductive health. The most important causes of misery have found to be inequality, intolerant attitudes, poor education, and missing sexual health services. Recent studies from Unicef and the Alan Guttmacher Institute show that teenage pregnancy is highest in countries with the greatest social and income inequalities. Poverty and budget cuts for health and social sectors can contribute to untreated STIs and poor health. Lower rates are seen in countries that accept young people have the right to be sexually active, provide good sex and relationship education and easy access to contraception and sexual health services.

Significant antecedents of premarital conception for both sexes are low socioeconomic status, low adolescent social adjustment, and a family environment characterised by family-child arguing, parental divorce or separation, or a family history of non-marital fertility (Russell, 1994). Poor, young women are the least able to plan pregnancies successfully and jointly with their partner.

Eastern Europe and central Asia are the regions of the world with the fastest growing HIV epidemic. HIV trends in these locations generally correlate with recent economic trends. Rapidly declining socioeconomic conditions and increasing inequity bring a sense of despair and hopelessness that is fertile ground for HIV transmission through increased risk behaviour including prostitution and drug use ; a struggling economy and political opposition on harm reduction strategies means few resources for prevention and care (Hamers and Downs, 2003).

The comparison studies have indicated that in a society when and where there was open and liberal policy as well the provision of sexuality education and related services (e.g. family planning), there were lower pregnancy, birth, abortion, and STD rates (Grunseit and Kippax 1997). Even a basic education can be of great improvement. In the developing world each extra year of school for

girls transforms into a reduction of 10% in fertility rates, as well as a decrease in maternal deaths in childbirth (African Development Forum, 2000).

Jones et al (1985) used a thirty-seven country comparison of patterns of adolescent pregnancy to examine the impact of government education policy, financial support for abortion and single parents, religiosity, openness about sexuality, ethnicity, and marriage laws on adolescent pregnancy and sexual activity. Findings from that study indicated that those countries that rated higher on openness about sex were also those that experienced the lowest birth-rates; teaching of birth control in schools was associated with low adolescent fertility; and low birth-rates were associated with low abortion rates. The openness gives a chance to improve individual knowledge and communication skills as well as the motivation to act accordingly.

The spirit of public discussion on sexual issues is more important than the coverage of the issue in the media. Despite the prevalence of sexual imagery in the media, society can adopt a moral and disapproving tone on sexual matters and frown upon open discussion of sex. Young people quickly learn that the subject is taboo. At the same time, society reinforces ingrained gender stereotypes that colour young people's behaviour. One of the consequences is that young women do not take true responsibility over the use of contraceptives.

Factors associated with failure to practice contraception include negative attitudes about methods; increased perceived barriers to method use; perceived low support from partners and peers; low self-efficacy; poor communication skills; involvement in risk behaviour; and, for teenagers, residence in neighbourhoods characterised by poor supervision, inadequate community resources and high levels of behaviours that depart from a conventional lifestyle (e.g. dropping out of school). (Santelli et al., 2003.)

7.2 The role of education and information on reproductive health

The aim of this subchapter is to summarise some findings of this study and other reference information of the role of education and information on reproductive health, and to put them into a more general framework. The theoretical points presented in the first part of this chapter will be applied to these considerations.

Education has many kinds of crucial impacts on values and behaviour patterns at the individual level. Individuals have different opportunities and motivation to educate and train themselves and the quality of education varies according to the economic and human resources and values present in the society. Secular and non-bureaucratic values in economically advanced society give more options to gain a comprehensive education. In such a society tolerant sexual attitudes gain more popularity and individual rights are

respected. In tolerant society more sexually relevant information is available and the government has a higher motivation to invest in sexual and reproductive health services.

Education has many-sided consequences and impacts on individual values and lifestyles. It can change life goals as well as social roles and aspirations. In many cases education may also decrease interest in partnerships and founding a family. The data presented here gives evidence that due to educational aspirations even sexual initiation will often take place at an older age. The highly educated often postpone their sexual initiation and steady relations in order to meet the other aims in their lives. As a consequence, they marry older and they also have their first child later than their peers. In summary, education has frequently impacted on values and lifestyles that in turn have implications on social and sexual interaction. The highly educated have at least moderate means and resources to control their lives. They have also better knowledge and skills to engage in rewarding couple relationships. Educated women are consistently better able to negotiate sexual matters with their partners. Higher education provides tools for improved and satisfied interaction with the partner, as well as resources to avoid sexual health hazards.

In some eastern European countries since the political transition young people have had more freedom but not enough resources, including sexual knowledge, to conduct responsible and enlightened sexual actions. Especially women from disadvantaged backgrounds have problems in gaining access to contraception. As a result, sexual health hazards have increased in eastern European countries. On the other hand, for some teenagers early childbearing may have been a means to acquire status and social identity that they could not have otherwise reached in their society.

Young women with low education have been found to be less motivated to gain more education and their parents are often poorly educated as well. Compared to their counterparts, they have a higher preference to raise a family and less motivation to have an abortion. For them early pregnancy is not considered a risk.

Sexual risk takings can be interpreted as signs of opposition or rebellion to authorities. The school together with its upper-class set of values is ideal for arousing such opposition. As working-class adolescents join the paid labour force earlier than their peers, they become economically more independent, and this independence is manifested in their sexual and other values (Kontula, 1991).

Higher education provides cognitive and attitudinal tools for empowerment and decision-making skills at the individual level. Knowledge on sexual issues helps to prevent pregnancies and to avoid STIs and HIV infections.

Knowledge promotes use of modern contraceptives and provides means to control fertility and postpone early marriages. In the developing world there are on average as many as 2.7 children less if the woman has secondary education compared to other women at the same age. Also in Europe higher school enrolment has usually correlated with a higher prevalence of contraception and with a sharp decline in teenage fertility. There is also some evidence that highly educated young women are more prone to have abortion if they get pregnant.

In most European countries the training of sexual health service providers is not sufficient. This has had implications on the quality of sexual counselling. Counsellors may have provided poor information, for example negative perceptions on contraceptives. This has been the case in the Russian Federation. These perceptions are more based on emotions than knowledge. They have generated distrust on hormonal contraception and labelled them unnatural and hazardous. In eastern Europe knowledge of contraceptive methods and the menstrual cycle has been found to be sketchy - traditional methods are better understood. In addition, when contraceptive provision is irregular and prices high, it is easy to understand why for instance the teenage pregnancy rate is high. In the Russian Federation two-thirds of all the pregnancies have been unwanted. Usually they end up in abortion.

In European surveys educational level and sexual initiation have correlated. Graduates have had their sexual initiation later than early school-leavers. The highly educated have also been found to be more active in using contraceptives. In New Encounter Module (NEM) surveys respondents with a higher level of education, both men and women, have a higher average age at first sexual intercourse. The difference in average ages according to the educational background is even more than two years. The highly educated also have a twice as high incidence in the use of contraceptives for their first sexual intercourse than the less educated.

When the incidence in the use of contraceptives is very low, as for instance in Estonia, even education cannot have much impact on their use. There has to be some infrastructure in sexuality related services first. Without sex education, counselling or family planning services in contraception, and proper provision of contraceptives, basic education is not able to contribute to the actual use of contraceptives.

Highly educated women postpone their pregnancies in all seven surveyed western European countries compared to women with a lower level of education. There were three types of countries. In the first type (France, Norway) the postponing effect on pregnancies was limited only to the age group under 30. In the age group 25-29 the proportion of women with a higher level of education, pregnancies were only a half of that level among lower

educated women. At age 30 and over these differences in pregnancies by educational level disappeared in this first type.

In the second type of country (Italy, Greece, Finland) the postponing effect was still clearly perceivable in the age group 30-34 (Greece, Finland) or in the age group 35-39 (Italy). In the age group 25-29 the proportion of pregnancies among higher educated women was less than half of that observable among less educated women. In Finland almost a half of better-educated women had not yet been pregnant before 35. In Greece and Italy the motivation to have a child in lifetime was among highly educated women roughly 10 percentage points lower (80-95% vs. 90-95%) than among less educated women.

In the third type of country (Spain, Switzerland) educational background seemed to make a permanent difference in the decision to have a child. Firstly, the postponing effect was much bigger in the age group 25-29. The proportion of pregnancies among highly educated women was almost only a quarter compared to the figures among lower educated women. By the numbers one could predict that around 30% of highly educated women in Spain and Switzerland would never have a child in their lifetime. Among lower educated women this proportion was only around 10%. Not surprisingly, highly educated women were more career oriented than other women who, on the contrary, were more family oriented.

Education can shape individual life style in crucial ways. Those who go to secondary school and later to university identify with adult patterns of behaviour less early, as they clearly experience a prolonged teenage role because of their position in the institution and their material dependence. Besides, preoccupation with exams and one's academic career may generate, in some students, an ascetic attitude in which sexual desire, as an element of self-construction, is inhibited. Conversely, there is no obstacle to social maturation, adult identification and sexual initiation for those who escape school discipline early and enter the labour market (Bozon and Kontula, 1998).

For the period of young adulthood, the expansion of the educational system is most important, as it obliges young people to follow standardised forms of education for increasingly longer periods of time. As a result, institutionalisation of young adulthood can be expected to lead both to a postponement of exit from the educational system and to a standardisation of the whole process of entry into adulthood, as young adults adapt their behaviour to the exigencies of modern life (Liefbroer and Dykstra, 2003).

There is also the effect of social norms, which generate the incompatibility between the youth role of being a student, and the adult role implied by marital status. Such sequencing norms concern the incompatibility of educational and marital or cohabitation roles. It has been shown that once an individual

enters a union, he or she is exposed to a higher risk of leaving school, and that such effects are stronger for women than for men (Coppola, 2003).

Education is considered a youth role, while marriage is associated with an adult role. Marriage prior to the completion of formal education generally violates the common sequencing norms. If a union is formed before marriage, partners will feel, in particular, the pressure of social norms reflecting the incompatibility between full time educational enrolment and union formation. Although the increased investments in human capital represent a means of establishing their economic position, it also means that women perceive a high cost in the form of having to spend their time on household intensive activities such as child rearing (Coppola, 2003).

In adulthood highly educated persons with high resources can take sexual risks. In the European surveys highly educated women more often had several sexual partners in the last year than less educated women. A high number of sexual partners have also been found among educated men (Kontula and Haavio-Mannila, 1995). This finding can be related to values that educated people have adopted in their childhood and during their education. In a study of job values (Halaby, 2003) the respondents who were advantaged with respect to family background, schooling, cognitive ability, and gender expressed a preference for entrepreneurial as opposed to bureaucratic job properties. These actors pursued a high-return, high-risk strategy. In other words, they had a high risk preference. This risk preference can be applied also in sexual interactions.

In preventing sexual health hazards there is a need for specific sex education, sexual counselling and training for professionals who work in the sexology field. There is a high need for theoretical tools to succeed with these aims. Some existing educational programmes have been evaluated with the aim to define the best practice in sexual health promotion.

Kirby et al (1994) identified the use of Bandura's social cognitive theory in the intervention design as one of the factors, which distinguished between successful and unsuccessful curricula. Based on this cognitive approach the Society of Obstetricians and Gynaecologists of Canada working group committees applied the well-validated health behaviour change theory as a basis for constructing its sexual and reproductive health promotion website. The theory includes the Information-Motivation-Behavioural Skills (IMB) model (Fisher and Fisher, 1993) of health behaviour change (Barak and Fisher, 2003).

According to the IMB model, sexual and reproductive health information, motivation to act on this information, and behavioural skills for acting on it effectively, are fundamental determinants of the performance of sexual and reproductive health promoting behaviours. To the extent that the individual

is well informed, well motivated, and possesses relevant behavioural skills, he or she is expected to initiate and maintain patterns of reproductive health promotion behaviour. To the extent that the individual is ill informed, unmotivated, and lacks necessary behavioural skills, he or she is expected to engage in sexual and reproductive health risk behaviours and in consequence to experience negative health outcomes. The IMB model specifies that sexual and reproductive health information and motivation work primarily through behavioural skills to influence sexual and reproductive health related behaviours (Barak and Fisher, 2003).

Sex education is the most important tool to promote reproductive health among teenagers in Europe. General attitudes on sexual issues have very crucial implications on the ways in which sex education is carried out in each society. In societies where sexual issues are limited only to the private sphere, sex education is often opposed with the argument that it may seduce young persons to be sexually active too young. Based on several reviews of the behavioural impacts of sex education this argument is unfounded. On the contrary, sex education can have many kind of positive implications on reproductive health.

Of forty-seven studies that evaluated interventions, twenty-five reported that HIV/Aids and sexuality education neither increased nor decreased sexual activity and attendant rates of pregnancy and STDs. Seventeen reported that HIV and/or sexuality education delayed the onset of sexual activity, reduced the number of sexual partners, or reduced unplanned pregnancy and STD rates. Only three studies found increases in sexual behaviour associated with sexuality education (Grunseit and Kippax, 1997).

The review by UNAIDS of over fifty studies has shown that sexual health programmes do not encourage sexual experimentation, that they can help to delay the age of first intercourse and, among adolescents who are sexually active, to reduce the instance of sexually transmitted diseases (UNAIDS 2000).

It has been found in many studies that broad-based programmes which involve the whole community and which take into consideration both sex education and health services for the young are efficient in promoting the sexual health of young people (Orton 1994 ; Vincent et al. 1985). Co-operation among the sectors of a community tends to increase the availability and efficiency of services. In the state of North Carolina in the United States a community-level intervention programme aimed at decreasing teen pregnancies in the 1980s significantly reduced the number of teen pregnancies in the target area. The opposite development occurred in the control area. (Vincent et al., 1985). Participants in the programme included school authorities, congregations, and parents. The aim of this programme was to develop

decision-making and interaction skills, to promote the self-esteem of the young, and to increase information about human reproduction and prevention of pregnancies (Liinamo, 2000).

7.3 Case studies in Bulgaria, Finland, the Russian Federation and the United Kingdom

Here is a short summary of the main findings from the case studies conducted in Bulgaria, Finland, the Russian Federation and the United Kingdom. Some conclusions on reproductive health issues will follow after the summaries.

In Bulgaria there is still much need to improve reproductive health. Especially the very high teenage birth rate (47 per thousand) could be much lower. This rate is the highest in Europe after Turkey. Also teenage abortions are very common: two to three times more prevalent than for example in Finland. Among adult women the abortion rate (42 per thousand) is five times higher in Bulgaria than in Finland. On the other hand, Bulgaria still has a very low incidence of HIV infections. In 2002, there were only forty-three new infections with the rate of 5.5 per million. This is even lower than in Finland. At the same time, there are steady increases in the incidence of syphilis and gonorrhoea that have reached epidemic thresholds in certain parts of the country.

The high birth rate among teenagers is mostly due to non-use of contraceptives. In some studies the incidence of use of modern contraceptives has been only 25%. In practice, abortion has been applied as a contraceptive method. Soviet tradition has still some implication on this low incidence. Another important explanation is the high cost of modern contraceptives. Thanks to the Bulgarian Family Planning Association (BFPA) modern contraceptives with 10% of the market price have been made available. However, there should be more large-scale subventions in contraceptive prices in order to prevent a higher proportion of unwanted pregnancies in Bulgaria.

Bulgarians are working hard to try to improve their reproductive health. The government has adopted a National Health Strategy and Action Plan and a National Strategy and Programme on HIV/Aids and Sexually Transmitted Diseases (STDs). Recently the National Reproductive Health Programme was drafted. Bulgaria aims to improve sexual and reproductive health by focusing on programmes for adolescents and women, and improving the quality of service provision.

There are already thirty family planning information centres and professional training in sexology has started. In 2004 sex education will be a mandatory subject in schools. This education should be more comprehensive than some medically stressed education programmes that have focused mainly on the female reproductive system. Sex education and reproductive health services

are difficult to improve in a society where it is still almost taboo to discuss of sexual issues. There is a high need to overcome myths and fears that relate to condoms. Real improvements will take place only after attitudes on sexuality among the general population will be more tolerant and open on sexual issues. There is a high need for public discussion and focused public information campaigns on sexual issues and sexual health.

In Finland the sexual and reproductive health situation has been good in a European perspective. The rates in teenage pregnancies and abortions are among the lowest in Europe. Only Belgium, Netherlands, Spain, Italy and Germany have significantly lower teenage pregnancy rates. The abortion rate for adult women is very low : 8.8 per thousand. It is among the lowest in Europe. Syphilis and gonorrhoea rates are also low and HIV infections are not common. In 2002, there was 130 new HIV infection with the rate of 25.1 per million. There are lower HIV rates only in the central European countries where IV-drugs have not yet become popular.

A considerably good reproductive health situation is due to a high incidence of use of contraceptives in Finland. In the long run condoms have been more popular than in any other European country. In previous studies only around 10% of the population has not used modern contraceptives during their most recent intercourse. This level of use is true also among teenagers.

There have been numerous actions to improve sexual and reproductive health in Finland. In public health care, family planning has already been available for over thirty years. Health care personnel and teachers have been trained in sexology. They have had a high interest in attending the training. The Ministry of Social Affairs and Health has organised and financed a variety of projects with the aim of improving sexual health. There have been local family planning programmes and fertility festivals. All teenagers and their parents have received via mail a sexual health leaflet and sex education has been provided to every man in the army and even in confirmation schools. School nurses have had a key position in providing useful knowledge and contraceptives to each new generation. This has guaranteed the flow of information of sexual issues to adolescents.

All these efforts have been feasible thanks to favourable public attitudes and opinions on sexual issues. The media has also been active in educating the grown up population to take better care of their sexual health. One implication of these favourable public opinions is that teachers do not have a moral standpoint on sex education. Their most important aim in sex education is to teach responsibility in sexual interaction, give factual information on sexual issues and to teach how adolescents could apply a natural attitude to sex. Sexual health leaflets, fertility festivals and a sexual health quiz have proved to be effective in promoting sexual and reproductive health.

In the Russian Federation abortions, though decreasing in incidence, continue to be a major reproductive policy issue. Together with Romania, the Russian abortion rate is highest (52 per thousand) in Europe and also in the whole world. According to some estimates there are thirteen abortions to ten births. Abortion has been claimed to represent personal freedom in a society that is highly controlled. Abortion has kept its popularity even though it costs 25-50% of the average monthly income.

The teenage pregnancy rate is also very high (77 per thousand). This rate and the high abortion rate are explained by the low rate of modern contraception. There are contradictory results and statistics on contraceptives but on average, every second adult has used modern contraceptives. Contraceptives have been labelled to be unnatural, immoral, harmful and expensive. They have been opposed also because they lead to decline in the birth rate and give too much sexual freedom to women. Due to the unpopularity of condoms (prejudices against them) STI rates have been continuously on the increase. At the same time, the IV-drug epidemic has caused the highest rates in HIV infections in Europe after Estonia. The HIV infection rate is ten times higher than in western Europe. Among teenagers HIV infection rate is even 100 times higher in the Russian Federation than in western European countries. Fortunately, there was some decrease in HIV rate in 2002. The Russian Federation should focus more on a harm reduction policy with free needle exchange activities.

The government's major concern has been negative population growth. Legislation on reproductive rights was discussed in the State Duma in 1997, but it was rejected due to political sensitivities based on religious grounds and pronatalist concerns. Measures being taken to improve the health care system for pregnant women and children have been hampered by a deteriorating socioeconomic situation (Country Profiles..., 2003).

Knowledge on sexual issues is very low in the Russian Federation according to several studies. Among teenagers even basic principles in reproduction and contraceptives are unknown to a high number of them. In some regions only half the teenagers know about pregnancy and safe sex and a fifth about STIs. There is no official sex education. The RFPA has produced sex education manuals and has distributed them to a number of regions. In some surveys a fifth of school children report that they have received some sex education. In the general population three-quarters support the idea of sex education but due to strong and powerful lobbying groups against sex education (church, former communists, some journalists etc.) this opinion has not been implemented.

In the Russian Federation there are 500 State Family Planning Centres and the RFPA has opened around fifty regional branches and youth centres to promote sexual and reproductive health. However, training in sexual issues is

almost completely missing among professionals in the health and social sector and contraceptive counselling is very insufficient. There are serious prejudices against condoms and oral contraceptives have been labelled harmful. Sexual counselling should be provided in health clinics but the staffs have not got any training to do so. This is the case also among the teachers who should carry out sex education in school. General policies emphasise control instead of harm reduction. One of the consequences has been a high risk of IV-drug use, including high rates of HIV infections. Without open public discussion on sexual issues and reproductive health, steps to improvement in reproductive health will be unfortunately very slow.

In the United Kingdom teenage birth and pregnancy rates have been the highest in western Europe. The teenage birth rate is 29 per thousand. This is almost as high as in the Russian Federation. Three-quarters of teenage pregnancies have been unplanned. The abortion rate is 16.7 per thousand, that is twice more than in Finland. The teenagers abortion rate is 18.6 per thousand. Abortion rates in the UK are half of that in eastern Europe.

STIs and HIV infections have increased heavily in the UK in recent years. Syphilis, gonorrhoea and chlamydia have been in continuous increase. In 2002, there were 6 025 new HIV infections, a rate of 101.0 per million. This rate is four times higher than in Finland. The number of teenage HIV infections was seventy-four in 2001. The UK HIV infection rate is the second highest after Portugal in western Europe and the rate has doubled in three years.

Reproductive health is poor in the UK even though many national and local programmes have been implemented to decrease teenage pregnancies and STIs and HIV infections. This may sound surprising because according to some surveys the proportion of adults who use modern contraceptives should be as high as 71% and among teenagers use of contraceptives has progressed very well. Contraceptive advice and often also supplies are free. Among the young generation the popularity of condoms has increased. During the first sexual intercourse around 75% had then used condoms (Wellings et al., 2001).

A Teenage Pregnancy Strategy has been formulated. It was implemented in 1999. One of the aims of the strategy is to halve conceptions in the under 18s by 2010. The strategy is aiming to provide knowledge to teenagers via sex education in schools (sexual and relationship guidance for schools) as well as via national media campaigns. The strategy also offers support to teenage parents. They recommend and promote local teenage pregnancy strategies. One aim is to provide more sexual health services for teens. At the same time, The Sexual Health and HIV Strategy is promoting safe sex in England. After these efforts, teenage pregnancies have had a 9% decrease in the last three years.

Keeping in mind these valuable efforts, what might explain the high teen pregnancy rate and increasing figures in STIs and HIV infections? There is no unanimous answer to this question. However, several assumptions can be made. The basic one is an intolerant public sexual culture in the UK. The society is divided into opposing groups that cannot agree how to promote sexual and reproductive health among the population. The government has taken a rather positive stand on reproductive health issues but it has to keep in mind the opposition that has very intolerant attitudes on sexual issues. There is strong opposition for example on abortion, sex education, and sexual health services for teens. Keeping this in mind, the government has given parents the right to take their children out of the mandatory sex education in school (that has strong moral connotations) and they have also the right to decide if their pregnant teenage girl is allowed to have an abortion. This means that there is lack of confidentiality in the services. For example, in Finland a teenage girl has a right for confidential reproductive health services.

While contradictory opinions exist in the UK open public discussion on sexuality is very difficult and individuals, including teenagers, are reserved when talking about sex. There has been a lack of information about contraceptive usage and embarrassment to discuss sex and contraception with the partner. This has unfortunate implications on sexual interaction from the viewpoint of sexual risk taking. According to the studies, 60% of teenagers use sexual health services only after their sexual intercourse, not before. Teachers have not had training in sex education and the education has concentrated mainly on biological aspects of sexuality. In secondary schools STIs and HIV infection have also been taught.

An additional explanatory point is that in the UK among the working class the young have low motivation to continue their education, they tend to leave school early. This creates a high number of teenage parents with low education and low income. Girls from the poorest backgrounds are ten times more likely to become teenage mothers than girls from professional backgrounds (Governmental Response..., 2002). In this group sexual risks are exceptionally prevalent in the UK. The proportion of 20 to 24-year-old women who gave birth under 20 in the low education category was, in the 1990s, almost twice higher in the UK (37%) than in among women with similar education in Sweden and France (Singh et al., 2001).

In summary, the case studies provided useful information which increases understanding of how health promotion via education and information can make a difference to reproductive health in different societies. Basically, all four countries represent very different cases in reproductive health even though the Russian Federation and Bulgaria have a lot in common. Activities

in education, including sex education, and in the provision of information on sexual issues vary very much from country to country.

The state of art in reproductive health was best in Finland. Thanks to a high incidence in the use of modern contraceptives (90%) the rates of abortions, teenage pregnancies and STIs and HIV infections were low. In the UK modern contraceptives were also advantaged (70%) but the aforementioned rates were several times higher than in Finland. In the Russian Federation the rate of use of modern contraceptives was around 50% and in Bulgaria only 25%. Not surprisingly, these low rates had serious implications on reproductive health. In both countries abortion and teenage pregnancy rates were very high and in the Russian Federation the rates of STIs and HIV infections were even at a record level.

All countries had conducted national efforts to improve reproductive health. The outcome of these activities was unsatisfactory when there was no public support to promote sexual and reproductive health. When the sexual issues were labelled taboo in the society and when there were major interest groups lobbying against reproductive health programmes and contraceptives, the existing programmes usually failed to make any real difference to the national and regional reproductive health. This was highly marked in the Russian Federation and to a somewhat lesser extent also in Bulgaria and the UK. Favourable and tolerant public attitudes on sexual issues in Finland have been found to have a very important impact on professional motivation and qualifications in the treatment of sexual issues and disorders in social and health care. Promotion of tolerant public opinion on sexuality is the first and perhaps also the most important activity to be carried out in order to be successful in the promotion of reproductive health. Tolerant public sexual attitudes also generate a very favourable climate for the promotion of comprehensive sex education, both nationally and locally.

Another crucial component in the promotion of reproductive health was the training of the people who have a professional interest in sexual issues and sexology. This training was very well advanced in Finland, and thanks to the Teenage Pregnancy Strategy, it was also improving promisingly in the UK. There had been some training activities also in Bulgaria and the Russian Federation, but basically, in both countries the professional motivation and expertise was still very low in reproductive health issues. They were dependent on foreign aid for professional training and for the provision of contraceptives. Unrealistic myths and fears of contraceptives still prevailed and a lot of necessary information was missing. As a consequence, especially the population with a lower economic and social status faced a lot of sexual risks and reproductive health disorders. These consequences could be prevented by

the systematic sexual and social policies that promote reproductive health and give rise to the use of modern contraceptives.

7.4 Policies and programmes to promote reproductive health

Reproductive health is a sub-concept of sexual health. Sexual health includes the ability to enjoy mutually fulfilling sexual relationships, freedom from sexual abuse, coercion, or harassment; safety from sexually transmitted diseases; and success in achieving or preventing pregnancy. Reproductive health puts attention on family planning and on the health implications of pregnancies. Reproductive health care includes methods, techniques, and services that contribute to reproductive health. In parallel with the IPPF European Network's values the aim of reproductive health is to promote the right to make free, informed and responsible choices regarding one's reproductive and sexual life. This includes the right to sexual and reproductive health services.

Promotion of reproductive health is a multilevel approach that has to be carried out both at the society, community and individual level. Everybody needs good knowledge of sexual issues and skills to behave accordingly with the aim to minimise or to prevent completely the risks of unwanted pregnancies or risks of getting STIs and HIV infections. Proper use of contraceptives and responsible behaviour will allow a satisfying sex life without risk and fears.

The status of reproductive health varies a lot in different European countries. This is why every country has to formulate their policy for reproductive health promotion according to their specific situation and suiting their resources for this preventive work. Some countries need for example to build up the infrastructure for their sexual health services, others need only to make some improvements in it. What each European country has in common is the need to provide a new generation with proper knowledge and information on sexual and reproductive health issues. Without knowledge there is nothing to build on.

There are different requirements in order to carry out this task. In some countries adolescents have quite good knowledge without sex education in schools thanks to media and other information sources that are easily available. In other countries these sources are missing and adolescents need very comprehensive education from their schools. And this knowledge is not enough. Sex education needs to provide adolescents also with the motivation to behave responsibly and the skills as to how to succeed in preventing the risks. In order to be successful, this message needs to be delivered to the whole population via media advertising campaigns and with the help of communication via the Internet, leaflets, billboards etc. Together with proper resources (including provision of contraceptives, and knowledge where,

when and from whom to acquire them) sexual and reproductive health can be successfully promoted.

Some eastern European countries have a marked need to build up programmes and policies to promote reproductive health in their society. After the political, economical and demographic transition in their countries there has also been a social movement towards a new kind of social behaviour pattern. This includes more sexual relationships in youth and without engagement to the partners. In other words, the non-married population is sexually more active than it used to be before. At the same time, this generation has not been educated on sexual issues and contraceptive services and provision have not been organised properly. This creates a number of problems for the inhabitants in these countries.

Kovács (1999) has listed concerns in reproductive health issues in the eastern European region. These include the lack of common definitions and adequate statistical data ; the lack of training of professionals ; deficiencies in knowledge about current family planning methods among professionals, consumers, policy makers and media representatives ; the lack of the modern contraceptive supplies needed to meet the needs of the populations of the participating countries ; the lack of sex education in schools ; the elevated maternal mortality ; the high level of induced abortions ; the high prevalence of infertility ; and the lack of ability to prevent, diagnose and treat sexually transmitted diseases. In the following section most of these points will be dealt with in more detail.

Work for improvement of sexual and reproductive health and rights can be successful only in the society that has openness and social tolerance on sexual issues. There is a great deal of evidence from research that "cultural openness", where sex is discussed in an open and accepting manner rather than being ambivalent, or the way in which young people's sexuality and sexual behaviour is socially represented and communicated, has a considerable impact on the effectiveness of local and national interventions.

In a society without openness in sexual issues government is less motivated to provide resources for sexual health services, personnel in charge for those services have a lower motivation to improve their expertise in sexology, teachers are less willing to provide sex education to their students (and also to educate themselves), teenagers are less willing to raise questions of sexual issues, partners will communicate less for example on precautions and their preferences in their sexual interactions etc. The openness in public discussion of sexual issues will crucially help sexual and reproductive health promotion at all societal levels. For instance, it can promote a more positive attitude towards condom use and an increased familiarity with condoms. It can also

balance and correct the information that has maintained mistrust and misinformation about modern contraceptive methods.

Although the school system, other public authorities, and various organisations do a lot of work to improve sexological knowledge, and attitudes and skills of the population, a large part of sex education and sexual health promotion occurs through the media. The media disseminates the latest sexological information, news from that field, and provides a public forum for discussion of the sexual topics. It also creates societal standards for approved or proper sexual activity. The media is one of the most important factors in determining peoples' views of the meanings of sexuality. Therefore, it is justifiable to consider the media as a significant societal institution affecting sexual health (Kontula, 2000).

Each country needs an action plan on how to promote reproductive health. This plan can be in the form of a strategy or programme including both resources allocated to sexual health services as well as an action plan for distributing and advertising information that will help to prevent unwanted pregnancies and other sexual health hazards. This is wise policy also from the viewpoint of a state budget. In the UK the Faculty of Family Planning and Reproductive Health has calculated in 1999 that an average investment of £80 per year to provide contraception to a teenager under eighteen, will result in a direct saving on abortion or maternity costs to the health budget of £750 for each pregnancy prevented.

There is a serious need for sexual health prevention campaigns and related services in Europe. In the United States it is common for effective programmes to use multiple approaches (for example skills development, community outreach, contraceptive access, contraceptive education, life option enhancement, self esteem and sexuality/STI/HIV/Aids education), and to use several methods of delivery, including group discussions, lectures, role-playing, videos, peers as educators and involvement of parents.

Often sexual health programmes focus on youth. Some aspects of young people's behaviour can be successfully addressed by risk-reduction interventions, which seek to improve knowledge, and to provide support to develop the skills that are needed to use this knowledge within relationships and in social situations. Policies can be divided in terms of community interventions, educational interventions and health service interventions.

The aim of youth development programmes is to tackle the education and life options of young people, school performance, belief in the future and general risk-taking behaviour and they can, for example, equip young women in particular with the communication skills to negotiate on sexual intercourse and contraception, and with motivation to delay early intercourse

and childbearing. At the family and community level, they address "nonsexual risk factors" - poverty, social disorganisation and isolation. These have been effective in reducing the actual rates of teenage pregnancy and childbearing.

Moreau-Gruet et al (1996) suggest that prevention programmes should emphasise, among boys, responsibility in contraception and the need for protection in situations of multiple partners, and among girls, a positive attitude towards condom use and an increased familiarity with condoms presented both in a perspective of contraception and prevention of STDs. The girls of a lower educational status should receive particular attention. They have a high teenage pregnancy rate.

The aims should not only be to prevent conception, through improved sex education and sexual-health services, but also to ensure that pregnant teenagers and teenage mothers complete their education and, if they are under 18, are not housed in isolated and unsupported accommodation. As part of a national campaign, parents should be encouraged to talk with their children about sex, and young men should be encouraged to be more responsible in their sexual behaviour.

The UK Health Development Agency argues that it is now widely recognised that teenage pregnancy and early motherhood can be associated with poor educational achievement, poor physical and mental health, social isolation, poverty and related factors. It is also increasingly clear that socioeconomic disadvantage can be both a cause and a consequence of teenage parenthood.

Fighting against poverty and promotion of basic education would create more favourable conditions to prevent teenage pregnancies and teenage STIs and HIV infections. The information presented in this report strongly supports this argument. Teenagers need also more anonymous sexual health services at low cost. Distribution of free or low cost contraceptives would decrease sexual health hazards. Prevention of STIs and HIV infections would require more social marketing of condoms with a low price or free. It is also important to improve the training of medical staff so they can provide better services to young people.

The health care system has responsibility in providing the population information, knowledge and counselling on sexual issues. This can be carried out in collaboration with the social system. The health system must make up for the limitations of sex education at school (DiCenso et al., 2002). Among the features of the health system, it must be stressed that staff training is essential, since normative attitudes can discourage young people from having any inclination for contraception (Durand et al., 2002).

The quality of services is as important as their availability. Youth may delay seeking services because they have inadequate or incorrect information regarding the location of services and their eligibility for care, they are not planning to have intercourse or they have easy access to condoms. Other reasons are embarrassment, concern that parents may be informed, lack of anticipation of when intercourse will occur and indifference to becoming pregnant.

Studies with young people have identified the features of a trusted and accessible service. These include an age specific focus, confidentiality, non-judgmental staff, accessible locations and opening hours, a friendly atmosphere and publicity in places where young people meet. To be effective, contraception and advice services for young people should be commissioned and provided against these criteria.

In the eastern region of Europe, HIV epidemics have been developing through injecting drug use for over five years and have spread progressively throughout the region. HIV prevention among injecting drug users should therefore be the cornerstone of regional and national prevention strategies. Although harm reduction programmes have been set up in several countries, their coverage (10% of injecting drug users had been in contact with needle exchange programmes by 2000) remains too low to significantly affect the evolution of the epidemic (Hamers and Downs, 2003). Harm reduction policies should be promoted also in the EU and Council of Europe.

In her report to the European Parliament on sexual and reproductive health and rights Van Lancker (2002) emphasises that countries should ensure the provision of unbiased, scientific and clearly understandable information and counselling on sexual and reproductive health, including the prevention of unwanted pregnancies and the risks involved in unsafe abortions carried out under unsuitable conditions. Advice and counselling must be confidential and non-judgmental.

All interventions on sex education, including school-based programmes, should aim to empower young people, promoting sexual self-acceptance and a positive and open view of sex and sexuality with young people and service staff working with them (Teenage pregnancy..., 2003). Young people need practical information that will enable them to take responsibility for their own health and to share responsibility for other people's health.

The information campaigns can apply many kinds of distribution techniques and apparatuses. Among the mass media, television is the most popular method for reaching young people overall. It is often watched with the family, so it would be inappropriate for messages aimed solely at young people.

Rather, a better use would be in helping to bridge the communication gap between parents and children.

Magazines are useful for rational arguments and detailed information, particularly for girls, because they tend to be consumed privately. Radio is particularly effective at delivering single item information, e.g. a helpline telephone number. As radio tends to be used as a background medium, a memorable jingle or slogan is useful in helping the message to cut through. Newspapers are useful for local sexual health services ads if they are correctly placed (Teenage Pregnancy..., 2000).

Increasing numbers of young people are accessing the Internet. This is a useful medium for providing detailed and up-to-date information, and it could give young people the chance to e-mail questions to experts or exchange information with each other about their experiences. Good sexual health web sites for young people already exist (Teenage Pregnancy..., 2000).

Leaflets are widely criticised by young people as being "official", dull, clinical, and too wordy and a chore to read. Other printed information, such as posters, booklets, postcards and credit-card-sized cards (for key information such as helpline numbers) can be helpful if placed in schools and colleges, cafés, pubs, clubs, shopping centres, leisure centres and other places where young people wait. Locations must be "safe", i.e. where young people can look without being noticed, so either totally private, such as the back of a toilet door, or totally public, such as a shopping centre (Teenage Pregnancy..., 2000).

In Europe a first priority in promoting sexual and reproductive health is to encourage and fund high-quality sexuality and life skills education nationwide from the earliest ages. Teachers and health care providers must be given the knowledge and the skills to communicate comfortably about sexual and reproductive health with young people (Greene et al, 2002). High quality sex and relationship education, begun early, tailored to young people's needs, linked to sexual health services and well delivered by trained staff remains of vital importance in enabling young people to make informed choices about their sexual health. Through education, young people learn negotiation and decision-making skills that they can apply to prevent unwanted sexual relationships, protect themselves from exploitation and violence, and negotiate condom use when sexually active.

Researchers have found that important factors determining the positive impact of sex education are, among others, clarity of goals, consideration of the age and cultural background of the pupils, the grounding of teaching in theoretical approaches, an adequate amount of time, versatile teaching methods and well-prepared teachers (Wight et al. 1998 ; Kirby and Coyle 1997).

The provision of sexuality education in the schools, which has increased in many countries (as part of societal efforts to counter the epidemic of HIV and Aids), is likely to have made a cumulative contribution to the improved knowledge of contraception, the ability to negotiate contraceptive use and the effectiveness of contraceptive use among adolescents (Singh and Darroch, 2000). The provision of sex education should be linked to access to contraceptive services ; for example, health service staff (school nurses) could lead sex education sessions given in schools to provide a 'bridge' into services. School nurses can be very effective in promoting sexual health.

Sexuality education must be considered in a holistic and positive way paying attention to psycho-social as well as bio-medical aspects and based on mutual respect and responsibility. The teaching in sexual education should be a collaborative effort among school personnel, community youth workers, reproductive health clinicians, parents, and communities.

There is overwhelming evidence to show that young people are especially sensitive to the way in which they are addressed, particularly by authority figures. They strongly reject communication they perceive as patronising, authoritarian or not addressed to them as equals. This includes sources which they perceive to be treating them as children, that try to be like them or that tell them what to do or to believe. The sources they respect treat them as equals, take the trouble to find out what their needs are and empathize with them, and then provide the necessary information to help them decide for themselves (Teenage Pregnancy..., 2000).

According to international literature good sex education should increase pupils' understanding of sexuality, support the sexual development of the pupil and promote a broad understanding of sexuality and factors related to sexual health. A precondition for this is that sexuality and sexual development are discussed in a broad way in sex education. Pupils ought to receive sex education at a time when they can profit from it and thus receive the relevant information before each phase of sexual development. Sex education should aim at supporting and improving the knowledge of the young and a broader understanding of sexuality, as well as increasing discussion and social skills.

To make these programmes and educational efforts truly effective and sustainable requires monitoring and evaluation. Research on prevention should be designed and conducted to inform the developments of the programmes and the policies. The issues that emerge as these programmes and policies are implemented, in turn, will raise questions that promote further research, which ultimately will inform the next generation of programmes and policies. Stamenkova and Georgieva, (2003) propose that the impact of the programme could be monitored with the decreased number of abortions, with the level of information of the young people in country, and with the fact

that young people start breaking the taboos and speaking about their own sexuality and perceiving it not only as a pleasure, but also as a responsibility.

The Council of European Union Development Ministers adopted, on 20 May 2003, a new regulation on "Aid for Policies and Actions on Reproductive and Sexual Health and Rights in Developing Countries" (Hindmarsh, 2003). The new regulation will ensure that 73.95 million of the EU development budget is allocated to reproductive health between 2003 and 2006. The Community new policy explicitly refers to the ICPD goal as the mandate for all reproductive health actors. The aim is to "make accessible, through the primary health care system, reproductive health care to all individuals of appropriate ages as soon as possible and no later than the year 2015." This international aim is a necessary and valid goal also for European countries. The target could be no later than the year 2008.

7.5 Summary of the key factors to improve reproductive health in Europe

1. National reproductive health strategies, empowering young people
2. A build up of the sound sexual health infrastructure
3. An increase in school enrolment and motivation to education especially among young women living in poverty
4. Realistic options for young women to gain social status, other than teenage motherhood
5. Favourable values and social norms in sexual issues in society ; open and liberal sexual policy ; sexual tolerance
6. Training of reproductive health service providers
7. Adequate dissemination of sexual information through a range of channels ; basic education is not enough
8. Awareness and knowledge of the unwanted pregnancies and sexually transmitted infections and HIV infections
9. Decreasing distrust and increasing trust and knowledge on modern contraceptives
10. The provision of comprehensive sex education that is linked to access to contraceptive services

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The author

Dr Osmo Kontula is a senior researcher at the Population Research Institute, Family Federation of Finland

Address :
Population Research Institute, P.O. Box 849, FIN-00101 Helsinki
Tel. +358-9-22805123
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