SEXUAL AND REPRODUCTIVE HEALTH & RIGHTS SEXUAL AND REPRODUCTIVE HEALTH & RIGHTS

A GUIDE FOR DEVELOPING POLICIES ON THE

SEXUAL AND REPRODUCTIVE HEALTH & RIGHTS OF YOUNG PEOPLE IN EUROPE

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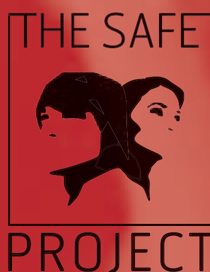

The SAFE Project

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The 26 IPPF EN Member Associations involved in the SAFE project:

Österreichische Gesellschaft für Familienplanung (ÖGF), Austria — Fédération Laïque de Centres de Planning Familial (FLCPF), Belgium — SENSOA, Belgium — Bulgarian Family Planning and Sexual Health Association (BFPA), Bulgaria — Family Planning Association of Cyprus (FPAC), Cyprus — Spolecnost pro plánování rodiny a sexuální výchovu (SPRSV), Czech Republic — Sex og Samfund, Denmark — Estonian Sexual Health Association (ESTL), Estonia — Väestöliitto, Finland — Mouvement Français pour le Planning Familial (MFPF), France — pro familia Bundesverband, Germany — Family Planning Association of Greece (FPAG), Greece — Magyar Család- és Novédelmi Tudományos Társaság, Hungary — Frædslusamtök um kynlíf og barneignir (FKB), Iceland — Irish Family Planning Association (IFPA), Ireland — Unione Italiana dei Centri di Educazione Matrimoniale e Prematrimoniale (UICEMP), Italy — Latvijas Gimenes Planošanas un Seksualas Veselibas Asociacija "Papardes Zieds" (LAFPSH), Latvia — Šeimos Planavimo ir Seksualines Sveikatos Asociacija (FPSHA), Lithuania — Mouvement Luxembourgeois pour le Planning Familial et l'Education Sexuelle (MLPFES), Luxembourg — Rutgers Nisso Group (RNG), Netherlands — Norsk forening for seksualitet, samliv og reproduktiv helse (NSSR), Norway — Towarzystwo Rozwoju Rodziny (TRR), Poland — Associação Para o Planeamento da Família (APF), Portugal — Slovak Family Planning Association (SSPRVR), Slovak Republic — Federación de Planificación Familiar de España (FPFE), Spain — Riksförbundet för Sexuell Upplysning (RFSU), Sweden — UK Family Planning Association (UKFPA), United Kingdom

IPPF European Network

IPPF is a global service provider and an advocate of sexual and reproductive health and rights for all; a worldwide movement of national organizations working with and for communities and individuals. The IPPF European Network is one of IPPF's six regions and promotes support for and access to sexual and reproductive health services and rights in 41 member associations throughout Europe and Central Asia.

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Table of Contents

PREFACE . . . 3

ACKNOWLEDGEMENTS . . . 4
ABBREVIATIONS . . . 5

INTRODUCTION . . . 7

POLICY AREA 1: Information, education and communication . . . 15
POLICY AREA 2: Health services . . . 23
POLICY AREA 3: Access to contraception . . . 31
POLICY AREA 4: Sexually transmitted infections (STIs) and HIV/AIDS . . . 39
POLICY AREA 5: Unwanted pregnancy and safe abortion. . . . 47

GLOSSARY . . . 55
REFERENCES . . . 61

Preface

This guide was created to inspire and assist policymakers and governments in the creation and/or improvement of policies and programmes that respond successfully to the sexual and reproductive health and rights (SRHR) of young people.[1] It identifies the main challenges to young people's sexual health and development and provides guidance based on evidence and good practice.

This publication is part of 'The SAFE Project: A European partnership to promote the sexual and reproductive health and rights of young people' and is funded under the European Commission's Health Strategy. The SAFE project is a collaborative effort between the International Planned Parenthood Federation (IPPF) European Network Regional Office and 26 of its Member Associations, together with Lund University and the World Health Organization (WHO) Regional Office for Europe. IPPF European Network is the lead implementing agency for this three-year project, which started in 2005 and aims to develop new and innovative ways to reach young people with SRHR information and services, and to inform, support and advance policy development.

The guide complements the WHO 'European Strategy for Child and Adolescent Health and Development'.[2] While the WHO strategy focuses on all elements of child and adolescent health and development, this guide focuses on SRHR, outlining the key aspects of young people's SRHR, identifying the main challenges to young people's sexual health and development, and providing guidance on good practice. It is divided into three broad sections: the introduction addresses the status of young people's SRHR, the role of the policy environment and the need for clear and coherent policies on young people's SRHR. This is followed by five chapters that outline key policy areas for the SRHR of young people. Each of these chapters provides a discussion of the policy area and a checklist for action by national and/or regional governments and other relevant agencies.

The guide was initially developed by the project partners, taking into consideration evidence from research, European and international guidelines, field experience and recognized good practice. It subsequently went through a series of consultations involving young people and representatives of ministries of health, DG Sanco and civil society organizations. The final document takes into consideration the feedback and suggestions provided by all these stakeholders.

The authors acknowledge that the recommendations in this guide aim to create an ideal policy environment for young people's SRHR, but that policy development actually takes place within a restricted environment that is affected by various factors, including existing legal and constitutional frameworks, limited financial resources, political constraints, priorities and timelines. We urge all policymakers and advocates to approach the policy process with a basic understanding: that supporting young people is of critical importance, and responding to their very specific needs – especially with regard to fundamental issues like sexual and reproductive health – can help us to build healthier societies and a better quality of life for all.

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1 The World Health Organization (WHO) defines young people as all people between 10 and 24 years of age, youth as those aged between 15 and 24 years, and adolescents as those aged between 10 and 19 years.

2 WHO Regional Office for Europe (2005) European strategy for child and adolescent health and development, Copenhagen: WHO Regional Office for Europe, 19 pp. www.euro.who.int/document/E87710.pdf

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We would like to commend the constructive but critical way the representatives of the governments have dealt with the challenging topics contained in the document. We hope that this final document will meet their expectations and that they will be willing to take ownership and promote and use the document with colleagues and ministers.

The guide could not have been undertaken, let alone completed, without the input and support of the 26 IPPF EN Member Associations that were involved in the SAFE project: these are non-governmental organizations working at the national level to endure that the sexual and reproductive health and rights of women, men and young people are met with adequate programmes, policies and resources.

We are particularly grateful to Duarte Vilar from APF in Portugal, Elisabeth Pracht from ÖGF in Austria, Niall Behan from IFPA in Ireland, and Bjarne Christensen from Sex og Samfund in Denmark for their feedback and suggestions. Also several members of the IPPF EN youth network, YSAFE, have provided their input, in particular Ruth Ennis.

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Further, there are the numerous participants of the several regional consultations which were organized during the drafting of this guide and whose input has led to the creation of an important document for the development of policies on the sexual and reproductive health of young people. Also the expert colleagues from IPPF Central Office have given their input, and we would like to thank Marcel Vekemans, Kevin Osborne and Upeka de Silva.

A special thanks goes to Daði Einarsson from DG Sanco who had the responsibility for our project and did this with great conviction, in a very supportive way and with a great deal of input. In this way the relationship with the donor was lifted to a true partnership.

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Vicky Claeys
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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Violence Against Women
ICESCR	International Covenant on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
ECP	Emergency Contraceptive Pill
HBSC	Health Behaviour in School-aged Children
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
ICPD	International Conference on Population and Development
IEC	Information, education and communication
IPPF EN	International Planned Parenthood Federation European Network
IUD	Intra-uterine device
MDG	Millennium Development Goal
NGO	Non-governmental organization
SAFE	Sexual Awareness for Europe
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary counselling and testing
WHO	World Health Organization

Introduction

Young people are a country's future, so it is in the interest of policymakers to ensure that young people can become healthy and active citizens. It is also a responsibility of policymakers to ensure that young people have the support they need to make informed choices about a wide range of issues, including their sexual and reproductive health. The way young people approach and express their sexuality and relationships – and the sexual and reproductive health choices they make today – can have a major impact on the future direction of their lives.

At present, there are few comparative data on the sexual and reproductive health and rights (SRHR) of young people in Europe, as recently demonstrated by research at Lund University.[1] However, we know from national research that the prevalence of STIs is increasing in many countries and that the quality of sexuality education is still not satisfactory. There is a need to address SRHR issues and to promote the healthy development of young people through information and services that are appropriate, affordable, accessible, and integrated into a sustainable and comprehensive response to their needs.

Comprehensive sexuality education and information is crucial for making sound choices and for dispelling myths and sexual stereotypes. It is also essential for preventing sexism, discrimination against people who are lesbian, gay, bisexual, transgender or living with HIV, for preventing behaviours that lead to gender-based violence, and increasing protection against sexual abuse and sexual violence. Access to youth-friendly health services is key to protecting young people from unwanted pregnancies, STIs and subsequent risks of infertility. The denial of the right to information, services, privacy and confidentiality significantly increases a young person's vulnerability to sexual and reproductive ill health. Furthermore, it deprives the young person of an essential framework to develop a positive self-image and important life skills to build healthy relationships and families based on respect and responsibility.

Vulnerability of young people

The research conducted under the SAFE project indicates that it is not just the most-at-risk groups (e.g. injecting drug users, school dropouts, ethnic minorities, young people living on the street) that suffer from poor sexual and reproductive health, but also less vulnerable young people attending school who are denied sexuality education, lack access to contraception, and are generally not provided with the life skills education to manage their sexuality and interpersonal relationships in a safe and positive manner.

Young people today face increasing pressures regarding sex and sexuality, including conflicting messages and norms. On the one hand, sexuality is portrayed in many instances (e.g. some sexuality education, health information data and messages) as negative and associated with guilt, fear and disease; and on the other, it is portrayed as positive and desirable by peers and is overemphasized and sometimes distorted in the media. Such pressures may be exacerbated by exposure to misleading or inaccurate information, a lack of skills and awareness of young people's rights, and by gender expectations. Whether sexually active or not, young people should feel comfortable with their bodies, sexuality and identity. They should also be able to protect themselves and feel protected by their environment.

The role of policy in supporting SRHR for young people

Policy has an impact on young people's abilities to access the information and services they need to make informed choices, as well as the means to act upon those choices. And policy is crucial in upholding young people's basic rights, which include:

1 IPPF EN (2007) Sex and young people in Europe: a research report of the sexual awareness for Europe partnership, Lund University, Sweden

• the right to comprehensive sexual and reproductive health information, education and services;
• the right to participate as active citizens and to express their views;
• the right to have pleasure and confidence in their sexuality and relationships; and
• the right to make their own choices without exploitation, oppression, or physical or emotional harm.

These rights are embodied in international treaties, agreements and conventions, including the Programme of Action of the International Conference on Population and Development (ICPD); the Convention on the Elimination of All Forms of Violence Against Women (CEDAW); the Convention on the Rights of the Child (CRC); the International Covenant on Economic, Social and Cultural Rights (ICESCR); and the World Health Organization (WHO) Global and European Regional Strategy on Sexual and Reproductive Health.[2] Furthermore, a rights-based approach to young people's SRHR is the basis of the Council of Europe Assembly Resolution 1399 (2004)[1] on a European strategy for the promotion of SRHR[3] and the European Parliament Resolution on Sexual and Reproductive Health and Rights (2001/2128 (INI) which was adopted following MEP Anne Van Lanker's Report on Sexual and Reproductive Health and Rights (June 2002), A50223/2002.[4]

At present, policies that help to protect the SRHR of young people do not always successfully meet their needs and are not always consistent within and among European countries.

The authors recognize that responsibility for the development and implementation of legislation, strategies and programmes concerning health is not solely the duty of ministries of health. These powers might lie with the central or federal government, the provinces or the local municipality – jointly, separately or even independently. Therefore, this guide provides information that can be of use to policymakers at all of these levels.

Components of a successful youth-friendly SRHR policy

A youth-friendly SRHR policy respects diverse values held by a wide range of groups; provides age-appropriate information that addresses the realities of young people's lives; supports young people to make healthy choices and decisions and to respect themselves and others; and supports enjoyment and

2 Key actions for the further implementation of the ICPD Programme of Action, 57. Other international agreements have called for prevention of unwanted pregnancies and for reproductive health and family planning services that respond to women s needs: The United Nations Fourth World Conference on Women Platform for Action, 83(1), 93, 99, 106(c,e,i,k,g), 122; ICPD Programme of Action, 7.14(b), 7.38, 7.41, 7.44(1), 8.12, 8.25; World Summit on Social Development, Declaration Commitments 2(b), 5(d), Programme 7, 36(b, h), 37(d), 39(e), 70, 73(c), (b); Convention on the Elimination of All Forms of Violence against Women 12, 14.2(b).

3 [1]. Assembly debate on 5 October 2004 (27th Sitting) (see Doc. 10266, report of the Social, Health and Family Affairs Committee, rapporteur: Ms McCafferty http://assembly.coe.int/Main.asp?link=http://assembly.coe.int/Documents/WorkingDocs/doc04/EDOC10266.htm; and Doc. 10310, opinion of the Committee on Equal Opportunities for Women and Men, rapporteur: Ms Zapfl-Helbling http://assembly.coe.int/Main.asp?link=http://assembly.coe.int/Documents/WorkingDocs/doc04/EDOC10310.htm). Text adopted by the Assembly on 5 October 2004 (27th Sitting).

4 See: www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+REPORT+A5-2002-0223+0+DOC+WORD+V0//EN&language=EN

pleasure, taking the perspective that sexuality is a positive force and not something to fear. Any policy development or area of legislation should also take into account and integrate a number of essential cross-cutting issues and principles related to young people's SRHR. These issues are as follows:

Gender focus

The social roles of women and men are shaped during childhood and adolescence by the social environment in which girls and boys grow up and develop. SRHR policies and programmes can play a vital role in this process, by encouraging positive attitudes regarding sexuality and gender roles, by promoting dialogue and open communication between boys and girls, and by challenging stereotypes.

In many societies and communities in Europe double standards and values still prevail regarding the sexuality of boys and girls, their freedom to make decisions in relation to family and children, and their role in society. These double standards have a major impact on the sexual and reproductive lives of all people, not only in terms of fertility and disease, but also through practices such as gender-based violence and abusive behaviour.

Boys and girls have some similar needs which can be met by a single policy or programme, but policymakers and programmers must make allowances for the fact that boys and girls also have a variety of different needs and risks. In particular, girls are generally at greater risk than boys when it comes to sexual and reproductive health. Women, especially young women, are biologically more vulnerable than men to diseases related to the reproductive system. And while both sexes are at risk of sexual abuse and exploitation, the risk for girls is greater.

On another level, studies from the UK indicate that boys report that sexuality education in schools focuses on negative aspects of sex, or on female reproduction.[5] [6] They also report a perception that they are unwelcome when asking for sexual and reproductive health services, or that they fear a lack of confidentiality.[7] Furthermore, boys and young men are subject to a higher psychological stress in relation to their 'sexual performance' that can lead to sexual disorders such as premature ejaculation, impotence, anxiety and depression, as well as unsafe behaviour such as alcohol, drug use and bullying.

Gender also appears to be an important factor in determining sexual behaviour. Recent research in Sweden shows that preventing pregnancy is perceived by young males as a 'girls' issue'.[8] The fact that young men in Europe appear less inclined to use contraception while girls still have a problem in negotiating the use of contraceptives is disturbing. It must be addressed in sexuality education and through individual counselling to promote better sexual health for adolescents as well as equal responsibility among boys and girls.

Policies and programmes must, therefore, be developed in consideration of gender differences. For example, the issue of trafficking for sexual

5 Hilton, GLS (2001) Sex Education the issues when working with boys, Sex Education Vol. 1 No. 1, 2001, pp. 31-41 www.hawaii.edu/hivandaids/Sex%20Education%20%20%20%20The%20Issues%20When%20Working%20with%20Boys.pdf

6 UK Youth Parliament (2000) Sex and Relationships Education Are you getting it? London: Department for Education and Employment http://www.ukyouthparliament.org.uk/campaigns/sre/AreYouGettingIt.pdf

7 Hilton, GLS (2001) Sex Education the issues when working with boys, Sex Education Vol. 1 No. 1, 2001, pp. 31-41 www.hawaii.edu/hivandaids/Sex%20Education%20%20%20%20The%20Issues%20When%20Working%20with%20Boys.pdf

8 Ekstrand, M, Larsson, M, Von Essen, L and Tyden, T (2005) Swedish teenager perceptions of teenager pregnancy, abortion, sexual behaviour and contraceptive habits A focus group study among 17-year-old female high school students, Acta Obstetricia et Gynecologica Scandinavica 2005; 84:980 6 and published in European Journal of Contraception and Reproductive Health Care June 2007; 12(2):111-118

exploitation is a major SRHR challenge in Europe. While boys are affected, it is girls who are disproportionately targeted for trafficking. A gender approach recognizes the different needs of boys and girls with regard to trafficking and can lead to the development of policies that support both boys and girls who are affected. Policies should also take a gender perspective when addressing the SRHR of young people from vulnerable groups. For example, teenage mothers require special healthcare and social services (e.g. child care) to enable them to continue their education and prepare themselves for their roles as active adult citizens and responsible parents, to ensure the development of healthy families.

Diversity and vulnerability

Young people come from a broad range of social, economic, ethnic and cultural backgrounds and may have different sexual identities. In most countries the age of first intercourse, the rate of teenage pregnancy and the prevalence of STIs are subject to considerable variation among different groups. It is important to recognize this diversity when developing policies.

Some young people are particularly vulnerable because they are marginalized or have special needs. These include:

- out-of-school youth;
- street children;
- young people with disabilities or special needs;
- orphans and young people living in residential institutions;
- ethnic minorities;
- young people living with HIV;
- migrants;
- refugees and asylum seekers;
- injecting drug users;
- sex workers and their clients;
- young people who are at risk of being or who have been trafficked;
- young people who have been sexually abused;
- girl children and girls who have been victims of female genital mutilation; and
- young people who are lesbian, gay, bisexual or transgender.

Flexible and creative approaches are needed to reach such groups. The most effective policies and programmes take young people's particular circumstances and experiences into account – as well as the different settings and environments in which they live – and adapt to their needs. They should be sensitive to religious and cultural beliefs and values, while always promoting a model based on human rights and gender equality.

Participation of young people

All too often, policymakers – and adults in general – do not have a very clear picture of the reality of young people's lives and the development of their sexual identities. Attitudes, values and behaviours are changing rapidly, and there can be considerable differences between generations. To ensure that policies are successful in reaching their targets, it is important to enable young people to participate in and influence policy development that affects them. Their participation will help to ensure that SRHR policies and programmes meet their real needs and aspirations. Therefore, policymakers are urged to call on youth councils or to create special youth advisory panels on SRHR to enable young people to be actively involved.

Protection policies for young people

Young people have the right to physical, psychological and social protection, particularly those with special needs or who are most at risk. All young people must be protected so that they are able to develop and evolve in society as citizens with full rights and consideration, without being denied or penalized for their sexuality.

Protection policies for children and young people need to be developed and put in place as a mandatory requirement in all institutions, facilities and locations that receive young people, particularly youth detention centres, reception centres for unaccompanied minors and children with disabilities, religious centres, and orphanages. Staff in these facilities should be trained to apply these policies and made fully aware of the procedure to follow should a problem or case of non-compliance occur.

Multi-sector support

Young people in Europe today face very different challenges compared to their predecessors of just 50 years ago. They are influenced by potentially conflicting and rapidly changing value systems. From their perspective, there are no boundaries between 'sectors' such as health, school and sports, and, therefore, those who wish to provide support, protection and guidance for young people need to employ holistic strategies involving multiple elements and actors.

The SRHR of young people is not purely a health issue, nor only the responsibility of health workers: the education, youth and sports sectors also have roles to play in supporting the healthy maturation of young people and preparing them to be active citizens and to make healthy choices. The legal and judicial systems must provide an adequate legal framework for young people's SRHR that is protective, non-oppressive and supportive.

Ministries of labour or employment and of the interior and social affairs also have important roles to play, as the possibility of employment – which provides a safety net against poverty, abuse or homelessness – is paramount for a safe passage into adulthood. Similarly, public immigration/refugee authorities are very important, since immigrants and asylum seekers are often vulnerable to ill health. Very often the all-important SRHR dimension is neglected in the training of staff working for these ministries and agencies, as well as in the programmes themselves.

It is suggested that a national strategy be developed by the respective ministries to ensure multi-sectoral collaboration including at the sub-national level by the corresponding, publicly-funded structures.

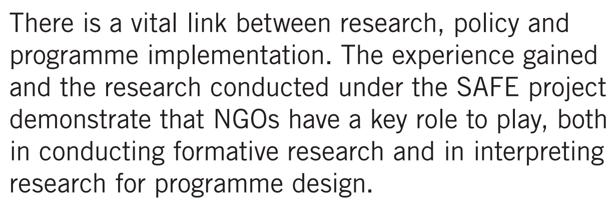
Ultimately, both in strategy and in implementation, it should be recognized that public authorities cannot do all of this alone. Involving non-governmental organizations (NGOs) and community-based groups in both the national strategy development and its local implementation is essential to ensuring success.

Effective monitoring and evaluation systems

Sound policies are founded on a robust base of evidence and draw on good practice. Similarly, up-to-date data and practical tools are essential to monitor the implementation and impact of policies. The research conducted under the SAFE project confirms that there is a clear lack of data on the SRHR of young people in Europe, particularly comparative data.[9] The data that do exist are often not age-disaggregated, which makes them difficult to use on a programme level. The same research also indicates that programmes are very often developed without an evidence base, most often due to the lack of formative research at the national level.

Collaboration with European initiatives and the national teams that collect data for the Health Behaviour in School-aged Children (HBSC) study is essential. All countries should improve their data collection, making sure that they are comparable with the data of other countries. A European template might be a useful tool for improving this situation.

9 IPPF EN (2007) Sex and young people in Europe: a research report of the sexual awareness for Europe partnership, Lund University, Sweden



There is a vital link between research, policy and programme implementation. The experience gained and the research conducted under the SAFE project demonstrate that NGOs have a key role to play, both in conducting formative research and in interpreting research for programme design.

Guidelines for creating youth-friendly policy

The cross-cutting issues and principles outlined in this chapter provide a brief overview of the components of youth-friendly SRHR policy. These issues are also addressed in the following chapters, which provide specific guidelines for creating SRHR policy for young people in five key policy areas. Each chapter provides a checklist for action by national and/or regional governments and other relevant agencies. While the issues covered are not exhaustive, they do address policy and programme areas that appear to have the greatest impact on young people's SRHR and on their abilities to make informed decisions and to protect their own health. Policymakers and programmers can use the information in the following five chapters to assess the effectiveness of existing policies and programmes, to advocate for improvement of existing legislation, or to develop new policies and programmes that are more responsive to young people's needs.

POLICY AREA 1:

Information, education and communication

Young people's right to information and education is embodied in several international treaties and conventions, and includes sexuality education. This right is documented in several international agreements such as the Convention on the Elimination of All Forms of Violence Against Women (CEDAW), the Convention on the Rights of the Child (CRC), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the ICPD Programme of Action.

While young people have a right to good sexuality education, it is also essential for helping them to prepare for healthy and fulfilling lives. High-quality information and comprehensive sexuality education can equip them with the knowledge, skills and attitudes they need to make informed choices now and in the future; enhance their independence and self-esteem; and help them to experience their sexuality and relationships as positive and pleasurable. For policymakers, teachers, parents and others, it is vital to recognize that young people are sexual beings who want to feel comfortable about their bodies and their sexuality – physically, intellectually, socially and emotionally. And young people who have experienced open communication with parents or a caring adult – such as a teacher or counsellor – are better prepared to communicate honestly and openly about sexuality, emotions and fears, and are less likely to engage in risky behaviour.

Young people receive conflicting messages on sex and sexuality: these are often negative and associated with guilt, fear and disease, yet the media and young people's peers generally portray them as positive and desirable. The effect these messages have on young people depends on their knowledge and skills, their awareness of their rights and responsibilities, and on gender expectations.

Providing young people with high-quality information and education on sexuality can give them the necessary skills for decoding mixed messages and underlying assumptions, which can in turn help to reduce discrimination, stigma and violence, including intimate partner and family abuse, by dispelling myths and sexual stereotypes.

The link between alcohol, drugs, and risky sexual behaviour[10] among young people is often ignored in young people's SRHR programmes and could lead to a crisis in sexual health. Research in Spain[11] and Sweden[12] confirms that risky sexual behaviour is more frequent among young people who regularly consume alcohol on weekends. In the United States, many studies have demonstrated that adolescents are more likely to engage in high-risk behaviours, such as unprotected sex, when they are under the influence of drugs or alcohol.[13] The US National Center for Chronic Disease Prevention and Health Promotion points out the consequences of underage drinking and the link with adolescent sexual health.[14] Young people who drink alcohol are more likely to experience unwanted, unplanned, and unprotected sexual activity; a disruption of normal growth and sexual development; physical and sexual assault; and a higher risk for suicide and homicide. Many parents who say they talk with their children about alcohol

10 Research on this topic can be found on the website: www.cspinet.org/booze/natlsurveys.htm

11 Castilla, J, Barrio, G, Belza, MJ and de Fuente, J (1999) Drug and alcohol consumption and sexual risk behaviour among young adults: results from a national survey, Drug and Alcohol Dependency 1999; 56:47-53

12 Ekstrand, M, Larsson, M, Von Essen, L and Tyden, T (2005) Swedish teenager perceptions of teenager pregnancy, abortion, sexual behaviour and contraceptive habits A focus group study among 17-year-old female high school students, Acta Obstetricia et Gynecologica Scandinavica 2005; 84:980-6 and published in European Journal of Contraception and Reproductive Health Care June 2007; 12(2):111-118

13 Leigh, B and Stall, R (1993) Substance use and risky sexual behavior for exposure to HIV: issues in methodology, interpretation, and prevention, American Psychologist 1993; 48:1035-1043

14 US National Center for Chronic Disease Prevention and Health Promotion www.cdc.gov/HealthyYouth/sexualbehaviors/index.htm

focus only on drinking and driving.[15]

There is a need to educate and train parents, teachers, and health and social workers on the dangers of alcohol for SRHR, because:

- teenagers who report drinking alcohol on at least one occasion are seven times more likely to have had sexual intercourse than non-drinkers;
- binge drinkers, like those who have used drugs, are three times more likely to have contracted an STI than non-binge drinkers and non-drug users;
- alcohol is more closely linked to sexual violence than any other drug and is a common companion to rape, including date rape; alcohol use, by the victim, the perpetrator or both, is implicated in 46 to 75 per cent of date rapes of college students.[16]

Parents should be the primary source of information about sexuality for young people, but very often parents do not feel comfortable or equipped to do this. Therefore, there is a strong need to provide training for parents, but also to ensure that all young people obtain the same basic information, both in schools and through out-of-school programmes.

Policymakers and programmers should also be aware of the major role and impact of the media on young people's views of sexuality and on their sexual health. On a daily basis young people are confronted with advertisements, soap operas, reality television, video games, websites and pornography, which deliver explicit and often covert sexual messages, both negative and positive. There is not much known about the impact of these messages on young people’s thinking and awareness of sexuality, but the influence is undeniable.

Moreover, providing information and education to young people on sexuality and SRHR is often highly controversial. Many complaints stem from false ideas that providing information and education will expose young people to inappropriate ideas, that it is not effective, and that it encourages young people to become sexually active and to engage in risky behaviour. However, research has frequently demonstrated the opposite to be true. There is now strong international evidence that sexuality education does not promote either early or increased sexual activity. In fact, in many cases it has been found that sexuality education leads to either a delay in the onset of sexual activity or to decreases in overall sexual activity.[17] Furthermore, among those who are sexually active, it has been found that sexuality education tends to lead to the adoption of safer sexual practices, such as the effective use of contraceptives.[18]

Sexuality education provides one of the few opportunities young people have for an open discussion on gender equality and gender roles in society. And sexuality education programmes are a crucial element of any strategy that aims to improve equality for all and to enhance intercultural dialogue among young people.

15 The Psychiatry Faculty at Harvard Medical School confirmed a worrying trend: many parents choose to avoid the issue for a variety of reasons. Sometimes they fear pushing their child away; sometimes it is denial. See quotes in the information posted on the website of advocates for youth: www.advocatesforyouth.org/parents/experts/blake.htm

16 The National Center on Addiction and Substance Abuse at Columbia University (1999) Dangerous Liaisons: Substance Abuse and Sex, New York: Columbia University

17 Collins, C, Alagiri, P and Summers, T (2002) Abstinence only vs. comprehensive sex education: What are the arguments? What is the evidence? San Francisco: AIDS Research Institute, University of California

18 IPPF EN (2006) Sexuality Education In Europe: A Reference Guide to Policies and Practices, Brussels: IPPF EN www.ippfen.org/NR/rdonlyres/7DDD1FA1-6BE4-415D-B3C2-87694F37CD50/0/sexed.pdf

KEY POLICY AREAS: **Information, Education and Communication (IEC)**

Encouraging participation
All too often the reality of young people's lives and the development of their sexual identities are little- or misunderstood. Young people should be able to participate in and influence programme development. Their participation will help to ensure that sexuality education programmes meet their real needs and aspirations.

Recommendation: *governments and service providers should put mechanisms in place that guarantee the active participation of young people in all policy and programme development.*

Supporting parents and families
Many parents find it extremely hard to raise and discuss sexual issues with their own children and do not have the information and knowledge to do so in a meaningful way. The UK FPA has developed the Speakeasy programme, supported by the UK government, as a highly successful model to train parents on sexual and reproductive health and safe sex messaging.

Recommendation: *consider training of parents in discussing sexuality with their children, and stimulate good communication between parents and teachers on this issue.*

Providing sexuality education in schools
School-based sexuality education is an important and effective way of enhancing young people's knowledge, attitudes and behaviour. It can either add to the education that young people receive from their families or make sure that those young people who have not received information and education at home are supported. Sexuality and sexual and reproductive health are part of life and, as such, should be included in a school curriculum. Government involvement is essential – given the taboos that have been associated with sexuality, it is not an easy task to carry out, and, if left to individual schools to decide, some may refuse to teach the subject, or otherwise the content may be excessively medicalized or shaped by individual religious views and therefore inappropriate.

Recommendation: *ensure that comprehensive sexuality education is a mandatory subject both for primary and secondary schools, with clearly set minimum standards and teaching objectives, and that the necessary resources and materials are provided for young people. The implementation of sexuality education should be monitored and evaluated.*

Reaching young people in a variety of settings
Policymakers need to consider ways to reach young people both in and out of school, in formal and informal settings. There are many opportunities for delivering information and education on sexuality in addition to formal classroom and health service settings. These could include waiting areas and youth clubs, during vocational training courses, at cinemas and campsites, at rock festivals and clubs, through community drama, and media events. New technologies, including CD-ROMs, mobile phones and the internet, also offer new ways to reach young people. Information needs to be accessible to everyone who needs it, when they need it.

Recommendation: *ensure that information and education on sexuality and SRHR is available in a wide variety of settings, accessible to young people both in and out of school.*

Offering developmental and age-appropriate information
Human sexuality is natural and an integral part of every human being from the moment of conception. As such, learning about sexuality is a life-long process, with messages about sexuality communicated either directly or indirectly through social interactions and experiences. It is important

that this informal learning process be supported by more formal education, which provides learning opportunities as individuals grow. Information and education on sexuality should, therefore, be made available to children and young people of all ages, although it is essential that programmes are adapted according to the age and stage of development of the specific target group. For example, sexuality education for young children could focus on aspects of their sexuality (e.g. feelings, roles and body image) that are relevant to their development.

Recommendation: *ensure that children and young people of all ages have access to age-appropriate information and education on sexuality in accordance with their evolving capacities.*

Reaching young people from diverse populations and groups

Young people represent a very diverse population, and it is important to recognize this diversity when developing policies to provide information and education on sexuality and sexual and reproductive health. The most effective programmes take account of young people's particular circumstances and experiences, and adapt to the needs of the group they are working with. Factors such as gender, social class, ethnicity, religion and sexual orientation should be taken into consideration as well as the special needs of physically and mentally challenged young people.

Information and education on sexuality needs to be provided in a culturally sensitive manner. In some cultures there can be prevailing taboos against the open discussion of sexuality, and it can seem a difficult task. However, in each cultural setting providers must try to introduce sexuality education in a way that will be acceptable and that is tailored to a culture's needs and values while emphasizing gender equality and rights.

Recommendation: *ensure that sexuality education programmes take into account the diversity of different groups and can be tailor-made for each group depending on their needs and abilities while emphasizing gender equality and rights.*

Reaching vulnerable young people

Special efforts need to be made to provide information and education to vulnerable and marginalized groups, such as those who drop out of school, street children, young people living with HIV, men who have sex with men, young people who are at risk of being trafficked, those subject to female genital mutilation, and ethnic minorities. Flexible and creative approaches are needed to reach these populations.

Recommendation: *take specific action to identify and reach vulnerable groups.*

Covering a comprehensive range of topics

Information and education on sexuality should not be restricted to the biological aspects of sex and reproduction. Rather, it should cover both biological and sociological perspectives – some of the most relevant topics are relationships, diversity, sexual orientation, abortion, masturbation, gender, pornography, and violence, in addition to the more traditional topics such as anatomy, puberty, reproduction and sexually transmitted infections (STIs). Ideally, the provision of information and education should take place in a broader framework that considers other related areas, such as alcohol and drug use.

Recommendation: *ensure that sexuality education and information is provided in a comprehensive manner that covers a broad range of topics relating to the physical and biological as well as the emotional and social aspects of sexuality, and the broader area of avoiding risk behaviour such as alcohol and drug use.*

Developing life skills and nurturing positive attitudes and values

Information in itself is not enough to change or maintain behaviour patterns. Young people also need to be given the opportunity to acquire essential life skills and develop positive attitudes and values. Life skills should, for example, cover critical thinking, decision-making, negotiation and communication. Fostering positive attitudes and values, such as open-mindedness, respect for oneself and others, and a sense of responsibility, should also form the basis for sexuality education. Programmes have proven to be more effective if sexuality is approached in a positive way, rather than focusing exclusively on the undesirable aspects of sexuality, such as STIs and unwanted pregnancy.

Recommendation: *ensure the availability of sexuality education that helps young people acquire the skills to negotiate relationships and safer sexual practices, including whether and when to engage in sexual intercourse, parenthood, and where to find help if needed.*

Engaging a variety of providers

In addition to teachers and parents, a wide range of people can be involved in providing information and education on sexuality. These could include health professionals, peer educators, youth recreation leaders, sociologists and psychologists, as well as those who specialize in teaching the subject.

Recommendation: *acknowledge and support the role of parents, peers and professionals in providing information and education on sexuality and SRHR.*

Training, supporting and supervising providers

Those who deliver information and education on sexuality need the necessary information, skills and attitudes to do so effectively. Training and skills development are as crucial in sexuality as in other subject areas and should cover facts, methods and personal reflection. Providers must be supported to ensure that they have an open and non-judgemental approach to young people's sexuality.

Recommendation: *ensure that those who deliver information and education on sexuality receive adequate training, ongoing support and supervision, and access to appropriate resources (including financial) and materials. Include sexuality education in the curriculum of teachers.*

Using active, participatory methods

Didactic methods are still commonly used to teach about sexuality and SRHR. However, methods that encourage participation in learning are more effective and are preferred by children and young people. Active methods include small-group work to explore scenarios and dilemmas, value clarification exercises, drama and role play, writing songs or poems, discussions and debates. Providers should be given the opportunity to practise new teaching methods during their training.

Recommendation: *ensure that a wide variety of teaching methods are used in providing information and education on sexuality to young people.*

Ensuring the quality of education

The quality of the sexuality education provided needs to be ensured. Tools such as standards, protocols, guidelines and checklists can be used for this purpose. Programmes should also be designed to include an assessment of learning and an evaluation of effectiveness.

Recommendation: *develop mechanisms to ensure the quality of sexuality education, including data collection and monitoring and evaluation of educational tools and methodologies.*

Ensuring links to other services

The provision of high-quality information and education on sexuality needs to have strong links to appropriate services. These could either be general sexual and reproductive health services (e.g. access

to contraception, STI/HIV testing and counselling) or more specialist services (e.g. those that could deal with cases of sexual violence). It is essential to ensure that effective referral systems are in place to ensure that young people have easy access to these types of services and related resources, if and when they need them.

Recommendation: *ensure that information and education on sexuality is linked to services and that the quality of the services is checked on a regular basis.*

Undertaking public information campaigns
Repeated initiatives are more effective than one-off measures. As young people get older, they need to have new opportunities to discuss new ideas and perspectives on sexuality, and to apply their experiences.

Recommendation: *ensure that sexuality is seen as an integral part of health promotion campaigns which should be organized on a regular basis to be effective.*

Establishing multi-agency partnerships
The choice of government ministry responsible for the provision of information and education on sexuality reflects the approach taken. Ideally, given the strong links between education and health in this matter, an inter-ministerial group would be set up to include both the ministries of health and education, as well as any other relevant ministries. This group should have a legal status and clear objectives. Civil society actors and youth representatives should also be included in the group.

Recommendation: *ensure a multi-agency approach to the development of policies and programmes, including the setting up of a multi-agency working group (including civil society and young people) to develop policies and programmes for the provision of information and education on sexuality to young people.*

Setting up protection policies
Issues relating to child protection might be disclosed during the provision of information and education on sexuality to young people. It is essential that protection policies and procedures are put in place, and that providers are fully aware of them. For example, a provider should know what to do if s/he suspects that a young person is being sexually abused.

Recommendation: *put in place referral systems and procedures.*

POLICY AREA 2:

Health services

In recent decades, research shows that both boys and girls are entering puberty earlier and, for some, sexual debut is occurring at a younger age.[19] [20] For example, research on the sexual behaviour of Spanish adolescents under the age of 20 indicates that the age at which first intercourse takes place has gradually fallen and is now around 16.[21] Research also shows that in the Nordic countries approximately 60 percent of 17-year-olds have experienced sexual intercourse.[22] A study on Norwegian adolescents gives similar findings indicating that the average age at first sexual intercourse is 16.[23] In addition to earlier sexual debut, changing social attitudes and family patterns, and the pervasiveness of sexual messages and images in the media and other cultural outlets, may negatively influence young people's behaviour, exposing them to the risks of STIs and unintended pregnancy at an earlier age. All of these factors point to a growing need for SRHR services specifically for young people, since there is strong evidence that as young people reach puberty and adolescence they will at some point need sexual and reproductive health services and that healthy behaviour must be established at a young age.

19 WHO (2003) Very Young Adolescence: The hidden people, Geneva: WHO www.who.int/child-adolescent-health/New_Publications/NEWS/NEWS_20/Participants_background.pdf

20 Fontes, M and Roach, P (2007) Predictors and confounders of unprotected sex: A UK web-based study, The European Journal of Contraception and Reproductive Health Care 2007; 11(4):36-45

21 Castilla, J, Barrio, G, Belza, MJ and de Fuente, J (1999) Drug and alcohol consumption and sexual risk behaviour among young adults: results from a national survey, Drug and Alcohol Dependency 1999; 56:47-53

22 Thorsen, C, Aneblom, G and Geemzell-Danielsson, K (2006) Perceptions of contraception, non-protection and induced abortion among a sample of urban Swedish teenage girls: Focus group discussions, The European Journal of Contraception and Reproductive Health Care. 2006; 11(4):302-309

23 Traeen, B and Samuelsen, S (2007) Sweet 16 and never been kissed? Experiences from a longitudinal Norwegian study, Electronic Journal of Human Sexuality 2007; 10 (April) www.ejhs.org/volume10/sexual_debut_ages.htm

Young people face many barriers to using sexual and reproductive health services, including:

- a lack of information on where and how to access them;
- restricted hours of services, especially for young people who are in school;
- the cost of the services;
- negative attitudes of service providers; and
- laws and policies that may restrict their access.

Some young people are more systematically vulnerable to sexual health threats than others, and for them, the barriers to services are magnified. Those who are particularly vulnerable include those who:

- have left school at an early age;
- are homeless;
- use alcohol and/or drugs (particularly injecting drugs);
- sell sex;
- are, or have been, sexually abused;
- are young migrants and refugees;
- are gay, lesbian, bisexual or transgender; or
- have mental or physical disabilities.

Another major barrier for young people who need to access sexual and reproductive health services is their fear of their parents' reaction should they discover that their adolescent son or daughter is sexually active. This makes confidentiality a key principle in the provision of services to young people. This issue is also closely linked with the stigma that can be associated with sexual activity, particularly when seeking services related to STIs, pregnancy testing or even contraception. Young men are particularly reluctant to seek reproductive health services, often fearing that they are unwelcome or that their information will not be kept confidential.

Youth-friendly services are those that effectively attract young people, respond to their needs, and retain young clients for continuing care. Youth-friendly services provide sexual and reproductive

health services based on a comprehensive understanding of what young people in a given society/community want. They are based on an understanding of and respect for the realities of young people's diverse sexual and reproductive lives. Careful consideration needs to be given to identify which populations of young people are being reached, which are not, and why. The aim is to provide all young people with services they trust and which they feel are intended for them.

Another area for attention is the way in which youth-friendly services are organized. Different models are currently being evaluated, ranging from adapting existing services to be more youth friendly to the establishment of integrated health (and other) services directed only at young people. The latter may mean a different vision and potentially new funding mechanisms, but could lead to a highly effective system over the long term.

The suggestions for creating better sexual and reproductive health services policy for young people could potentially be the most complicated for governments and other policymakers – any action in this area will have links with the general health and health insurance systems, which are often complex and heavily burdened. However, given the importance of young people's SRHR for the health and future of any country, it is essential to look anew at how to synchronize people's needs with existing health systems.

KEY POLICY AREAS: **Health services**

Encouraging participation

Key to the design of youth-friendly services is the involvement of young stakeholders in determining the factors that best relate to their needs. Young people themselves are best placed to articulate their needs and state their issues, as well as to provide feedback on the extent to which these are addressed. Young people should be consulted on how, where and when services should be provided, and mechanisms integrated into service systems to involve young clients in assessing the quality and effectiveness of those services. Young people and service providers should be provided with tools to facilitate participation.

Recommendation: *ensure opportunities for young people to be involved in designing, implementing and evaluating health services.*

Maximizing accessibility to health services

Sexual and reproductive health services for young people should be easy to reach, closely situated to where they congregate, or easily accessible by public transport. Young people should be provided with clear indications -- both in promotional/informational materials as well as in the health centre itself -- as to where to go and who to see. Services for young people should be available at times when they can attend (i.e. before and after school/work). Young clients should be given a choice of times for appointments without any difficulty in finding a suitable time. There should also be the possibility of drop-in times when young clients may receive services without an appointment, and without waiting too long. When sexual and reproductive health services are provided as part of a larger healthcare facility, young people should be able to reach them without drawing attention to themselves.

Recommendation: *establish services in easily accessible locations with flexible opening hours and ensure that young people are given information on the services so that they know where they are, what they offer, how much they cost and how they should be treated.*

Offering a wide range of services

Young people should have access to and be able to choose from a wide range of gender-sensitive sexual and reproductive health services, including: sexuality

information; counselling; services for those who experience emotional or physical (domestic) violence, rape, gender-based violence, trafficking or female genital mutilation (FGM); family planning; pregnancy testing; abortion; and STI/HIV testing and treatment. The ideal service would offer a full integration of different services directed at young people or at least a good referral system to high-quality specialist services which are youth friendly.

Recommendation: *ensure that a comprehensive range of sexual and reproductive health services are made available to young people and that effective referral systems are in place.*

Providing counselling as an integral component of services

High-quality counselling is particularly important when addressing the sexual and reproductive health issues of young people. Service facilities and programmes should provide a separate room for young clients to receive medical and counselling services. The counsellor should be ready and able to answer all questions to the young client's satisfaction, using language that young people understand. Counsellors should include nurses and psychologists – not just doctors. Counselling sessions should allow time for and encourage young people to express their problems in their own words. Most important, young clients should feel at ease and unembarrassed. Online counselling and telephone helplines should also be an option.

Recommendation: *ensure that counselling is included in all sexual and reproductive health services for young people, in accordance with an established set of guidelines or norms.*

Ensuring the high quality of services

It is important that a system be in place at each service delivery point to ensure that the services provided are of the highest quality. Services should be provided against a set of standards based on clients' rights (see below) as well as on providers' needs and in compliance with internationally-recognized technical or medical norms and procedures (WHO, JHPIEGO, IPPF). The quality assurance system should include a process that enables young clients to provide their feedback on services and a mechanism to ensure that this feedback is taken into consideration. Many of the elements of high-quality services are included at the end of this section. Service providers should be provided with support in implementing quality assurance procedures.

Recommendation: *ensure that quality assurance mechanisms are in place and operational at all levels where services are provided.*

Ensuring the confidentiality of services

The autonomy of young people is a sensitive issue and difficult to regulate, as age is not the best indicator and maturity difficult to measure. However, for sexual and reproductive health services to be successful in reaching out to young people and be effective, it is essential that confidentiality and anonymity are guaranteed. This means that the service providers deal directly with young people and will only ask for an adult's involvement (parents, guardian, authorities) with the full consent of the young person in those cases where there is an absolute need to do so for the sake of the young person.

Recommendation: *ensure that systems are in place to guarantee anonymity and confidentiality, including in social security systems.*

Allowing for different needs of young women and young men

Young men and young women should both feel comfortable when visiting or receiving services, whether individually or as partners. This encourages dialogue, joint decision-making and shared responsibility. It might be appropriate to provide separate services for young men that take into consideration male values, motivations and feelings.

Clients should be given the choice of a male or female service provider. Traditional values of boys and young men should be identified and taken into consideration.

Recommendation: *ensure that services are designed to meet the needs of both male and female clients.*

Reaching vulnerable young people

Special consideration should be given to addressing the needs of vulnerable groups of young people, or groups with special needs, without causing embarrassment or stigma. Specific attention should be given to disabled young people, immigrants, migrants, sex workers, injecting drug users, and men who have sex with men. Where possible and appropriate, measures should be taken to mainstream vulnerable groups into regular youth-friendly services. This means paying extra care to informational materials, service procedures and protocols, and service providers' attitudes and communication skills. Where feasible and appropriate, outreach sexual and reproductive health services might be provided in specific locations for some vulnerable groups (e.g. young prisoners). Services should also be integrated in special settings such as needle exchange centres, day centres for street children, etc. Recent migrants – especially illegal ones – often fall out of the standard health systems and lack the necessary information. Proactive measures should be taken to inform and assist them. Stakeholders from vulnerable groups should be included in the design and ongoing assessment of services.

Recommendation: *ensure that services are inclusive and available in locations that are feasible and easily accessible, and that they address the needs of all young people, including marginalized young people. Include proactive measures for (illegal) migrants.*

Reaching young people in a variety of settings

Youth-friendly services can be provided in a variety of settings, ranging from a clinic reserved exclusively for young people to adding 'adolescents-only' hours at existing facilities, providing emergency hotlines, or offering services in places where young people congregate, such as schools, youth centres, sporting events or work sites. Information must be provided confidentially and discreetly. For community and/or outreach workers it might mean including sexual and reproductive health issues during their home visits to young people. In clinics that cannot offer special hours for adolescents only, then a 'fast-track' system can be used. Where possible, young people prefer to have a separate (more discreet) entrance/exit from the main clinic entrance. Pharmacies and social marketing outlets (e.g. condom dispensers) can also be an appropriate and effective setting for certain types of services for young people. The internet can be a good medium for providing information and certain types of counselling.

Recommendation: *ensure that youth-friendly services are available in a wide variety of settings.*

Training, supporting and supervising service providers

Staff who provide services to young people need to be trained, to develop the appropriate attitudes and communication skills. They also need support in addressing issues that might arise or in dealing with their own dilemmas and issues as service providers in a youth-friendly services setting (see 'Clients' Rights' and 'Providers' Needs' boxes). In particular, providers of services to young people should be welcoming, friendly and non-judgemental, understand the importance of respecting confidentiality, explain why questions are being asked, and understand young people's concerns on sexuality and sexual relationships.

Recommendation: *ensure that service providers receive adequate training on a regular basis and that staff receive support and supervision to work competently, sensitively and respectfully with young people on their sexual and reproductive health needs.*

Making services affordable for young people

Cost can be a major barrier to young people seeking health services. A fee schedule should be established so that services are either free or within the purchasing power of young people A sliding scale can be established, according to client affordability criteria, alongside credit and flexible payment options. Some studies have shown that young people like to pay something for services in order to value them.

Recommendation: *ensure that services are available to all young people, irrespective of their ability to pay.*

Adopting a clients' rights approach

As young citizens on the path to adulthood, young people have the right to good health and health services. Sexual and reproductive health services for young people fall within the general framework of child and human rights. It is important that policymakers – as well as service managers and providers – take a rights-based approach in the provision of sexual and reproductive health services for young people. IPPF has developed the 10 clients' rights listed at the end of this section as a simple and effective tool for providers and clients. This tool can be posted in service centres and included in service delivery guidelines and client information materials

Recommendation: *adopt a rights-based approach in the provision of services for young people which centres on the concepts of accountability and choice and enables freedom of expression of young people, and increase public awareness of clients' rights in public and private institutions.*

Stimulating a multi-disciplinary approach

Experience has shown that the multi-faceted nature of sexual and reproductive health issues requires a multi-disciplinary approach to services. Young people should have access not only to highly-trained medical and paramedical staff, but also to psychologists, social workers and other field workers. The various service providers should work as a team to assess and address the issues and needs of their young clients. Peer educators can be included in such multi-disciplinary teams, although they need to be provided with sufficient and sound back-up support.

Recommendation: *ensure that sexual and reproductive health services are developed and delivered by multi-disciplinary teams.*

Establishing a protective environment

Young clients have a right to be protected in all matters related to sexual and reproductive health services. This means that adequate measures need to be put in place to protect them against mental and physical harassment, coercion, or any situation in which they feel unsafe and vulnerable.

Recommendation: *ensure that services have child protection policies in place and that young clients are made aware of these policies.*

CLIENTS' RIGHTS

The following 10 rights set the standards for the provision of sexual and reproductive health services:

- Information: to know about the benefits and availability of sexual and reproductive health services and to know their rights in this regard
- Access: to obtain services regardless of race, gender, sexual orientation, marital status, age, religious or political beliefs, ethnicity or disability
- Choice: to decide freely on whether and how to control their fertility and other aspects of their sexual health
- Safety: be able to protect themselves from unwanted pregnancy, disease and violence
- Privacy: to have a private environment during counselling and services
- Confidentiality: to be assured that any personal information will remain confidential
- Dignity: to be treated with respect, empathy, courtesy, consideration and attentiveness
- Comfort: to feel comfortable when obtaining services
- Continuity: to receive sexual and reproductive health services and supplies for as long as needed
- Opinion: to freely express views on the services provided.

PROVIDERS' NEEDS

The needs of service providers must also be addressed, to make clients' rights a reality. Therefore, the service providers need:

- Training: to have access to the knowledge and skills they need to perform all the tasks required to do their work
- Information: to be kept informed on issues related to their duties
- Infrastructure: to have the appropriate physical facilities and organization to provide services at an acceptable level of quality
- Supplies: to have continuous and reliable supplies of the methods of contraception and materials which are required for the provision of sexual and reproductive health services at appropriate standards of quality
- Guidance: to have clear, relevant and objective guidance: the type of guidance which will reinforce their commitment and competence for delivery of high-quality services
- Back-up: to be reassured that whatever the level of care at which they are working, they are members of a larger grouping in which individuals or units can provide support to each other
- Respect: to have recognition from the programme of their competence and potential, and respect for their human needs.
- Encouragement: to get stimulus in the development of their potential and creativity
- Feedback: to get feedback concerning their competence and attitudes as judged by others
- Self-expression: to express their views concerning the quality and efficiency of the programme.

Source: Terki, F and Malhotra, U (2004) Medical and service delivery guidelines for sexual and reproductive health services, 3rd edtion, London: IPPF, 435 pp.

POLICY AREA 3:

Access to contraception

Although the circumstances and behaviour of adolescents and young people vary, it is clear that this is the time of life when they are likely to have sexual relations for the first time and when sexual behaviours are established, including use of contraception. It is easier to keep a healthy behaviour that was established at a young age than to change risk behaviour later. This principle is particularly relevant for health authorities that are investing in health promotion and prevention programmes.

Unsafe sexual practices carry particular hazards for young people. For example, maternal morbidity and infant mortality rates are higher for women under 18 years of age than those for older women.[24] Moreover, early parenthood tends to curtail opportunities for education and employment, and hampers social and cultural development. Other consequences of unsafe sexual behaviour for both sexes are the risk of STIs (including HIV)[25] and the psychological and health consequences of sexual violence.

Access to contraceptives is an integral element of any strategy for reducing rates of unwanted pregnancies, STIs including HIV, and their associated health problems,[26] and for serving the general health needs of young people. The consistent use of contraceptives, particularly barrier methods against STIs, such as female and male condoms, ensures that young people can protect their health while also being in a position to have children if and/or when they choose.

However, regular and effective use of contraception by young people is reliant on a wide variety of factors which must be considered when creating policies and programmes. For example, the study of young people in Spain found that a very high percentage of the participants did not use condoms appropriately and tended to have intercourse without protection once they had a partner.[27] Thus, the impact of stable relationships on the use of contraceptives deserves attention, and should be researched further – it may in fact increase vulnerability to STIs and unwanted pregnancy, rather than the opposite.

In Sweden in 2005, a national survey indicated that alcohol use appears to be one of the major contributors to failure to use contraceptives correctly: over 20 per cent of the male respondents had unprotected sex due to alcohol consumption.[28] Also, the age of sexual debut is a factor in contraceptive use. In the Spanish study, among adolescents under the age of 20, the age of sexual debut has gradually fallen and is now around 16. The most common contraceptive method for the first sexual intercourse is the condom, and those who had their first sexual intercourse at an early age and who have had more sexual experiences were less likely to use condoms.[29] Similar findings were reported from the

24 Ozalp, S et al (2003) Health risks for early (more than 19) and late (less than 35) childbearing in: Archives of Gynecology and Obstetrics. 2003 Aug; 268(3), pp. 172-174

25 See next section on STIs/HIV for more details

26 Such as cervical cancer, ectopic pregnancy, pelvic inflammatory disease, or infertility. The presence of STIs other than HIV also increases the risk of HIV transmission.

27 Castilla, J, Barrio, G, Belza, MJ and de Fuente, J (1999) Drug and alcohol consumption and sexual risk behaviour among young adults: results from a national survey, Drug and Alcohol Dependency 1999; 56:47-53

28 Hvitfeld, T and Rask, L (2005) Drug trends in Sweden 2005, Stockholm: Swedish Council for Information on Alcohol and other Drugs

29 Castilla, J, Barrio, G, Belza, MJ and de Fuente, J (1999) Drug and alcohol consumption and sexual risk behaviour among young adults: results from a national survey, Drug and Alcohol Dependency 1999; 56:47-53

UK,[30] Ireland,[31] Sweden[32 33] and Italy,[34] indicating that there is a complex set of factors involved with promoting effective contraceptive use which cannot be addressed simply by making contraception available. Thus, programmes must also include information and education on a wide range of issues, such as alcohol and relationships. In Finland, for example, the problems related to increased risk behaviours among young people have led to the creation of a high-level government working group to tackle the issue.

Currently, increasing rates of teenage pregnancy and STIs in some countries indicate that there is a need to improve young people's understanding of safer sex, and their abilities to protect themselves and their partners.[35] Sexuality education and information cannot be effective if they are not accompanied by access to a wide range of contraceptives that suit young people's needs, including emergency contraception and male and female condoms. Nonetheless, a number of factors have been shown to prevent young people gaining access to contraception, including:

- cultural attitudes and linguistic barriers;
- stigma in accessing health services, and the fear of discrimination;
- gender inequality;
- socio-economic factors; and
- legal barriers.

Furthermore, surveys show that some young people are shy or ashamed to buy contraceptives, while others are afraid of the potential or perceived side-effects of some contraceptive methods, which may be influenced by inaccurate information.[36] Many do not know what is available, what is the most appropriate for their needs or how to get it. Social and behavioural issues are important considerations in their choice of contraceptive methods, including factors such as sporadic patterns of intercourse and the need to conceal sexual activity and contraceptive use.

Young people often have limited financial means and, therefore, more difficulty purchasing contraceptives. The cost and affordability of contraceptives depends in many countries on their inclusion on the list of essential medicines and on the national health insurance system. Reducing the cost of contraceptives through the social security system is very important but might not be enough to address the needs of the most vulnerable young people, such as ethnic minorities, illegal migrants, street children and poor people, who are not covered by the health insurance system. Attention should also be given to unemployed young people when health insurance depends on being in employment.

Few data are available about the frequency of sexual intercourse after sexual debut, prevalence of contraceptives use and knowledge and attitudes about modern methods of contraception. More research is needed on young people's sexual

30 Mercer, CH, Wellings, K, Macdowall, W et al (2006) First sexual partnerships age differences and their significance: empirical evidence from the 2000 British National Survey of Sexual Attitudes and Lifestyles (Natsal2000), Journal of Adolescent Health 2006; 39:87-95

31 Jones, S (2005) Emergency contraception use by Irish teenagers, European Journal of Contraception and Reproductive Health Care 2005; 10:26-8

32 Wulff, M and Lalos, A (2004) The condom in relation to prevention of STIs and as a contraceptive method in Sweden, European Journal of Contraception and Reproductive Health Care 2004; 9:69-77

33 Herlitz, C and Ramstedt, K (2005) Assessment of sexual behaviour, sexual attitudes and sexual risk in Sweden (1989 2003), Archives of Sexual Behaviour 2005; 34:219-29

34 Dei, M, Bruni, V, Bettini, P et al (2004) The resistance to contraceptive use in young Italian women, European Journal of Contraception and Reproductive Health Care 2004; 9:214-20

35 Dehne, K and Riedner, G (2005) Sexually Transmitted Infections Among Adolescents: The need for adequate health services, Geneva: WHO www.who.int/reproductive-health/publications/stis_among_adolescents/stis_among_adolescents_adequate_health_services.pdf

36 WHO (2004) Contraception in adolescence: Issues in adolescent health and development, Discussion Papers on Adolescence, Geneva: WHO pp. 39-41

behaviour, especially among vulnerable groups and the current usage and attitudes towards contraception, barriers encountered when trying to access contraceptives, and why knowledge is not transformed into behaviour.

Europe has a diversity of social, cultural, economic and political environments between countries, and even within countries, which affect the accessibility of contraception. Adults, in particular parents, often have difficulty accepting that their son or daughter has entered adult life and is intimate with someone the adult does not know. Their reaction will depend very much on the cultural and/or religious context within which they live, but will also have an effect on the degree to which policymakers make contraception available. Regardless of how parents feel about contraception, however, policymakers are obliged to develop policies which respond to the needs of all segments of the population, including young people. Therefore they must strike a balance between developing policies consistent with cultural and social expectations, but which also meet the needs and respect the rights of young people who are sexually active.

Providing access to affordable contraceptives for young people might also compete with other budgetary priorities. Therefore, more research needs to be done on the costs and benefits of providing free or subsidized contraceptives. Overall, it appears logical that providing free or cheap contraceptives for young people is a better investment than some of the alternatives, which could include having to fund programmes for young people who have dropped out of school because of an unplanned pregnancy or who are teen parents, or having to pay for life-long treatment for HIV or other STIs.

Young people have a right to sexual and reproductive health. It is not the purpose of this document to debate the age at which young people should have access to contraceptives or what type of contraceptives. They need them when they declare their need, even at a young age. It is up to service providers to establish a dialogue with a young person if they feel that she or he is too young or not mature enough. A young person asking for contraceptives creates a good opportunity to have a dialogue on sexual and reproductive health, and this is preferential to denying them access to contraceptives and subsequently needing to provide them services related to the more negative impacts of sexual activity. In principle, any request to obtain contraceptives should be met positively, as it indicates that a young person is aware of the risks and wants to protect her- or himself and their partners.

KEY POLICY AREAS: **Access to Contraception**

Encouraging participation
Civil society actors and youth representatives should be consistently involved in the development of programmes and policies to ensure that needs are properly covered and that effective strategies are in place.

Recommendation: *ensure that systems are put in place at all levels that guarantee the meaningful participation of young people in the development of policies and programmes that effectively increase access to contraception.*

Providing a broad range of contraceptives
International surveys indicate that, in general, the greater the choice of methods, the greater the likelihood that people will use them.[37] Young people need access to a complete range of contraceptive methods that are appropriate for their physical

37 WHO (1994) Health Benefits of Family Planning, Geneva: WHO, pp. 19-20 www.who.int/reproductive-health/publications/health_benefits_family_planning/FPP_95_11_chapter3.en.html

development, lifestyle and behaviour. These should include as a minimum the most effective methods which are appropriate for young people, such as condoms, pills and emergency contraception as well as other effective methods such as the intra-uterine device (IUD), injectable contraceptives (MPA for those over 18 years of age), the ring or the plaster. In all cases, young people should be provided with proper information and counselling on all methods for them to make an informed choice and ensure proper use.

Recommendation: *ensure that young people are aware of and have access to a broad range of contraceptives and that service providers are able to counsel young people appropriately.*

Ensuring the high quality of services
Regardless of the setting in which services are provided, young people should have access to accurate information, advice and counselling as well as referral to specialist services as and when necessary. In formal settings, service provision should include appropriate counselling that enables young clients to make sound, informed choices. Quality standards and quality assurance mechanisms of the type described in Policy Area 2 of this guide should also be put in place, applied and monitored. When contraceptives are provided in less formal settings (see below) information should be included on how to use them and how to obtain further information, counselling and consultation.

Recommendation: *ensure that comprehensive, high-quality contraceptive services are accessible to young people and that policies are in place to monitor them.*

Reaching young people in a variety of settings
A distinction needs to be made between different types of contraceptives. The hormonal pill will require a formal setting with medical advice, while condoms can be distributed more widely. Settings for condom distribution can also include youth clubs, rock festivals, bars, nightclubs and supermarkets.

The effectiveness of emergency contraception depends on the time of the intake. Therefore, physical, economic and legal barriers to the provision of emergency contraception to young people should be avoided, since they result in an increased risk of unwanted pregnancies and potential health risks. Both WHO and IPPF recommend emergency contraception to be available over the counter at any time.[38] Condoms and emergency contraception should be accessible free of charge in areas with a high incidence of teenage pregnancies, STI/HIV and sexual violence, and in institutions such as prisons, orphanages, detention centres, and reception centres for asylum seekers.

Recommendation: *ensure that contraceptives, in particular condoms and emergency contraception, are available in a wide variety of settings that are accessible to young people.*

Offering a wide variety of providers
In addition to medical institutions and pharmacies, other providers could be involved, in particular in providing ‘subsidized’ contraceptives. These could include family planning staff, peer educators, school doctors and nurses, social workers and midwives.

Recommendation: *ensure that a wide range of service providers are adequately trained to be able to reach vulnerable groups, including young people, both in and out of school.*

38IPPF (2004) IMAP Statement on Emergency Contraception, March 2004, London: IPPF
www.ippf.org/NR/rdonlyres/93F42BD4-CB30-4F6B-ABDA-51F076A7AEE3/0/IMAPstatementmarch2004.pdf

Ensuring confidentiality
Confidentiality is a crucial factor for many adolescents who are sexually active but do not want their parents or others to know. For many adolescents it is not possible to keep contraceptives at home, due to cultural attitudes or gender inequality. This might lead to unprotected sex.

Recommendation: *ensure that a clear legal framework and procedures are in place which respect the confidentiality of young people.*

Ensuring a positive attitude among service providers
The attitude of service providers (pharmacists and medical professionals) might represent a barrier to access to contraception, especially for young people. For example, in some countries young people are refused a prescription or are not treated with the respect and fairness to which they are entitled, due to the personal beliefs or religious convictions of certain service providers.

Recommendation: *ensure that clear guidelines are in place so that the private convictions of some practitioners do not prevent the delivery of agreed services and guarantee appropriate referral at least.*

Training, supporting and supervising providers
Those who deliver contraceptives need the necessary information, skills and attitudes to do so effectively. Training and skills development are as crucial in sexuality as in other subject areas and should cover facts, methods and personal reflection. Providers must be supported to ensure that they have an open and non-judgemental approach to young people's sexuality and to all methods of contraception including dual protection.

Recommendation: *ensure that those who deliver contraceptives and counselling on contraceptive use are adequately trained, receive ongoing support and supervision, and have access to appropriate resources and materials.*

Minimizing the fear of being judged, stigma and discrimination
The lack of self-confidence and the fear of being judged might also delay or limit young people's access to contraceptives. Even if service providers are not judgemental, young people might fear their reaction and prefer to conceal or deny problems or not request a service to which they are entitled. This barrier might be even greater for people suffering from stigma and discrimination on other grounds.

Recommendation: *create mechanisms to ensure and reward youth-friendly services in which all young people – without distinction – feel confident and comfortable.*

Making contraceptives affordable for young people
In some countries contraceptives are included in the national health insurance system, but in many countries they are not. The price of contraceptives and the medical costs associated with them can severely undermine the right of young people to protect themselves.

Recommendation: *ensure that young people, particularly those in vulnerable groups who are least likely to be able to pay, have access to free contraceptives.*

Improving young people's knowledge of contraceptives
Many young people do not know how to use contraceptives, what kinds of methods are available or the most appropriate for them.

Recommendation: *governments should ensure that children and young people receive appropriate information and education in relation to sexual and reproductive health in general and contraception in particular. These issues should be addressed through a consistent and integrated policy on youth-friendly services. Service providers should ensure that young*

people are aware of the range of contraceptives available to them, how they can access them and how to use them.

Ensuring gender equity
Oral contraceptives and emergency contraception are mostly sold on medical prescription, which results in an increase in the cost of this type of contraception. This places young girls at a disadvantage compared to young men. Girls also pay the highest price for early pregnancy in terms of health risks and missed opportunities in education and employment. Additionally, the right to use contraceptives is seriously undermined in certain family settings, ethnic communities and in the sex trade.

Recommendation: *ensure that any policy and/or guidelines on contraception include specific attention to gender equality.*

Reaching young people from diverse populations
Young people represent a very diverse population, and it is important to recognize this diversity when developing policies on contraceptives. Factors such as gender, social class, ethnicity and sexual orientation should be taken into consideration in education materials and programmes and in contraceptive counselling.

Recommendation: *develop programmes that take account of young people's particular circumstances and experiences and adapt to the needs of the group they are working with.*

POLICY AREA 4:

Sexually transmitted infections (STIs) and HIV/AIDS

STIs, including HIV, continue to be a major public health threat to young people across Europe. The latest figures show that the rates of STIs are increasing all over the region, and particularly in the 15–24 age group.[39] Although HIV is the most serious, many other STIs such as chlamydia, syphilis, gonorrhoea, Human Papillomavirus (HPV) and hepatitis C can also have a devastating impact on young people's reproductive health, particularly their fertility. And the presence of STIs increases the risk of HIV transmission.

The rising rates of STIs in Europe point to a resurgence in unprotected sex or risky sexual behaviour and potentially to 'AIDS fatigue'[40] among the population. Therefore, there is a clear need for new and more effective education and prevention programmes, with a particular emphasis on young people. Access to high-quality information, and comprehensive sexuality education and services can lead to an increase in safer sex practices and use of contraception.[41] Sexuality education, if it encompasses and includes issues around attitudes and behaviours, can also help to reduce the stigma and discrimination associated with STIs and HIV/AIDS.

As the incidence of STIs is increasing, it is absolutely essential to put more emphasis on the promotion of condoms: both male and female condoms are still the major means of prevention against STIs and, to a lesser extent, unwanted pregnancies. The male condom is also widely available and relatively affordable and, therefore, accessible. However, female condoms are not, and this needs to be addressed to offer women greater independence regarding their sexual behaviour. Sexuality education for boys and young men, including gender awareness and the use of condoms, should be higher on the political agenda.

The importance of the prevention of STIs and HIV cannot be underestimated. Since stigma and discrimination have not disappeared, the individual and societal impact is enormous. Prevention is also far more cost-effective than treatment, in particular for HIV. The fact that HIV/AIDS is no longer a killer disease but has become a chronically manageable disease means that the direct economic impact has decreased but that the cost of life-long treatment is very high and will in some countries put a serious burden on health systems.

The need to establish a co-ordinated and multi-sectoral response to HIV/AIDS has been well documented. A key element of this should be for policymakers to strengthen the links between sexual and reproductive health and HIV/AIDS programmes. An increasing number of HIV infections are acquired sexually, and people living with HIV have a greater life expectancy than in the past, are often young, and want to be sexually active and have families. Therefore, the link between HIV/AIDS, sexuality and reproductive health is a crucial consideration for policymakers and programmers. Stronger links should lead to a number of important public health benefits, including for example, improved access to and uptake of services related to HIV and sexual and reproductive health, reduced stigma and discrimination and better access to appropriate sexual and reproductive health services for young people living with HIV.

To be effective, it is important that the response to HIV/AIDS keeps pace with the changing patterns of transmission that are being seen in Europe. In many areas, one of the biggest changes in recent years has been the emergence of unprotected heterosexual intercourse as a cause of new HIV infections. In certain settings, one of the reasons for this increase has been the migration of people from regions with generalized epidemics. Policymakers need to address

39 Dehne, K and Riedner, G (2005) Sexually Transmitted Infections Among Adolescents: The need for adequate health services, Geneva: WHO

40 AIDS fatigue means that people become desensitized to the risks of HIV and AIDS and are, therefore, less likely to undertake protective measures

41 IPPF EN (2007) Sex and young people in Europe: a research report of the sexual awareness for Europe partnership, Lund University, Sweden

these issues urgently and sensitively by addressing the needs of migrants as a key vulnerable group when formulating HIV prevention policy.

Overall, policies and programmes must address the rights and needs of key vulnerable groups, including men who have sex with men, injecting drug users, and sex workers and their clients, who may be of any age.

Injecting drug use is still the most common and therefore important route of transmission for HIV, particularly in countries such as Estonia and Latvia where there has been a dramatic rise in new HIV infections among young recreational injecting drug users[42]. It is clear that policymakers in these countries need to target this group with the appropriate information, skills and services to avoid complacency and the consequent further spread of infection through contaminated equipment. Another challenge in this context is to limit HIV transmission from HIV-positive drug users to their sexual partners.

Meanwhile, in parts of Western Europe, there has been a resurgence in the number of new HIV infections among men who have sex with men, and hence there is a need to re-focus on safer sex programmes for them.

Another group that should receive special attention are those young people who are already infected with HIV. Positive prevention policies for people living with HIV include a set of actions that help them protect their sexual health, avoid other STIs, delay HIV and AIDS disease progression and avoid transmitting HIV to others. Their participation in prevention programmes is useful for designing and conveying appropriate messages to promote safer sexual behaviour, reach other young people living with HIV and help to strengthen their self-esteem and self-confidence. In Europe a new phenomenon linked to the fact that HIV is no longer life threatening is that those young people infected might want to have children. They should have the means to fulfil their sexual and reproductive rights, including parenthood. Sexual and reproductive health and HIV policies and services, through the principles of positive prevention, should be prepared to assist them in this by providing information and support in all settings, including medical centres, treatment delivery sites, family planning clinics, home-based care programmes and community centres.

HPVs cause the most common STIs in up to 35 per cent of young sexually active adults. Infections with oncogenic high-risk HPV types are the major cause of cervical cancer.[43] Despite extensive and often costly screening efforts, approximately 27,000 new cases of cervical cancer are diagnosed each year in the EU, and 11,000 women die from the disease. Prevention is crucial.

Cervical cancer has long been connected with lifestyle and sexual behaviour. The most common risk factors are:

- age at sexual debut;
- number of sexual partners;
- smoking; and
- STIs such as chlamydia trachomatis and herpes virus simplex 2.

HPV is highly transmissible. The peak incidence of infection occurs soon after the onset of sexual activity. HPV infection usually resolves spontaneously, but it may persist, and precancerous cervical lesions may follow which may progress to cervical cancer. Young people are particularly vulnerable to HPV infections. One of the recommendations of the WHO Comprehensive

42 IPPF EN (2007) Sex and young people in Europe: a research report of the sexual awareness for Europe partnership, Lund: Lund University, Sweden

43 WHO Regional Office for Europe (2007) Can we prevent cervical cancer? Screening-Vaccine, Entre Nous, The European Magazine for sexual and reproductive health No. 64 2007, Copenhagen: WHO Regional Office for Europe, www.euro.who.int/document/ens/en64.pdf

Cervical Cancer Control Guide[44] is to make health education an integral part of any national cancer control strategy. It is also vital to raise awareness of effective condom usage. Well-organized cervical cancer screening and HPV vaccination could reduce cervical cancer rates and mortality from this preventable disease.

Finally, gender must factor heavily in any policy or programme because it is such a major determinant of vulnerability to STIs. For example, young boys are more at risk of HIV infection because they make up the majority of injecting drug users. Girls and young women, on the other hand, are more biologically vulnerable to STIs because the vagina is more susceptible to the virus. Socially, young women are not always in a position to negotiate the use of condoms, and economically, some young women have to earn their income as sex workers, where again the possibility to negotiate safer sex is questionable. These all highlight the ways that gender plays a role in young people's vulnerability to STIs, and reasons why policymakers and programmers must take a gender approach to addressing STIs, particularly HIV.

KEY POLICY AREAS: **STIs and HIV/AIDS**

Encouraging participation of young people and civil society

The participation of civil society in the prevention of STIs and HIV is crucial, since civil society has access to the young people most at risk. Through NGOs, young people are provided with comprehensive information and education on STI and HIV prevention, treatment and care. Youth NGOs are able to support the most vulnerable youth, including those out of school, and help them to build skills to prevent STIs and HIV, through outreach programmes and peer education. Civil society actors and youth representatives from target groups should be consistently involved in the development and implementation of national STI and HIV policies, strategies and programmes, to bring about effective results and meet the needs of youth. In particular, the involvement of young people living with and affected by HIV in the development of policies and the implementation of programmes helps to ensure that they meet the real needs of the people they aim to serve. They also help to ensure that programmes are free of stigma and discrimination.

Recommendation: *ensure active involvement of civil society and young people, including those living with HIV, when developing and implementing STI and HIV prevention, treatment and care policies and programmes.*

Targeting each of the groups vulnerable to STIs and HIV/AIDS

Young people are a major vulnerable group for HIV infection and STIs in Europe. Among them, special consideration should be given to migrants, asylum seekers, refugees, ethnic minorities, injecting drug users and their partners, men who have sex with men, people living in institutions, prisoners, sex workers and their clients, trafficked people, and street children. Although these groups differ from each other, all of them need better access to healthcare, social services and education.

Recommendation: *targeted long-term multi-sectoral programmes should be developed to address the needs of each of the most vulnerable groups.*

- *Across borders: remove legislation barriers that make it difficult to reach vulnerable groups.*
- *Provide comprehensive harm-reduction initiatives for injecting drug users within a supportive environment that enables programmes to reach them.*

44WHO (2006) Comprehensive Cervical Cancer Control: A guide to essential practice, Geneva: WHO, www.who.int/reproductive-health/publications/cervical_cancer_gep/index.htm

Providing a comprehensive range of STI and HIV services

Young people need to have access to comprehensive STI and HIV services that include prevention, diagnosis, treatment, care and harm-reduction strategies. To make them accessible, STI and HIV services should be integrated with other health services, particularly with sexual and reproductive health services, and be available at a wide variety of settings at the primary healthcare level. The settings may include youth-friendly clinics and centres, school clinics, counselling centres, general practitioners, and family planning clinics. Integration of HIV services with sexual and reproductive health services will contribute to a reduction of stigmatization of HIV/AIDS, especially among young people.

Recommendation: *ensure the provision of comprehensive and relevant HIV and STI health services linked with, or integrated into sexual and reproductive health services, at a wide variety of settings that are both youth friendly and actively involve key populations in the delivery of the service.*

Providing comprehensive STI and HIV prevention programmes

To be effective, STI and HIV prevention for young people should be widely accessible, evidence-based, grounded in human rights, age-specific and gender responsive, linked with treatment and care and should help build life skills to enable young people to reduce their vulnerability.

Recommendation: *promote balanced and comprehensive prevention programmes for young people, including STIs and HIV education, condom use, clean needles, pre- and post-exposure prophylaxis, voluntary counselling and testing (VCT), and harm-reduction programmes, linked to sexual and reproductive health services and life skills education. People living with HIV and the principles of positive prevention should be integral to such policies and programmes.*

Improving access to condoms

Condoms are the most effective method of preventing HIV infection for both men and women. They are the only contraceptive method that can prevent both pregnancy and STIs if used correctly and consistently. A major advantage of condoms is that they can be obtained without a medical prescription – an important consideration for many young people. Male and female condoms should be made easily accessible for young people through a variety of settings at affordable prices. Condoms should be promoted among young people and be provided for free to young people during promotion campaigns

Recommendation: *increase condom supply and include condom provision and distribution within any STI and HIV prevention programmes. Female condoms should be made more available at an affordable price so that they are also accessible to all.*

Promoting dual protection

Many sexually active young people need dual protection: protection against unwanted pregnancy and against STIs including HIV. Condoms are the only contraceptive method that can prevent both pregnancy and STIs if used correctly and consistently. Therefore, it is recommended that condoms are used for infection prevention at the same time as another contraceptive method.

Recommendation: *ensure that dual protection promotion is integrated in sexuality information and education programmes and understood by service providers.*

Training service providers in STI and HIV prevention, treatment and care

Access to, and quality of, STI and HIV/AIDS prevention and treatment depends on the skills and attitudes of service providers. To achieve successful integration of high-quality STI and HIV/AIDS services throughout the healthcare system, service providers

should regularly update their knowledge of STI and HIV prevention, care and treatment and build their skills in providing youth-friendly services. Training should also address service providers' attitudes, to make sure that they are able to provide STI and HIV/AIDS services and condoms to young people in a sensitive and non-judgemental manner, free from stigma and discrimination.

Recommendation: *allocate funds and establish mechanisms to ensure regular training on prevention, care and treatment of STIs and HIV/AIDS for those service providers who are involved in healthcare services for young people at all levels of the healthcare system.*

Offering high-quality HIV counselling and testing
HIV counselling and testing is a cornerstone of all HIV services, as it allows early diagnosis of HIV infection and ensures timely access to appropriate intervention. Young people should be empowered and have access to HIV testing and counselling, regardless of their social background, ethnicity, gender, sexual orientation, age and residency. HIV testing and counselling must be confidential, non-judgemental, tailored to individual needs, only conducted with informed consent (meaning that it is both informed and voluntary) and be accompanied by counselling.

Recommendation: *ensure that there is a legal framework to secure young people's access to voluntary HIV testing and counselling; ensure that there is a quality assurance and assessment mechanism in place to ensure that services are voluntary, confidential and of a high quality.*

Encouraging and promoting voluntary counselling and testing (VCT)
VCT should be widely promoted among young people and be linked with high-quality treatment and care.

Recommendation: *encourage and promote VCT on a national scale.*

Ensuring access to sexual and reproductive health services for young people living with HIV
Sexual and reproductive health services for young people living with HIV are very important to protect them from HIV re-infection, STIs, unwanted pregnancies and mother-to-child transmission. Their needs should be integrated into and addressed by existing sexual and reproductive health services, which should be easily accessible, of high quality, confidential, and provided in a non-judgemental and respectful way. Prevention for young people living with HIV should be closely linked with treatment and care integrated with social services and support.

Recommendation: *ensure that young people living with HIV have access to HIV prevention, treatment and care programmes and that their participation in the programme design and implementation is encouraged.*

Reducing HIV-related stigma and discrimination
Stigma and discrimination – including self-stigma – drive people underground and make prevention even more difficult. A supportive and enabling legal environment is a fundamental cornerstone of prevention strategies, as it recognizes that those based on coercion and criminalization are not the answer. HIV programmes should deliver a comprehensive package of inclusive messages – irrespective of status – which could act as a way of reducing stigma. The greater involvement of people living with HIV in these processes can act as a catalyst for breaking down stigma and ensuring that discrimination continues to be reduced.

Recommendation: *based around a rights-based approach and drawing on the principles of positive prevention, develop and support policies and programmes that reduce the stigma and discrimination that people living with, and affected by HIV, continue to face.*

Decriminalizing HIV
In response to HIV/AIDS epidemics, some countries have moved to liberal policies and laws on HIV/AIDS that have had a positive effect on the HIV situation in those countries. Criminalization of HIV was proved to be ineffective in the prevention of HIV transmission. In the long term, decriminalization of HIV will contribute to a reduction of stigma and discrimination against people living with HIV.

Recommendation: *ensure that legal frameworks remove barriers to effective, evidence-based HIV prevention, eliminate stigma and discrimination and protect the rights of young people living with HIV or vulnerable to or at risk of HIV infection.*

Establishing long-term STI and HIV policies and programmes
STI and HIV programmes require a long-term commitment and undertaking. Instead of short-term or isolated initiatives, effective national programmes need to sustain essential programmatic and policy actions at a sufficient scale over the long term, responding to changes in infection patterns and social environments.

Recommendation: *support long-term policies and programmes on STI and HIV reduction, considering changes in infection patterns and the social environment.*

Supporting education on STI and HIV prevention
Prevention of HIV and STIs among young people is possible only if information and knowledge are combined with changes in their sexual behaviour. Therefore, it is important that schools and other educational settings include STI and HIV prevention in their sexuality education and/or life skills health education programmes. Raising knowledge of and building skills on STI and HIV prevention will also contribute to reducing stigma and discrimination among young people. Information and education on STIs and HIV should use positive messages.

Recommendation: *support and encourage schools and other educational settings to include STI and HIV prevention as part of sexuality education and/or life skills health education curricula.*

Addressing issues of diversity and vulnerability
Some groups of young people are much more vulnerable to STI and HIV infection than others. Factors such as poverty (that can lead to high-risk livelihood strategies such as sex work), sexual orientation, behaviour, injecting drug use, and ethnicity need to be taken into consideration. Girls and young women are disproportionately at risk of STIs and HIV for biological, social and economic reasons. It is essential that policymakers consider gender issues in their response to the epidemic. Services for survivors of sexual assault and trafficked persons should include HIV post-exposure prophylaxis as well as high-quality counselling and emergency contraception.

Recommendation: *ensure that STI and HIV programmes pay special attention to the needs of specific vulnerable groups (such as men who have sex with men, injecting drug users, sex workers and their clients), and that special actions are taken to address the needs of young women and girls.*

POLICY AREA 5:

Unwanted pregnancy and safe abortion

While pregnancy and parenthood are positive choices for some young people, many are faced with unintended or unwanted pregnancies, which can lead to negative social and psychological consequences such as incomplete education, poverty, social isolation and low self-esteem. At a time of life when fertility is high and young people have limited experience using contraceptives, particularly condoms, the risk of becoming pregnant is compounded. More than at any other age, becoming pregnant will significantly influence the future of the young woman and her child, and in some cases of her partner; and in addition to the social and economic consequences, early pregnancy carries a higher risk of maternal morbidity and infant mortality.

Also, there are various factors related to gender roles and expectations that might influence the choice of a young person to have a child: for example, a girl may feel that having a baby gives her an important role to play in her family or society, or she may see it as a way to secure her relationship with her partner. However, teenager pregnancies are mostly not intended. Unwanted pregnancy among adolescents is a challenge even in Europe, and is exacerbated by various factors, including a lack of knowledge about menstruation and pregnancy; a lack of access to and knowledge about how to use contraception; difficulties in using contraception because of a partner's or family's objections; contraceptive failure; and sexual assault.

It is not possible to completely eliminate unwanted teenage pregnancy because of the multiple causes and factors involved with it. While some adolescents will choose to carry pregnancies to term, there will still be a significant number who will choose to terminate their pregnancies. Even where abortion is prohibited or highly restricted by law, teenagers seek abortions for many reasons, which may relate to the following factors:

- becoming pregnant as a result of incest or sexual abuse;
- becoming pregnant due to lack of contraceptive use or contraceptive failure;
- fears of upsetting parents or bringing shame to the family;
- fears of expulsion from the family home, school or workplace;
- lack of a stable relationship;
- lack of financial means to care for a child;
- a desire to complete education or achieve other goals;
- already having a young child for which to care;
- fears of difficulty in finding a marriage partner (in communities where men prefer to marry virgins); and
- dislike of the man who caused the pregnancy or having a poor relationship with him.

The UN Committee on the Rights of the Child, which monitors compliance with the International Convention on the Rights of the Child, has stated that countries '(a) should develop and implement programmes that provide access to sexual- and reproductive-health services, including family planning, contraception and safe-abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) should foster positive and supportive attitudes toward adolescent parenthood for their mothers and fathers; and (c) should develop policies that will allow adolescent mothers to continue their education.'[45]

WHO has pointed out that, when performed by a trained healthcare provider with the proper equipment and under safe conditions, abortion is one of the safest medical procedures. But where laws restrict access to abortion, or services are inadequate, women often resort to unsafe methods to terminate unwanted pregnancies. Restricting access to safe, legal abortion disproportionately affects women, including adolescents, who do

45 UN Committee on the Rights of the Child (2003) www.ohchr.org/english/bodies/crc/index.htm

not have the means to procure safe procedures. Adolescent health is a major focus for WHO, and its guidelines on the provision of safe, legal abortions state that attention should be given to the special needs of adolescents.[46] The UK government has issued guidelines on access to abortion for minors that do not require parental consent. The BBC reported that the UK medical profession shares the government's view that a failure to respect confidentiality would deter girls from accessing the healthcare and advice that they need, both in respect of abortion and contraception.[47]

Adolescents differ from adult women regarding induced abortion in the following ways:

- Adolescents are less likely to have information about abortion or resources to access safe services, and they are more often at risk of using unsafe methods, including self-induced abortion.
- Adolescents are more likely to seek abortion from unskilled providers.
- Adolescents tend to delay seeking abortion from qualified providers. Some young women do not recognize pregnancy in the earlier stages; others fear stigma and discrimination or lack money to pay for an abortion.
- Adolescents also frequently delay seeking care for complications from a clandestine abortion, due to lack of transportation, lack of knowledge about where care can be obtained, fears of healthcare providers' attitudes, or lack of money to pay for services.
- Adolescents are likely to experience isolation and emotional stress because of a lack, or perceived lack, of support from their parents or partners.

Where induced abortion is highly restricted by law, adolescents have the highest risks of suffering serious complications from unsafe abortions. Worldwide, many teenagers seek abortions at a later stage of pregnancy when the risk of complications is higher.[48]

As stressed before, adolescents may postpone having abortions until after the first trimester, because they do not recognize or acknowledge the pregnancy, they fear the abortion procedure or parental reactions, or they need time to find money to pay for the procedure. While the risk of complications increases with gestational age, later abortions performed by skilled providers are still very safe. However, to reduce the possibility of future unwanted pregnancies, special considerations for adolescents' needs should be factored into clinical practice, as well as counselling before and after the procedure. Health systems and providers should work to make youth-friendly services available.[49]

Youth-friendly healthcare facilities offering abortion services should be organized to provide young women with options that are convenient, private, and that best meet their individual circumstances and preferences. A woman-centred comprehensive abortion care model incorporates a range of medical and related health services that support young women in exercising their sexual and reproductive rights and is comprised of three key elements: choice, access and high-quality services.

Sexuality education, the availability of contraceptives, and youth-friendly services should all be components of a comprehensive approach to avoiding unwanted pregnancies and abortion. Nevertheless, where all the surrounding measures are in place, abortion will always be needed in some cases. Therefore, it is important that policymakers ensure that these can take place in optimal

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46 WHO (2003) Safe abortion: technical and policy guidance for health systems, Geneva: WHO, 106 pp. www.who.int/reproductive-health/publications/safe_abortion/

47 http://news.bbc.co.uk/2/hi/uk_news/politics/6444725.stm

48 Olukoya, AA et al (2001) Unsafe abortion in adolescents. Special communication from the World Health Organization, International Journal of Gynecology and Obstetrics November 2001; 75(2):137 147

49 De Bruyn, M and Packer, S (2004) Adolescents, Unwanted Pregnancy and Abortion: Policies, Counseling and Clinical Care, Chapel Hill, NC: Ipas

circumstances, with respect for the young woman and making use of the most appropriate method, whether it is surgical or medical abortion. Abortion is a very sensitive issue in a number of countries, but for the sake of the health and future of young women in Europe, it cannot be ignored.

KEY POLICY AREA: **Safe abortion**

Encouraging the effective participation of stakeholders

It is only by listening to primary and secondary stakeholders – including clients – that sound and adequate strategies and legal frameworks can be developed.

Recommendation: *ensure meaningful partnerships with key stakeholders and potential clients in the development and implementation of the legislative framework.*

Clearly defining the grounds for abortion

All abortion legislations include a series of criteria by which an abortion is considered legal or not. This can range from a very extensive interpretation to a very restrictive one that only includes a risk for the life of the woman, the risk of severe malformation of the fetus, and rape or incest. It is not efficient to try to define these criteria in the legislation. The reasons for an abortion can be complex, personal and rooted in many areas that cannot be easily identified. The evidence is that if the law denies legal access to abortion to a person who needs it, the person will look for an illegal and potentially unsafe service.

Recommendation: *legislation which respects the right of a woman to make her own decision should not include any grounds or be formulated in a way which allows for misinterpretation.*

Ensuring that the legal gestational limit is well known

In many countries the gestational limit is linked to the criteria by which abortion is legal. In most European countries abortion on demand is possible up to 12 weeks of pregnancy, while on medical grounds there is often no limit. Young women are often less likely than older women to detect the pregnancy or find help within the legal period. This exposes young women to a higher risk of seeking illegal solutions.

Recommendation: *ensure that legal gestational limits are well known and that this information forms part of sexuality education programmes.*

Ensuring there is no mandatory waiting period

An obligatory waiting period for an abortion is a barrier for many women in terms of the need to return to healthcare services (in cost and time) and a risk of exceeding the gestational limit. Checking whether the decision made is really that of the woman and nobody else should be left to the service providers serving the client. The State has the duty to protect the rights of the client, which means setting the conditions for women's decisions to be taken freely and in the time and space most appropriate for the person concerned. The law should not press to delay or accelerate the provision of any service.

Recommendation: *a pre-determined period for reflection should not be made mandatory and should not be included in the legislation but left to the judgement of counsellors or service providers.*

Ensuring that parental/adult consent is not mandatory

In some countries young women are confronted with mandatory consent from their parents or spouse. This requirement is often a serious barrier for some young women to seek help and undermines their right and their ability to make a decision. In

counselling, an open dialogue between the young client and the parents should be stimulated where possible to increase the young person's wellbeing, but this should not be a legal condition for obtaining a service. It should also be taken into account that the procedures in some hospitals require the signatures of the parents for anaesthesia and/or the operation.

Recommendation: *ensure that parental/adult consent is not part of a legal framework and that an exception to regular procedures of public hospitals should be stipulated to protect the right to confidentiality of a minor seeking an abortion.*

Providing high-quality counselling
In principle, pre- and post-abortion counselling is good when it is used to check whether the woman is comfortable with her decision and that no pressure has been put on her. It is also a good moment for information on and preparation for the act of abortion and contraceptive use. However, counselling should only be given to those women who want it, and there should be no legal obligation for them to receive it.

Recommendation: *the content of counselling should be part of guidelines and protocols set up to deliver high-quality services. The implementation of the guidelines should be monitored to ensure that the counselling offered is of a high quality.*

Ensuring broad geographical access and minimizing stigma
Young women from rural areas can face more difficulties in accessing abortion services because of distance or lack of privacy in small villages and the stigma attached to abortion.

Recommendation: *ensure broad access to abortion throughout the country and provide an environment for young people that reduces stigma and respects privacy and confidentiality. At least one local hospital or clinic should provide abortion services, and it is the responsibility of the government to ensure that they are provided without discrimination.*

Expanding the type of service provider who can perform legal abortions
It is necessary to expand the type of service providers in many countries to ensure access to abortion in urban and rural areas. There is no reason why this procedure, in particular medical abortion, should be limited to obstetricians or gynaecologists. As long as medical education includes abortion in its curriculum for general practitioners and midwives and/or they receive the necessary training, they should be able to perform abortions. This is particularly important in settings where conscientious objection is widespread among gynaecologists.

Recommendation: *ensure training of other health professionals to perform abortions (in particular medical abortion) in resource-limited situations.*

Providing a wide range of settings
An abortion, and certainly medical abortion, does not require a hospital setting. In many countries there are small-scale abortion clinics with high-quality performance. This type of environment presents lower barriers for young women and ensures a variety of service delivery points and a wider range of choice. However, settings need a multi-disciplinary team and control mechanisms in place, which private practices of individual doctors cannot deliver.

Recommendation: *ensure that young women are able to access abortion services in a mix of medical settings to increase accessibility and quality of care.*

Ensuring a high quality of services
Young women may encounter quite judgemental attitudes from service providers, which increase the stigma around abortion. The rights of the client (privacy, confidentiality, choice in methods, modern techniques for surgical abortion, the quality of pre- and post-abortion counselling) are often not met and cause additional distress and sometimes even bad treatment ending in complications and infertility.

Recommendation: *ensure that quality assurance mechanisms based on clients' rights are in place to verify that services are of high quality. The implementation of quality assurance schemes and the protection of clients' rights should be regularly monitored and evaluated.*

Training and supporting service providers
Service providers might lack the necessary training in performing abortions using modern techniques and providing the necessary counselling respecting the woman's perspective.

Recommendation: *ensure that curricula for service providers include training on abortion and the delivery of youth-friendly services and that in-service training is provided.*

Establishing a clear legal position on conscientious objection
Sometimes medical practitioners object to performing an abortion on religious or moral grounds. The State must ensure a balance between the respect for individual beliefs and the respect for the provision of public services foreseen by law.

Recommendation: *ensure that there is a clear legal framework that makes referral to a colleague obligatory when a service provider has a conscientious objection to providing abortion services.*

Providing easily accessible information
Stigma around abortion is the result of lack of knowledge, information and cultural and religious prejudices. Stigma and discrimination do not stop women seeking abortion but expose them to higher risk in terms of health and safety. They also fuel the black market, making abortion less visible and, therefore, less controllable. The negative culture around abortion must be addressed and combated. People have the right to know where they can get help, and therefore information should be easily accessible.

Recommendation: *ensure that information about the legality, access and costs of abortion is communicated to the public and service providers and is accessible to young people.*

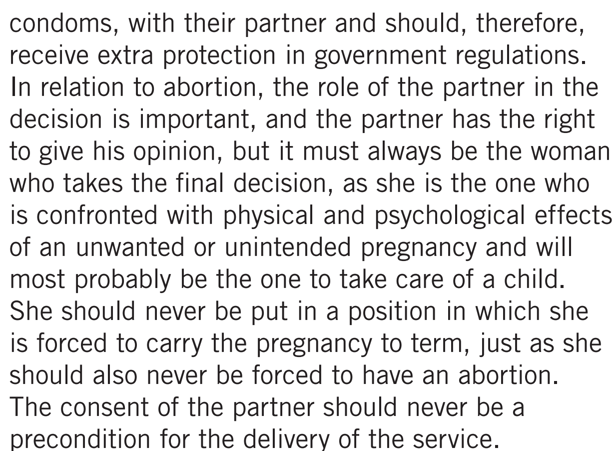
Ensuring that abortion is affordable to all young women
For a government, the cost of high-quality abortion is not that high compared to the health risks of unsafe abortion and the consequent risk of ill health and infertility. The cost for infertility treatment exceeds by far the cost of an abortion. Also, if a young woman has to bear the costs herself, this is again a barrier to seeking adequate help. Many countries know well the high cost of missed opportunity in relation to teenage pregnancy, which includes lower educational achievement, reduced income, domestic violence, etc.

Recommendation: *ensure that abortion can be provided at low cost or free for young women who cannot pay, in both the public and private sector.*

Promoting prevention policies
The prevention of abortion can only be done by comprehensive and age-specific sexuality education, the provision of affordable and easily-accessible contraceptives, including emergency contraception, and the provision of youth-friendly services.

Recommendation: *governments should ensure that abortion legislation is integrated into an overall strategy of prevention which includes comprehensive and rights-based sexuality education and the provision of contraception, emergency contraception and youth-friendly services.*

Ensuring that women make their own decision
In developing legislation or legislative frameworks in the area of sexual and reproductive health, and abortion in particular, specific attention needs to be paid to gender. Women are not always in a position to negotiate safe sex practices, like the use of



condoms, with their partner and should, therefore, receive extra protection in government regulations. In relation to abortion, the role of the partner in the decision is important, and the partner has the right to give his opinion, but it must always be the woman who takes the final decision, as she is the one who is confronted with physical and psychological effects of an unwanted or unintended pregnancy and will most probably be the one to take care of a child. She should never be put in a position in which she is forced to carry the pregnancy to term, just as she should also never be forced to have an abortion. The consent of the partner should never be a precondition for the delivery of the service.

Recommendation: *ensure that women have the means to make their own decision and cannot be forced into pregnancy.*

Reaching vulnerable groups

In developing a legislative framework or protocols and procedures for implementation, specific attention should be paid to vulnerable groups such as physically and mentally deprived people, ethnic minority groups, young people living in residential institutions, and people living with HIV. Specific guidelines will need to be developed to ensure that they are equally informed and equally protected as anyone else. Attention needs to be paid to cultural, language and physical barriers.

Recommendation: *ensure that adequate information and services are available to all those who need it, including the most vulnerable groups.*

Glossary

Abortion
Termination of pregnancy before the fetus has become capable of sustaining an independent life outside the uterus. An abortion can occur either spontaneously, when it is called a spontaneous abortion or miscarriage, or it can be brought about by deliberate intervention, when it is called an induced abortion. It is with this last meaning that the word is generally used. The stage at which a fetus is considered viable varies according to different legislations and recommendations.

Adolescence
There is no universally agreed definition of adolescence, and it must be emphasized that it is a phase – rather than a fixed time period – in an individual's life. However, the UN defines adolescence as 10–19 years, with further divisions into early adolescence for 10–14 years and late adolescence for 15–19 years.[50]

Advocacy
A campaign or strategy to build support for a cause or issue. Advocacy is directed towards creating a favourable environment, by trying to gain people's support and by trying to influence or change legislation.

Child
The UN Convention on the Rights of the Child defines a child as being under the age of 18 years.

Comprehensive sexuality education
Comprehensive sexuality education gives young people the tools they need to feel more confident in making informed decisions about their sexuality and to develop healthier and more satisfying relationships. It also assists young people in developing their own values and attitudes and recognizing their rights as sexual beings. Rather than using only a single approach to sexuality education, comprehensive sexuality education includes an emphasis on sexual expression, sexual fulfilment and pleasure, representing a shift away from methodologies that focus exclusively on the reproductive aspects of adolescent sexuality.

Emergency contraception
A method of contraception used to avoid pregnancy after a single act of sexual intercourse that was unprotected due to lack of use or failure of a contraceptive. Two types are available:
- hormonal treatment with high-dose oestrogen, low-dose oestrogen-progestagen combination or progestagen-alone Emergency Contraception Pills (ECPs), which should be taken as soon as possible after unprotected sex; and
- the insertion of an intra-uterine device, which has to be carried out within five days of unprotected sex.
- ECPs are thought to prevent ovulation, fertilization, and/or implantation. They are not effective once the process of implantation has begun and will not cause abortion. Recent studies have provided new information concerning the regimen for levonorgestrel-only and Yuzpe ECPs. This research indicates that ECPs can prevent pregnancy up to five days (120 hours) after unprotected intercourse.

Female condom
The female condom consists of a lubricated poly-urethane or nitrile sheath shaped similarly to the male condom. The closed end, which has a flexible ring, is inserted into the vagina, while the open end remains outside, partially covering the labia. The female condom, like the male condom, is available without a prescription and is intended for one-time use.

50WHO (1998) The Health of Youth, Document A42/Technical Discussions/2, Geneva: WHO www.un.org.in/Jinit/who.pdf

Female genital mutilation
Also referred to as female circumcision or female genital cutting, female genital mutilation is a traditional practice that involves cutting away parts of the female external genitalia, or other injury to the female genitals, for cultural or other non-therapeutic reasons, rendering intercourse and childbirth painful and potentially hazardous and having a life-long impact on the mental health and wellbeing of the girl/woman. It is usually carried out by traditional practitioners under unhygienic conditions.

Gender equality
Measurable equal representation of women and men. Gender equality does not imply that women and men are the same, but that they have equal value and should be accorded equal treatment.

Informed choice
Voluntary decision by a client to use, or not to use, a contraceptive method (or accept a sexual and reproductive health service) after receiving adequate information regarding options, risks, advantages and disadvantages of all available methods. Exercising the right to both access family planning and to make informed and responsible decisions about childbearing requires full knowledge of the benefits, purposes and practice of family planning, access to services, and the personal, familial and societal consequences of individual reproductive behaviour.

Positive prevention
Positive prevention aims to increase the self-esteem and confidence of HIV-positive individuals to protect their health, to avoid new STIs, to delay HIV/AIDS disease progression, to avoid re-infection, to prevent passing their infection to others, and to adopt a lifestyle aimed at prolonging their life. Positive prevention needs to be implemented within an ethical framework that respects the rights and needs of people living with HIV, and it needs a supportive legal and policy environment. Positive prevention represents the most fundamental synergy between prevention, care, treatment and support.

Policy
A set of decisions to pursue courses of action for achieving goals; a goal being an aim towards which to strive.

Reproductive health
The International Conference on Population and Development stated: ‘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. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counselling and care related to reproduction and sexually transmitted diseases.’

Reproductive rights
The International Conference on Population and Development stated: ‘Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning.’

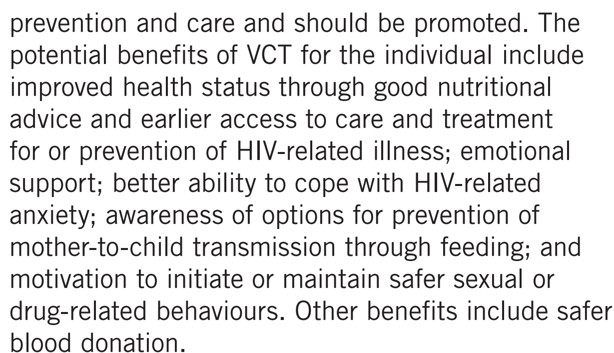
Sexuality
The sexual knowledge, beliefs, attitudes, values, and behaviours of individuals. Its dimensions include the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles and personality; and thoughts, feelings, and relationships. The expression of sexuality is influenced by ethical, spiritual, cultural, and moral concerns.

Sexuality education
Education about all matters relating to sexuality and its expression. Sexuality education covers the same topics as sex education but also includes issues such as relationships, attitudes towards sexuality, sexual roles, gender relations, and the social pressures to be sexually active. It also provides information about sexual and reproductive health services and may include training in communication and decision-making skills.

Sexually transmitted infection
Disease resulting from bacteria or viruses and often acquired through sexual contact. Some sexually transmitted infections (STIs) can also be acquired in other ways (i.e. blood transfusions, injecting drug use, and mother-to-child transmission). The term 'STI' is slowly replacing 'STD' (sexually transmitted disease) in order to include HIV infection. Most STIs, like HIV, are not acquired from partners who are obviously ill, but rather through exposure to infections that are asymptomatic or unnoticeable at the time of transmission.

Unsafe abortion
An induced abortion conducted either by persons lacking the necessary skills or in an environment lacking the minimal medical and hygienic standards, or both. Although the majority of the world's women live in countries where laws permit an induced abortion if they request one and if there are health or social grounds for allowing it, a quarter of women live in countries where there is no access to legal abortion. Even in countries where abortion is legal, women may not be able to obtain abortions easily for reasons of bureaucracy, availability or accessibility. In these circumstances women with unwanted pregnancies frequently resort to unsafe abortion.

Voluntary counselling and testing
Voluntary counselling and testing (VCT) is the process by which an individual undergoes counselling that enables him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual, and he or she must be assured that the process will be confidential. VCT has a vital role to play in a comprehensive range of measures for HIV



prevention and care and should be promoted. The potential benefits of VCT for the individual include improved health status through good nutritional advice and earlier access to care and treatment for or prevention of HIV-related illness; emotional support; better ability to cope with HIV-related anxiety; awareness of options for prevention of mother-to-child transmission through feeding; and motivation to initiate or maintain safer sexual or drug-related behaviours. Other benefits include safer blood donation.

Vulnerable people
A person or group is vulnerable when support is required to enable or promote independent living and safe and active participation in the community. Factors that may make groups of people vulnerable include poverty, gender, age, race, language, disability and special needs. Vulnerable young people might be: out of school; street children; those with disabilities or special needs; orphans or living in residential institutions; ethnic minorities; those living with HIV; migrants; refugees and asylum seekers; injecting drug users; sex workers and their clients; those at risk of being trafficked; and those who are lesbian, gay, bisexual or transgender.

Youth
Both the UN General Assembly and the World Health Organization define youth as those persons falling between the ages of 15 and 24 years inclusive. However, many countries define adulthood as the age at which a person is given equal treatment under the law, which is 18 in many countries.

Young people
Those persons who are aged 10–24 years.

References

General
- Council of Europe (2004), European strategy for the promotion of sexual and reproductive health and rights Strasbourg: Council of Europe http://assembly.coe.int/Main.asp?link=/Documents/WorkingDocs/Doc04/EDOC10266.htm
- IPPF EN (2007) Sex and young people in Europe: a research report of the sexual awareness for Europe partnership, Lund: Lund University, Sweden
- WHO Regional Office for Europe (2005) European strategy for child and adolescent health and development, Copenhagen: WHO Regional Office for Europe, 19 pp. http://www.euro.who.int/document/E87710.pdf
- World Bank (2007) World Development Report 2007 – Development and the Next Generation, Washington, DC: The World Bank http://web.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTWDRS/EXTWDR2007/0,,menuPK:1489865~pagePK:64167702~piPK:64167676~theSitePK:1489834,00.html

Information, education and communication
- Bellander Todino, I and Trousson, P (2006) Daphne Toolkit: Resources for combating violence against children, young people and women (EU-funded project under the Daphne Programme) http://www.daphne-toolkit.org/prjListe.asp?pays=DK&lang=EN
- Center for Reproductive Rights (CRR) (2002) Bringing Rights to Bear: An Analysis of the Work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights, New York: CRR
- Frans, E (2003) Good Lovers – a new concept of sex education, Ghent: Sensoa http://www.sensoa.be/downloadfiles_shop/concept_good_lovers.pdf
- Helfferich, C and Heidtke, B (2006) Country Papers on youth sex education in Europe, Cologne: Bundeszentrale für gesundheitliche Aufklärung (BZgA)
- IPPF (2002) A Young Person's Guide, London: IPPF http://www.ippf.org/NR/rdonlyres/1F0F2AA6-5A35-4771-8222-E002874748F1/0/Ayoungpersonsguide.pdf
- IPPF(2006) Comprehensive sexuality education framework, London: IPPF http://www.ippf.org/NR/rdonlyres/CE7711F7-C0F0-4AF5-A2D5-1E1876C24928/0/Sexuality.pdf
- IPPF European Network (2004) Peer education handbook on sexual and reproductive health and rights teaching vulnerable, marginalized and socially excluded young people, Brussels: IPPF EN, 80 pp.
- IPPF European Network (2006) Sexuality education in Europe. A reference guide to policies and practices, Brussels: IPPF EN, 94 pp, www.ippfen.org/en/Resources/Our+Publications/Sexuality+Education+in+Europe.htm
- SIECUS (2005) Sexuality education community action kit, New York: SIECUS http://www.communityactionkit.org/getting_ready.html
- UNICEF (2006) Child and youth participation resource guide, New York: UNICEF http://www.unicef.org/adolescence/index_38074.html
- UNICEF Innocenti Research Centre (2006) Comparing child well-being in OECD countries: concepts and methods, Working Paper, December 2006, Florence: UNICEF Innocenti Research Centre, http://www.unicef-irc.org/publications/pdf/iwp2006_03_eng.pdf
- UK FPA, Speakeasy, http://www.fpa.org.uk/community/speakeasy/index.cfm?contentid=36
- WHO Regional Office for Europe (2005) European strategy for child and adolescent health and development, 2005, Copenhagen: WHO Regional Office for Europe http://www.euro.who.int/childhealtdev/strategy/20060919_1

Health Services

- Dickson-Tetteh, K et al (2000) Going for gold: a clinic guide to the national adolescent friendly clinic initiative, Bertsham, South Africa: University of Witwatersrand, Reproductive Health Research Unit
- Engenderhealth (2002) Youth Friendly services. A manual for service providers, New York: Engenderhealth, http://www.engenderhealth.org/res/offc/qi/yfs/index.html
- WHO (2002) Adolescent Friendly Health Services: An Agenda for Change, Geneva: WHO http://www.who.int/child-adolescent-health/New_Publications/ADH/WHO_FCH_CAH_02_14.pdf
- WHO Europe (2004), Youth friendly health services in Europe, Entre Nous, N° 58 http://www.euro.who.int/entrenous/20020905_1

Access to contraception

- FHI (2005) Creating Youth-Friendly Pharmacies, YouthLens, No. 17, August 2005 http://www.fhi.org/NR/rdonlyres/e4eknuzx7faq2badu6rjxv6asystnxmrsl5txovodrrar5z45ym5tgj2oehdzot3d3uxw7gl2lbmep/YL17e1.pdf
- Harper, Cynthia C et al (2005) The effect of increased access to emergency contraception among young adolescents, Obstetrics and Gynaecology 2005; 106:483 491
- Abstract: http://www.greenjournal.org/cgi/content/abstract/106/3/483
- IPPF/The International Medical Advisory Panel (IMAP) (2002) Statement on hormonal methods, London: IPPF/IMAP, http://www.ippf.org/NR/rdonlyres/7399150A-D144-4250-A863-AB057C7EC52C/0/IMAPstatementmay2002.pdf
- Marston, C et al (2005) Impact on contraceptive practice of making emergency hormonal contraception available over the counter in Great Britain: repeated cross-sectional surveys, British Medical Journal 2005; 331:271
- WHO (2004) Contraception in adolescence: Issues in Adolescent Health and Development, Discussion Papers on Adolescence, Geneva: WHO, 56 pp.

STIs and HIV/AIDS

- Council of Europe Parliamentary Assembly (2007), HIV/AIDS in Europe – Resolution 1536 (2007)1, Strasbourg: Council of Europe http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta07/ERES1536.htm
- EuroHIV (2006) HIV/AIDS Surveillance in Europe. End-year report 2005, Saint-Maurice: Institut de veille sanitaire, 2006, No. 73 http://www.eurohiv.org/reports/report_73/pdf/report_eurohiv_73.pdf
- European Commission Communication from the Commission to the Council and the European Parliament on combating HIV/AIDS within the European Union and in the neighbouring countries, 2006-2009, Brussels: European Commission http://ec.europa.eu/health/ph_threats/com/aids/docs/com_2005_654_en.pdf
- German Council Presidency (2007) Bremen Declaration on Responsibility and Partnership – Together against HIV/AIDS, Bremen: German Council Presidency http://www.eu2007.de/en/News/download_docs/Maerz/0312-BSGV/070Bremen.pdf

- IPPF (2004) Integrating Voluntary Counselling and Testing Guidelines for Programme Planner, Managers and Service Providers, London: IPPF SAR, http://www.ippf.org/en/Resources/Guides-toolkits/Integrating+Voluntary+Counselling+and+Testing.htm
- Matic, S, Lazarus, JV and Donoghoe, C (2005) HIV/AIDS in Europe. Moving from death sentence to chronic disease management, Geneva: WHO, http://www.euro.who.int/InformationSources/Publications/Catalogue/20051123_2
- UNAIDS/WHO (2006) AIDS epidemic update: December 2006, New York: UNAIDS, Geneva: WHO, http://www.unaids.org/en/HIV_data/epi2006/default.asp
- WHO Regional Office for Europe (2007) Can we prevent cervical cancer? Screening-Vaccine, Entre Nous, The European Magazine for sexual and reproductive health No. 64 2007, Copenhagen: WHO Regional Office for Europe, http://www.euro.who.int/document/ens/en64.pdf

---

Unwanted Pregnancies and Safe Abortion

- De Bruyn, M and Packer, S (2004) Adolescents, Unwanted Pregnancy and Abortion: Policies, Counseling and Clinical Care, Chapel Hill, NC: Ipas http://www.ipas.org/Publications/asset_upload_file38_2419.pdf
- IPPF European Network (2007) Abortion legislation in Europe, Brussels: IPPF EN http://www.ippfen.org/NR/rdonlyres/2EB28750-BA71-43F8-AE2A-8B55A275F86C/0/Abortion_legislation_Europe_Jan2007.pdf
- UN Committee on the Rights of the Child (2003) http://www.ohchr.org/english/bodies/crc/index.htm
- UNFPA (1999) Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development, adopted by the 21st special session of the General Assembly, New York, 30 June to 2 July 1999, New York: UNFPA http://www.unfpa.org/publications/detail.cfm?ID=276
- WHO (2003) Safe abortion: technical and policy guidance for health systems, Geneva: WHO, 106 pp., http://www.who.int/reproductive-health/publications/safe_abortion/
- WHO Europe (2007) Health for All Database (containing latest Europe-wide statistics on abortions and live births among teenagers) http://data.euro.who.int/hfadb/
- WHO Europe (2005) Abortion in Europe, Entre Nous, N° 59 http://www.euro.who.int/document/ENS/en59.pdf

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