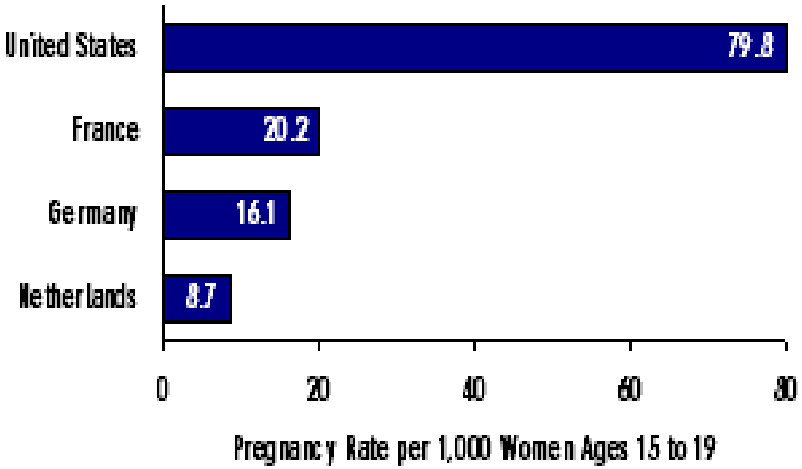
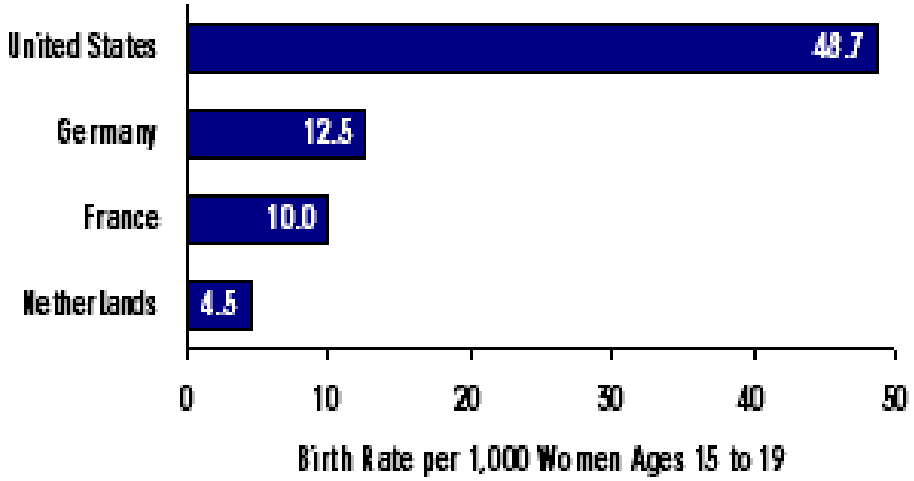
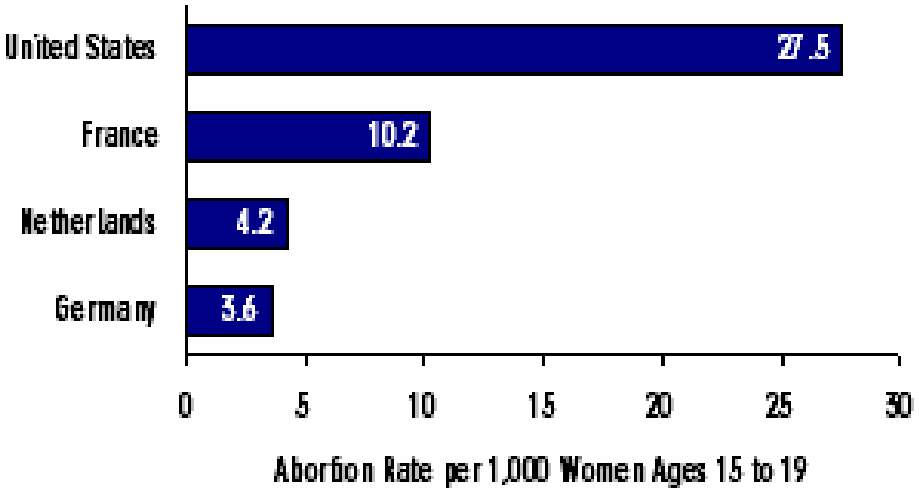
Sexual health: from research to policy

Kaye Wellings

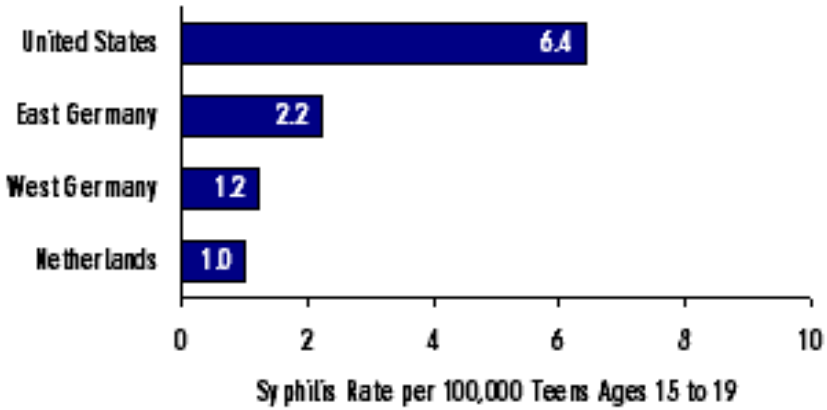
Pregnancy, birth and abortion rates: selected European countries compared with the United States

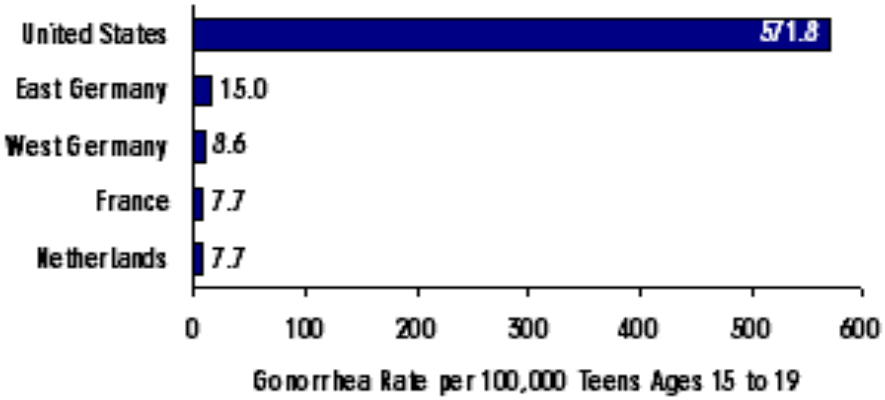


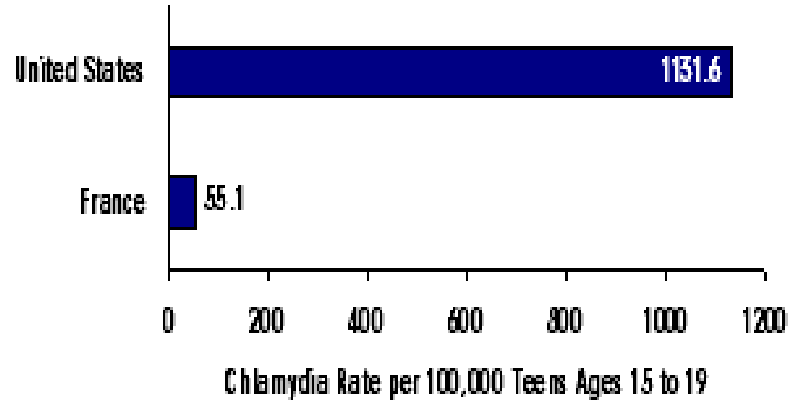




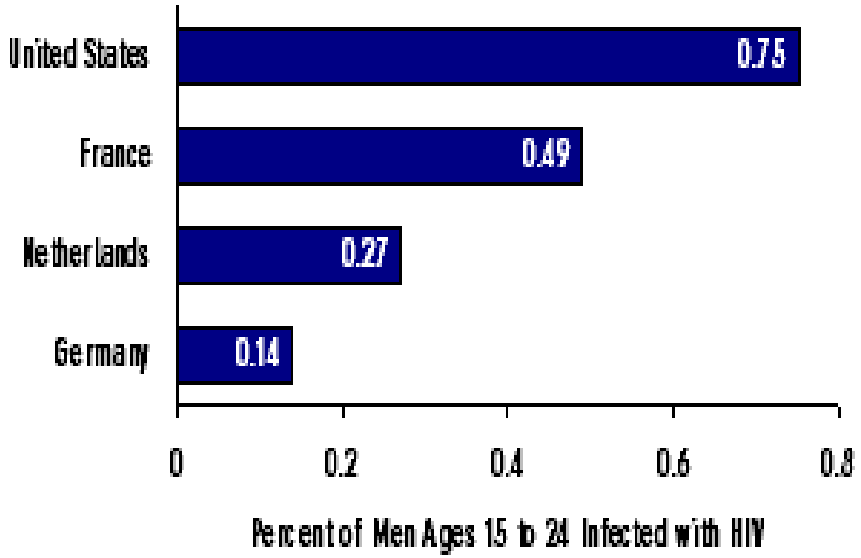
STIs in selected European countries compared with the United States

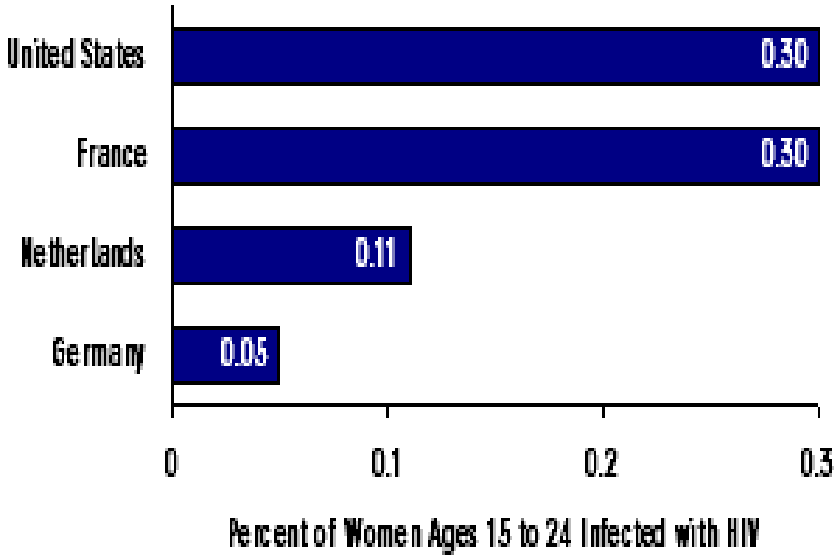




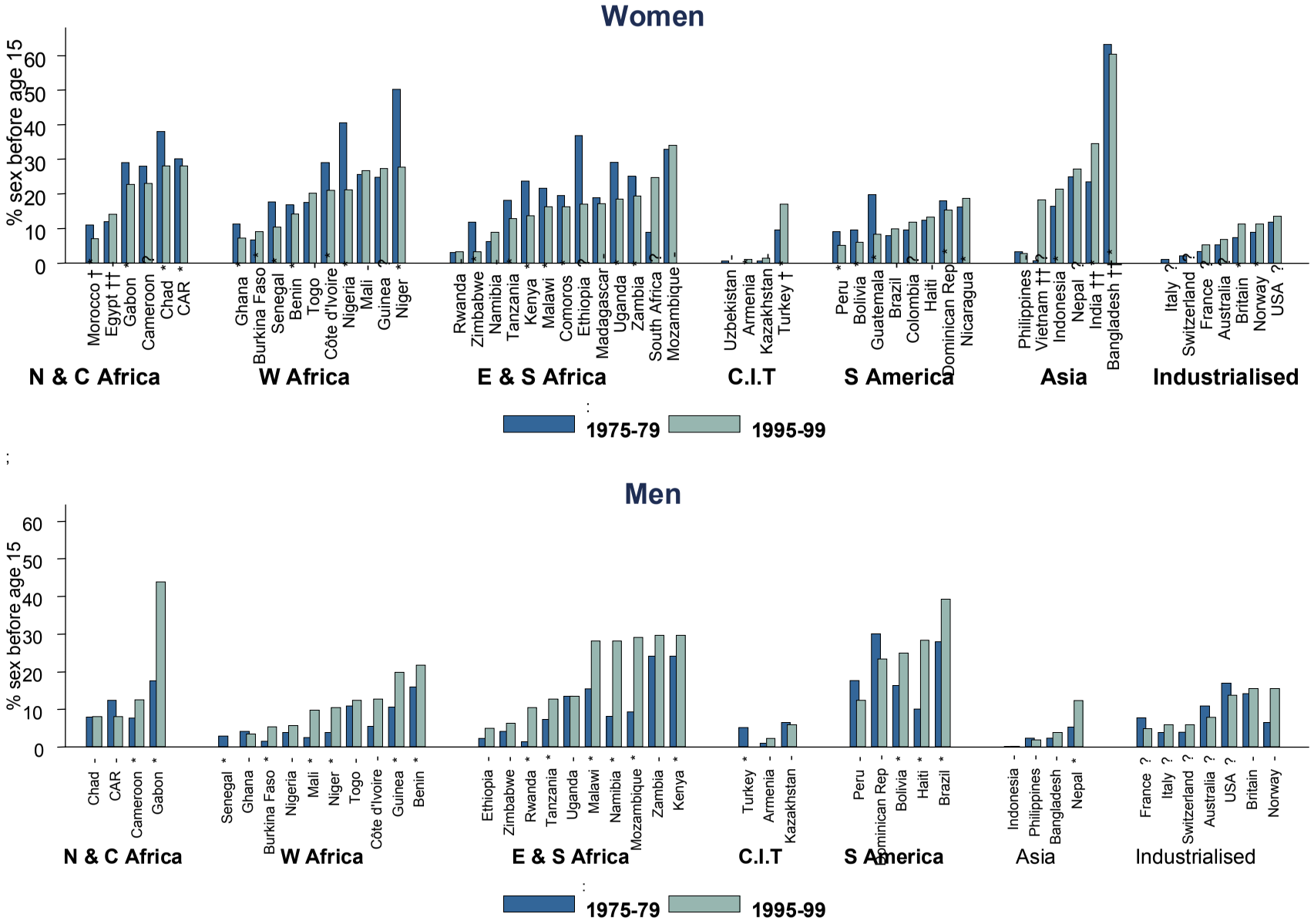


HIV infection in selected European countries compared with the United States





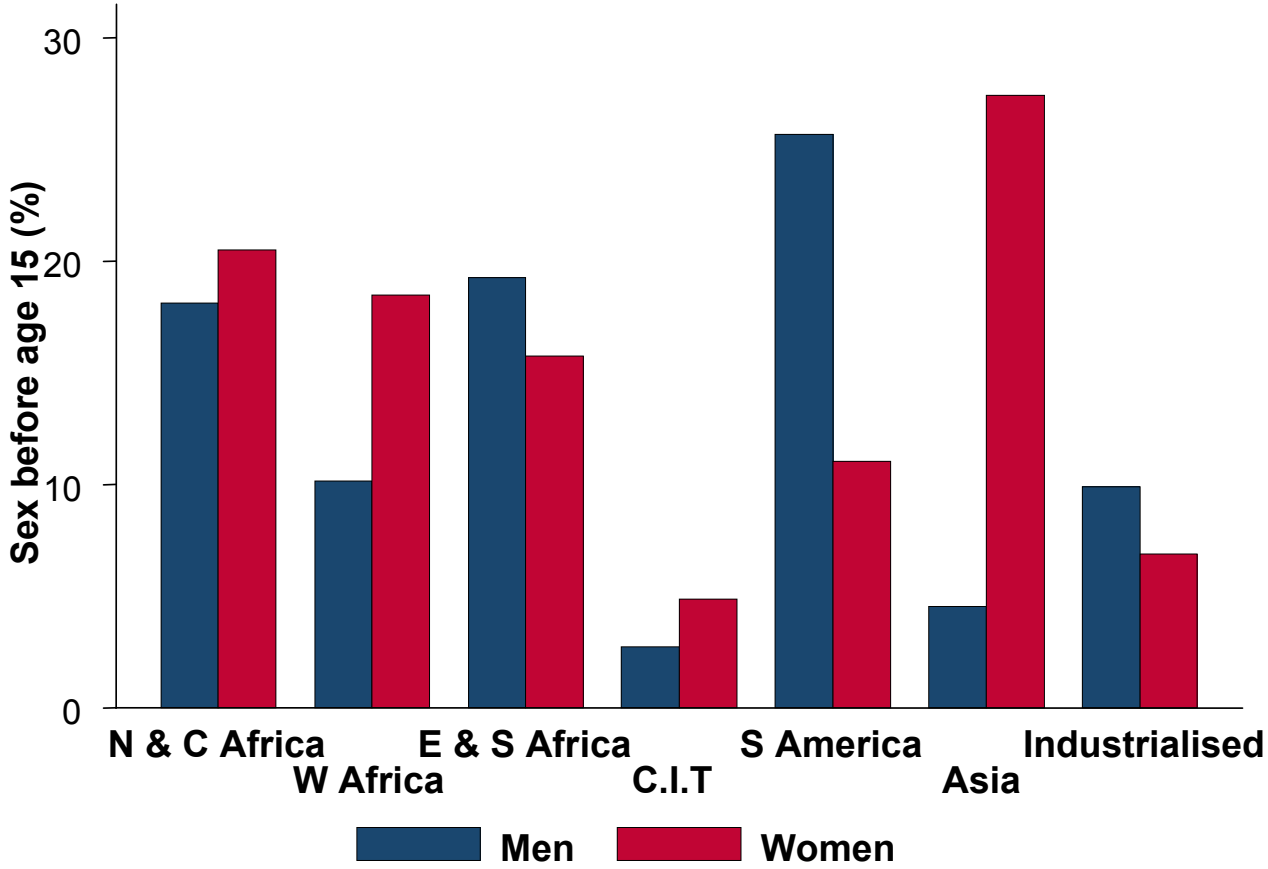
Proportion having sexual intercourse before age 15 by region (reached age 15 during 1995-99)



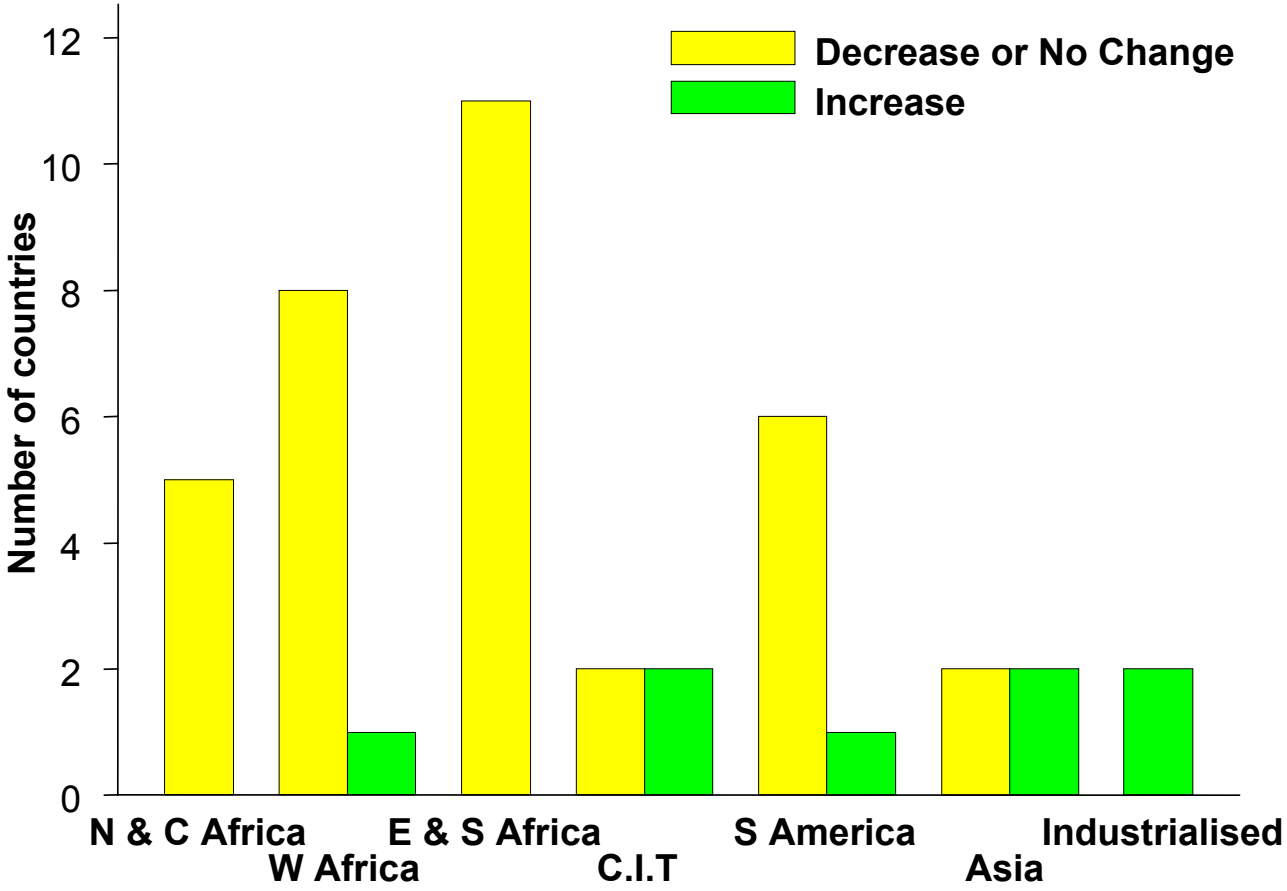
Difference between cohorts: * p<=0.05, - p>0.05, ? test not possible

Proportion having sexual intercourse before age 15 by region

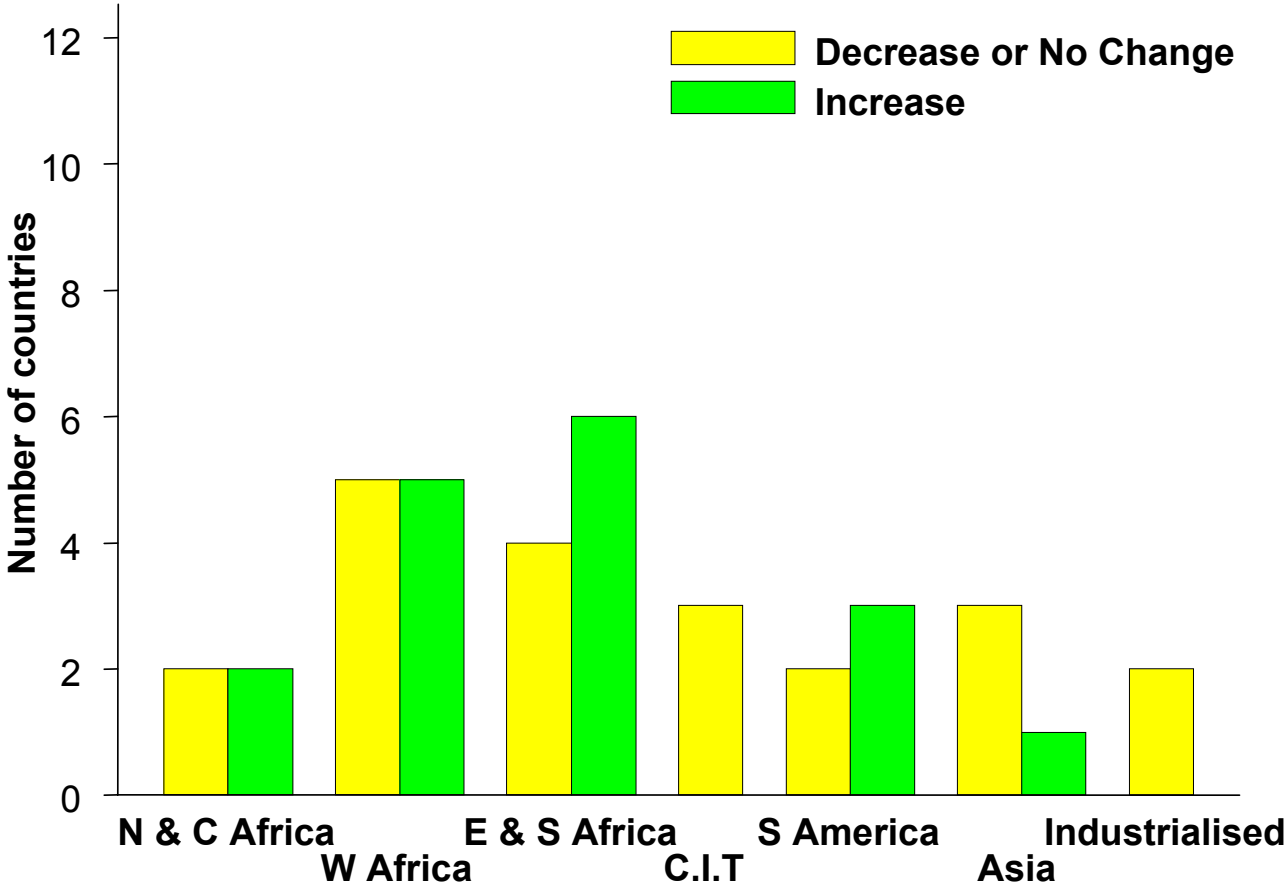
(reached age 15 during 1995-99)



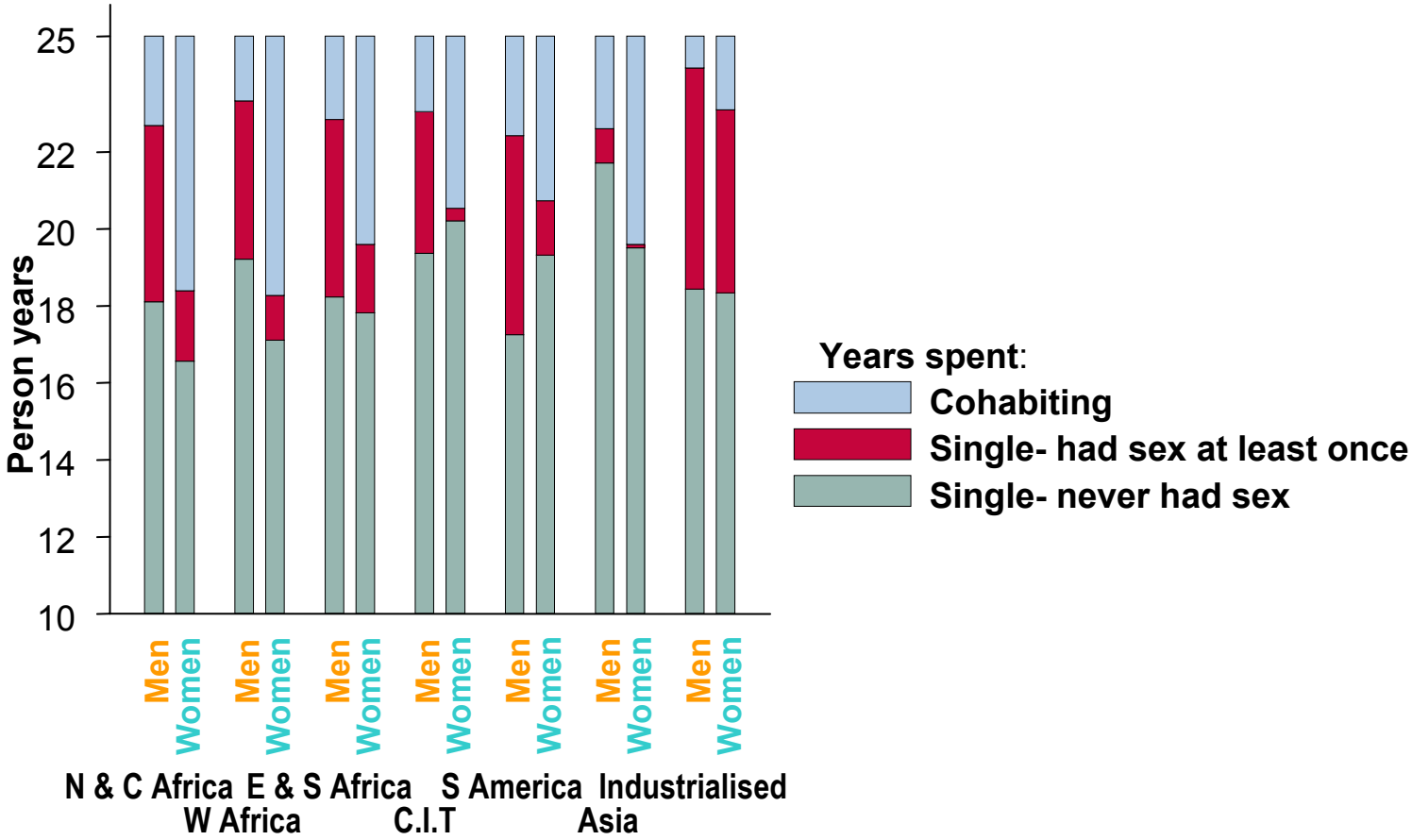
Trend in proportion of women sexually active by age 15
1975 -79 to 1995-99



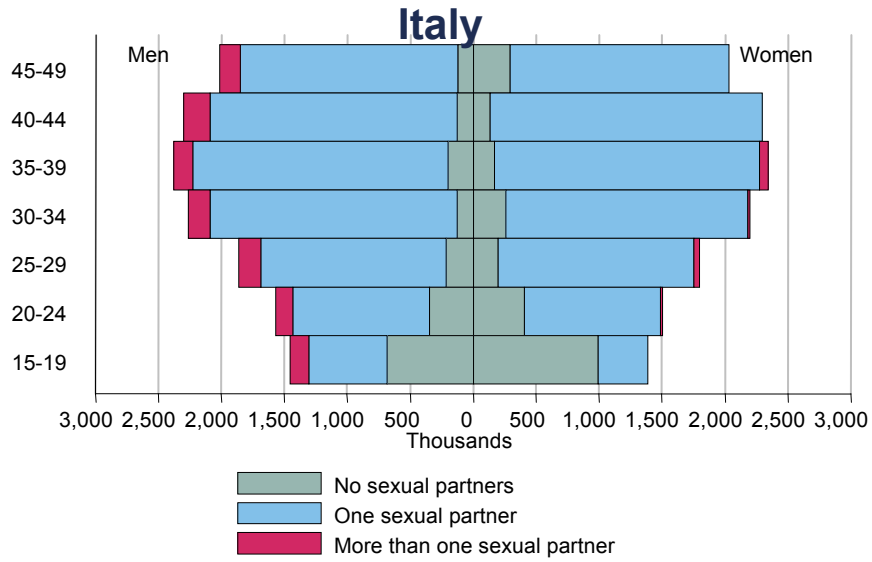
Trend in proportion of men sexually active by age 15 1975 -79 to 1995-99

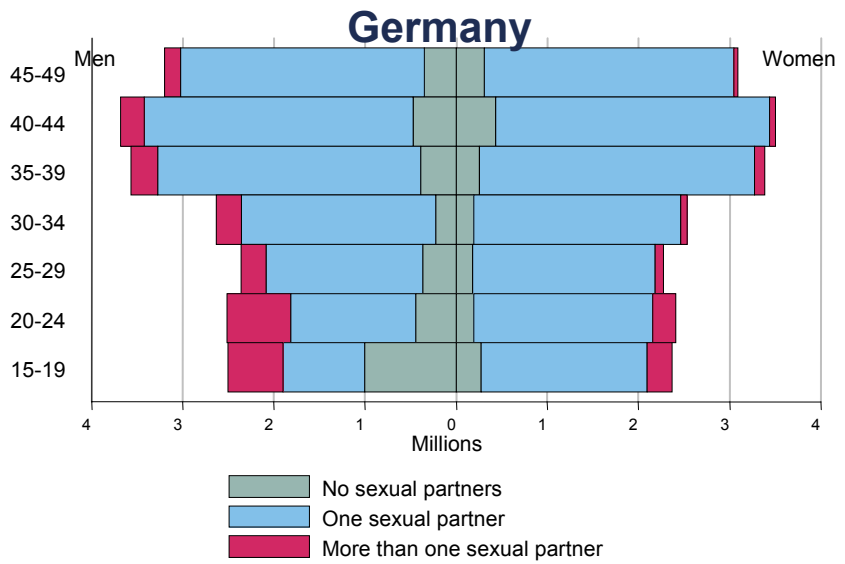


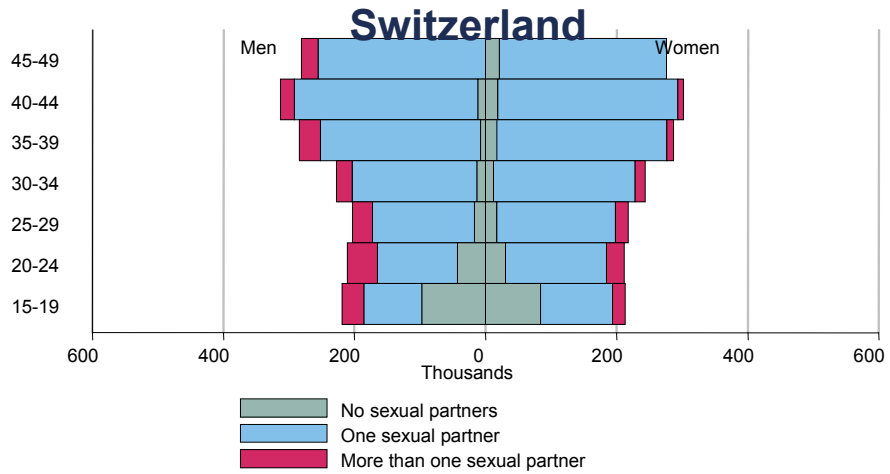
Sexual activity and relationship status

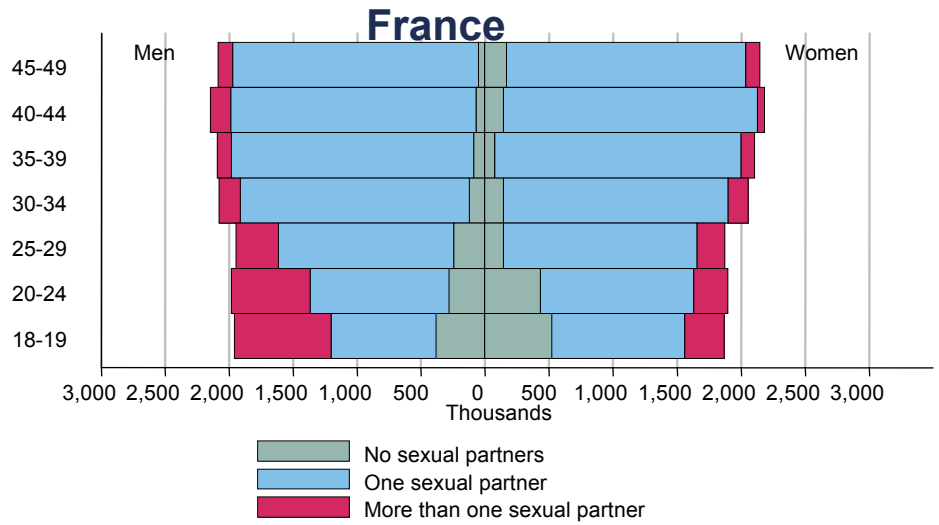


Population distribution by age and sex, and number of sexual partners in the past year, 15 to 49 year olds.



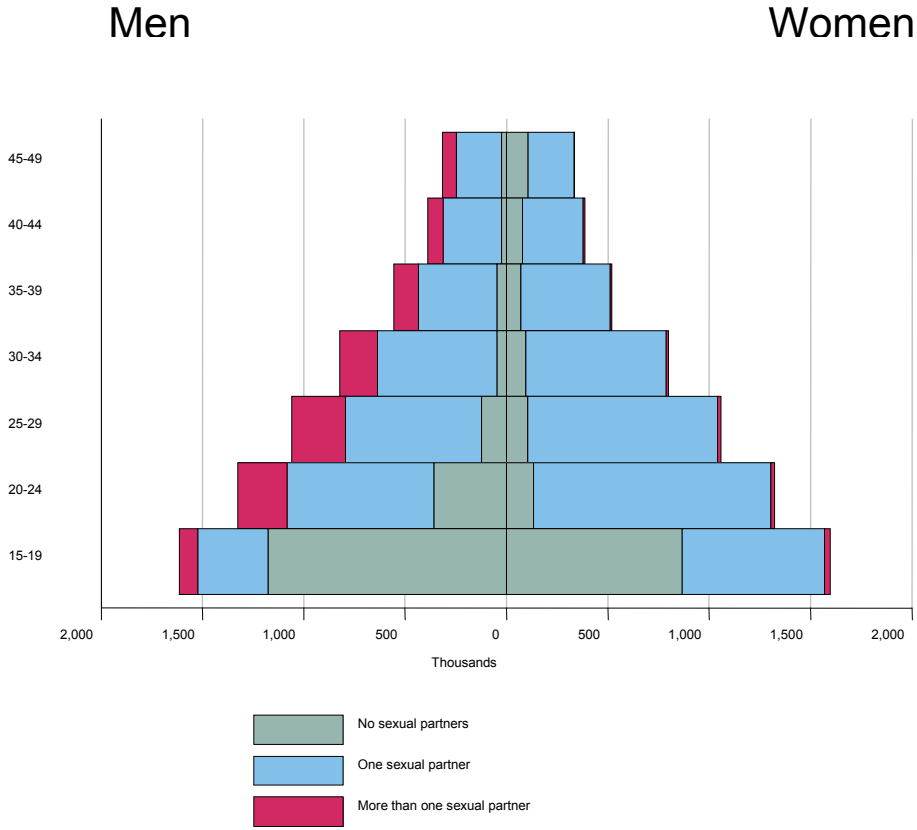




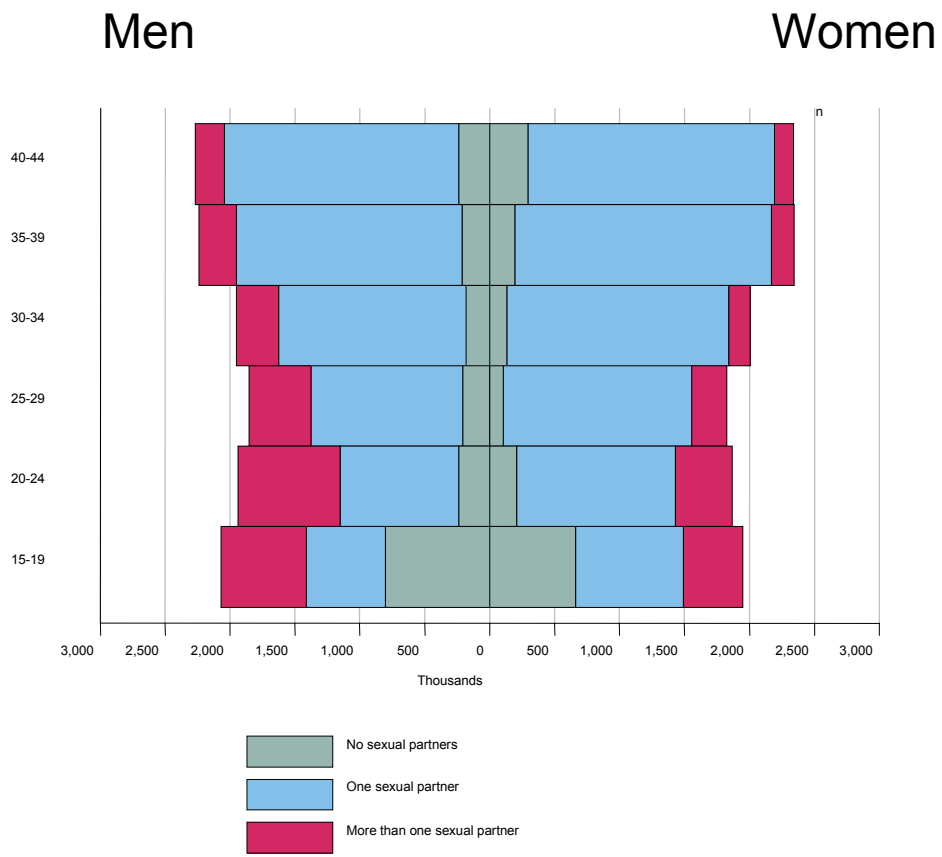


Population distribution by age and sex and number of sexual partners in the past year, 15 to 49 year olds.

Uganda



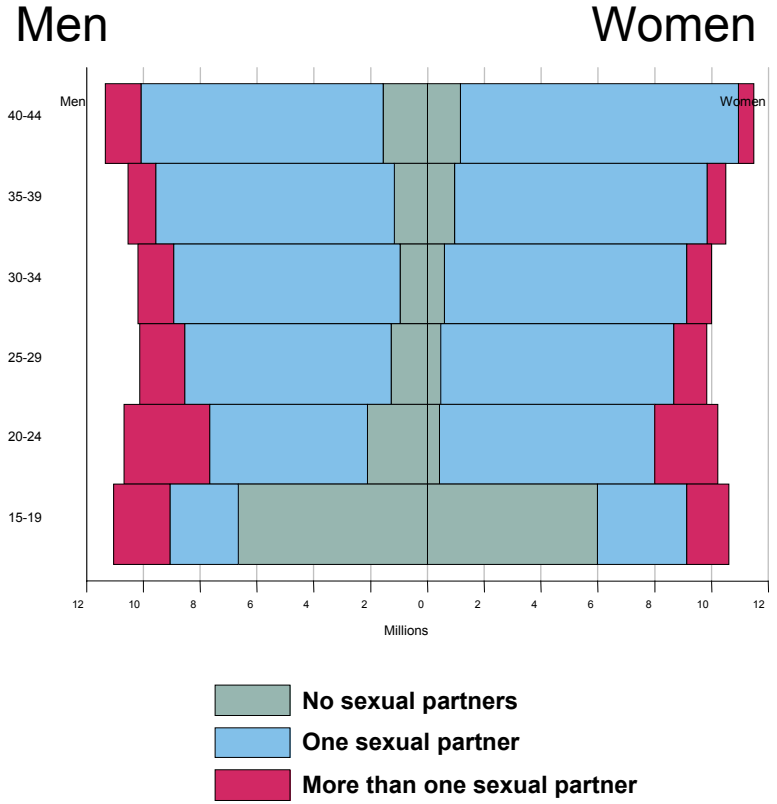
Britain



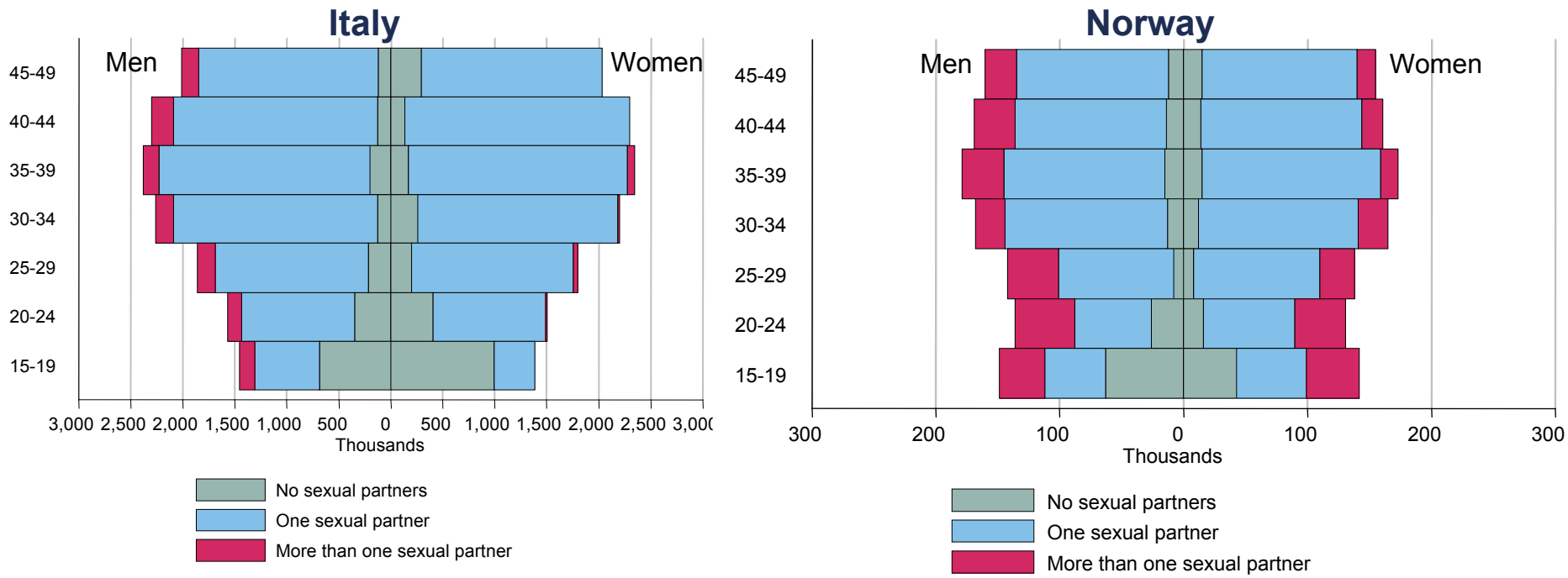
Population distribution by age and sex and number of sexual partners in the past year, 15 to 49 year olds.

Britain

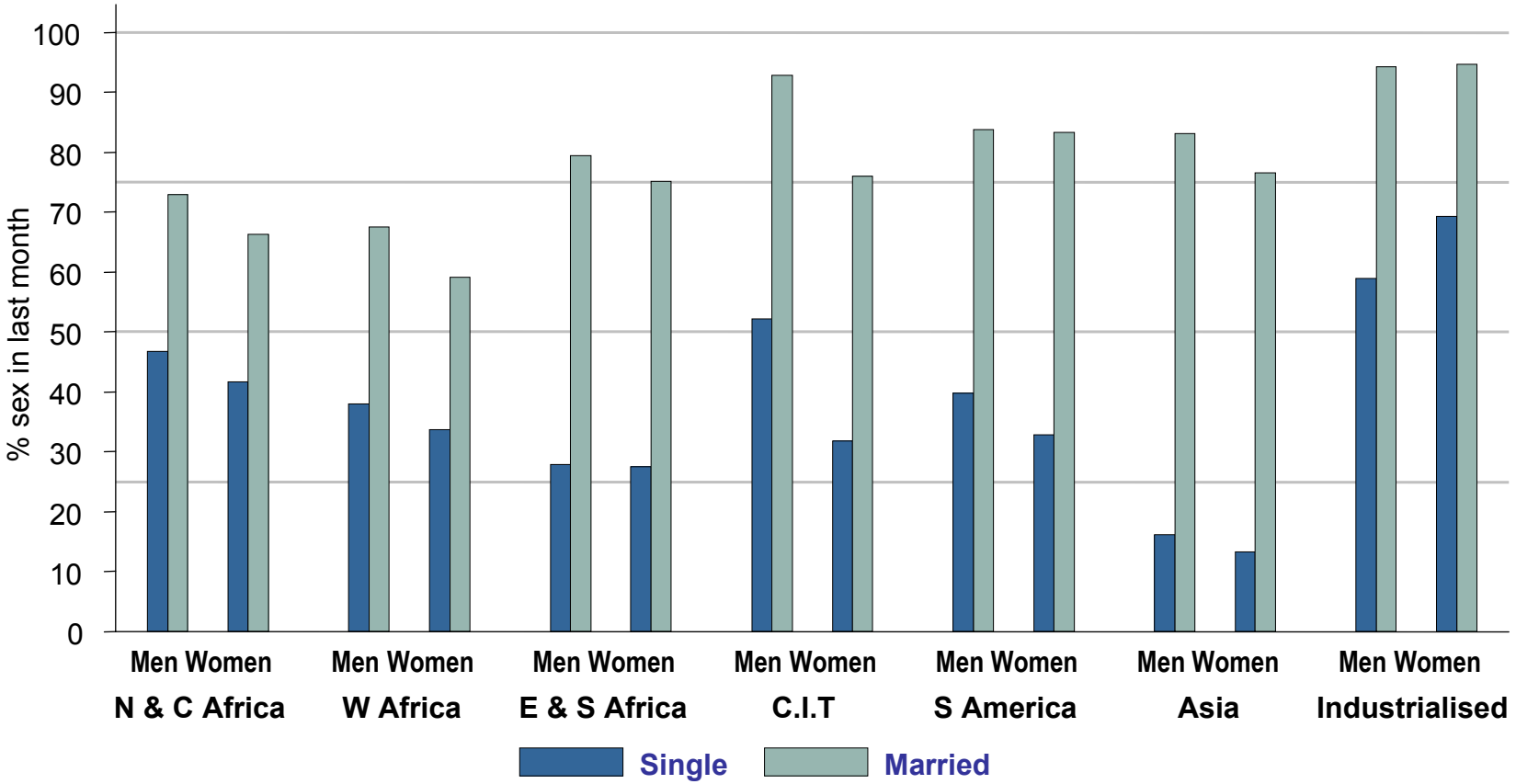
USA



A North South Divide



Frequency of sex



Proportion 15 year olds with experience of sexual intercourse

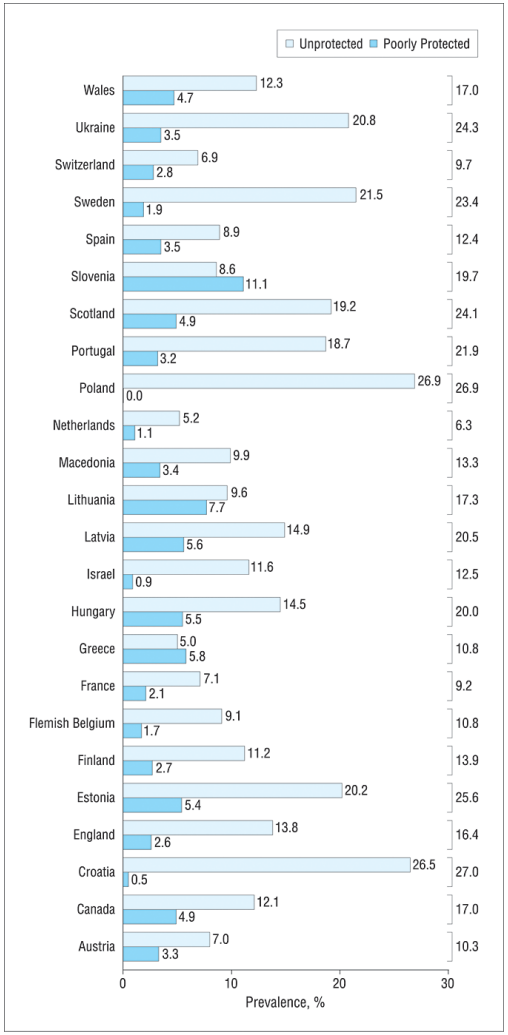
Table 1. Prevalence of Participants Reporting Ever Having Had Sexual Intercourse by Country and Sex According to the 2002 World Health Organization Health Behaviour in School-aged Children Study

Country	Participants, No.	Boys Who Reported Having Had Sexual Intercourse, No. (%)	Girls Who Reported Having Had Sexual Intercourse, No. (%)
Austria	1227	133 (21.7)	110 (17.9)
Canada	1102	114 (24.1)	150 (23.9)
Croatia	1388	131 (21.9)	65 (8.2)
England	1675	290 (34.9)	409 (39.9)
Estonia	1237	114 (18.8)	89 (14.1)
Finland	1700	193 (23.1)	282 (32.7)
Flemish Belgium	1946	238 (24.6)	225 (23.0)
France	2505	312 (25.1)	224 (17.7)
Greece	1255	196 (32.5)	62 (9.5)
Hungary	1302	123 (25.0)	132 (16.3)
Israel	1135	167 (31.0)	49 (8.2)
Latvia	1053	86 (19.2)	75 (12.4)
Lithuania	1842	229 (24.4)	83 (9.2)
Macedonia	1342	214 (34.2)	19 (2.7)
Netherlands	1235	143 (23.3)	127 (20.5)
Poland	2110	207 (20.5)	102 (9.3)
Portugal	783	108 (29.2)	79 (19.1)
Scotland	1115	179 (32.1)	190 (34.1)
Slovenia	1010	143 (28.2)	101 (20.1)
Spain	1672	134 (17.2)	124 (13.9)
Sweden	1179	145 (24.6)	172 (29.2)
Switzerland	1434	177 (24.1)	142 (20.3)
Ukraine	1600	341 (47.1)	172 (24.0)
Wales	1096	153 (27.3)	206 (38.5)

2002 World Health Organization Health Behaviour in School-aged Children Study Godeau, E. et al. Arch Pediatr Adolesc Med 2008;162:66-73.

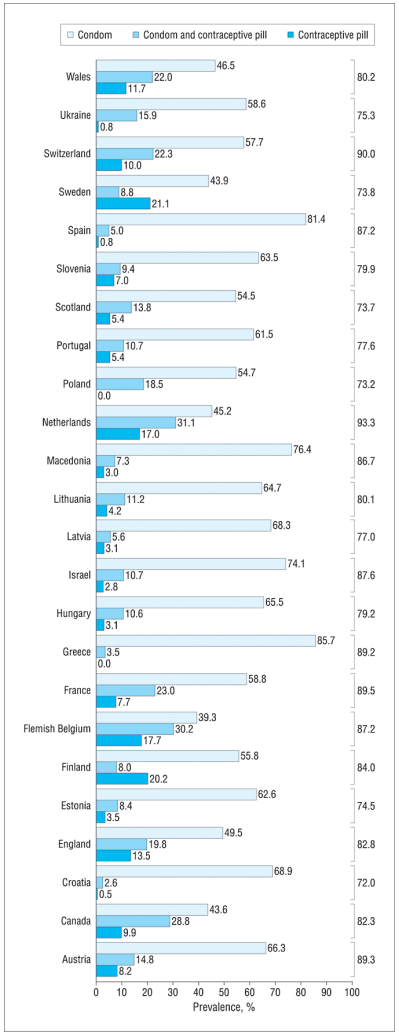
ARCHIVES OF PEDIATRICS & ADOLESCENT MEDICINE

Proportion 15 year old girls whose last intercourse was unprotected, or poorly protected



2002 WHO Health Behaviour in School-aged Children study
Godeau, E. et al. Arch Pediatr Adolesc Med 2008;162:66-73.

Condom and OC use, and dual use, at last sexual intercourse



2002 WHO Health Behaviour in School-aged Children study
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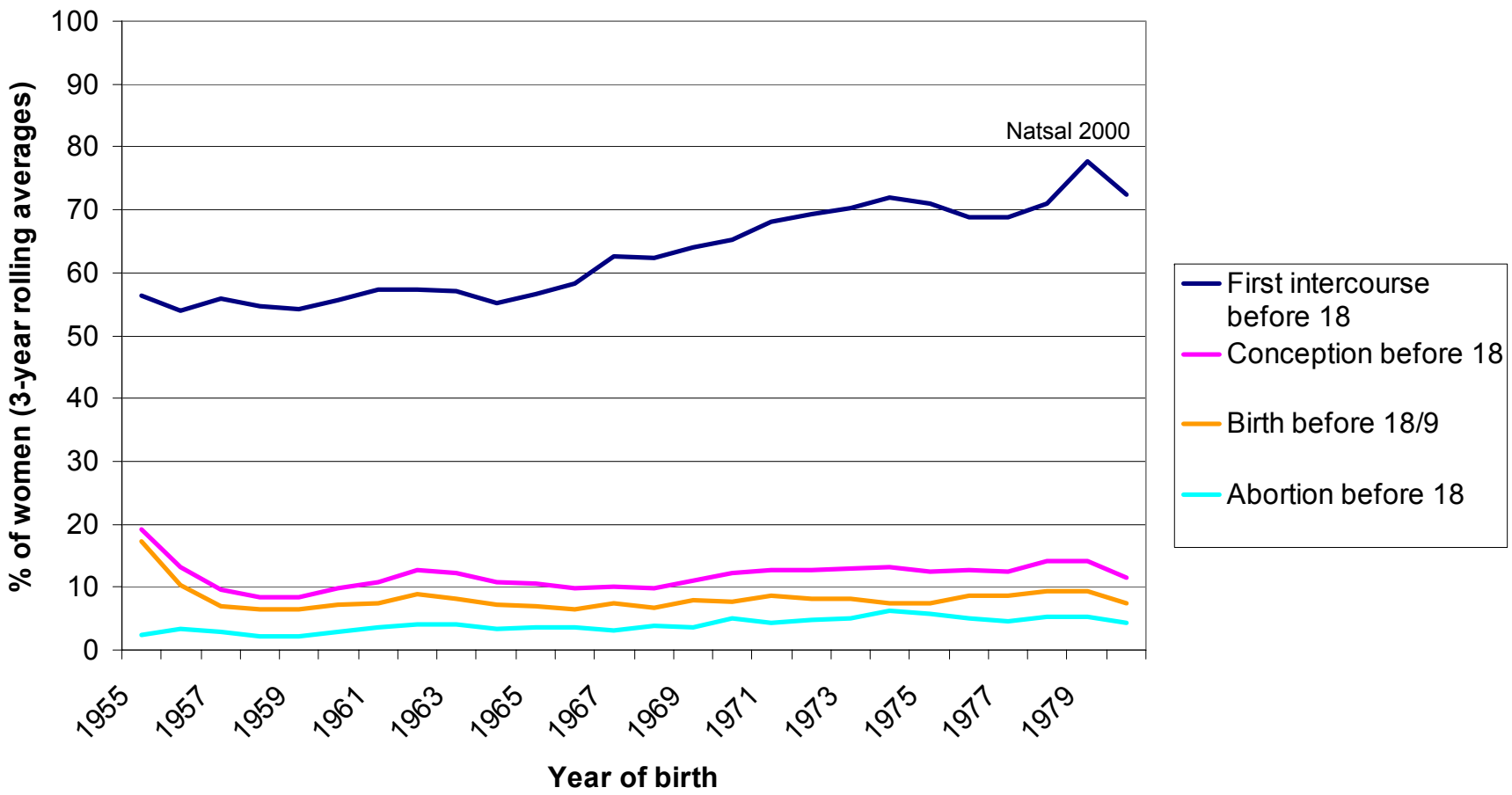
‘Combinations’ of risk behaviour, selected countries

(WHO/HSBC data, 2002)

High prevalence sex at 15* + Low prevalence unprotected	**Low prevalence sex at 15 + Low prevalence unprotected**
England Finland French Belgium Netherlands Slovenia Switzerland Wales	**Austria France Greece Israel Macedonia Spain**
High prevalence sex at 15 + high prevalence unprotected	**Low prevalence sex at 15 + High prevalence unprotected**
Canada Scotland Sweden Ukraine	**Croatia Estonia Latvia Lithuania Poland Portugal**
* ie. more than 20% had SI at 15 ** ie. more than 20% had unprotected last intercourse	

Sexual and reproductive trends in young people

(Women aged 18/9-44; Natsal 2000)

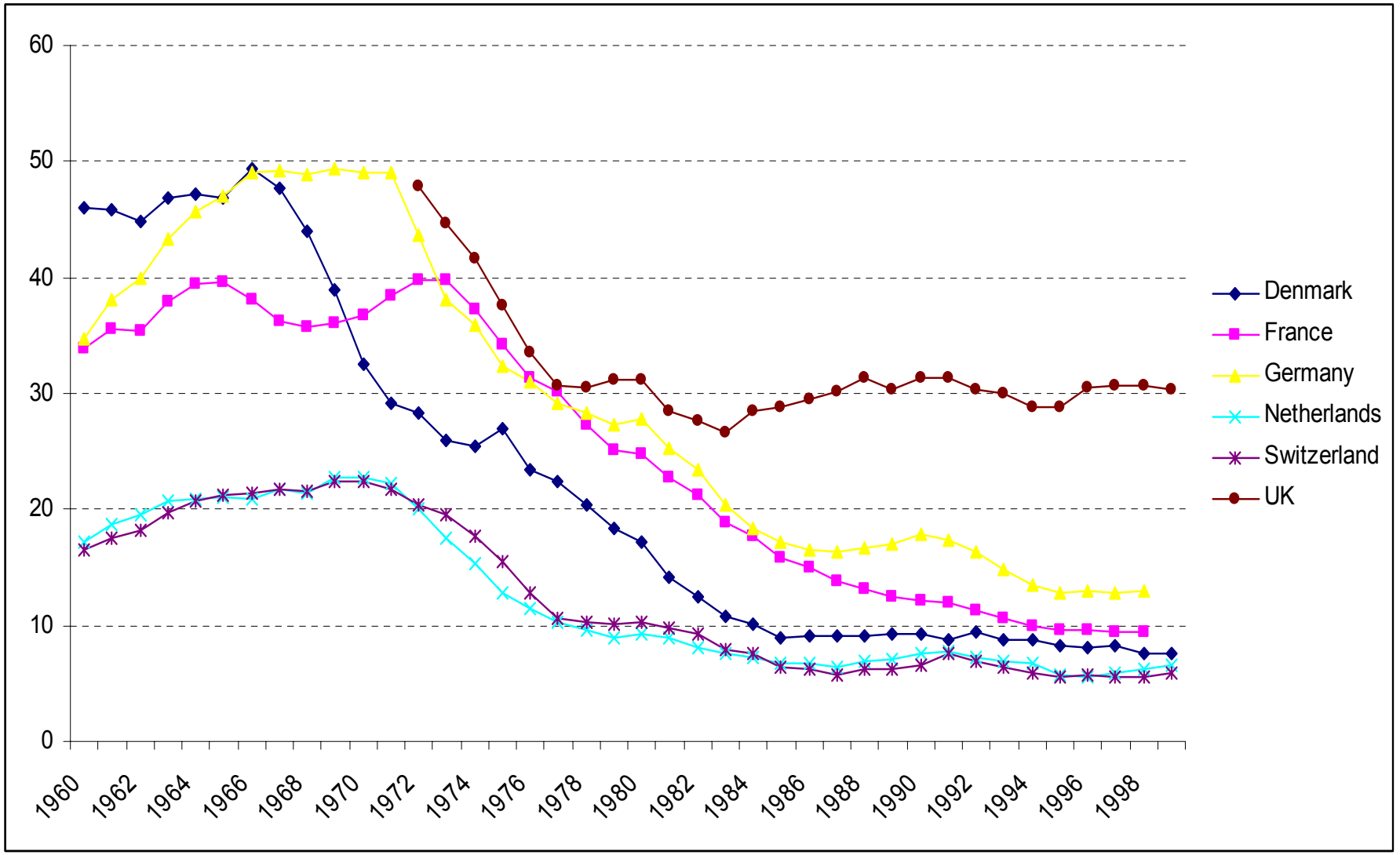


Teenage birth rate per 1,000 women, selected European countries

Switzerland	5.5
Netherlands	6.2
Sweden	6.5
Denmark	8.1
France	9.3
Belgium	9.9
Norway	12.4
Germany	13.1
Portugal	21.2
Iceland	24.7
Britain	30.8
US	43.0

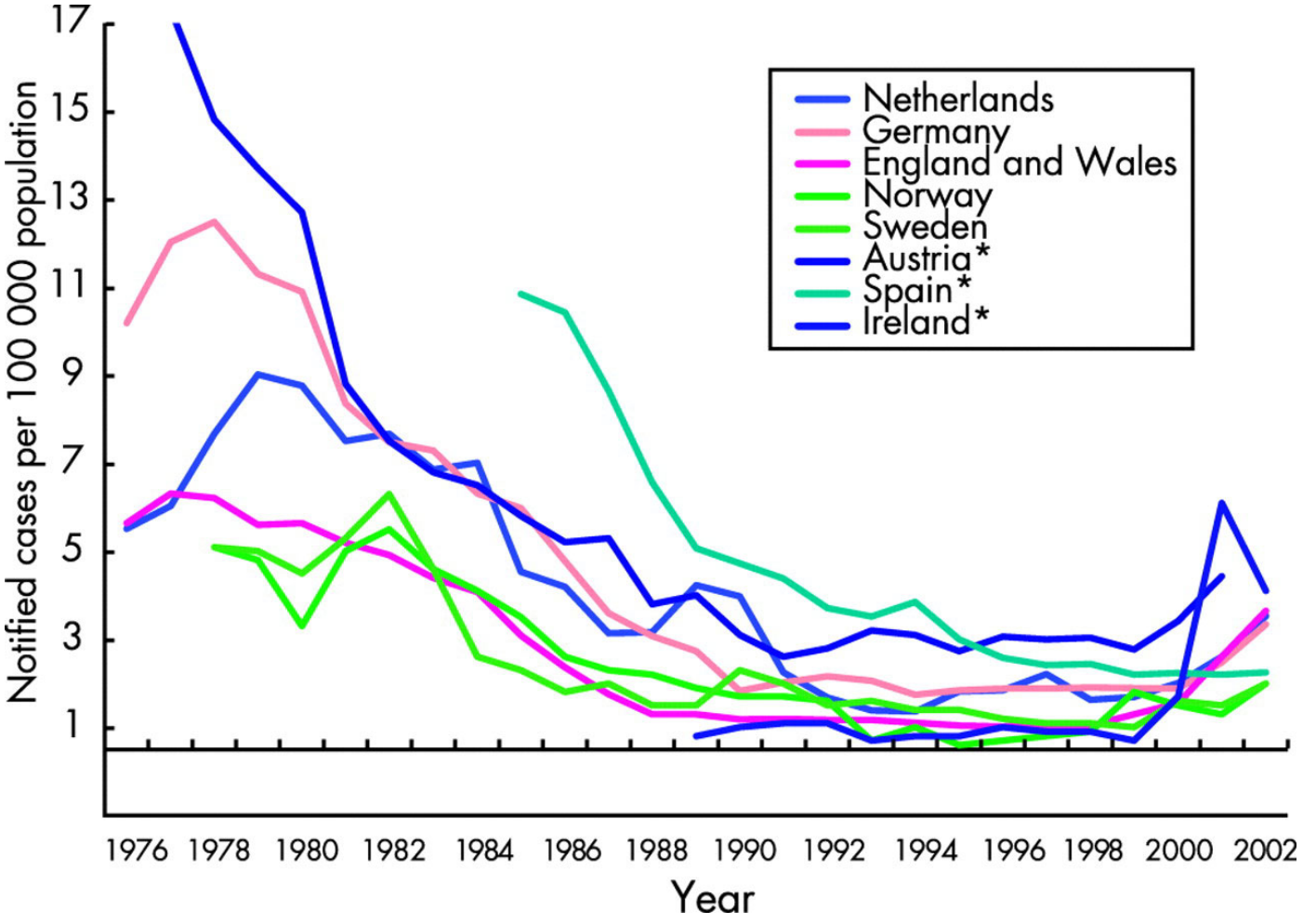
UNICEF, Innocenti report card No 3

Births per 1000 women aged under 20



Notifications of syphilis in selected European countries

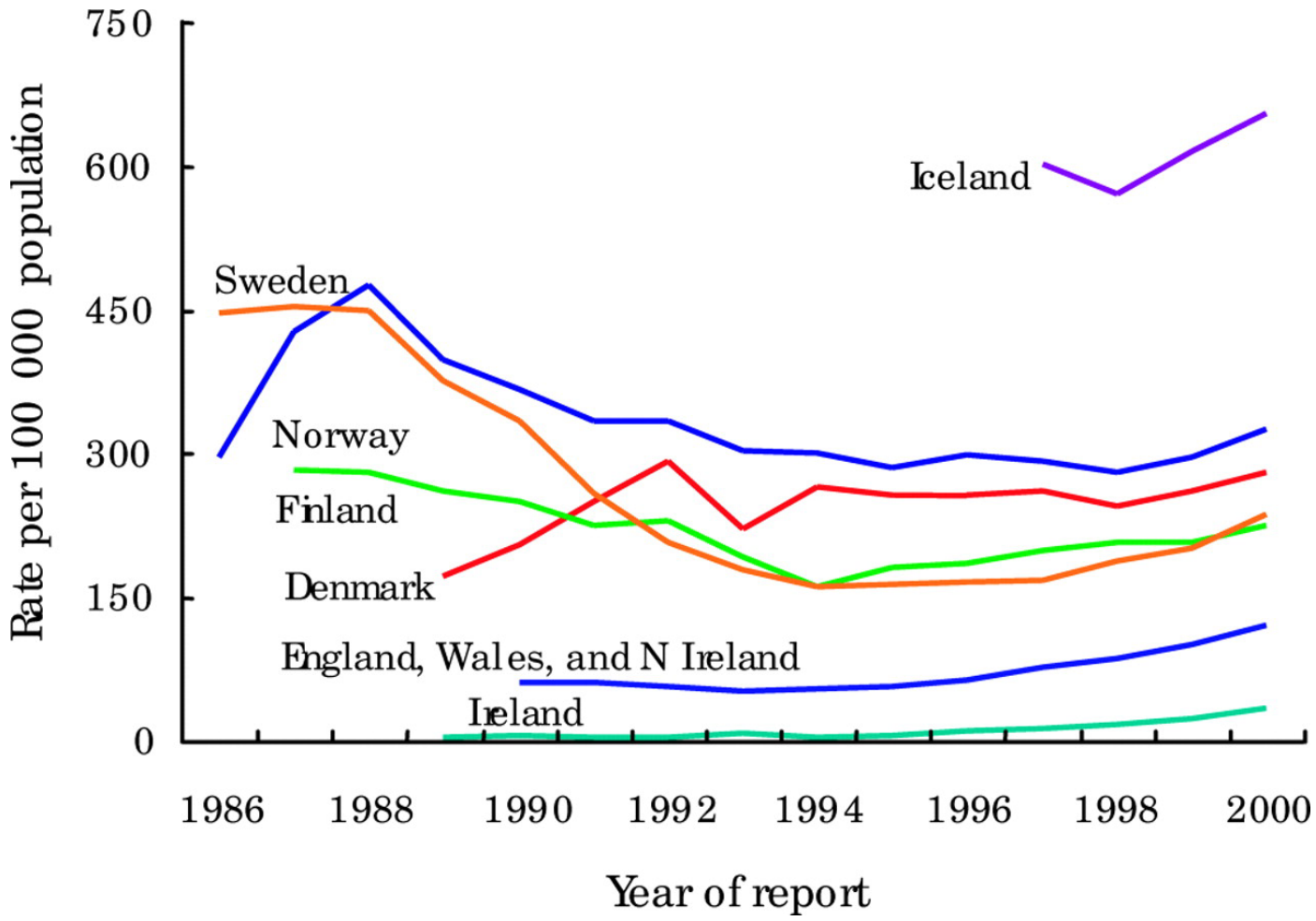
(WHO data: CISID)73 + national surveillance databases)



Fenton, K A et al. Sex Transm Infect 2004;80:255-263

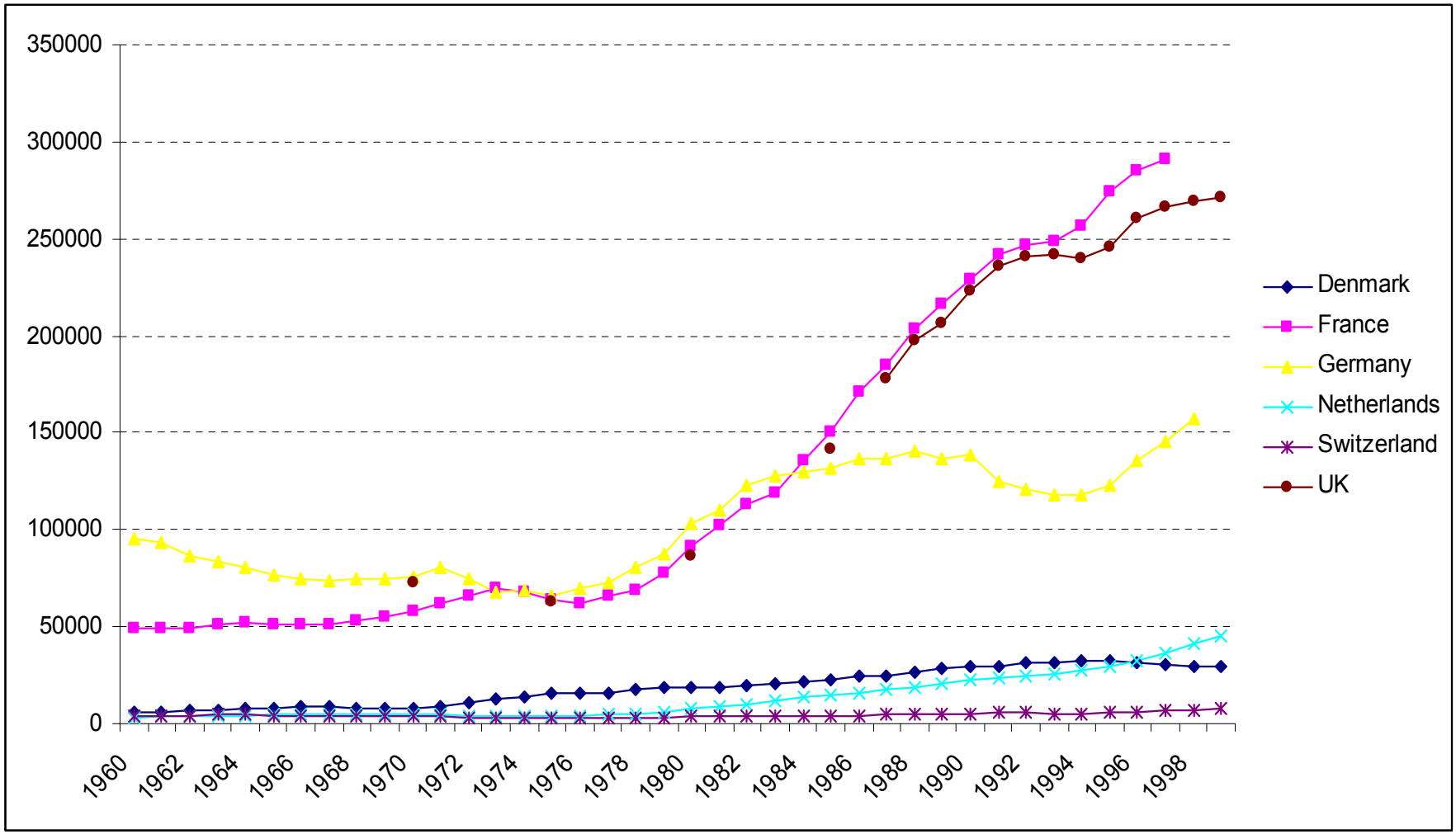
Chlamydial infection in selected European countries

(WHO data: CISID)73 + national surveillance databases)



Fenton, K A et al. Sex Transm Infect 2004;80:255-263

Total number of extra-marital births



Need to take account of social structural factors as well as individual risk behavior

Poverty predictor of unequal academic and economic opportunity, of risk behaviours, and of early childbearing.

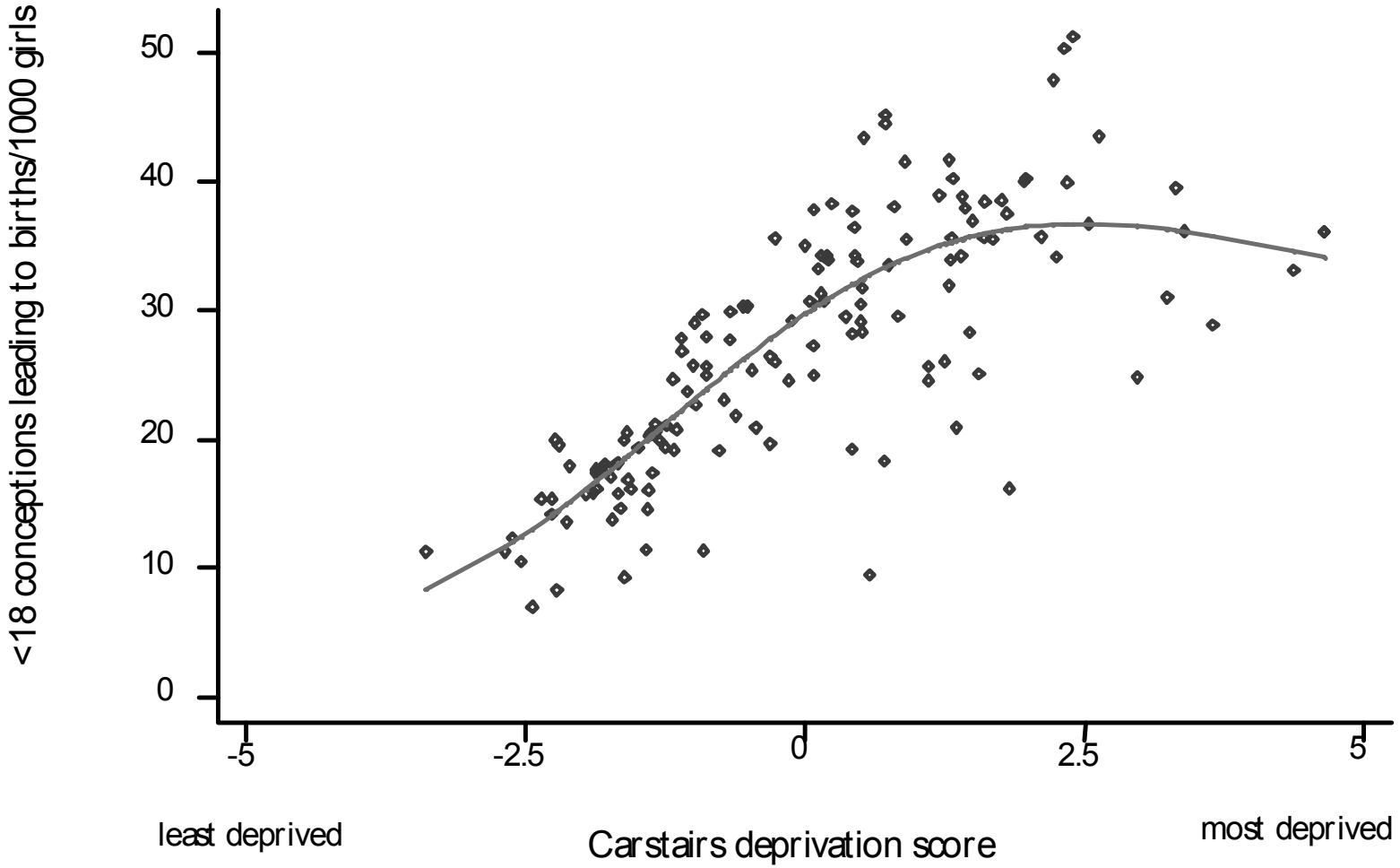
- Higher rates of STIs among some migrant and ethnic minority groups.
- Highest rates of STIs and early pregnancy in central metropolitan areas.
- Increase in STIs and early pregnancy in some countries eg. Sweden almost entirely amongst immigrants
- Majority of German teenage mothers are residents of former Eastern German states or are immigrants.

NB. US has 16.5% poverty* score, cf Netherlands 8.2%; Germany 10.5%; France 11.8%.

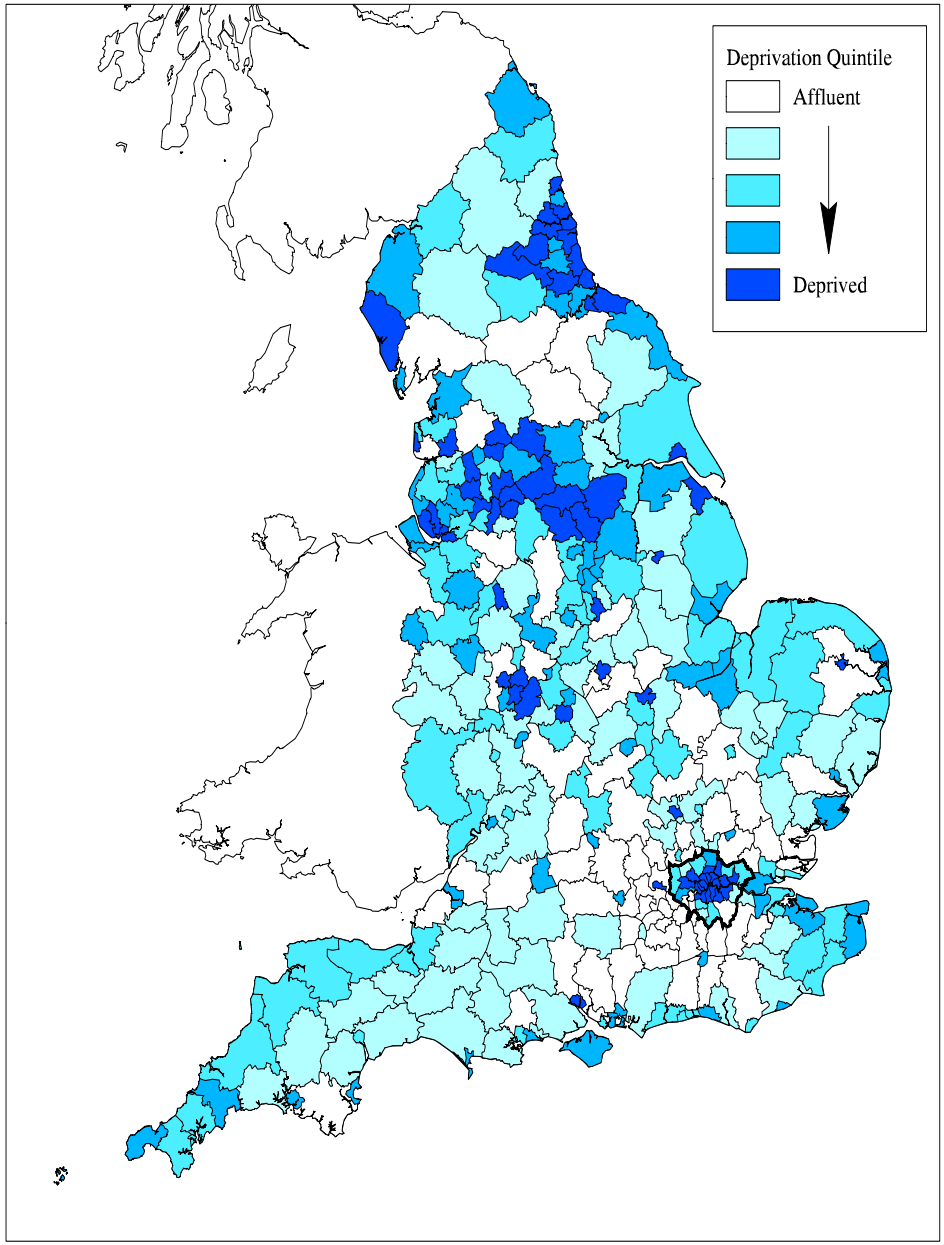
20% US pop foreign born, cf 4% Netherlands, 11% UK; 9% Germany; 5% France.

*measured by UN in terms of longevity, literacy, disposable income below 50%, and long term unemployment.

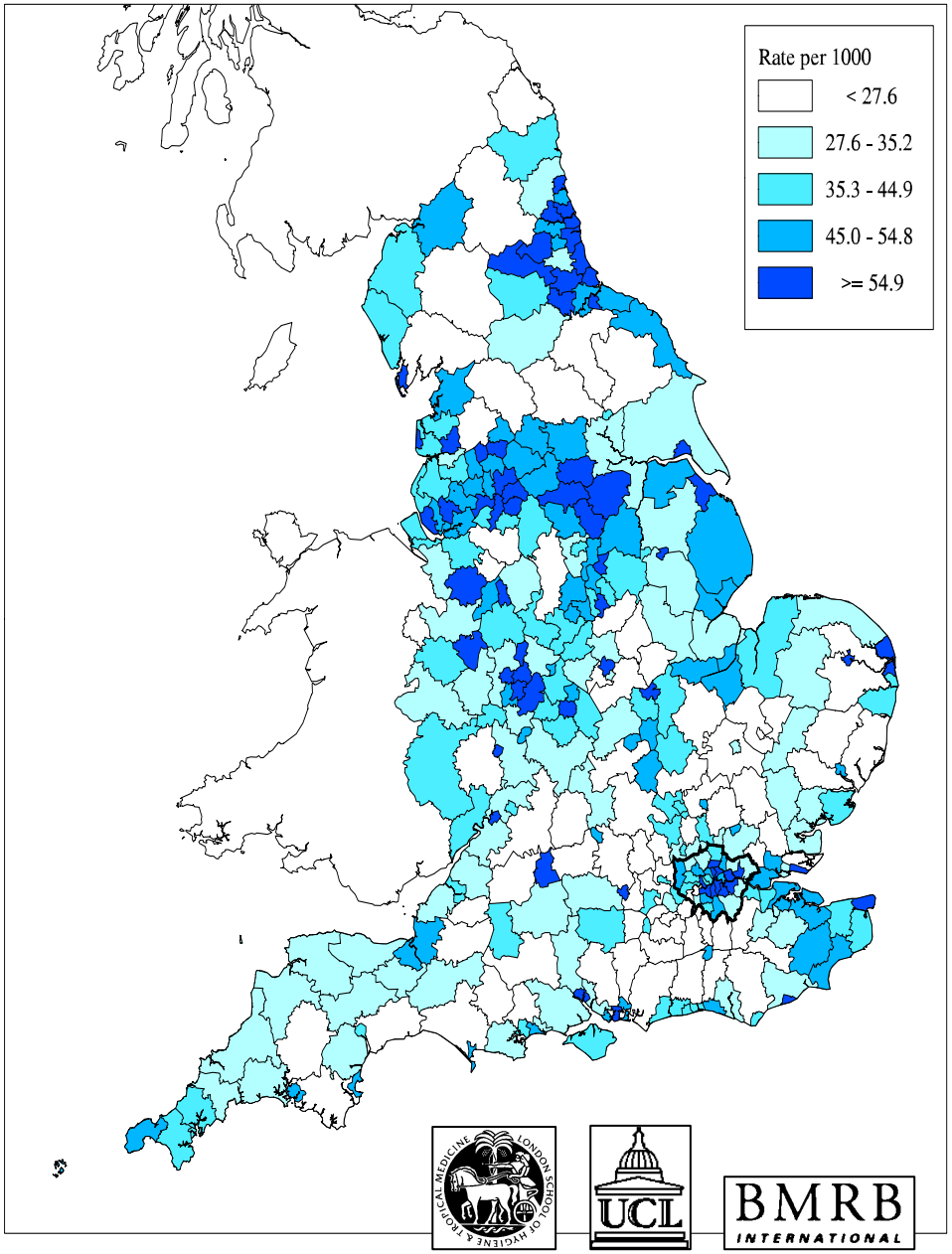
Relationship between under 18 conceptions leading to births and socio-economic deprivation



Deprivation by area



Under 18 conceptions by area



Influences on trends in sexual behaviour

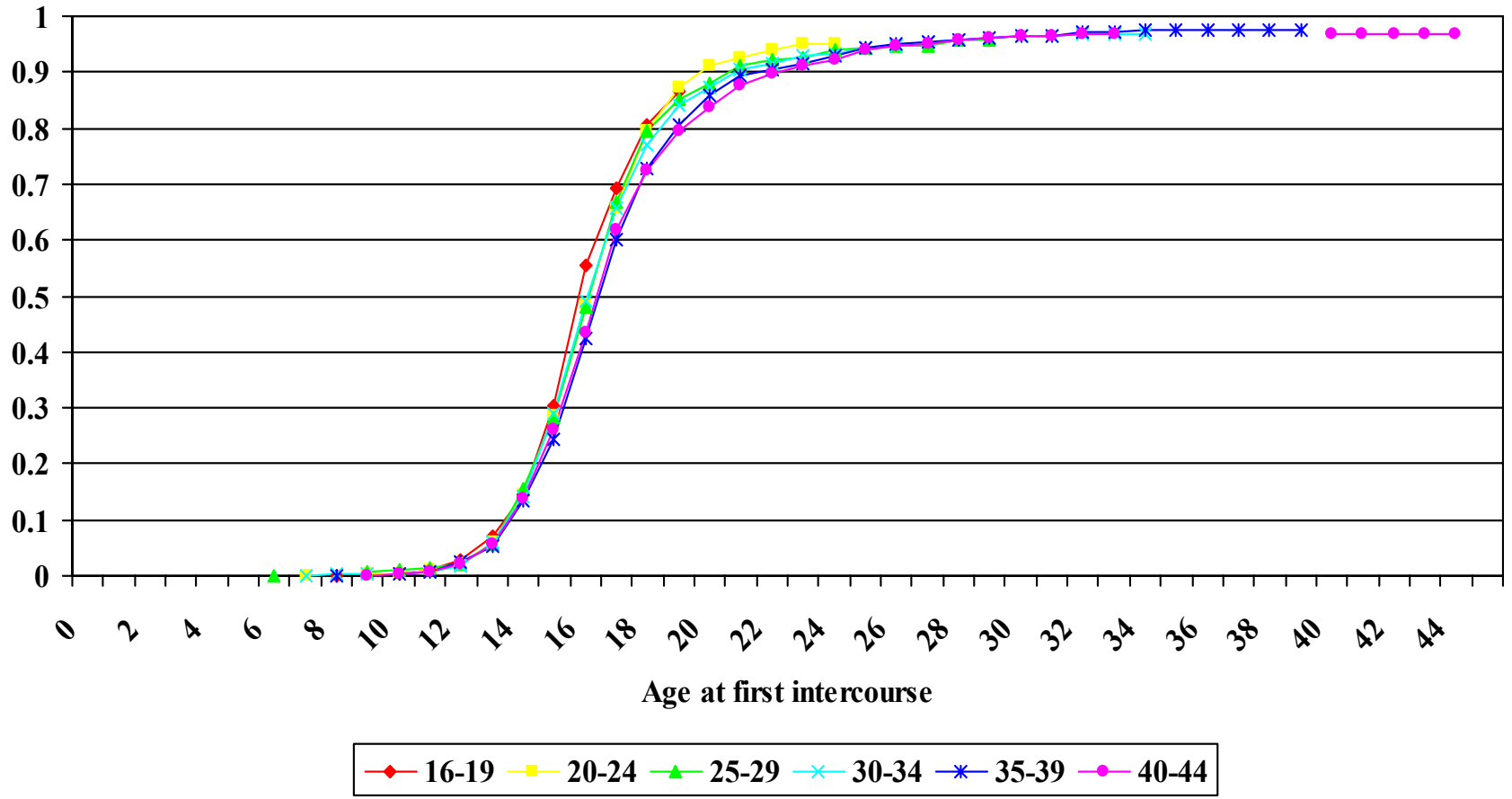
- Socio-economic changes:
  - poverty
  - education
  - employment
- Demographic changes:
  - age structures of populations
  - mobility and migration, urban/rural movement; seasonal labour; social and political disruption
- Changes in social attitudes:
  - influence of communications (eg.Internet), on social norms
- Therapeutic advances:
  - access to contraception
  - HIV interventions

Legislation relating to age of sexual consent and sexual experience at age 15

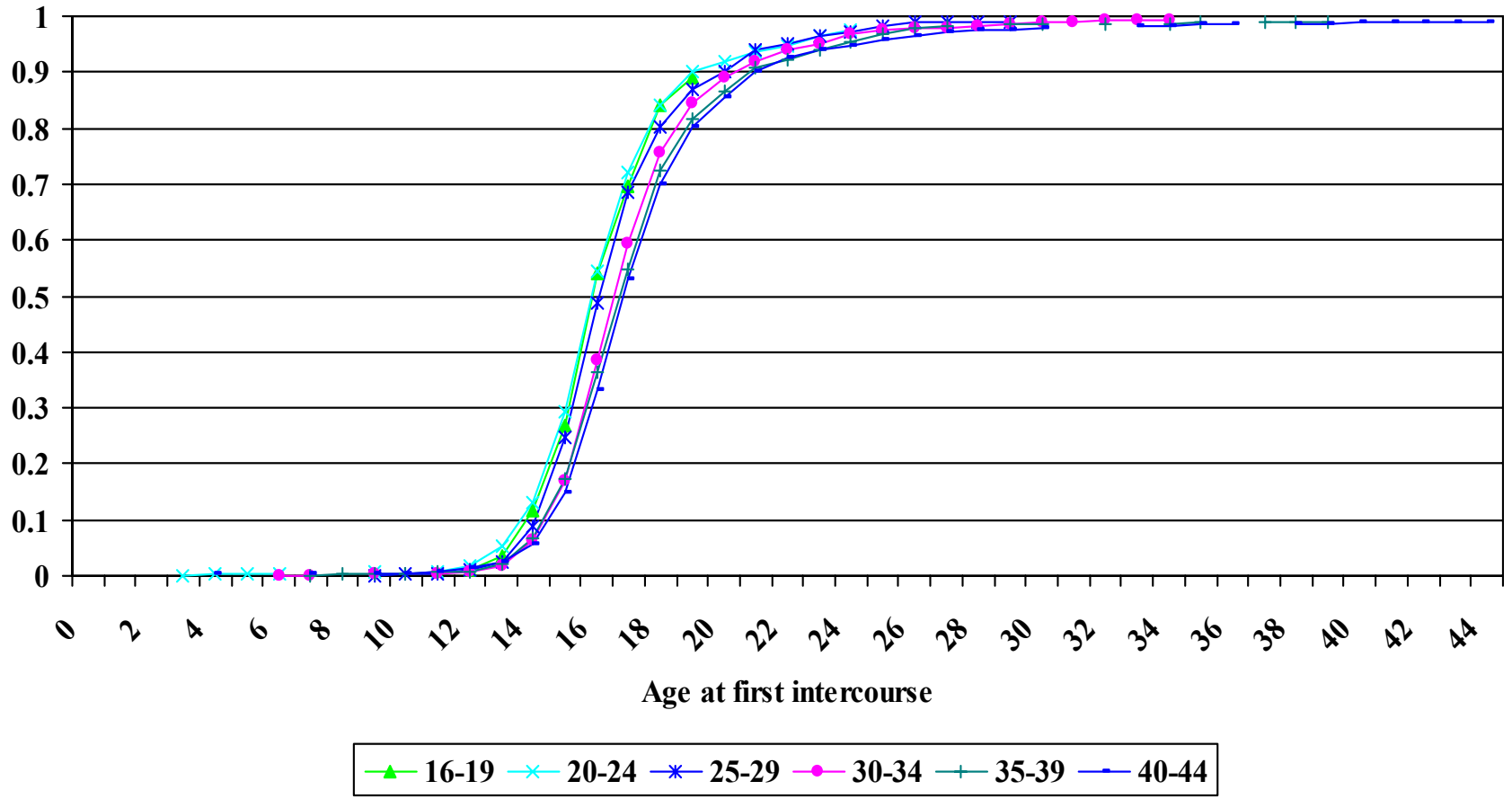
Country	Age of sexual consent	Proportion girls experienced sexual intercourse at 15*
Belgium	16	23.0%
Finland	16	32.7%
France	15	17.7%
GB	16	39.9%
Greece	15	9.5%
Netherlands	16	20.5%
Portugal	16	19.1%
Switzerland	16	20.3%

*WHO/HSBC figures

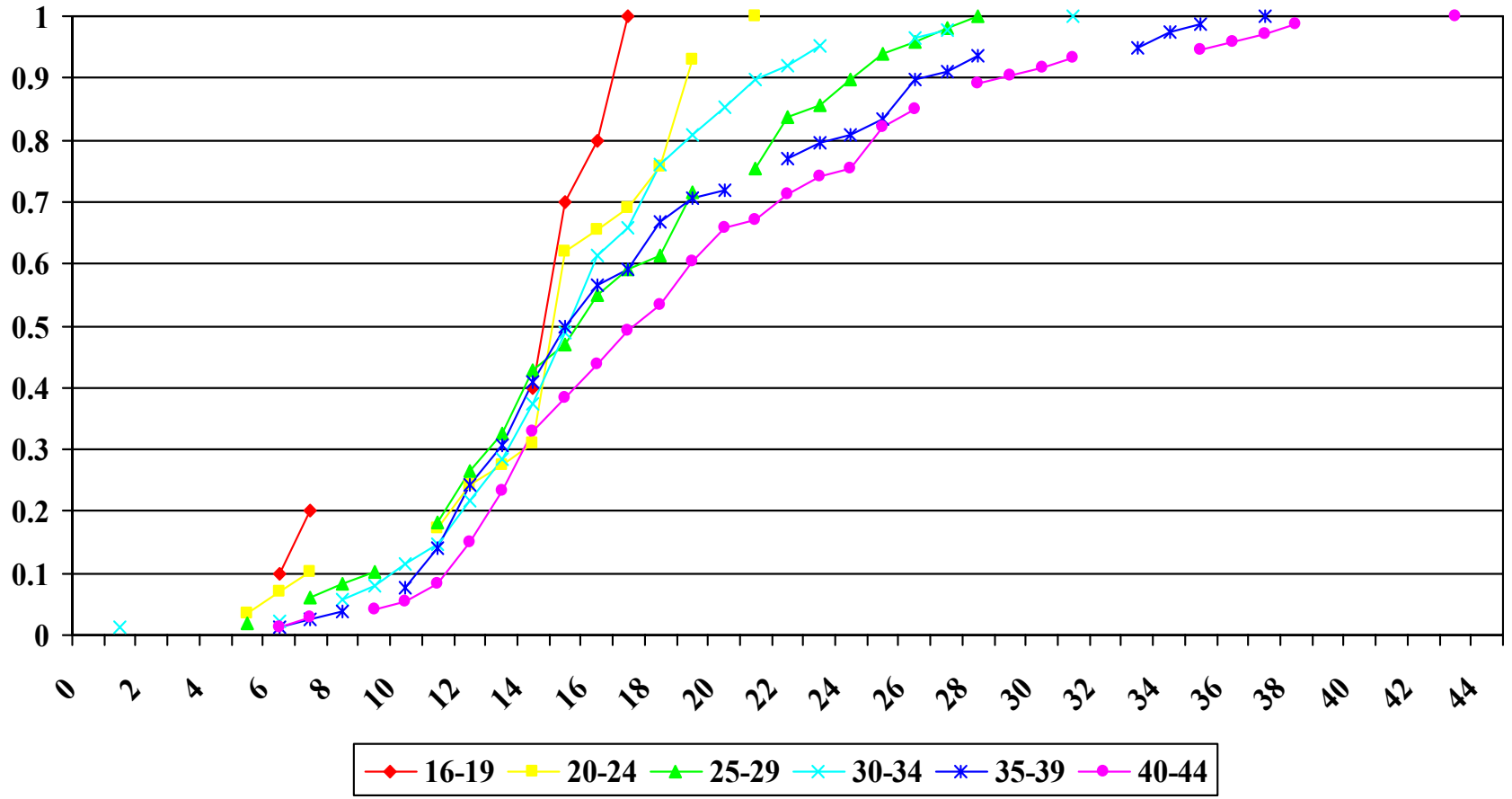
Age at first heterosexual intercourse, by 5 year age groups. MEN (life table analysis)



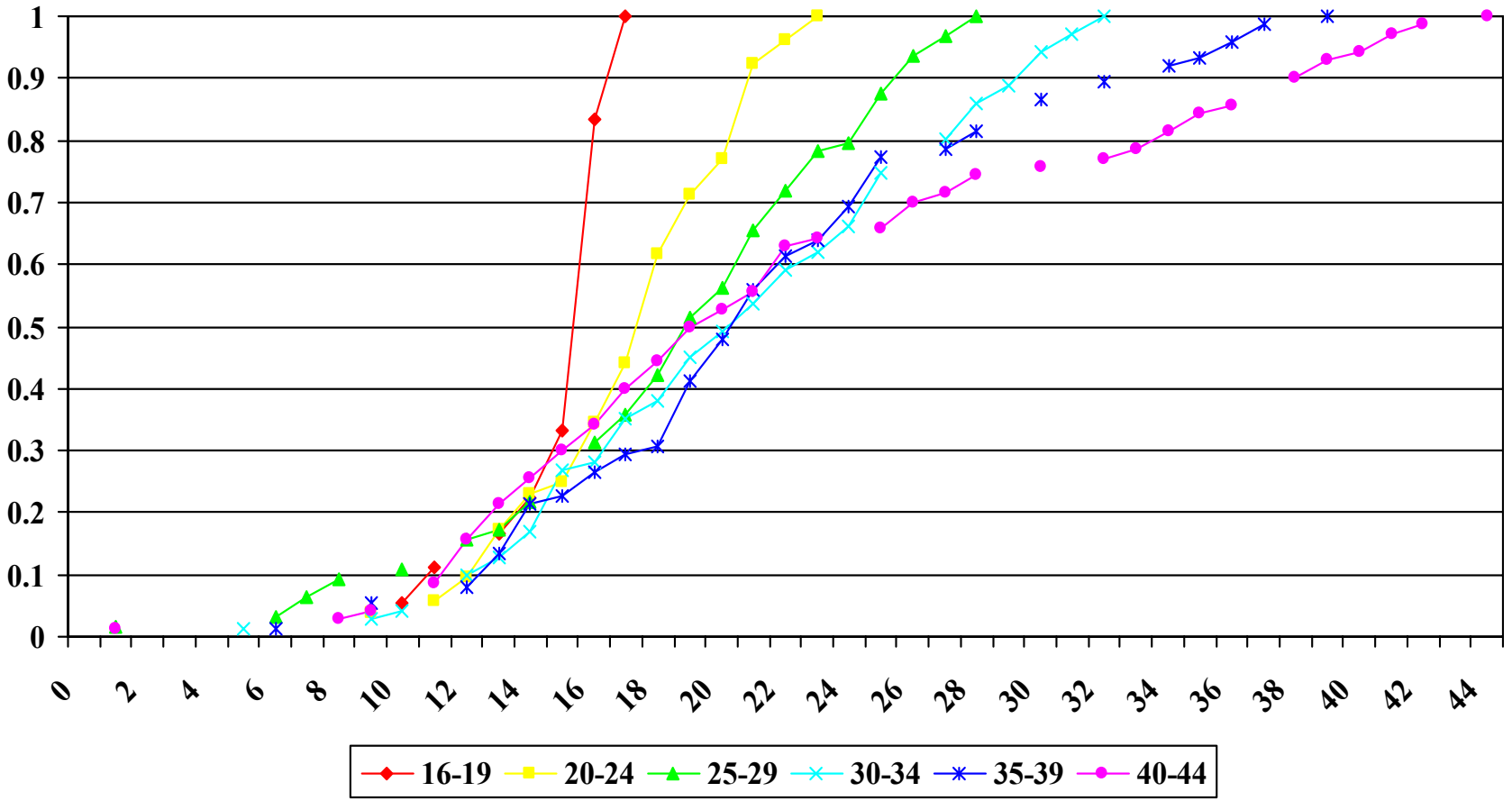
Age at first heterosexual intercourse, by 5 year age groups. WOMEN (life table analysis)



Age at first homosexual experience involving genital contact by 5 year age groups. MEN (life table analysis)



Age at first homosexual experience involving genital contact by 5 year age groups. WOMEN (life table analysis)



‘Sexual competency’ at first sexual intercourse

- **FREE FROM REGRET**
  (did not report wishing had waited longer)
- **AUTONOMOUS DECISION**
  (main reason not ‘peer pressure’ or ‘being drunk’)
- **CONSENSUAL**
  (both partners equally willing)
- **PROTECTED**
  (oral contraception and / or condom used)

National Survey of Sexual Attitudes and Lifestyles II

% aged under 16 at first intercourse

	16-19	20-24	25-29	30-34	35-39	40-44	All
Men	29.9	25.8	29.2	29.5	23.6	27.1	27.4
Women	25.6	28.4	24.5	16.7	17.0	13.8	20.4

All **young people** of the world regardless of **sex**, religion, **colour**, sexual orientation or mental and **physical** ability have the following **rights** as **sexual** beings

1. The right to be yourself – free to make your own decisions, to express yourself, to enjoy sex, to be safe, to choose to marry (or not to marry) and plan a family.
2. The right to know – about sex, contraceptives, STDs/HIV, and about your rights.
3. The right to protect yourself and be protected – from unplanned pregnancies, STDs/HIV and sexual abuse.
4. The right to have health care – which is confidential, affordable, of good quality and given with due respect.
5. The right to be involved – in planning programmes with and for youth, attending meetings/seminars etc. at all levels and trying to influence governments through appropriate means.

International Planned Parenthood Federation

For Health Professionals

How to treat us young people:

- Be confidential with us
- Provide us with the information and services we need
- Accept us as we are, do not moralize or demoralize us
- Use language or means we understand
- Ask and respect our opinions about the services
- Allow us to decide for ourselves
- Make us feel welcome and comfortable
- Don't judge us
- Provide services at the time and within the time frame we have available

International Planned Parenthood Federation

“What's the secret? Is there a 'silver bullet' solution for the United States?”

The United States can use the experience of the Dutch, Germans, and French to guide its efforts to improve adolescents' sexual health.

- Adults *[in Europe]* value and respect adolescents and expect teens to act responsibly.
- Governments strongly support education and economic self-sufficiency for youth.
- Research is the basis for public policies to reduce unintended pregnancy, abortion, and STIs, including HIV
- Political and religious interest groups have little influence on public health policy.
- A national desire to reduce the number of abortions and to prevent STIs, including HIV, provides the major impetus in each country for unimpeded access to contraception, including condoms, consistent sexuality education, and widespread public education campaigns.
- Governments support massive, consistent, long-term public education campaigns utilizing the Internet, television, films, radio, billboards, discos, pharmacies, and health care providers. Media is a partner, not a problem, in these campaigns. Campaigns are far more direct and humorous than in the U.S. and focus on safety and pleasure.
- Youth have convenient access to free or low-cost contraception through national health insurance.
- Sexuality education is not necessarily a separate curriculum and may be integrated across school subjects and at all grade levels. Educators provide accurate and complete information in response to students' questions.
- Families have open, honest, consistent discussions with teens about sexuality and support the role of educators and health care providers in making sexual health information and services available for teens.
- Adults see intimate sexual relationships as normal and natural for older adolescents, a positive component of emotionally healthy maturation. At the same time, young people believe it is "stupid and irresponsible " to have sex without protection and use the maxim, "safer sex or no sex."
- The morality of sexual behavior is weighed through an individual ethic that includes the values of responsibility, respect, tolerance, and equity.
- European countries work to address issues around cultural diversity in regard to immigrant populations and their values that differ from those of the majority culture.

Sexual health interventions and strategies must:

- be tailored and targeted to context
- take account of social-structural factors (eg. poverty, gender and mobility) as well as individual risk behaviour
- take account of diversity
- be multifaceted
- have support from government
- be guided by research

Research needs

Need comparative data on behaviour AND interventions, to be able to see what works, where and why

Precursors (causes)

Teenage mothers are more likely to have:

- had worse off parents
- lived in a deprived area as a child
- lived with lone/neither parent
- a family history of early school leaving
- had mothers who were teenage mothers

Outcomes (consequences)

Teenage mothers are more likely to be/have:

- currently in manual or no job
- living in a deprived area as an adult
- living as a lone parent
- left school early with no qualifications
- daughters who will be teenage mothers

Sexual and Reproductive Health 2

Sexual behaviour in context: a global perspective

Kaye Wellings, Martine Collumbien, Emma Slaymaker, Susheela Singh, Zoé Hodges, Dhaval Patel, Nathalie Bajos

Lancet 2006; 368: 1706–28
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This is the second in a Series of six articles about sexual and reproductive health

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Research aimed at investigating sexual behaviour and assessing interventions to improve sexual health has increased in recent decades. The resulting data, despite regional differences in quantity and quality, provide a historically unique opportunity to describe patterns of sexual behaviour and their implications for attempts to protect sexual health at the beginning of the 21st century. In this paper we present original analyses of sexual behaviour data from 59 countries for which they were available. The data show substantial diversity in sexual behaviour by region and sex. No universal trend towards earlier sexual intercourse has occurred, but the shift towards later marriage in most countries has led to an increase in premarital sex, the prevalence of which is generally higher in developed countries than in developing countries, and is higher in men than in women. Monogamy is the dominant pattern everywhere, but having had two or more sexual partners in the past year is more common in men than in women, and reported rates are higher in industrialised than in non-industrialised countries. Condom use has increased in prevalence almost everywhere, but rates remain low in many developing countries.

The huge regional variation indicates mainly social and economic determinants of sexual behaviour, which have implications for intervention. Although individual behaviour change is central to improving sexual health, efforts are also needed to address the broader determinants of sexual behaviour, particularly those that relate to the social context. The evidence from behavioural interventions is that no general approach to sexual-health promotion will work everywhere and no single-component intervention will work anywhere. Comprehensive behavioural interventions are needed that take account of the social context in mounting individual-level programmes, attempt to modify social norms to support uptake and maintenance of behaviour change, and tackle the structural factors that contribute to risky sexual behaviour.

The ability of individuals or couples to pursue a fulfilling and safe sex life is central to achievement of sexual health. Creation of supportive environments in which safe sexual behaviour can take place is vital if the Millennium Development Goals (MDGs) for sexual equality, maternal health, and HIV/AIDS are to be achieved.[1] Conventionally, public health has focused on adverse outcomes of sexual behaviour. As important determinants of fertility patterns and transmission of sexually transmitted infections, sexual behaviours contribute substantially to the burden of disease.[2–4] The past decade has seen growing attention in the international policy arena to sexual rights, and new standards are being formulated for the creation and maintenance of a sexually healthy society, invoking values of dignity, respect, and choice.[5] Information about sexual behaviour is essential to the design and assessment of interventions to improve sexual health. Importantly, too, empirical evidence is needed to correct myths in public perception of behaviours. Yet despite being scrutinised everywhere, sexual behaviour poses challenges for scientific enquiry. The same paradox is

Panel 1: Key messages

- Information about sexual behaviour is essential to inform preventive strategies and to correct myths in public perceptions of sexual behaviour. Increased research in this area in the past two decades provides a historically unique opportunity to take stock of sexual behaviour, and efforts to safeguard it, at the beginning of the 21st century. Gaps in knowledge remain, especially in Asia and the middle east, where obstacles to sexual-behaviour research remain.
- Trends towards earlier sexual experience are less pronounced and less widespread than sometimes supposed (in many developing countries the trend is towards later onset of sexual activity for women), but the trend towards later marriage has led to an increase in the prevalence of premarital sex.
- Most people are married and married people have the most sex. Sexual activity in young single people tends to be sporadic, but is greater in industrialised countries than in developing countries.
- Monogamy is the dominant pattern in most regions; but reporting of multiple partnerships is more common in men than in women, and generally more common in

Early sexual experience, more likely to be:

- regretted
- unprotected
- non-consensual
- non-autonomous
- disappointing

Condoms are free.

If you're under 18 and want to know where to get free condoms, or need advice about sex or contraception, call Sexwise on 0800 28 29 30 or visit us at www.ruthinking.co.uk The call is free and confidential. Textphone (for people with hearing impairments) 0800 328 1651.

sex

Are you thinking about it enough?