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Challenges

durex network - Raising awareness of sexual health across the globe

Issue 4, 2009

# Happy teens – healthy teens

## Adolescent health researchers increasingly agree that higher aspirations and a better outlook on future life bear a strong influence on risk taking with health, especially when it comes to sex

TEENAGERS THROUGHOUT the globe are disproportionately affected by unplanned pregnancies and STIs including HIV/AIDS.

According to the 2008 *World Population Prospects* report (WPP), there are 1.17 billion young people aged 15 to 24 in the world, making 17.8 per cent of the global 6.8 billion population.

The latest UNAIDS *Epidemic Update,* released in 2007, estimates that these young people account for 40 per cent of all new HIV infections. And the WPP further indicates that young girls in that age group, who make up 48.8 per cent of young people globally, will be expected to have given birth to just under 300 million babies between 2005 and 2010.

Yet every day, new interventions are undertaken to try and give young people the tools to make informed decisions for their sexual health. New education curricula are created and taught, new healthcare services are provided and new ways of disseminating family planning supplies are pioneered.

But what if all these efforts were partly falling on deaf ears? What if the way young people were being approached failed to engage them for reasons that had seldom been considered before? This is what many adolescent health researchers are now beginning to suspect.

An increasing number of studies are looking at the wider picture in the lives of teenagers around the world in a bid to better understand the factors that influence what they do – and what they don't do – to protect themselves.

According to Robert Blum, who is William H. Gates Senior Professor and Chair of Population, Family and Reproductive Health at the Johns Hopkins School of Public Health, commented. "When we're talking about teen pregnancy, we focus on factors that are most proximal. For example, why aren't they using contraception?

"And we build our interventions on the very proximal factors that influence behaviour.

"But we need to focus on those factors that influence sexually risky behaviour. And those powerful determinants aren't always the factors that are most proximal."

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# Professor Freya Sonenstein on the sexual health of young men

## As part of our occasional series looking at leaders in the world of sexual and reproductive health, *Challenges* spoke to Professor Freya Sonenstein about her views on the role of young men in sexual health, particularly in the United States

PROFESSOR SONENSTEIN is Director of the Center for Adolescent Health Promotion and Disease Prevention and a Professor of Population, Family and Reproductive Health at Johns Hopkins University Bloomberg School of Public Health. Her primary interests include sexual and reproductive health with a special emphasis on adolescents and males. She has recently completed a review of research assessing programmes that involve males in preventing teen pregnancy, and analysing how young men establish stable romantic relationships.

**Why does your research into sexual attitudes and contraception focus mostly on young men?**

This work began more than 20 years ago. At that time men's role in family planning was virtually ignored. Data about sexual and contraceptive behaviour were gathered only from women and family planning clinics only served females. It seemed obvious that men's attitudes and behaviours contributed to unintended pregnancies but no one had tried to gather information from a national sample of men before.

I like to think that our original work in this area has brought some changes. In the US our *National Survey of Family Growth* now includes interviews with men and the Office of Family Planning funds demonstration programmes in this area.

**Do you feel that education and sexual health programmes focus enough on young men?**

I think that in spite of our best efforts there are still many education and sexual health

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What Professor Blum is pointing at is those factors present in a teenager's life that will or will not push them to take risks, whether sexually or through other channels such as drugs and alcohol abuse. And among these factors, one of the most prominent seems to be a teenager's overall wellbeing and outlook on life – a teenager's happiness.

Professor Blum adds: "Contracepting is like putting money in the bank. Kids aren't going to contracept if they don't think they have much of a tomorrow."

Transition is what epitomises adolescence. In the journey young people have to take between childhood and adulthood, they have to leave behind many physical, psychological, emotional and social certainties and plunge into the unknown with the hope of emerging on the other side, one way or another.

It is not surprising, then, that many are finding this transition period somewhat challenging and that some of them engage in risk taking activities.

According to a University of Minnesota Medical School study published in the July 2009 issue of *Pediatrics*, a teenager's belief that it is highly likely they will die young – whether or not this belief is founded – is a strong predictor for engaging in risky behaviour. The study further points out that such teenagers are significantly more likely to be diagnosed with HIV/AIDS within six years.

But far from being a simple case of a conscious decision made to push the limits beyond the realm of known outcomes, risk-taking behaviour in adolescents is influenced by a complex array of factors.

As Kaye McLaren – writing in *Building Strength*, a New Zealand Ministry of Youth Affairs youth development report published in 2002 – puts it: "The most up to date research tells us that parents, schools, peers and communities can make a big difference by providing certain conditions which make it more likely that young people will thrive."

Take any of these factors out of the equation, or change their positive influence into a negative one, and the balance is broken – sometimes to an irreparable degree.

Lacking the presence of a caring adult, being – or feeling – excluded from social circles, coming from poor material circumstances and feeling generally unhappy all have the potential to translate into low expectations for one's future, and therefore not wanting to care enough to protect oneself effectively.

But we don't even have to go this far. According to a 2005 study by the London School of Hygiene and Tropical Medicine, there is a strong association between dislike of school and an increased risk of teenage pregnancy, regardless of the young person's sexual health knowledge or confidence.

The message is clear: it is the whole of a teenager's immediate environment and outlook on life that will ultimately influence whether or not safer sex will be practiced consistently.

So before handing out a condom or an information leaflet on STIs or pregnancy to a teenager, maybe it would be worth finding out how happy they are. ■

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programmes that are not built on an informed view of men.

The stereotypical view of men is that many are sexual marauders with no interest in forming enduring and satisfying relationships. However, evidence collected over the last two decades suggests the majority of young men in the US are monogamous and they and their female partners tend to have a number of monogamous relationships with partners over time.

Also, a number of prevention programmes have demonstrated that men will come into family planning clinics when they are welcomed and services are tailored to their needs.

**What do you feel is the primary difference between young men and women in their attitudes towards sexual health?**

The differences are not as large as we think, and over time they have become less sharp. For example, in the US, adolescent males used to report a much younger age of first sexual intercourse than females. In 2002, for the first time, adolescent males and females reported similar ages at first intercourse. This is the result of more boys postponing sexual initiation rather than girls starting earlier. We can speculate that some of this change is due to the recognition of the risk of HIV and other STIs as both sexes are at risk.

However, young women do suffer disproportionately from the negative consequences of unintended pregnancies, but even in this area stricter child support enforcement has led to a diminishing of differences.

**How do you feel about intervention programmes which target young men, such as *Program H*?**

*Program H* is a good example of a programme that has been rigorously evaluated and shown to produce changes in young men's sexual and contraceptive behaviour. The programme includes a curricular component as well as a social marketing arm. It focuses on changing attitudes and behaviours of young men regarding gender role equality, the acceptability of interpersonal violence, and safer sex. It has been implemented in Brazil and India and other countries as well. I know there is an effort to try it here in the US.

It is certainly one of an array of programmes that have been demonstrated to lead to less risky sexual behaviours among young men but does require fairly intensive resource investments.

**Do you feel that enough emphasis is placed on the role of young men in current sex education programmes?**

Most sex education in the US is coeducational. The problem is that much of what is offered is too little, too late. There are now a number of curricula that have been demonstrated to be effective and schools and youth serving agencies need to use them. Educators must understand that assisting young people to develop healthy and responsible views about their sexuality is as important in the overall scheme of things as mastering calculus.

**What research are you working on at the moment?**

Developing and testing approaches to help youths, like those in inner city Baltimore, move into successful adult roles. Given the high rates of teen pregnancy, STIs and HIV here, providing sexual and reproductive health programmes is important.

But these alone will not lead to success. We have found that our efforts need to address educational and job training needs, severe mental health and substance misuse issues and high levels of interpersonal violence.

**Why are you looking at this particular area?**

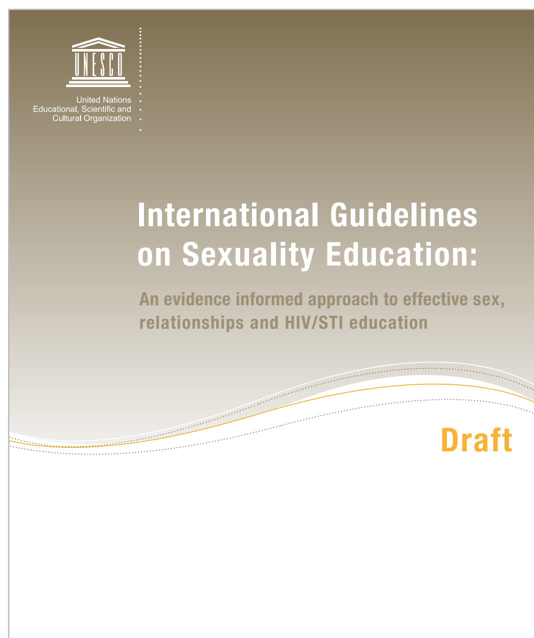
I want to make a real difference. Sexual and reproductive health programmes have demonstrated modest success. I think more comprehensive approaches for very high risk youth are what we need.

**What do you think is the way forward in terms of reducing unwanted pregnancy and the transmission of STIs?**

In the US we need greater public acceptance of the appropriateness of discussing sexual behaviour and safer sex in our schools, our churches, our youth serving programmes and our mass media. ■

# Division over UNESCO's new sex education guidelines

**Imagine riding a unicycle across a tightrope blindfold while juggling with one arm tied behind your back – that should be a fair description for those brave enough to enter the debate on sex education**


UNESCO
United Nations Educational, Scientific and Cultural Organization

International Guidelines on Sexuality Education:

An evidence informed approach to effective sex, relationships and HIV/STI education

Draft

THERE ARE some subjects which spark a degree of interest, others which fail to flicker into light and then those which ignite a raging inferno of conflicting views which can be fuelled by vitriolic outbursts from entire swathes of society, and this is where the rights and wrongs, whys and wherefores of sex education enters the fray.

This month, October 2009, should see UNESCO release new guidelines to governments and education bodies around the world on how, and equally importantly, when children should be taught about sex and sexual health.

Designed to be taught to four different age groups, starting at 5 and ending at 18, the document was drafted in the face of statistics showing only 40 per cent of young people aged 15 to 24 had accurate knowledge about HIV and transmission while they account for 40 per cent of all new infections.

*The International Guidelines on Sexuality Education* were drafted by researcher Dr Doug Kirby and Nanette Ecker, a leading practitioner in the field of sex education. According to UNESCO they provide an "evidence-informed approach to effective sex, relationships and HIV/STI education".

The draft guidelines, which have been available since late summer via the UNESCO website, recommend the teaching is "age appropriate, culturally relevant and scientifically accurate" and breaks down the elements into four age groups – 5 to 8 years, 9 to 12 years, 12 to 15 years and 15 to 18 years.

"Few young people receive adequate preparation for their sexual lives. This leaves them potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexually transmitted infections including HIV," says the document.

The guidelines came about after the commissioning of a systematic review of literature on the impact of sex education on sexual behaviour, it says. The research looked at 87 studies – 47 of them conducted in America, 29 in developing countries and 11 from other developed countries.

The statistics it highlights include the fact there are 10 million young people living with HIV, 4.4 million abortions worldwide and 111 million cases of curable STIs in the 10-24 age group. Added to that are the 10 per cent of all births coming from teenage mothers. Figures like these appear to illustrate all too clearly the need for a more cohesive approach to sex education.

The pro-life media has highlighted the fact that the report says, to steal a phrase, "the naming of parts" should begin at age 5, along with a mention of masturbation and, predictably, the ensuing publicity has been in the inferno category – particularly in America.

Press in the UK has picked up on the story and run a similar line in papers supportive of a pro-life stance – prompting a flurry of correspondence from the green-pen brigade who are ever-willing to aspire to the Utopia which can never be. ■

Credit: WHO

Sex education in a Mexican school

# Violence between partners: a social ill with many layers

## Intimate Partner Violence (IPV) is an issue that affects millions of men, women and children across the world. The problem transcends religious, cultural and economic boundaries and its consequences can be physical, psychological, social and financial

NUMEROUS GOVERNMENTS have attempted to tackle the issue and, in the last few months, IPV has cropped up a number of times on the global news agenda. But what exactly is IPV, who is most at risk and what is being done to try and reduce the problem?

Intimate Partner Violence can be defined as abuse that occurs between two people in a close relationship, and this can include current and former spouses as well as dating partners. IPV can take a number of forms including physical abuse, sexual abuse, threats and emotional abuse such as stalking, name-calling and intimidation.

Although the majority of victims are female, IPV may be perpetrated by both men and women. Research in the US, for example, has found that 29 per cent of women and 22 per cent of men have experienced physical, sexual or psychological IPV during their lifetime.

According to the Centre for Disease Control and Prevention, nearly 5.3 million women in the US are victims of IPV every year – the current US female population is 154.7 million – whilst in South East Asia, says the South East Asia office of WHO, almost half of women reported physical violence by their husband or partner. But what is particularly worrying is that the problem can arise at any age.

In September 2009, for instance, the UK media reported that one in three teenage girls claim to have been sexually abused by their boyfriend, with a quarter being physically assaulted. Of the 1,300 youngsters aged between 13 and 17 who took part in the survey, which was carried out by the University of Bristol, one in six girls and one in 17 boys said they had been pressured into having sex.

Britain's problems, however, pale in comparison with those of other, less developed nations.

In August 2009, a report in South Africa published in *The Lancet* revealed that the number of women killed by their intimate partner is six times more than the global average. Some 88 per cent of women in Soweto – in the city of Johannesburg – said they had experienced physical or psychological abuse by their partners while more than 40 per cent of South African men admitted to being physically violent towards their girlfriend or wife.

With IPV prevalent across all levels of society, its consequences are serious and widespread. The most obvious effects of Intimate Partner Violence are physical, ranging from bruises and broken bones to STIs and heart conditions. According to *Intimate Partner Violence and Physical Health Consequences* (Campbell et al, 2002), women with a history of IPV report 60 per cent higher rates of all health problems than those with no history of abuse.

Less noticeable – but potentially just as damaging – are the psychological effects of IPV. The study *Violence and Health: the United States in Global Perspective* (Mercy et al, 2003) found that abused women often experience adverse mental health conditions such as depression, anxiety and low self-esteem, and are more likely to resort to substance abuse, alcoholism and even suicide.

Victims of IPV can also encounter restricted access to services and public life, strained relationships with health providers and employers and isolation from their friends and relatives. But the consequences of IPV are not limited to those directly involved.

Researchers report that children who witness domestic violence are at greater risk of developing psychiatric disorders, developmental problems, school failure, violence against others and low self-esteem.

Aside from resulting in around 1,600 deaths every year, the financial cost of IPV in the US is around $8.5 billion a year, which includes medical care, mental health services and lost productivity.

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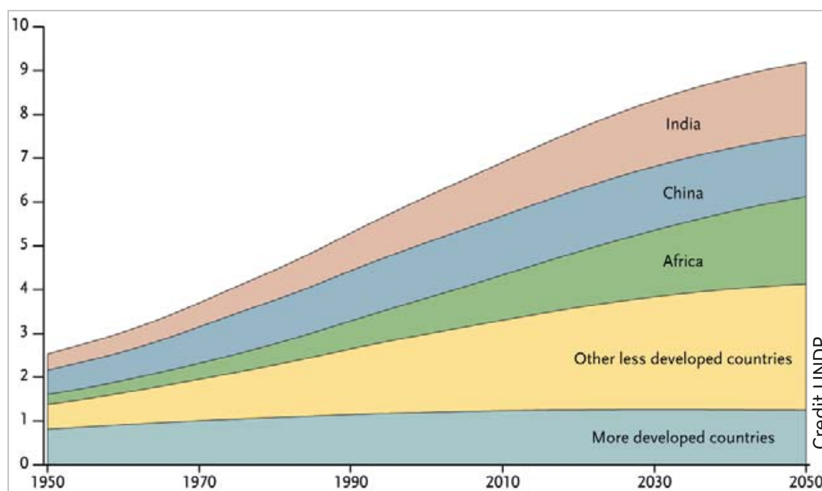
# Facing the global challenges of a rising population

## There are currently 6.8 billion people living on the planet and this figure is expected to rise to 9 billion by 2050. But different countries face very different challenges when it comes to the issue of population control

ACCORDING TO figures released by the Office for National Statistics in August 2009, the UK population has now reached a record 61 million and is growing twice as fast as in the 1990s. In 2008 there were an extra 19,000 babies born in Britain, which took the total births to 791,000 and resulted in 408,000 more people living in the UK than in the previous year. This represents the biggest annual rise since 1962, but what is behind the dramatic increase?



World Population Prospects: The 2006 Revision

One reason is that the UK has been experiencing its highest fertility rate for 15 years. The statistical average number of children born to each woman – or fertility rate – has risen from 1.63 in 2001 to 1.96 in 2008, the highest since 1973. This can be attributed to a number of concurrent factors including births from women in their thirties and forties, the increased popularity of IVF treatment and a higher fertility rate for women living, but not born, in Britain – 2.51 against 1.84 for British born women.

However, although there are now more women of childbearing age from the Indian sub-continent and Eastern Europe in the UK, they only account for 24 per cent of the total births recorded over the period. The Office for National Statistics also suggests that better support for families, including tax credits and more generous maternity leave, may also be a factor behind the increase.

Across the English Channel the story is much the same. New figures show that France is the most fertile country in Europe, with nearly 800,000 babies born for a mainland population of 63 million and a fertility rate of 1.90 – well above the European average of 1.50 children per woman.

Since the middle of the 20th Century, French governments have consistently rewarded large families with generous tax benefits and excellent day and nursery schools. Working mothers are the norm and they benefit from the country's relatively flexible and shorter working hours.

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It is not surprising, therefore, that a number of governments have attempted to tackle the issue of IPV.

The *Duluth Domestic Abuse Intervention Project* was launched in the US in 1981 and involved co-ordinating the actions of a variety of agencies – including police officers, shelters for battered women, and probation officers – to deal with domestic situations more effectively. The programme seeks to eliminate domestic violence through written procedures, policies, and protocols governing intervention and prosecution of criminal domestic assault cases.

A study published in 2002 sponsored by the federal government found that people who complete the Duluth programme are less likely to repeat acts of domestic violence than those who don't.

In 2005 the UK Home Office published its *National Domestic Violence Delivery Plan.* The initiative – which was designed to increase the identification of IPV victims, provide effective advice and support and improve the criminal justice response – has already made a significant impact.

In the UK, for example, there are now 122 specialist domestic violence courts, which are proven to be more effective than the normal court system in dealing with the issue of domestic violence. And in 2008 the Crown Prosecution Service exceeded its target of successfully prosecuting 70 per cent of domestic violence cases.

IPV is a problem that permeates countries, cultures and classes across the globe, with its effects reverberating throughout society. In recent years there have been increasing efforts to understand and tackle the problem, although knowledge about how to prevent IPV is still in its infancy. It is now clear that the battle against IPV will only be won through educating young people, changing attitudes and offering help to perpetrators as well as victims. ■

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Another factor is the near universal acceptance of childbirth out of wedlock in France. In 2008, for example, some 52 per cent of births were to unmarried women. A record 21 per cent of all first births, meanwhile, were to women over 35, compared with 16 per cent a decade earlier.

The upsurge in births has already increased pressure on health services in both countries, including NHS maternity units in the UK. It will also intensify competition for nursery, primary and secondary school places over the next few years – just at a time when public spending faces severe cuts.

But there is also the longer-term issue of the environment to consider. Many environmentalists are now coming round to the view that curbing population growth will be crucial to combat climate change. The Optimum Population Trust, for example, is currently running a campaign in the UK urging parents to 'Stop at Two'.

UK green guru Jonathon Porritt and the director of the Science Museum, Chris Rapley, have also spoken of the environmental importance of tackling population growth – although it is also being argued that blaming population growth alone for climate change is only a distraction from the main issue of over-consumption in richer countries.
But officials need to be aware of the dangers of drastic population control policies, and nowhere is this more evident than in China.

With a staggering 1.3 billion inhabitants, China is already the most populated country in the world. This enormous number of people is ageing rapidly, and by 2050 about a quarter of all Chinese people – some 320 million – will be aged over 65. The country's workforce is already far too small to support the elderly population, and there are fears that this problem will reach a critical level in the near future.

This is one of the consequences of China's three-decade-old 'One Couple, One Child' family planning policy, and means that the country's generation of only children will find themselves having to support two retired parents and four ageing grandparents.

Japan has a similar problem. As of September 2009 the country was home to a record 29 million elderly people – an increase of 800,000 on the previous year. Meanwhile 25.4 per cent of the female population are aged 65 or over, topping 25 per cent for the first time since comparable data began in 1950.

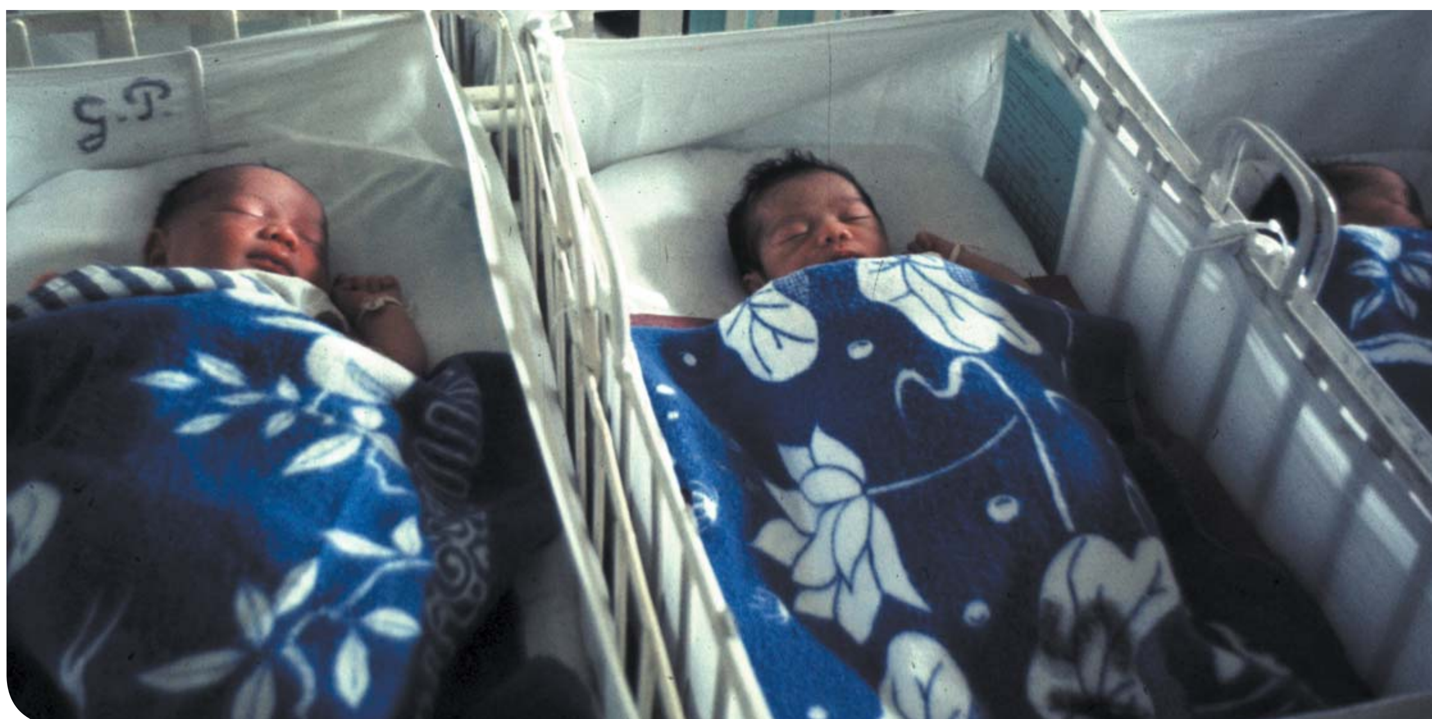
The figures fuel concerns about the ability of Japan's health system to cope with the country's ageing population, whilst also raising questions about how the existence of such a large proportion of elderly citizens could lead to a shortage of workers and put a strain on the pension fund.

Although more births would be one way of trying to deal with the problem, as is now being advocated by the head of family planning in Shanghai, China's Communist Party is unlikely to relegate its 'One Child' system, which has prevented at least 400 million births since its introduction in 1979.

The state pension systems will be the first to feel the negative effects of the declining population. Prudently, the Japanese Government introduced a pension reform in 2004, with later retirement and higher contributions from employers, employees and the Government. But the calculations, derived from the most conservative demographic projections available, were not conservative enough. Unless the birth rate rises – which looks unlikely – either pensions will have to fall or a new round of reforms will be needed.

One option is to encourage men and women to work post-retirement, while another is to introduce a similar tax benefits system to the one that has been used so successfully in France.

Population control is a complex and unpredictable issue that is truly global in its magnitude. As the world's economy and resources strain under the weight of an ever increasing number of inhabitants, policy makers will need to work hard to strike a balance between maintaining individual freedom and ensuring the population remains manageable and self-sufficient. ■



Credit: Dominique Roger - UNESCO

# European committee sanctions sexuality education programme

## The European Committee for Social Rights (ECSR) has given the green light for Croatia to continue with its sex education programme based on promoting abstinence

THREE HUMAN rights groups filed a suit against the Croatian government alleging that the curriculum in the predominately Roman Catholic country violated the European Social Charter by failing to offer comprehensive or adequate sexual and reproductive health education for children and young people.

The groups claimed that topics such as the use of effective contraception were often deliberately excluded and "in some respects the information is inaccurate and replete with bias and discrimination".

Moreover, the Croatian curriculum focuses on the "negative aspects of contraception to the exclusion of any information about its medically proven benefits and advantages," the groups alleged.

Although the Charter requires all Council of Europe countries to supply children with mandatory "sexual education", it doesn't clearly define how this should be achieved.

The ECSR decided the groups failed to show sufficient evidence that the education provided could not "reasonably fulfil" the aim of raising awareness about sexual and reproductive health to the extent required by the Charter.

"The Committee considers that it is not its role to assess in fine detail the content of national curricula," it ruled.

Following the Committee's decision, Alliance Defence Fund legal counsel Roger Kiska, who represented the organisation that produced the curriculum, said it was a victory for parents.

"Parents should be the ones responsible for making educational choices for their children. We are pleased that the European Committee for Social Rights has upheld the right for parents to choose an option that does not violate the core religious and moral beliefs of these families," he added.

"The committee not only agreed that Croatia has cultural sovereignty over its moral issues, it also acknowledged the low prevalence of sexually transmitted diseases and teen pregnancies in Croatia as compared to the rest of Europe." ■

*Challenges* is an occasional publication produced by the Durex Network. While the articles are accurate summations of current sexual health matters, the views and opinions expressed are not those of the editor.

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## Conferences and events

**6th Global Conference: Sexualities - Bodies, Desires, Practices**
**Date:** 10 to 12 November 2009
**Location:** Salzburg, Austria
**Key theme:** The conference will provide a space for inter, multi and post disciplinary debate about the interplay of identities, orientations, desires, pleasures, taboos, relations, behaviours and practices of sex and sexuality across a range of critical, contextual and cultural perspectives.
**Contact:** www.inter-disciplinary.net/critical-issues/transformations/persons-and-sexuality/call-for-papers/

**5th SAHARA Conference on the Social Aspects of HIV and AIDS**
**Date:** 30 November 2009 to 3 December 2009
**Location:** Johannesburg, South Africa
**Key theme:** Since 2003, SAHARA has convened four conferences as platforms for interaction between researchers and policy makers, with the goal of sharing information and best practices relating to the social aspects of HIV and AIDS. The 4th conference highlighted the fact that there are vastly different opinions on issues such as male circumcision and homosexuality. The 2009 conference will thus have the theme "socio-cultural responses to HIV" in order to explore these controversies.
**Contact:** http://conference.sahara.org.za

**Meeting the Millennium Development Goals: Old Problems, New Challenges**
**Date:** 30 November 2009 to 1 December 2009
**Location:** Melbourne, Australia
**Key theme:** This conference will critically engage the Millennium Development Goals and the processes or rather possibilities for change. One key aim is to bring together development practitioners, academics, policy makers and the business community.
**Contact:** www.latrobe.edu.au/humansecurity/MDGconference.html

**5th International Conference on Sexology**
**Date:** 10 to 13 December 2009
**Location:** Chennai, India
**Key theme:** This is the largest and biggest conference of its kind in India. Sexologists, urologists, psychiatrists, venerologists, endocrinologists and general practitioners, HIV specialists, psychologists and therapists are contributing their research experiences.
**Contact:** http://internationalconferenceonsexology.com