Information Service of the Federal Centre for Health Education

FORUM

SEXUALITY EDUCATION AND FAMILY PLANNING

02_2024

International studies

» Scientific reports » Infothek

BZgA Bundeszentrale für gesundheitliche Aufklärung

Content

Scientific reports

4 **A teacher survey in Flanders: laying the groundwork for sexual education campaigns**

Wannes Magits

10 **Comprehensive sexuality education in Italian secondary schools: the EduForIST national project**

Gianluca Paparatto, Alice Chinelli, Domenico Martinelli, Marco Ubbiali, Lara Tavoschi

16 **Sex under the age of 25: sexual health of young people in the Netherlands**

Hanneke de Graaf, Yolin Kraan, Koenraad Vermey

22 **REPEAT project: exploring and addressing repeat teenage pregnancies in Southwestern Uganda**

Olena Ivanova, Elizabeth Kemigisha

29 **Knowledge transfer for the prevention of sexualised violence**

Britta Buschmann, Anja Borchert, Ulrike Urban-Stahl

37 **Perspectives on hormonal contraception among young adults in the European Region**

Erica Selznick, Leonidas Galeridis, Kristien Michielsen

48 **Insights into the Swiss LGBTIQ+ Panel: key findings**

Tabea Hässler, Léïla Eisner

60 **Insights from the Austrian LGBTIQ+ health report 2022**

Johanna Pfabigan, Sylvia Gaiswinkler

Infothek

68 **Brochures, projects, studies**

International Studies

The Bundeszentrale für gesundheitliche Aufklärung (BZgA; Federal Centre for Health Education in Germany) is assigned by schedule 1 paragraph 1 of the Schwangerschaftskonfliktgesetz (SchKG; Germany's Pregnancy and Family Assistance Act) to develop concepts and put in place sex education and family planning measures, and to supply these materials nationwide free of charge. BZgA shares this task with Germany's federal states, working in close cooperation with actors across all family counselling agencies and organisations.

BZgA has for many years provided in-depth, fact-based knowledge about the sexual and contraceptive behaviour, media use and information sources of young people and adults in relation to their sexual and reproductive health. This is based on representative surveys repeated at regular intervals. Examples of these are the studies on youth sexuality and on the contraceptive behaviour of adults. Individual research projects and related evaluation studies are also taken into account. These studies are commissioned or funded by BZgA and serve as a basis for the development of materials and measures to actively promote health and prevention. This transfer of research into practice undergoes continuous assessment and evaluation. BZgA has been a WHO Collaborating Centre for Sexual and Reproductive Health since 2012. The main focus of this work is on sexuality education in the European WHO region.

"FORUM Sexuality Education and Family Planning" (www.forum.sexualaufklaerung.de) has appeared as a series of publications since 1996. It provides a regular overview of the new media, projects and measures focusing on sexuality education and family planning in Germany, while also presenting the results of recent academic research and evaluations. The aim is to support and promote dialogue between academia and practitioners.

Review of recent international studies

Each publication has a specific area of focus. In recent years FORUM has repeatedly presented a range of topics from international sources. The 2/2024 issue deliberately picks up on the theme of "international studies" in the field of sexual and reproductive health (SRH). It aims to give an insight into the challenges currently being faced in the field of sexual health and sexuality education and to facilitate dialogue between countries. This issue of FORUM has been published in English.

Eight articles from Austria, Belgium, Germany, Italy, the Netherlands, Switzerland and Uganda examine the themes of sexuality education; sexual behaviour and the sexual health of young people; teenage pregnancies; prevention of sexualised violence; hormonal contraception among young adults in the European region; and the health care experiences, challenges and discrimination of LGBTIQ+ people.

We hope you enjoy reading this issue of FORUM.

The editor

A teacher survey in Flanders: laying the groundwork for sexual education campaigns

Wannes Magits

Sensoa, the Flemish expertise centre for sexual health, supports teachers in providing relational and sexual education (RSE) by offering them teaching tips, distributing lesson materials, organizing teacher trainings and coordinating an annual campaign to reach even more teachers. However, which interventions are most helpful for teachers? Can we maximize our impact by focusing on certain interventions and messages and concentrating less on others?

To answer these questions, Sensoa conducted 'de grote lerarenbevraging' (The Great Teacher Survey; Magits, 2023), a research project in 2 phases:

(1) An online survey of teachers to obtain an overall picture (started in October 2022).

(2) Focus groups with teachers to explore the survey results in depth (January 2023).

The study focused on four educational levels: special primary education (SPE), special secondary education (SSE), ordinary primary education (OPE) and ordinary secondary education (OSE), the latter including part-time vocational secondary education. Special education focuses on pupils who have difficulties learning in ordinary education, or who have a (physical, cognitive, temporary or permanent) disability that requires an adapted learning environment. Special education uses individualized programmes, adapted to the needs and learning tempo of each pupil.

767 teachers started the survey, 583 completed the first question and 432 completed the survey in full. The sample is not representative of the Flemish teacher population. Moreover, the teachers who participated in the survey are probably more engaged in the topic than the broader teacher population due to the self-selection bias. Nevertheless, the study has revealed some clear trends, from which we can draw conclusions that will help us provide teachers with even better support.

Method

Setting up the survey

The questions for the online survey were selected based on Sensoa's most pressing information requirements. SurveyMonkey was chosen as the survey programme. We tested the survey on 31 teachers from different educational levels. The intention of this test was to ensure that the phrasing and response options were relevant to all 4 educational levels. We subsequently decided to keep the phras-

ing of the questions exactly the same for all four levels. Importantly, we tried not to deter teachers with little or no experience of delivering relational and sexual education (RSE) from taking part in the survey.

The survey was disseminated through a magazine for teachers, support organizations for teachers, Sensoa's newsletter, Facebook groups for teachers and advertisements on Facebook. We used the results of the pretest to help us with the content of the advertisements. In primary education the most frequently taught subjects were 'feelings' and 'boundaries and resilience', so we created advertisements that mentioned those subjects rather than mentioning 'relational and sexual education'. The latter might have deterred teachers who did not consider their lessons to be sexual education. This approach might have had an effect on the self-selection bias or even a priming effect once the respondents had started the survey.

For the secondary education levels we used the barriers to teaching RSE that had been mentioned most in the secondary education pretest as key words so as to increase the chance of recruiting teachers with little or no experience of teaching RSE. We chose three barriers for the advertisements: 'no time', 'pupils aren't ready' and 'can't find lesson materials'.

Analysis

The data was filtered according to the four levels of education: special primary education (SPE), special secondary education (SSE), ordinary primary education (OPE) and ordinary secondary education (OSE).

Respondents who did not complete the survey were still included in the analysis because we were also curious about the opinions of teachers who have little experience of RSE or did not have time to answer all the questions. Before we started analysing the data, the respondents' personal data were separated from their answers to ensure their anonymity. Very little demographic data was gathered in order to reduce survey completion time. Our intention was to look primarily at respondents as teachers, independent of their other characteristics. Not every teacher was equally likely to see the recruitment message (selective sampling). Our findings can therefore not be extrapolated to the entire population of teachers. Most questions involved variables at the ordinal or nominal level. A chi-square test to compare groups was often not possible because the frequencies within some answer categories were too low.

There was no time to carry out an extra recruitment round, which may have led to improved representativeness and more opportunities to perform a chi-square test, particularly in special education. The percentages can be understood more as an indication of the order of magnitude of the results than as exact percentages. The error rates at a 95% confidence level at the beginning of the survey (n=583; SPE 14.7%, SSE 10.9%, OPE 7.4%, OSE 5.8%) increase towards the end of the survey (n=432; SPE 17.6%, SSE 11.9%, OPE 8.8%, OSE 6.7%).

Nevertheless, the results do provide an initial indication of possible differences between educational levels, for example. These differences were explored further in the focus groups during the later stages of the study. Thanks to the Arteveldehogeschool, we were also able to submit some of the questions from our survey to Teacher Tapp (Education Intelligence Limited, 2017), an app that polls education professionals' opinions on various topics on a daily basis. This confirmed that our sample contained a relatively high percentage of teachers who already had some experience of RSE.

Results

Majority of teachers feel capable and motivated

The survey shows that a large majority (81%) of the surveyed teachers feel able to discuss relationships and sexuality with their students. Respondents feel it is important to discuss the topic: they feel that young people are entitled to good information. They want to protect pupils from risks and ensure that they can enjoy relationships and their sexuality. Teachers also find these fun lessons to teach. Themes such as 'feelings' and 'boundaries and resilience' are addressed in lessons relatively often across all four levels of education. About a third of the teachers indicated that they did not experience

any barriers to teaching RSE, although this group seems smaller in special primary education (SPE).

Finding appropriate teaching materials is the most important barrier

Some barriers remain in the way of teaching relational and sexual education (RSE). The most important is the need for appropriate teaching materials (Table 1). Among respondents from SPE and OPE, the idea that 'pupils do not need it (yet)' is a noticeable barrier. At all four levels of education, the 'fear of the reaction of (some) parents' was a frequently mentioned barrier. In OSE, lack of time is most often cited as a barrier, while in SPE, SSE and OPE about 1 in 10 teachers also mention lack of time as being one of their top three most important barriers. In OSE respondents were particularly wary of meeting with negative reactions from pupils and being asked questions about their own sexual experiences. Lack of support from colleagues or management, or concern about their reactions seem to be less important barriers to respondents.

In OSE (55%) and OPE (42%) teachers seem to find it easier to teach a lesson on a new relational or sexual topic than in SPE (26%) or SSE (31%).

TABLE 1

TOP 7 OF THE MOST IMPORTANT BARRIERS TO TEACHING RELATIONAL AND SEXUAL EDUCATION, PER EDUCATIONAL LEVEL

Respondents were allowed to pick a maximum of 3 barriers.
Percentages should be interpreted accordingly.

	Total (n=477)	SPE (n=34)	SSE (n=70)	OPE (n=137)	OSE (n=236)
1	*I don't experience any barriers (34%)*	*I can't find appropriate lesson materials for my pupils (39%)*	*I don't experience any barriers (40%)*	*I don't experience any barriers (35%)*	*I don't experience any barriers (33%)*
2	*I can't find appropriate lesson materials for my pupils (17%)*	*I think (some) parents might react negatively (29%)*	*I can't find appropriate lesson materials for my pupils (33%)*	*I think (some) parents might react negatively (22%)*	*I have insufficient time to take on this task (22%)*
3	*I think (some) parents might react negatively (16%)*	*My pupils have no need for this (yet) (21%)*	*I have insufficient time to take on this task (11%)*	*My pupils have no need for this (yet) (18%)*	*I can't find appropriate lesson materials for my pupils (14%)*
4	*I have insufficient time to take on this task (16%)*	*I don't experience any barriers (18%)*	*I think (some) parents might react negatively (10%)*	*I can't find appropriate lesson materials for my pupils (12%)*	*I think (some) pupils might react negatively (14%)*
5	*I don't want pupils asking questions about my private life or sexuality (11%)*	*I don't know enough about sexual development or sexual health (15%)*	*I think (some) pupils might react negatively (9%)*	*It's not my role/task to give RSE (9%)*	*I don't want pupils asking questions about my private life or sexuality (14%)*
6	*I think (some) pupils might react negatively (11%)*	*Other reasons, namely ... (15%)*	*I think I'm not going to do it well (7%)*	*I don't want pupils asking questions about my private life or sexuality (9%)*	*I think (some) parents might react negatively (13%)*
7	*It's not my role/task to give RSE (9%)*	*I have insufficient time to take on this task (12%)*	*Other reasons, namely ... (7%)*	*I have insufficient time to take on this task (9%)*	*I think I might lose control over the class when we talk about this (11%)*

Context: In recent years there has been a teacher shortage in Flanders.
Source: Magits (2023)

TABLE 2

TOP 7 OF WHAT WOULD MOST HELP YOU TO (START) TEACHING RSE, PER EDUCATIONAL LEVEL
Respondents were allowed to pick a maximum of 3 forms of support. Percentages should be interpreted accordingly.

	Total (n=432)	SPE (n=31)	SSE (n=67)	OPE (n=123)	OSE (n=211)
1	Lesson materials tailored to my pupils. (61%)	Lesson materials tailored to my pupils. (65%)	Lesson materials tailored to my pupils. (75%)	Lesson materials tailored to my pupils. (56%)	Lesson materials tailored to my pupils. (60%)
2	Overview of lesson content appropriate for each age / developmental phase (38%)	Tips on how to teach RSE to pupils from diverse backgrounds (52%)	Overview of lesson content appropriate for each age / developmental phase (37%)	Overview of lesson content appropriate for each age / developmental phase (45%)	Tips on how to teach RSE to pupils from diverse backgrounds (38%)
3	Tips on how to teach RSE to pupils from diverse backgrounds (36%)	Tips on how to address a certain topic (35%)	Tips on how to teach RSE to my pupils (33%)	Tips on how to teach RSE to pupils from diverse backgrounds (33%)	(Online) training for me as a teacher (37%)
4	(Online) training for me as a teacher (33%)	Overview of lesson content appropriate for each age / developmental phase (32%)	Tips on how to teach RSE to pupils from diverse backgrounds (31%)	(Online) training for me as a teacher (30%)	Tips on how to address a certain topic (37%)
5	Tips on how to address a certain topic (33%)	(Online) training for me as a teacher (26%)	(Online) training for me as a teacher (28%)	Tips on how to teach RSE to my pupils (28%)	Overview of lesson content appropriate for each age / developmental phase (38%)
6	Tips on how to teach RSE to my pupils (30%)	Tips on how to teach RSE to my pupils (26%)	Tips on how to address a certain topic (27%)	Tips on how to address a certain topic (28%)	Tips on how to teach RSE to my pupils (31%)
7	A school vision with respect to relationships and sexuality (25%)	Observing someone teaching RSE (23%) or a good website with info for young people (23%)	Good website with info for young people (27%)	A school vision with respect to relationships and sexuality (27%)	Clarity on curriculum goals in relation to these topics (27%)

Context: Curriculum goals have been under revision by the Flemish government.
Source: Magits (2023)

What do teachers think could help?

There is broad agreement among teachers on what might help them teach (more) RSE. Teaching materials tailored to students would help most at all 4 educational levels. Teachers would also like to be provided with an overview of lesson content appropriate for each (developmental) age (Table 2). Furthermore, they would like to be given teaching tips on how to tailor RSE to their target group or pupils from diverse backgrounds, and on other specific themes (e.g. gender and sexual diversity). Training, including online, would also be a help.

Need for better organisation and clearer school policies

Half of the surveyed teachers (50%) have a clear understanding of how RSE is organised at their school. Teachers in SSE (66%) and OPE (62%) seem to have a better understanding than teachers in SPE (43%) and OSE (44%). School policy on sexual health is

not always clear to teachers: between 28% and 31% do not have a clear understanding of their school's current policies. Teachers give the quality of RSE at their school an average rating of 6.4 out of 10.

Just over half (55%) of respondents discuss RSE at school with colleagues. In SPE (77%) and SSE (70%) this seems to happen more often than in OPE and OSE (50% each). Agreements on the division of lesson content are certainly not common in all schools. Only 36% indicate that their school has such agreements, compared with 40% who indicate that their school has no such agreements. The surveyed teachers in special education seem slightly more likely to work in schools where there are such agreements.

Learning objectives and evaluation

About half of the surveyed teachers (55%) say they write down the learning objectives for each RSE lesson. Formulating learning objectives is clearly more common in special education. This is probably because they are used to adapting their lessons to the socio-emotional development of their class group, or even of individual pupils. 31% of all respondents indicated that their school has a plan to achieve the educational goals set out by the government.

The majority (72%) of teachers evaluate the knowledge acquired by pupils during or after their lessons on relationships and sexuality. Only 24% indicate that their school has an agreement on how to evaluate the goals set out by the government.

It could be that teachers use short on-the-spot techniques to evaluate the knowledge of their students, without having written down learning objectives beforehand.

There is still a lack of policies and visions with respect to sexual (transgressive) behaviour

As far as policies are concerned, progress still needs to be made with respect to sexual health. A minority of schools (ranging from 23% to 34%) have a policy with respect to sexual (transgressive) behaviour, a vision with respect to sexual health, a plan to promote sexual health, or guidelines about how to respond in incidents of sexually transgressive behaviour. Only a few of the teachers who have such a policy at their schools say they also use these interventions regularly (ranging from 14% to 20%).

A large proportion of respondents say that their schools do not have any such policies (ranging from 35% to 49%), some of whom say they would like to implement these policies in the future (ranging from 11% to 15%). In general, schools in special education seem to have policies in place more often than schools in ordinary education. Especially in OPE, few policies are in place.

Few teachers are prepared during their teacher training

Only 7% of the surveyed teachers indicated that they were properly or excellently prepared to teach RSE during their pre-service teacher training. Well-prepared teachers find it easier to teach RSE and are more likely to work in schools where there are stronger policies with respect to sexual health. We cross-checked this question with Teacher Tapp and noticed that this lack of preparation is also present among teachers who have recently graduated.

Teachers who have not (yet) planned a lesson this school year

Teachers who have already taught or scheduled a lesson on RSE this school year have similar motivations for teaching RSE to teachers who have not (yet) scheduled a lesson. The motivation for both groups are grounded in principles: the rights of and benefits to students are their major motivation.

Respondents who had not (yet) scheduled a lesson seem slightly more likely to say that they themselves had not been given enough information in the past and wanted to ensure that this did not happen to their pupils. These respondents expect the reactions of '(some) parents' or '(some) pupils' to be more negative and feel less comfortable talking about sexual health with their pupils. They are equally likely to say that they do not have enough time to take on this task.

Of the surveyed teachers who had not (yet) planned or taught a lesson, a higher proportion (38%) indicated that they would find it rather or very difficult to teach a lesson on a new relational or sexual topic

than among the group that had already taught or scheduled such a lesson (20%). Nevertheless, 40% of them indicated that they would find it relatively or very easy. Among teachers who had already planned or taught a lesson this year this percentage was 46%.

Impact on our work

These results, and the input we received from the focus groups, gave direction and a clear focus to our work with schools. It helped us determine the topics for our Spring Fever Week, an annual campaign aimed at teachers. Prior to the survey we typically focused on a different topic every year (e.g. sexting, contraception, boundaries) and concentrated mainly on ordinary secondary education. We decided to shift our focus from yearly themes to addressing specific barriers to teaching RSE, since many of the barriers are present at all four education levels. In 2024 we focused on school-parent communication. In 2025 we intend to focus on teaching groups with a mix of cultural/religious backgrounds, sexual orientations and gender identities. We had already addressed most of the barriers to teaching RSE experienced by teachers in our existing support resources prior to the survey. We have now expanded the support we offer on school-parent communication and present the support we already offer more often throughout the year.

We identified the most common communication channels at all four education levels to determine how best we should communicate with teachers. Some of the barriers to teaching RSE were more relevant at some education levels (e.g. 'lack of knowledge on sexual development' in SPE) and we identified specific communication channels that are used more frequently at those education levels, adding a targeted approach to our more general approach.

Although we had already started planning an online course for teachers on RSE, the results indicating inadequacies in RSE in pre-service training caused us to direct our focus more towards pre-service teachers in the development of our course.

Literature

Magits, W. (2023). *De grote lerarenbevraging 2023. Rapport en toelichting.* Sensoa. https://www.sensoa.be/sites/default/files/rapport-lerarenbevraging-relationele-seksuele-vorming.pdf

Education Intelligence Limited (2017). *Teacher Tapp.* [online app] https://teachertapp.co.uk/ or the Flemish adaptation by Arteveldehogeschool https://sites.arteveldehogeschool.be/deleraardenkt/over-teacher-tapp-vlaanderen

Authors

Wannes Magits is Policy Officer on Sexual Development at Sensoa, the Flemish expertise center on sexual health. Magits focuses on the development of educational tools to provide comprehensive sexuality education and tools to implement school policies on sexual health and integrity. Spring Fever Week is an annual campaign that aims to boost the popularity of these tools in education.
Contact: wannes.magits@sensoa.be

Citation

Magits, W. (2024). A teacher survey in Flanders: laying the groundwork for sexual education campaigns, *FORUM sexuality education and family planning: information service of the Federal Centre for Health Education (BZgA), 2*, 04–09. https://doi.org/10.17623/BZgA_SRH:forum_2024-2_en_art_teacher-survey-flanders

Comprehensive sexuality education in Italian secondary schools: the EduForIST national project

Gianluca Paparatto, Alice Chinelli, Domenico Martinelli, Marco Ubbiali, Lara Tavoschi

This article outlines the co-construction, implementation and evaluation process of a pilot CSE intervention conducted in Italian secondary schools in 2023 as part of the EduForIST project.

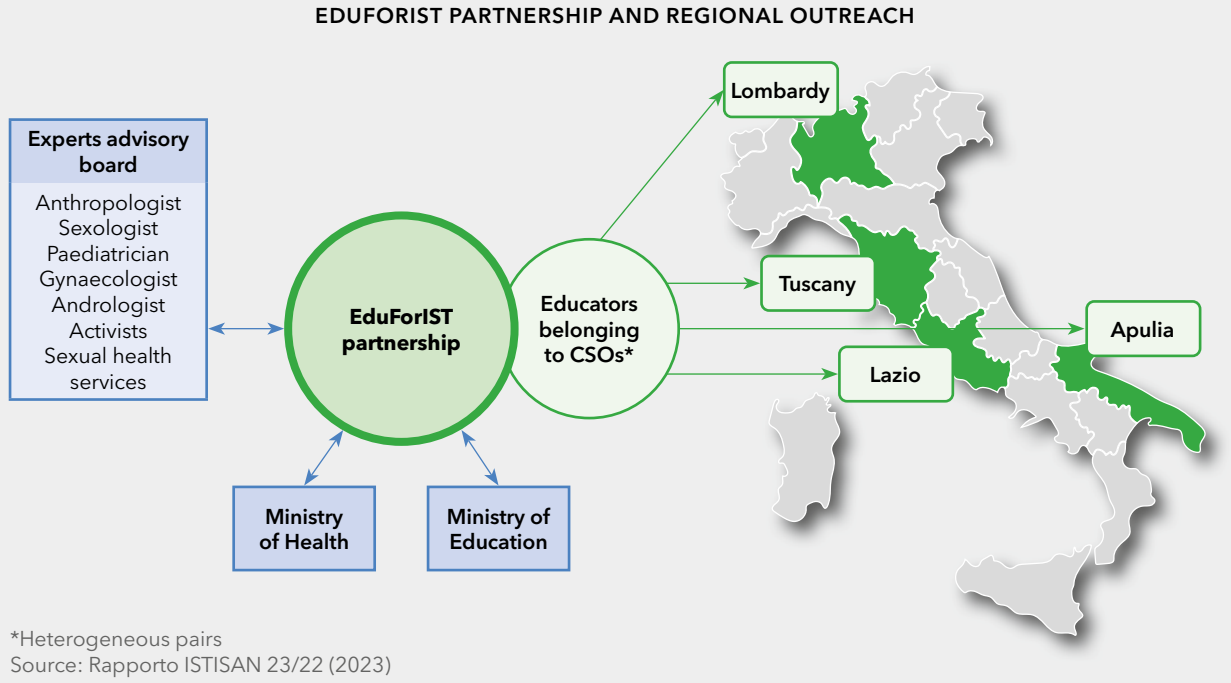
Introduction

Comprehensive Sexuality Education (CSE) is defined by UNESCO as "a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives". In recent years, a few studies have focused on understanding the landscape of Sexuality Education (SE) and CSE initiatives in Italy, particularly in school settings. These efforts have involved various stakeholders, including civil society organizations (CSOs), local health departments, and professionals from diverse fields, aiming to address the gap created by the absence of a national SE programme and shared standards (Fontana, 2018). Traditional SE activities tend to prioritise biological aspects, love, family, contraception, and protection from sexually transmitted infections (STIs), often overlooking key elements like consent, gender identity, human rights, pleasure and disability (Lo Moro et al., 2023). Most of these initiatives target primarily the prevention of STIs and provide information rather than education, with limited geographical coverage. Moreover, although many programmes declare that they perform evaluation, their results are rarely accessible or published (Chinelli et al., 2022). Only a few Italian studies published between 2000 and 2023 assessed SE programmes, finding increased knowledge but not necessarily safer sexual behaviours (Capuano et al., 2009; Bogani et al., 2015; Benni et al., 2016). According to the European Expert Group on Sexuality Education (Ketting et al., 2016), SE programme evaluation should encompass programme content, implementation processes and outcomes, informed by mixed methods approaches and educational theories.

Methodology

Firstly, the EduForIST Working Group (WG) was formed, comprising 17 representatives from institutional, academic and civil society organisations, as well as representatives from the Italian Ministry of Health and Ministry of Education (see Figure1).

FIGURE 1



*Heterogeneous pairs
Source: Rapporto ISTISAN 23/22 (2023)

This group, overseen by a multidisciplinary team of 15 experts in sexuality education, relationships education and STI prevention, was responsible for developing the pilot intervention. The group analysed past educational approaches used in Italian experiences. These leaned towards liberal and critical viewpoints aimed at empowering students and deconstructing cultural norms. Based on the principles of CSE proposed by UNESCO (2018), the WG developed the pilot intervention during the course of online consultations involving Italian experts and stakeholders to identify the target population and intervention objectives. Focus groups then determined the structure of the intervention, including the frequency of sessions, the objectives and content and the methods for content delivery. A methodology consistent with that proposed by Ketting et al. (2016) was used to develop evaluation tools for the pilot intervention. Assuming a pedagogical perspective, the evaluation of the implementation process was reinterpreted as a source of information on the educational strength and weaknesses of the project. Qualitative analysis tools such as field journals and SWOT analysis were therefore proposed in order to critically understand educators' actions, their 'life of mind', and also the reflections and feelings that emerged during the implementation of the pilot intervention with their students. As far as the students were concerned, short-term outcomes were assessed by means of pre/post-tests on the knowledge acquired and satisfaction level surveys were conducted.

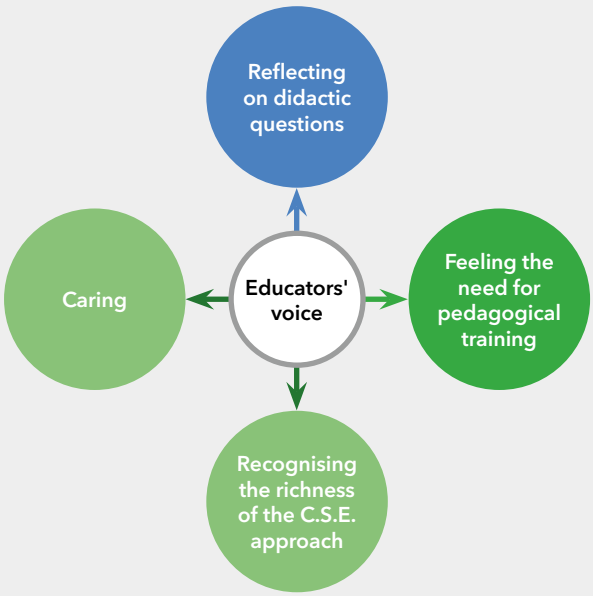
Co-construction of the pilot intervention

The co-construction process aimed to develop a CSE pilot intervention promoting scientifically accurate, age-appropriate and culturally relevant knowledge as well as positive attitudes on sexuality for 14-16 year-old students. This process resulted in five learning objectives for the EduForIST project divided into interactive modules addressing various dimensions of sexuality. The modules of the EduForIST intervention covered the following 4 dimensions: A) changes in adolescence, B) development of sexual

identity, C) first sexual experiences, D) STIs and the prevention of unintended pregnancies. Each module consisted of theoretical and practical sessions, employing participatory tools like role-playing and group activities to engage students. The implementation of the pilot interventions commenced in four Italian regions (Lazio, Lombardy, Puglia and Tuscany), thus ensuring geographical diversity. Educators from CSOs planned activities in schools, aiming for geographical representation across urban and rural areas within each region. Educators from different organisations conducted interventions in teams of two to facilitate skills sharing, cross-fertilisation and standardisation. School managements approved the intervention, often integrating it into existing educational programmes after having received the parents' formal approval. Teachers played a key role, coordinating activities and facilitating discussions in classrooms, although they were usually not present during interventions to ensure that students felt comfortable. Efforts were made to involve families by means of pre/post-intervention meetings, although parental participation varied across schools. Feedback sessions were held post-intervention to evaluate the experience, with some parents expressing interest in receiving additional support to help them with their communications with adolescents about sexuality.

FIGURE 2

MAIN DOMAINS REVEALED BY THE ANALYSIS OF EDUCATORS' DIARIES



Source: Rapporto ISTISAN 23/22 (2023)

Evaluation of the implementation process

School activities targeting second-year upper secondary school students took place between February and June 2023 and involved 585 students across 13 schools in the four regions. Educators' feedback on the EduForIST pilot intervention emphasised its strong educational value. They expressed appreciation for the theoretical foundations and practical implementation of CSE. They recognised the need for deeper pedagogical training and the importance of expanding competences. In addition, educators identified educational action as an act of care that goes beyond the mere transmission of information. Within a just relational framework, they valued nurturing others and promoting self-care. Finally, educators understood their political role in shaping society through rights advocacy and the promotion of a caring approach to CSE.

Evaluation of short-term outcomes

In total, 585 students initially responded to the pre-intervention questionnaire, with 508 completing it post-intervention. Table 1 shows the percentage changes and level of significance for each item examined.

According to our results, male students were less likely to answer several of the items correctly in the post-test, especially those related to STI prevention. Additionally, living in a northern Italian region was associated with a reduced probability of a correct response to specific items. Previous exposure to CSE topics in school activities increased the likelihood of a correct response to certain items, as did teacher participation in pilot activities and favourable pare-

tal attitudes towards the intervention. Moreover, parental attendance at meetings positively influenced responses to certain items. Regarding satisfaction, 569 students completed the questionnaire and indicated a high level of interest in discussions on STIs and their prevention. However, less interest was shown in topics concerning gender identity, sexual orientation and gender roles, with a considerable portion of students expressing indifference toward these items.

Conclusions

The EduForIST project has facilitated the development, implementation and evaluation of sexuality education interventions in upper secondary schools across Italy, following the CSE approach recommended by international guidelines (Eisenberg et al., 2008; UNESCO, 2018; Goldfarb & Lieberman, 2021). While students exhibited good baseline knowledge of certain topics such as adolescent

TABLE 1

N. AND PERCENTAGE (%) OF STUDENTS WHO ANSWERED THE ITEM CORRECTLY. % CORRESPONDING PERCENTAGE. DIFF: PERCENTAGE DIFFERENCE PRE/POST-TEST. P: P-VALUE

Dimension/Investigated Item		Pre-Evaluation (n. 585) N	%	Post-Evaluation (n. 508) N	%	Diff %	p
A. Changes in adolescence	1. The timing of physical changes during adolescence is the same for everyone (FALSE)	532	90.9	482	94.8	+3.9	**<0.05**
	2. It is rare to experience intense emotions during adolescence (FALSE)	425	72.6	421	82.9	+10.3	**<0.05**
	3. Empathy, the ability to put oneself in others' shoes, is fundamental for building good relationships (TRUE)	498	85.1	452	88.9	+3.8	>0.05
B. Development of sexual identity	4. A person's identity is built through interaction with others (TRUE)	212	36.2	240	47.2	+11	**<0.05**
	5. A person's gender identity (i.e., feeling male, female, or other) always matches their biological sex (FALSE)	423	72.3	431	84.8	+12.5	**<0.05**
	6. Sexual orientation indicates the sex/gender of the people an individual is romantically and/or sexually attracted to (TRUE)	428	73.0	398	78	+5.1	**<0.05**
	7. A stereotype is a rigid and generalized opinion (TRUE)	434	74.2	413	81.3	+7.1	**<0.05**
C. First sexual experiences	8. Pleasure during sexual intercourse depends on the size of the penis (FALSE)	330	56.4	412	81.1	+24.7	**<0.05**
	9. Pain is always normal during the first sexual intercourse (FALSE)	133	22.7	225	44.3	+21.6	**<0.05**
	10. Once you have said yes to sexual intercourse, you cannot change your mind (FALSE)	506	86.5	473	93.1	+6.6	**<0.05**
D. STIs and unwanted pregnancies prevention	11. It is not possible to get a sexually transmitted infection (STI) during the first sexual encounters (FALSE)	477	81.5	463	91.14	+9.6	**<0.05**
	12. The need to urinate frequently with burning sensation can be a symptom of a STI (TRUE)	232	39.7	385	75.8	+36.1	**<0.05**
	13. There are medications that allow people with HIV not to get sick with AIDS and not to transmit the infection to others (TRUE)	137	23.4	313	61.6	+38.2	**<0.05**
	14. The contraceptive pill protects against sexually transmitted infections (FALSE)	370	63.2	409	80.5	+17.3	**<0.05**
	15. It is not possible to get pregnant during the first sexual intercourse (FALSE)	490	83.8	464	91.3	+7.5	**<0.05**

Source: Rapporto ISTISAN 23/22 (2023)

changes, they demonstrated a poor understanding of sexual identity and prevention measures for STIs and unintended pregnancies. This suggests ongoing gaps in addressing key themes in sexuality education within the country. The pilot interventions spanned various regions and revealed geographical differences in knowledge levels. These were higher in northern and urban areas than in southern and rural areas. Gender disparities were also revealed, with girls generally exhibiting higher competencies and being better informed, especially regarding prevention. The gap could be ascribed to some protective factors with respect to girls, such as the fact that they tend to seek more sexual health services/advice than boys, or that they have been placed at the centre of Italy's HPV vaccination campaigns, which have only recently been extended to include boys (Donati et al., 2000; Psaroudakis et al., 2020; Brunelli et al., 2022). This highlights the need to involve male adolescents more actively in sexual health care and education. Overall, the study underscores the importance of integrating CSE programmes into the Italian school curricula to foster not only personal sexual and reproductive health awareness but also non-discriminatory attitudes towards marginalised communities, including those living with HIV/STIs or LGBTQIA+ persons. The results reported in this article show how the EduForIST pilot intervention, including the evaluation tools, could provide a model for future implementation of CSE educational interventions and potentially be scaled-up and transferred to different regions and secondary schools in Italy.

Bibliography

Benni E, Sacco S, Bianchi L, et al. Evaluation outcomes of a sex education strategy in high schools of Pavia (Italy). *Global Health Promotion*. 2016;23(2):15-29. doi:10.1177/1757975914558309

Bogani, G., Cromi, A., Serati, M., Monti, Z., Apolloni, C., Nardelli, F., … Ghezzi, F. (2014). Impact of School-Based Educational Programs on Sexual Behaviors Among Adolescents in Northern Italy. *Journal of Sex & Marital Therapy,* 41(2), 121–125. https://doi.org/10.1080/0092623X.2014.958791

Brunelli, L., Bravo, G., Romanese, F., Righini, M., Lesa, L., De Odorico, A., Bastiani, E., Pascut, S., Miceli, S., & Brusaferro, S. (2022). Sexual and reproductive health-related knowledge, attitudes and support network of Italian adolescents. *Public Health in Practice, 3* (February), 100253. https://doi.org/10.1016/j.puhip.2022.100253

Capuano, S., Simeone, S., Scaravilli, G., Raimondo, D., & Balbi, C. (2009). Sexual behaviour among Italian adolescents: Knowledge and use of contraceptives. *The European Journal of Contraception & Reproductive Health Care, 14*(4), 285–289. https://doi.org/10.1080/13625180902926920

Chinelli, A., Salfa, M. C., Cellini, A., Ceccarelli, L., Farinella, M., Rancilio, L., Galipò, R., Meli, P., Colaprico, L., Oldrini, M., Ubbiali, M., Martinelli, D., Mortari, L., Palamara, A. T., Suligoi, B., & Tavoschi, L. (2022). Sexuality education in Italy 2016-2020: a national survey investigating coverage, content and evaluation of school-based educational activities. *Sex Education*, 1–13. https://doi.org/10.1080/14681811.2022.2134104

Donati S, Medda E, Spinelli A, Grandolfo ME. Sex education in secondary schools: an Italian experience. *J Adolesc Health*. 2000 Apr;26(4):303-8. doi: 10.1016/s1054-139x(99)00081-6. PMID: 10734278.

Eisenberg, M. E., Bernat, D. H., Bearinger, L. H., & Resnick, M. D. (2008). Support for Comprehensive Sexuality Education: Perspectives from Parents of School-Age Youth. *Journal of Adolescent Health, 42*(4), 352–359. https://doi.org/10.1016/j.jadohealth.2007.09.019

Fontana, I. (2018). *Mapping sex and relationship education (SRE) in Italy*. https://gen-pol.org/2018/10/mapping-sex-and-relationship-education-sre-in-italy/

Goldfarb, E. S., & Lieberman, L. D. (2021). Three Decades of Research: The Case for Comprehensive Sex Education. *Journal of Adolescent Health, 68*(1), 13–27. https://doi.org/10.1016/j.jadohealth.2020.07.036

Ketting, E., Friele, M., & Michielsen, K. (2016). Evaluation of holistic sexuality education: A European expert group consensus agreement. *European Journal of Contraception and Reproductive Health Care, 21*(1), 68–80. https://doi.org/10.3109/13625187.2015.1050715

Lo Moro, G, Bert, F, Cappelletti, T, Elhadidy, HSMA, Scaioli, G, Siliquini, R. (2023). Sex Education in Italy : An Overview of 15 Years of Projects in Primary and Secondary Schools. *Archives of Sexual Behavior, 0123456789.* https://doi.org/10.1007/s10508-023-02541-6

Psaroudakis, I., Quattrone, F., Tavoschi, L., De Vita, E., Cervia, S., Biancheri, R., & Lopalco, P. L. (2020). Engaging adolescents in developing health education interventions: A multidisciplinary pilot project. *European Journal of Public Health, 30*(4), 712–714. https://doi.org/10.1093/eurpub/ckaa012

Raporto ISTISAN 23/22 (2023). *Educare alla sessualità nelle scuole italiane: l'esperienza di un progetto tra analisi dell'evidenza, implementazione e valutazione.* A cura di Barbara Suligoi, Maria Cristina Salfa, Alice Chinelli, Lara Tavoschi (https://www.iss.it/-/rapporto-istisan-23/22-educare-alla-sessualita-nelle-scuole-italiane-l-esperienza-di-un-progetto-tra-analisi-dell-evidenza-implementazione-e-valutazione-a-cura-di-barbara-suligoi-maria-cristina-salfa-alice-chinelli-lara-tavoschi)

UNESCO (2018). *International technical guidance on sexuality education: An evidence-informed approach*. https://doi.org/10.54675/UQRM6395

Authors

Gianluca Paparatto is a medical doctor, Resident in Hygiene and Preventive Medicine at the University of Pisa and a PhD candidate in Health Science, Technology and Management at Sant'Anna School of Advanced Studies. His main research area is the social sustainability of healthcare systems with a focus on the role of civil society organisations in socially deprived populations.
Contact: g.paparatto@studenti.unipi.it

Alice Chinelli is a sex educator and psychologist and holds a Master of Arts in Gender Analysis in International Development. She has worked in the UK and Italy as an educator leading adolescent-based interventions on sexual health issues, in particular STI and HIV prevention. Since 2020 she has been a research fellow at the University of Pisa where she works on the coordination of the EduForIST project, following all of its phases, including the creation, implementation and evaluation of a pilot model involving extensive sexuality education in school contexts implemented on a national scale.
Contact: alice.chinelli@gmail.com

Lara Tavoschi is Senior Researcher in Public Health at the University of Pisa. She has worked for the Italian National Institute of Health and the European Centre for Disease Prevention and Control in the field of translational research and evidence-based public health and was based in South Africa for more than 5 years. Her areas of research are the prevention and control of communicable diseases, including viral hepatitis and STIs, with a focus on people in prison and other socially-deprived groups.
Contact: lara.tavoschi@unipi.it

Domenico Martinelli is Professor of Hygiene and Public Health at the University of Foggia, Apulia, South Italy. He is a medical doctor and has a PhD in oncology. His main areas of interest are epidemiological and biostatistic methodology, epidemiology of infectious diseases and their prevention.
Contact: domenico.martinelli@unifg.it

Marco Ubbiali is a temporary assistant professor at the University of Verona (Italy) where he teaches the epistemology of qualitative research. He has a PhD in pedagogy and his main research interests are phenomenological method applied to empirical research and care ethics. He is part of the scientific committee of the EduForIST project.
Contact: marco.ubbiali@univr.it

Citation

Paparatto, G., Chinelli, A., Martinelli, D., Ubbiali, M., & Tavoschi, L. (2024). Comprehensive sexuality education in Italian secondary schools: the EduForIST national project, *FORUM sexuality education and family planning: information service of the Federal Centre for Health Education (BZgA), 2*, 10–15. https://doi.org/10.17623/BZgA_SRH:forum_2024-2_en_art_eduforist-project

Sex under the age of 25: sexual health of young people in the Netherlands

Hanneke de Graaf, Yolin Kraan, Koenraad Vermey

"Sex under the age of 25" is a large-scale representative survey of the sexual behaviour and sexual health of young people aged 13 to 25. The survey has been conducted three times before: in 2005, 2012 and 2017. In 2023 more than ten thousand young people completed the online questionnaire on a variety of sexuality-related topics. The main results are described below.

Method

"Sex under 25" is a participatory action research project. This implies collaboration with stakeholders from policy, practice and research in the field of (sexual) health promotion across the entire process, from research to action. The selection of topics in the questionnaire is partly the result of the stakeholders' preferences with regard to the research, which in turn is based on the information they need for their work.

Participants were recruited both through randomly selected secondary schools and through a random sample drawn by Statistics Netherlands (CBS) from the municipal population registers. An invitation to fill out the online survey was sent to the home addresses of the latter group. The final sample consisted of 10,620 participants. Weighting techniques were applied to correct for selective non-response. The sample was thus representative of the Dutch youth population aged 13 to 24.

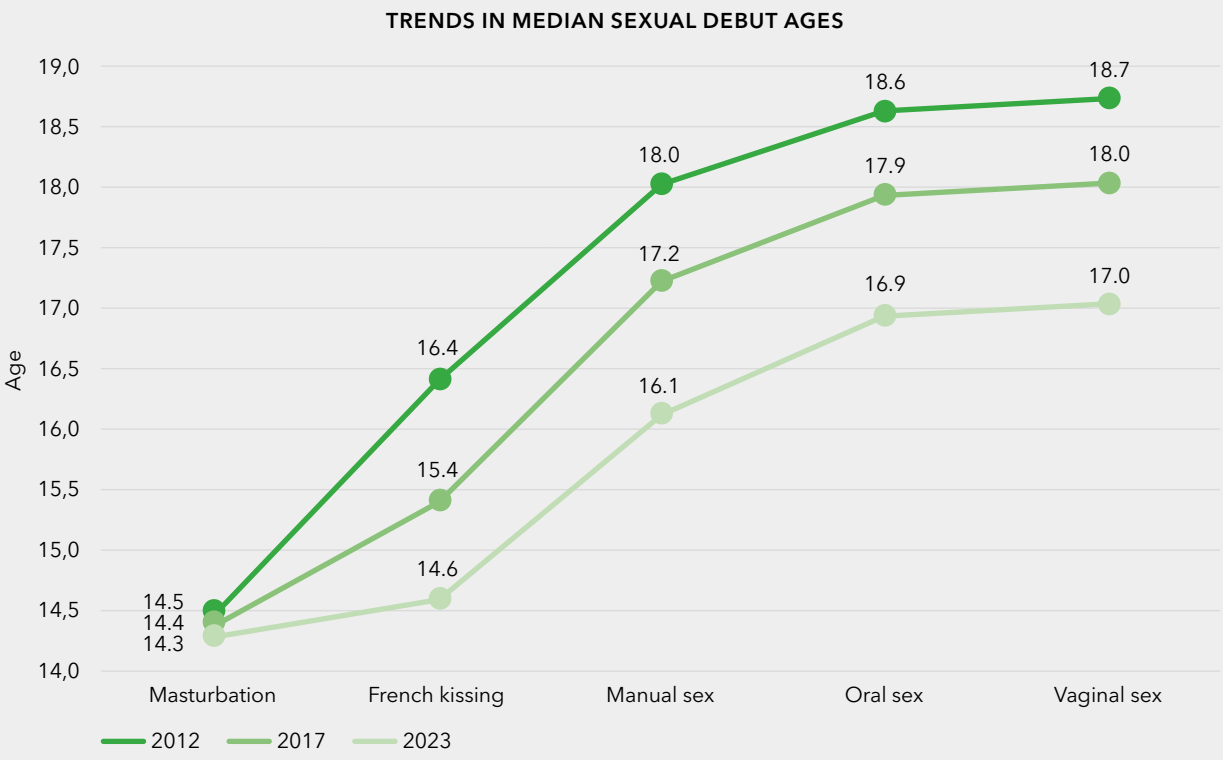
Sexual initiation later than in 2017

Young people start having sex at an older age compared with 2012 and 2017 (see Figure 1). All types of sex with a sexual partner show a rise in median sexual debut ages, except for masturbation. By 2023 half of young people had French kissed by the age of 16.4. Half of young people had engaged in manual sex by the age of 18.0, and half had engaged in oral sex by the age of 18.6. Half of young people had engaged in vaginal sex by the age of 18.7, compared with 18.0 in 2017 and 17.0 in 2012. The percentage of young people aged 13 to 18 who had been in love or had had a relationship also declined compared with 2017 and 2012.

Girls experience less sexual pleasure than boys

Sexual pleasure is the most important reason for young people to have sex. Eight in ten young people

FIGURE 1



Source: Graaf, H. de et al. (2024)

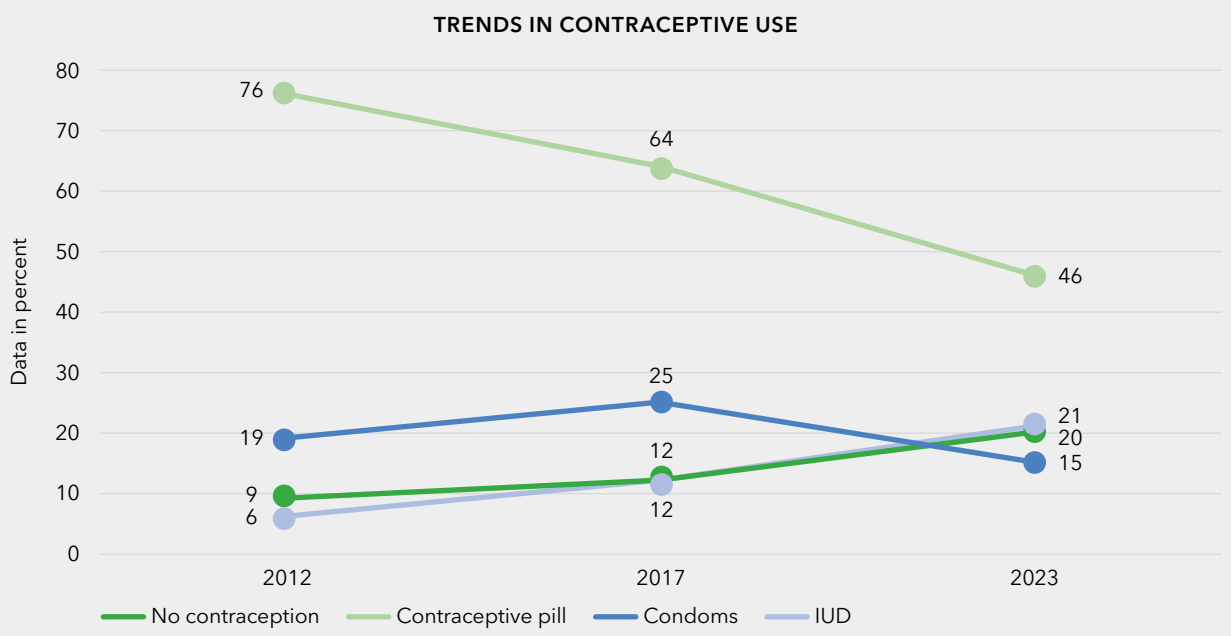
enjoy sex very much and nine in ten young people felt pleasure during sex with their last sexual partner. Young people rate their sex life positively (7 out of 10). In this respect, boys and girls are very similar.

However, when having sex with a sexual partner, girls experience significantly less sexual pleasure than boys. Two thirds (64%) of the boys report that their first vaginal sex was pleasurable, compared to 28% of the girls. This may have to do with the discomfort experienced during first vaginal sex, which was described as somewhat or very painful by three-quarters of the girls. Girls also experience less sexual pleasure than boys in later sexual experiences. Boys (85%) are more likely than girls (75%) to state that they enjoy sex very much. Additionally, more boys (85%) than girls (49%) usually or always had an orgasm with their last sex partner. Furthermore, girls (23%) are more likely than boys (10%) to have a sexual problem (e.g., experiencing distress over problems associated with desire, arousal or orgasm).

More sexual and gender diversity

One in thirty young people is trans or gender diverse: these young people indicate that their gender identity does not (fully and exclusively) match their assigned sex at birth or that they are questioning their gender identity. Compared with 2017 this group is slightly larger among birth-assigned girls. This increase is primarily due to a higher number of gender-diverse and questioning adolescents. One in nine boys and one in four girls are not exclusively sexually attracted to individuals with the opposite gender identity. This group has also increased slightly since 2017.

FIGURE 2



Source: Graaf, H. de et al. (2024)

Social acceptance of sexual and gender diversity has also increased among young people. In 2017 there was a significant decline in the number of young people who disapproved of expressions of homosexuality, and this trend is still ongoing. In 2012 half of the boys and a quarter of the girls disapproved of two boys kissing each other on the street, compared with a quarter of the boys (24%) and one in eleven girls (9%) in 2023.

Attitudes and relationships are changing

Although young people continue to associate sex with love and relationships, there appears to be a shift, mainly among girls. In 2012 a quarter of the girls (26%) believed it was acceptable for two people to have sex without being in love. In 2017 nearly half (47%) and by 2023 nearly two-thirds (62%) believed this was acceptable. This is the first time that girls and boys have had similar perspectives on this. Furthermore, although the majority of young people report that they had a relationship with their first vaginal sex partner (62%), this percentage has decreased since 2017 (70%). Similarly, for an increasing number of young people, their most recent sexual partner was someone with whom they had sex more than once but did not have a relationship. Still, for two-thirds of young people, the last sexual partner was a steady partner.

Use of dating apps on the decline, sexting essentially unchanged

The online world also plays a role in the relational and sexual development of young people. For example, 18% of young people met their last sexual partner online (e.g. through a dating app or social media). It is especially the oldest group who use dating apps. A third (35%) of all 17- through 24-year-olds used a dating app in the past six months. In the same period 9% of boys and 8% of girls aged 17 and older had a date via a dating app and 5% of boys and 3% of girls had sex with someone they met through a dating app. However, the use of dating apps has

declined significantly since 2017 when nearly half of 17- through 24-year-olds used a dating app. Online media are also used to exchange nude pictures or sex videos (sexting). One in eight young people say they sent a nude or sex video of themselves to someone in the past six months. This tendency increased significantly in 2017 compared with 2012, but now appears to have stabilized.

Sharp decline in contraceptive pill use

Use of the contraceptive pill has declined sharply among females with experience of vaginal sex, from 76% in 2012 to 46% in 2023 (see Figure 2). In contrast, IUD use has increased from 6% in 2012 to 21% in 2023. Not all girls who do not use contraceptive pills opt for another form of contraception. The percentage of girls not using contraception has increased from 9% in 2012 to 20% in 2023. More than half of the girls in this group stated that they do not wish to use hormones. However, this does not explain why IUD use has increased, as these are mainly hormonal IUDs, nor does it explain why condom use is also on the decline.

Despite declining pill use, the use of contraceptives when having vaginal sex is still high among young people in the Netherlands. Nine out of ten young people use contraception the first time they have vaginal sex and eight out of ten always used contraception with their last vaginal sex partner. Furthermore, the number of unintended and unwanted pregnancies among young people remains low. Eighteen out of 1,000 adolescents aged 16.5 and older have had an unintended pregnancy at some point in their lives. Fourteen in 1,000 boys and ten in 1,000 girls of this age have experienced an unwanted pregnancy. This number has not increased since 2017 and has even decreased slightly among girls.

Sharp decrease in condom use, but no increase in STI diagnoses

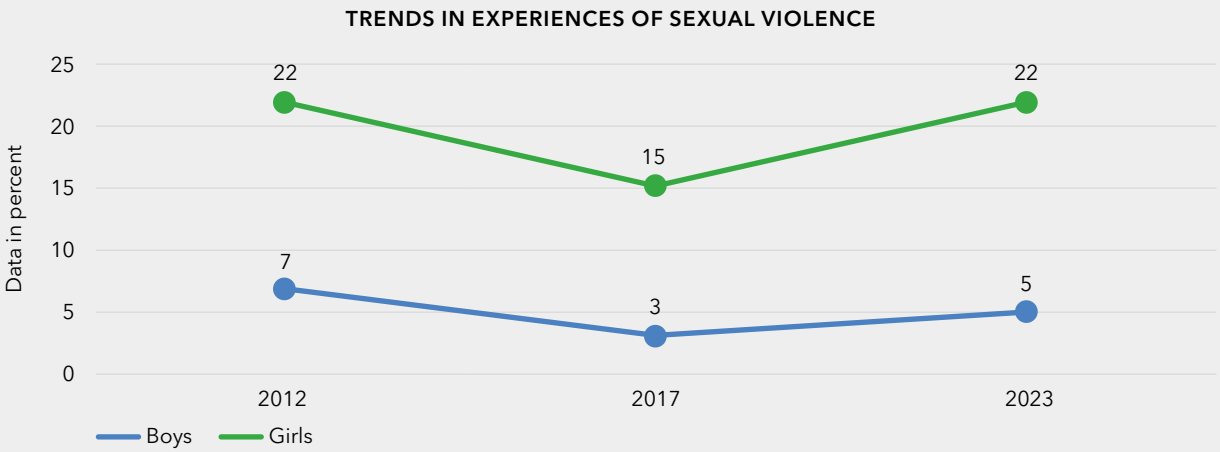
The use of condoms has decreased substantially among young people in the Netherlands. In 2017 75% of boys and 72% of girls used a condom for their first vaginal sex. By 2023 this had decreased to 64% and 69%, respectively. Among young people who did not have a relationship with their most recent sexual partner, the group of boys who never used a condom increased from 25% in 2012 to 40% in 2023, while this group of girls increased from 36% in 2012 to 46% in 2023. The fact that these recent casual sexual partners were often someone with whom they had had sex more than once might play a role. There might be more trust in these kinds of sexual relationships than in one-night stands. One frequently cited reason for not using condoms is "we trust each other."

In the past year 12% of sexually experienced boys and 18% of sexually experienced girls were tested for STIs and/or HIV. This number has not changed since 2012 and 2017. The percentage of positive STI and/or HIV tests also remained constant among young people aged 17 through 24. Two percent of boys and 4% of girls of this age tested positive in the past year. Most young people go to their general practitioner (GP) or the Public Health Service (PHS) for an STI test. Girls choose their GP slightly more often (47%) than boys (39%), while boys choose the PHS more often (42%) than girls (31%).

More young people report experiencing sexual victimization

Two in three girls (66%) and one in three to four boys (29%) have experienced sexual victimization, ranging from unwanted sexual comments and touching to all forms of sex against their will. Between 2017 and 2023 there was an increase in the number of young people reporting that they have been forced into sex or have experienced sex against their will (see Figure 3). Among girls, the percentage who had been forced to perform sexual activities against their will increased from 12% in 2017 to 20% in 2023. In 2023 5% of boys and 22% of girls report having experienced sexual violence, which includes forced sexual activities, and/or manual, oral, vaginal, or anal sex against their will. It is possible that these various types of sexual victimization are more prevalent. However, this trend could possibly be linked to greater media coverage of sexual harassment and sexual violence and greater public attention to the

FIGURE 3



Source: Graaf, H. de et al. (2024)

topic. As more young people become aware of sexual harassment and violations, they are more likely to report it in a questionnaire.

Young people do not always perceive consent correctly

Only 6% of young people believe they have had sex with someone without having been certain that the other person also wanted to have sex. The majority of young people state that they always check whether the other person wants sex, especially with new partners. Ten percent of young people report they do not always check this, primarily because they assume they know without checking. This seems to contradict the fact that many young people report having had sex against their will. Moreover, some young people may not always notice that the other person does not want to have sex. Over half (52%) of young people who have experienced sexual violence report that they did not make it clear that it happened against their will. There were several reasons for this: some people did not realize (yet) that they did not want to have sex, some people were afraid, and some froze. It is important to note that although these sexual experiences did not involve a clear refusal, they also did not involve an explicit consent.

Young people want better sex education

Although practically everyone receives some information at school about sexuality, this is very limited according to young people. It focuses mostly on contraception, reproduction and STI/HIV. Nevertheless, only a minority of young people say they received enough information on these three topics. The vast majority of young people report receiving little to no information on sexual violence, sexual pleasure, and sex in the media. Young people rated sexuality education in school moderately (5.6 out of 10), which was slightly lower than in 2017. Girls, LGBTQ + youth, and older adolescents gave even lower ratings to the information they received in school.

Young people want good sex education. Those who rated sex education poorly were asked for the reason why. Two-thirds of these young people indicated that there were too few lessons, while half of them indicated that they did not receive the information they wanted. Over 50% of young people reported that they sometimes have questions regarding sexuality. Three-quarters of young people use the internet to find the answers to their questions. More than half ask their friends. It is uncertain to what extent the information they obtain online or from friends is reliable.

Conclusion

"Sex under the age of 25" 2023 shows that young people continue to do well in several areas of sexual health. Young people are taking their time before starting to have sexual experiences. They enjoy sex and protect themselves well against pregnancy. There also seems to be more room for sexual and gender diversity, and diversity in sexual relationships.

Other outcomes are concerning. Sexual violence is still too prevalent and young people appear to be insufficiently able to assess and express sexual consent correctly. There is a considerable gap in orgasms between boys and girls. Issues such as pain during sex and limited sexual pleasure are common among girls during their sexual debut and persist in their later sexual experiences. Furthermore, contraception and condom use are on the decline. Young people generally give sex education a poor rating. These concerning outcomes show that there is a greater need for investment in prevention and continuous sex education with a more positive and gender-sensitive approach towards sexuality and sexual pleasure. These insights of "Sex under the age of 25" provide input for interventions, policy and further research, aiming to further improve the sexual health of future generations.

Acknowledgements

This research was conducted by Rutgers and Soa Aids Nederland in collaboration with the Dutch National Institute for Public Health and the Environment (RIVM), Statistics Netherlands (CBS) and the municipal health organisations (GGD). The study was funded by the Dutch Ministry of Health (VWS) and the RIVM.

Literature

Graaf, H. de, Oldenhof, A., Kraan, Y., Beek, T., Kuipers, L. & Vermey, K. (2024). *Seks onder je 25e. Seksuele gezondheid van jongeren in Nederland anno 2023*. Eburon. https://doi.org/10.60116/sov3KloWq3

Authors

Hanneke de Graaf, PhD, is Program Manager and Senior Researcher at Rutgers, the Dutch Centre of Expertise on Sexuality. She studied clinical psychology at Utrecht University (1999) and received her PhD (2010) from the same university with a dissertation on parenting and adolescent sexual health. De Graaf is the principal investigator on the survey Sex under the age of 25.
Contact: h.degraaf@rutgers.nl

Koenraad Vermey, MSc, is Senior Project Officer at Soa Aids Nederland. With a multidisciplinary background in social sciences and health promotion, he has been working in the field of sexual health research and innovation of sexual healthcare for more than 10 years. Vermey's role in Sex under the age of 25 is that of project lead.
Contact: kvermey@soaaids.nl

Yolin Kraan, Msc, is Research Assistant at Rutgers. She earned a Bachelor's Degree in Liberal Arts and Sciences and a Master's Degree in Sociology from Utrecht University. Kraan's role in Sex under the age of 25 involves data-analysis and reporting results.
Contact: y.kraan@rutgers.nl

Citation

Graaf, H. de, Kraan, Y., & Vermey, K. (2024). Sex under the age of 25: sexual health of young people in the Netherlands, *FORUM sexuality education and family planning: information service of the Federal Centre for Health Education (BZgA), 2*, 16–21. https://doi.org/10.17623/BZgA_SRH:forum_2024-2_en_art_sexu-health-ni

REPEAT project: exploring and addressing repeat teenage pregnancies in Southwestern Uganda

Olena Ivanova, Elizabeth Kemigisha

A less-addressed aspect of adolescent pregnancy is that of repeat pregnancies, which is a persistent issue in Uganda. The REPEAT Project, funded by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) "Academic" line, aims to identify risk and protective factors for repeat teenage pregnancies and pilot a context-adapted intervention to promote uptake of modern contraception among adolescents in Southwestern Uganda. This article presents selected results from a situation analysis and details of the intervention development process.

Background

Adolescent pregnancy is a global public health challenge with serious health, social and economic consequences (UNICEF, 2022). In 2022 13% of adolescent girls gave birth before the age of 18 (WHO, 2024). Around 21 million girls aged 15 – 19 in developing countries become pregnant every year, with 12 million giving birth (WHO, 2024).

Teenage pregnancies result in maternal complications like preterm delivery, low birth weight, and postpartum haemorrhage (UNICEF, 2022; Todhunter et al., 2021). Maternal conditions are the fourth leading cause of disability-adjusted life years (DALYs) and the second most common cause of adolescent mortality due to complications (UNICEF, 2022). Pregnant teenagers often drop out of school, and experience stigma, isolation and violence (UNICEF, 2022).

Repeat adolescent pregnancy, a critical but less-addressed issue, has adverse effects on offspring and varies in prevalence across Sub-Saharan Africa with the highest prevalence recorded in Gabon (20.93%) and the lowest in South Africa (4.82%) (Ahinkorah

et al., 2023). In Uganda, repeat pregnancy rates vary widely, with some studies reporting up to 74% within 24 months among young women (Burke et al., 2018). Although the overall adolescent birth rate had been declining slowly in Uganda, the Covid-19 pandemic caused a sudden 25% increase in teenage pregnancies in three Ugandan districts. In total, 67 districts reported a rise in teenage pregnancies between 2019 and 2020 (Amongin et al., 2020; UNFPA, 2021).

Interventions targeting cognitive, behavioural, environmental and psychosocial changes have been implemented globally to combat repeat pregnancies in adolescents and young women (Manjarres-Posada et al., 2022; Hindin et al., 2016). Strategies such as cash transfers, sexual and reproductive health (SRH) education, contraceptive provision and vocational training have shown a potential to reduce the incidence of teenage pregnancies (Hindin et al., 2016). Evidence shows that interventions focusing on contraceptive uptake and immediate postpartum contraceptive selection decrease the incidence of maternal and infant mortality and repeat pregnancies, especially when contraceptives are directly distributed to adolescents and integrated into post-abortion or postnatal care services (Hindin et al., 2016).

Uganda has made efforts to improve the SRH of adolescents and prevent unwanted pregnancies through various laws, policies and guidelines. These include but are not limited to the "Adolescent Health Policy Guidelines and Service Standards" (2012) (Ministry of Health, 2020) and the "Revised Guidelines for the Prevention and Management of Teenage Pregnancy in School Settings in Uganda" (2020) (Ministry of Education and Sports, 2020). However, despite these guidelines being in place, the level of implementation remains weak, deterring the uptake of essential preventive services for adolescents, particularly contraception (Perehudoff et al., 2022).

The aims of this project are:

(1) To identify risk and protective factors for repeat adolescent pregnancy in Southwestern Uganda to inform effective intervention(s).

(2) To co-create, implement and evaluate a pilot intervention aimed at increasing contraception use among adolescents after their first pregnancy.

Situation Analysis

We conducted a cross-sectional mixed-methods study involving a variety of stakeholders. The findings were presented at the research dissemination conference in Mbarara, Uganda in September 2023. Below, we highlight the methods used and provide a snapshot of the results.

Quantitative study

A total of 115 girls with single pregnancies and 93 with repeat pregnancies participated in the study conducted in four districts of Southwestern Uganda: Mbarara, Rwampara, Isingiro and Ibanda. We used a tablet-based questionnaire to collect data on socio-demographic characteristics, sexual behaviours, SRH knowledge, pregnancy outcomes, experiences of violence and mental health. Trained research assistants – six females and two males, with prior experience interviewing adolescents in this setting – administered the questionnaires. Descriptive statistics and logistic regression were performed to analyse the responses.

The mean age of the study participants was 19.3 years. The majority (92%) had dropped out of school, having achieved primary-level education (67%). The mean socio-economic score was significantly lower in the repeat teenage pregnancy group (3.5 vs 4.2).

The mean age of sexual debut (15.2 vs. 16.2 years) and first pregnancy (16.4 vs. 17.3 years) was lower among those with repeat pregnancy compared with those with single pregnancy. Nearly three-quarters of the participants (73.1%) had experienced some form of violence in the past 12 months. The knowledge and sources of SRH information are described in Table 1.

In the repeat pregnancy group, 24.7% reported abortion/miscarriage and 6.5% reported stillbirths

TABLE 1

SRH KNOWLEDGE AND SOURCES OF INFORMATION

SRH Knowledge		Single pregnancy (N= 115)	Repeat pregnancy (N = 93)	p-value
Knowledge of STIs	Less than 2	39 (33.9%)	29 (31.2%)	0.529
	More than 2	76 (66.1%)	64 (68.8%)	
Knowledge of contraceptive methods	Less than 3	65 (56.5%)	47 (50.5%)	0.471
	More than 3	50 (43.5%)	46 (49.5%)	
Source of SRH information	Doctors/nurses	50 (43.5%)	42 (45.2%)	0.232
	Family and relatives	31 (27.0%)	15 (16.1%)	
	Friends/peers/school	12 (10.4%)	15 (16.1%)	
	Media (TV/radio/internet/books)	11 (9.6%)	14 (15.1%)	
	Others	11 (9.6%)	7 (7.5%)	

Source: Own situation analysis

for their first pregnancy. The single-pregnancy group had a higher percentage of live births (92.2% vs. 67.7%). Most participants (78.4%) delivered at a healthcare facility and had vaginal births. Antenatal care attendance was higher in the single pregnancy group (96.5% vs. 82.8%). Postnatal care within the first two months was reported by 56.3% of participants in both groups.

Several factors were associated with repeat teenage pregnancy including risky sexual behaviour and experience of some form of violence.

Qualitative study

We conducted 14 focus group discussions (FGDs) and 28 individual in-depth interviews (IDIs) with girls who have had experience of teenage pregnancy, adolescent boys and partners, community leaders (e.g., religious leaders, probation officers), healthcare workers (HCWs) and midwives. All interviews were conducted in person, audio recorded, and later transcribed by trained study team members. Transcripts were securely imported into a qualitative content analysis software (Dedoose) and analysed by several team members. A codebook was created collaboratively.

Participants discussed numerous risk factors associated with adolescent pregnancy, with a particular emphasis on the lack of comprehensive SRH knowledge and access to services. Many highlighted that family planning and SRH services are primarily designed for adults, leaving a significant gap in youth-friendly services. One HCW shared a story about secretly providing SRH information to young girls to help reduce the stigma they faced when attending clinics alongside adults. While most young girls were aware of family planning services, the interviews revealed significant misconceptions. For instance, some believed that using family planning methods could lead to infertility, illness, or even death. Others feared that contraceptives could cause cancer or other severe health issues. Additionally, there was a general lack of basic SRH knowledge among many of the participants.

"These teens do not have enough information about SRH, family planning services and what else they can

do to protect themselves from getting pregnant." (FGD, HCW).

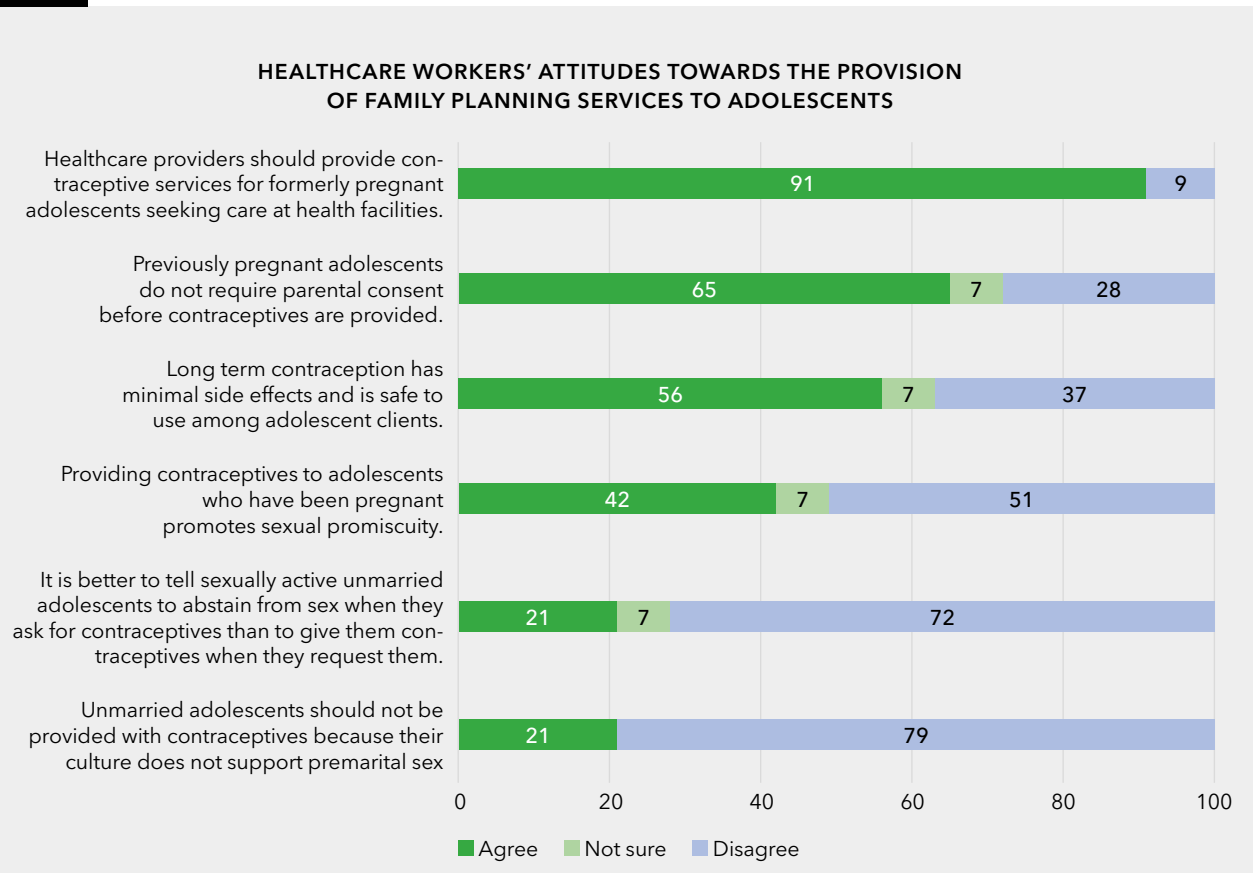
Healthcare facilities assessment

We surveyed 43 healthcare facilities of levels three and four (HC III and HC IV) in the region. Interviews were conducted with the people in charge of the healthcare facility, or their delegates, using pre-tested structured questionnaires. We extracted 6-month data from registers on repeat pregnancies, postabortion care and postnatal adolescent visits. A checklist was used to assess the availability of family planning consumables, services, and other medical equipment. Descriptive statistics were generated.

Adolescents accounted for 4.9% of repeat pregnancies, 16.3% of postabortion cases, and 14.8% of postnatal consultations recorded at all primary healthcare centres (PHCs). Our observations revealed a shortage of perinatal care staffing, with 79% of HC IIIs lacking adolescent peer educators (n=34) and 60.5% missing counsellors (n=26). There is a significant need for training in providing adolescent-friendly services, including postnatal and postabortion care, with over 90% of respondents indicating that this is necessary. Additionally, PHCs were found to be poorly equipped for postabortion care and intrauterine device (IUD) insertion.

Healthcare workers generally exhibited positive attitudes toward providing contraceptive services to adolescents who have previously been pregnant, as well as to offering post-pregnancy family planning without requiring parental consent. Despite these favourable views, significant concerns remain about the potential side effects of contraception for

FIGURE 1



Source: Own situation analysis

previously pregnant adolescents. Some HCWs also express apprehension about inadvertently encouraging sexual promiscuity or addressing the needs of unmarried adolescents (Figure 1).

Pilot Intervention Development

Using the findings from our situation analysis and available global evidence, we designed and implemented an intervention aimed at increasing contraception use among adolescents after their first pregnancy.

Co-creation workshop

A one-day workshop was held to reflect on the results and develop a pilot intervention. A variety of stakeholders took part in the workshop: ten healthcare providers, four adolescent girls (peer leaders), and eight researchers from Mbarara University of Science and Technology (MUST). The main discussions were around interpretations of the findings from the situation analysis that highlighted the challenges adolescent mothers face in seeking healthcare services, and what could be done to address such challenges at healthcare facilities, particularly to enhance attendance of postnatal care services and postpartum uptake of contraception. The participants also discussed the proposed components for an intervention to promote postdelivery/postabortion uptake of contraception and how the intervention could be tailored to the needs of the HCWs and adolescents from the various health facilities that were represented.

Format and content of the intervention

The final intervention consisted of: 1) training of HCWs in adolescent-friendly services and contraception; 2) a facilitation guide for the group session with postpartum or postabortion adolescents.

Training

The training was divided into three parts and delivered in three days. Ten HCWs were trained in four facilities as follows:

(1) The trainers' session was a half-day activity designed to prepare and distribute roles and discuss the training objectives with an existing pool of HCWs and trainers specializing in maternal and newborn health, including adolescent health and family planning.

(2) The theory part of the training included topics on adolescent development and communication, understanding the risks of adolescent pregnancy, contraception (types, mode of action, side effects and myths), postnatal and postabortion care components, HIV/STIs prevention and management of sexual violence.

(3) The skills-based or practical session involved participants being shown all the methods of family planning and practicing an IUD and implant insertion and removal, as well as procedures for using manual vacuum aspiration (MVA) for postabortion care using uterine and arm models.

A pre-and post-test assessment of HCW's knowledge revealed an improvement in scores, with a mean increase from 28.9 to 35.9 (+7 rate of change). Feedback collected from the participants highlighted their appreciation for the training, describing it as "educative," "rich in content," "relevant to adolescent care," "informative," "easy to implement," and "clear." Most participants enjoyed multiple topics, especially adolescent communication, postnatal and postabortion care and contraception methods. The practical skills sessions were particularly well-received.

Implementation

The intervention was implemented at four facilities using the group session guide that had been developed and that contained theoretical materials as well as participatory exercises. The sessions were facilitated by trained HCWs and lasted approximately 1.5 hours. Baseline and end line assessments were conducted using a questionnaire to measure knowledge and uptake of contraception among girls. Data was also collected from five control facilities which already offered a adequate standard of care so as to be able to compare and understand the effectiveness of our intervention. The analysis is ongoing and the results will be presented in a peer-reviewed publication in 2025.

Conclusions and Implications

The study explored multiple risk and protective factors associated with repeat pregnancies among adolescents in Southwestern Uganda. It also assessed the readiness of healthcare systems to provide SRH services to adolescents. By testing a group postnatal/postabortion intervention, we hope to increase contraception use and support governmental efforts in improving SRH service provision for adolescents in Uganda. However, there is an urgent need for a more holistic and multifaceted approach towards repeat adolescent pregnancy. Healthcare systems' interventions should be enhanced by educational, mental health and social support programmes.

Ethical considerations

Ethical approvals were sought from the Mbarara University Research Ethics Committee (REF: MUST-2022-656) and the Uganda National Council of Science and Technology (REF: HS2972ES). The study also obtained approval from LMU in Germany (Project N: 23-0617). Written informed consent was obtained from all participants following a thorough explanation of the study.

Acknowledgments

We would like to thank all the participants for their valuable time and contribution to the study. We would particularly like to acknowledge Vivienne Kirabo, Nakitende Declan, Aheebwe Lennah, Monica Natukunda, Jamila Nsamba, Iqra Aheebwa, Timothy Taremwa, Edmand Tumwesiga, Shakirah Namatovu, Jackline Tumuhairwe, Honest Twinomujuni, Arimpa Amerias, Odmaro Ayesimira and Ronald Nuwamanya who participated in the data collection and Rinah Marlone Arinaitwe who designed the database for data collection. Our special thanks goes to Viola N. Nyakato, Rupa Ramachandran, Daniel Atwine and Sophie Lyon for their support with the study conceptualization and data analysis.

References

United Nations International Children's Emergency Fund (UNICEF) (2022). *Early childbearing*. Available at: https://data.unicef.org/topic/child-health/adolescent-health/

World Health Organisation (WHO) (2024). *Adolescent Pregnancy*. Available at: https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy#:~:text=As%20of%202019%2C%20adolescents%20aged,births%20(1%2C2).

Todhunter L., Hogan-Roy M., & Pressman E. (2021). Complications of pregnancy in adolescents. *Seminars in Reproductive Medicine*; 40: 098–106.

Ahinkorah B. O., Aboagye R. G., Okyere J., et al. (2023). *Correlates of repeat pregnancies among adolescent girls and young women in sub-Saharan Africa*. BMC Pregnancy and Childbirth; 23. Epub ahead of print February 3, 2023. doi: 10.1186/s12884-023-05361-7

Burke H. M., Santo L. D., Bernholc A., et al. Correlates of rapid repeat pregnancy among adolescents and young women in Uganda. I*nternational Perspectives on Sexual and Reproductive Health 2018; 44: 11.*

Amongin D., Nakimuli A., Hanson C., Nakafeero M., Kaharuza F., Atuyambe L., & Benova L. (2020). Time trends in and factors associated with repeat adolescent birth in Uganda: Analysis of six demographic and health surveys. *PLoS One*. 2020 Apr 14;15(4): e0231557. doi: 10.1371/journal.pone.0231557. PMID: 32287303; PMCID: PMC7156070.

UNFPA (2021). *Teenage pregnancy factsheet*. Available at: teenpregnancy_factsheet_3.pdf (unfpa.org) https://uganda.unfpa.org/sites/default/files/pub-pdf/teenpregnancy_factsheet_3.pdf

Manjarres-Posada, N. I., Benavides-Torres, R. A., Pérez Baleón, G. F., Urrutia Soto, M. T., Onofre-Rodríguez, D. J., Barbosa-Martínez, R. del C., & Márquez-Vega, M. A. (2022). *Effective Interventions to Prevent Repeat Pregnancies in Adolescents: A Systematic Review*. Sage Open, 12(4). https://doi.org/10.1177/21582440221130309

Hindin M. J., Kalamar A. M., Thompson T. A., Upadhyay U. D. (2016). Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature. *J Adolesc Health*. 2016 Sep;59(3 Suppl):S8-S15. doi: 10.1016/j.jadohealth.2016.04.021. PMID: 27562452.

The Reproductive Health Division, Department of Community Health, Ministry of Health (2012). *Adolescent Health Policy Guidelines and Service Standards*. Available at: https://www.prb.org/wp-content/uploads/2020/06/Uganda-Adolescent-Health-Policy-and-Service-Standards-2012.pdf

Ministry of Education and Sports (2020). Revised guidelines on Prevention and management of teenage pregnancy in school settings in Uganda. Available at: https://www.ungei.org/sites/default/files/2021-02/Revised-Guidelines-Prevention-Management%20-Teenage-Pregnancy-School-Settings-Uganda-2020-eng.pdf

Perehudoff, K., Kibira, D., Wuyts, E., Pericas, C., Omwoha, J., van den Ham, H. A., Mantel-Teeuwisse, A. K., & Michielsen, K. (2022). A comparative human rights analysis of laws and policies for adolescent contraception in Uganda and Kenya. *Reproductive Health 19*, no. 1 (2022): 37.

Authors

Olena Ivanova, MD, MPH, PhD, Institute of Infectious Diseases and Tropical Medicine, LMU University Hospital, Munich, Germany. Global health and women's health senior researcher and FemTech advisor, focusing on advancing sexual and reproductive health globally through research, education and innovation.
Contact: olena.ivanova@lrz.uni-muenchen.de

Elizabeth Kemigisha, MD, MMED, PhD, Faculty of Interdisciplinary Studies, Mbarara University of Science and Technology (MUST), Mbarara, Uganda and the Emerging and Re-emerging Infectious Diseases Unit, Health and Wellbeing theme for the African Population and Health Research Center, Nairobi, Kenya. Senior lecturer and researcher focusing on sexuality education and adolescent health.
Contact: ekemigisha@must.ac.ug

Citation

Ivanova, O., & Kemigisha, E. (2024). REPEAT project: exploring and addressing repeat teenage pregnancies in Southwestern Uganda, *FORUM sexuality education and family planning: information service of the Federal Centre for Health Education (BZgA), 2*, 22–28. https://doi.org/10.17623/BZgA_SRH:forum_2024-2_en_art_repeat-project-ug

Knowledge transfer for the prevention of sexualised violence

Britta Buschmann, Anja Borchert, Ulrike Urban-Stahl

The acquisition of knowledge regarding the protection of children and young people against sexualised violence can facilitate the creation of safer environments in educational fields and care. This article examines the potential of incorporating diverse perspectives and expertise in the development and transfer of educational products for professional practice.

Since 2010 when numerous cases of sexualised violence in schools, boarding schools, and other educational institutions were made public, the examination in society as a whole of sexualised violence against children and adolescents could no longer be avoided. After survivors, practitioners and researchers had worked to bring attention to the issue for several decades, the protection of young people has now become an increasingly important topic in Germany, both in educational and care institutions and in public research. Child and youth welfare facilities such as daycare centres and residential homes, and in a growing number of federal states also schools, are required to provide a prevention concept[1]. Similarly, there has been a growing trend towards the introduction of obligations in organised sports. On this basis, clubs and associations develop and implement protection measures (e.g. Rulofs et al., 2023). However, there is still a need for further awareness-raising, qualification, and support for professionals and volunteers in various fields. In 2013 the Federal Government's Round Table on Child Sexual Abuse[2] concluded that the generation, communication and acquisition of knowledge can significantly contribute to protecting children and young people against sexualised violence (BMJ et al., 2013). Scientific knowledge not only provides systematically generated insights into a topic or problem context according to scientific principles, but also serves as a reflective tool for professional practice and for the analysis of organisational structures.

In research on knowledge utilisation and (pedagogical) professionalisation, attention is drawn to the differences between the systems of science

1 Prevention concepts aim to ensure that minors and adults living in care settings can develop free from (sexualised) violence. For more information and details on the components of a prevention concept such as further training and risk and potential analysis in organisations, please refer to https://beauftragte-missbrauch.de/en/themen/schutz-und-praevention/prevention-concepts and Wolff et al., 2017.

2 The Round Table "Child Sexual Abuse in dependency and power relationships in private and public institutions and in the family" was constituted in 2010 to support those affected and to prevent sexual violence.

and practice and their distinct approaches to knowledge. Science is characterised "by an increase in the complexity of the construction of reality with the aim of distanced reflection" (translated from Radtke, 2004, p. 119). In contrast, "in the case of practice, it's about reducing complexity and necessary shortcuts [...] on the way to decisions/actions that cannot be postponed" (ibid.). In general, tasks and challenges must be addressed promptly, specifically, sometimes intuitively, and reflexively (Dackweiler & Schäfer, 2020; Sehmer et al., 2020; Thole et al., 2016). In addition to descriptive and explanatory knowledge, the ability to assess the (pedagogical) situation is crucial for the formulation of professionally justifiable decisions (Dewe et al., 1992).

The fact that knowledge only becomes meaningful in the social contexts of the scientific community, the profession and the organisation, and that the logics of "knowledge utilisation" in science and practice differ significantly (Dewe et al., 1992; Dewe, 2005), has implications for knowledge transfer. Transfer does not mean simply passing on research findings as "basic instructions to practice or as objectives set by research for practice to adhere to" (translated from AGJ, 2009 p. 3). Scientific findings, suggestions for reflection and recommendations for action are only rendered usable through practice-related translation and transformation oriented towards field-specific mandates, problems or case constellations.

The above describes some of the core complexities facing research into and the development of application-oriented products in science-practice transfer. Transfer is the focus of the current third funding round of the funding line set up by the Federal Ministry of Education and Research (BMBF) in 2011 to promote research on sexualised violence against children and young people in educational contexts and care. The current research projects bring together partners from science and practice. They build on the research and product development conducted by previous funding rounds (2012 to 2021). During these rounds basic knowledge, particularly of risk and protective factors, as well as concepts, materials and training courses on prevention and intervention against sexualised violence were developed (Wazlawik et al., 2019; 2020). Above and beyond this debates and reflections on "valuing lived experience as a form of expertise" (World Health Organization, 2023, p.23), how the knowledge of people with lived experience has been essential for research on sexualized violence, and participatory research, have been crucially important to reflect the breadth of the issue of preventing sexualised violence against children and adolescents. Projects in the current funding round are developing new products for specific fields and target groups, and adapting earlier ones for a broader application in educational and social work contexts. At present, nine joint research projects and one meta-project receive funding through this programme.[3]

The following section examines factors that need to be considered when developing educational products for practice use to prevent sexualised violence. In this context, the collaboration between science, practice, relevant target groups, and adult survivors of child sexual abuse is of particular importance. Based on this, the paper outlines the potential of collaborative knowledge development and cooperation for designing products and facilitating transfer.

In this paper products are considered as a means of offering knowledge, because from a subjective perspective knowledge is not readily available and transferable. Products are for practitioners, volunteers and young people (e.g. educational materials, concepts and training). They offer thematic content, expert information or recommendations for practice use and implementation. By engaging with the offered content, individuals can obtain basic knowledge, comprehend connections, and acquire deeper knowledge and competencies.

Knowledge, development and cooperation

In the scientific discourse on transfer it is becoming increasingly clear that the development of knowledge in science-practice collaborations can con-

3 For more information please refer to: https://www.bmbf.de/SharedDocs/Publikationen/de/bmbf/3/31765_Kinder_und_Jugendliche_vor_sexualisierter_Gewalt_schuetzen.html.

tribute to the success of transfer and implementation (e. g. Blatter & Schelle, 2022; Dewe, 2005; Schuster et al., 2024). Relational and transformative perspectives on transfer posit that knowledge is created and transformed when different systems, typically science and practice, interact with each other (Schmiedl, 2022). The participants are engaged in an educational process in which they become acquainted with both the other and their own system, engage in dialogue about the different logics of the systems, and collaboratively develop new knowledge. Comprehension and knowledge are thus conceived to be the result of collaborative knowledge production between scientific researchers and practitioners, and as a further extension of the classic model of dialogue, also include young people or adult survivors as experts by experience and/or as researchers (e. g. Bitzan, 2008; in the field of sexualised violence, for example; Henningsen et al., 2022; Rieske et al., 2018; Stern & Nathanaili-Penotet, 2023).

Studies into various forms and models of cooperation between science and practice reveal the importance of interactive settings, dialogue and intermediation (Blatter & Schelle, 2022; Gredig et al, 2021; Hüttemann et al., 2016; Hüttemann, 2016; Oestreicher, 2014; Rothe, 2014). It has been observed that the goals of cooperation, which include knowledge production, the development of procedures, organisational and practice development, and the conceptual orientations of the collaborating parties can influence the nature of their relationship (Hüttemann, 2016). In addition to the culture of cooperation and the fashioning of relationships, the social welfare regime and financial support structures also appear to have an impact on the modalities of collaboration (Gredig et al., 2021). The nature of the collaborative relationship can therefore be either symmetrical or asymmetrical.

Actors involved in collaborative projects focusing on protection against sexualised violence contribute different types of knowledge. Theoretical, empirical and methodological knowledge is the domain of academia, while educational and social work practice primarily provides field-oriented knowledge based on practice experience relating to case constellations, target groups and action. Participants who have experienced sexualised violence and representatives of the target groups contribute personal experience to the process. This would not be captured by a purely theoretical approach, nor by cooperation solely between science and practice. The encounter between academics, practitioners, young people and survivors is also an encounter of different forms of knowledge. This can be constructively challenging while also providing an impetus for updating knowledge and expertise.

It is important to consider personal and practical references with regard to practitioners, volunteers and young people as users of the products. From a systemic-organisational perspective, knowledge emerges when a certain content (a piece of information) is embedded in personal experience and is classified as relevant to the reference system, which includes the person and the organisation that person is part of (Kade, 2004, p. 53). The purpose and manner of knowledge production for transfer fundamentally depend on the problem that the new knowledge is expected to address and how the problem is socially contextualised. Products can

a) facilitate the acquisition of contents and rather technical know-how,

b) promote the understanding of problems, problem-solving, and of action to change organisational structures, or

c) stimulate experiential appropriation of knowledge and competency development.

The appropriation of knowledge is the most demanding and learning-intensive goal. It can influence "(individual and collective) mental models – and thus attitudes, patterns of thought and behaviour" (translated from Reinmann & Vohle, 2004, p. 236). For instance, such reflective appropriation processes can occur in connection with a (self-) critical examination of presuppositions, interpretations, defensiveness, routines and rules of behaviour. Reflective appropriation processes typically require a greater investment of time, continuous engagement, and a more profound emotional, cognitive,

and social involvement on the part of the individual and the organisation than the basic acquisition of fact and information based knowledge. With regard to the topics of sexuality and violence, these processes can assist in the development of an individual and organisational attitude towards the topics, for example in training courses (Kavemann & Nagel, 2018) and in the development of a prevention concept.

Development and transfer: challenges and potentials

Development and transfer processes can be challenging and require expertise from various fields. In research on sexualised violence as well as in the development and transfer of preventive measures, it is important to consider that sexualised violence is a highly sensitive and intimate issue associated with various, sometimes intense emotions (regarding implications, especially for qualitative research, see Gulowski, 2022; Helfferich et al., 2016; Vobbe & Kärgel, 2022). It can evoke emotions such as shame, guilt, fear and feelings of powerlessness, to which people and organisations may react with defensiveness, empathy, withdrawal or actionism and activism. In light of their failure to critically reappraise sexualised violence in educational contexts, pedagogical professions have experienced a "fundamental crisis of confidence" (translated from Wazlawik & Christmann, 2018, p. 535). Within the framework of the above mentioned funding line various strategies are being developed to address the challenges faced by transfer projects focusing on the topic of sexualised violence. In addition to the scientific perspective, which contributes current research findings, theoretical and methodological knowledge, the inclusion of other forms of expertise is of crucial importance.

- Research on sexualised violence builds on the accounts and the knowledge of adult survivors. They contribute their expertise and concerns regarding sexualised violence experienced during childhood and adolescence to research and product development. Their expertise is essential to create products that are more sensitive to people who have experienced sexualised violence. Research and development can draw on their knowledge to assess the suitability of content and form for children and young people, who may be victims or survivors. It is also crucial to consider the expertise of survivors when developing materials addressing the critical reappraisal of sexualised violence.

- The collection and analysis of data on young people´s perspectives is intended to provide insights for the development of prevention measures (Grieser et al., 2023). Through the participatory involvement of young people who may or may not have experienced sexualised violence (e.g. Fixemer, 2024; Stehr et al., 2023; for ethical standards see Poelchau et al., 2015) products can be designed to be sensitive to diversity and closely aligned with the realities of youth. This helps facilitate identification with the products.

- Practitioners from various disciplinary backgrounds contribute interpretations of and knowledge about problem constellations, conditions and approaches to action in different fields of practice that have evolved within their disciplines. On the one hand, this is important in order to expand basic scientific knowledge, e. g. about perspectives on protection and empowerment (Schmidt et al., 2023), gender and power, and disability (Schönecker, 2022). On the other hand, practical knowledge is relevant for the conceptualisation of products. Firstly, in order to address topics and perspectives of practice; secondly, because the knowledge appropriated in engagement with educational content can only be transferred into action when it is put into actual practice. This applies to interactional knowledge, such as the ability to conduct conversations with children (Krause et al., 2024), as well as to action knowledge and knowledge about processes (e. g. of protection, implementation, organisational development) derived from expert papers, guidelines or procedural schemes. Practical knowledge contributed to research and development cannot replace the effort of an individual translating a product into their own practice. However, it can contribute to creating products

with closer proximity to real-world situations, conditions, and possibilities for action. During implementation, additional expertise (e. g. on organisational development, legal advice and/or specialised counselling) may be necessary, especially if the products aim to change organisational structures and procedures.

The funding line´s research also shows that collaboration with specialised counselling centres as key actors for training, support and guidance in protection processes, with umbrella organisations, and with central institutions for prevention, training and further education (so-called intermediaries) is of significant importance for knowledge transfer. Sustainable field-specific strategies for dissemination and transfer can be developed through such collaboration. In order to fully leverage the potential of collaborative knowledge transfer to prevent sexualised violence, actors rely on stable infrastructures for dissemination and transfer in the various fields of practice.

Literature

Arbeitsgemeinschaft für Kinder- und Jugendhilfe [AGJ] (2009). *Rahmenbedingungen des Forschungstransfers in die Praxis. Diskussionspapier der Arbeitsgemeinschaft für Kinder- und Jugendhilfe – AGJ. [Framework Conditions for Research Transfer into Practice. Discussion Paper of the Working Group for Child and Youth Welfare – AGJ]* Arbeitsgemeinschaft für Kinder- und Jugendhilfe – AGJ.

Bitzan, M. (2008). Praxisforschung, wissenschaftliche Begleitung, Evaluation: Erkenntnis als Koproduktion. [Practice Research, Scientific Support, Evaluation: Knowledge as Co-Production]. In R. Becker & B. Kortendiek (Hrsg.): *Handbuch Frauen- und Geschlechterforschung.* Wiesbaden: VS Verlag für Sozialwissenschaften, pp. 336–342.

Blatter, K., & Schelle, R. (2022). *Wissenstransfer in der frühen Bildung. Modelle, Erkenntnisse und Bedingungen. [Knowledge Transfer in Early Education: Models, Findings, and Conditions].* München: Deutsches Jugendinstitut e.V.

Bundesministerium der Justiz [BMJ], Bundesministerium für Familie, Senioren, Frauen und Jugend [BMFSFJ], & Bundesministerium für Bildung und Forschung [BMBF] (Hrsg.) (2013). *Abschlussbericht Runder Tisch Sexueller Kindesmissbrauch in Abhängigkeits- und Machtverhältnissen in privaten und öffentlichen Einrichtungen und im familiären Bereich. [Report of the Federal Government´s Round Table on Sexual Abuse of Children in Dependency and Power Relations in Private and Public Institutions and within the Family].* Berlin: BMJ, BMFSFJ & BMBF. Retrieved May, 5, 2024, from https://www.bmfsfj.de/bmfsfj/service/publikationen/sexueller-kindesmissbrauch-86342

Dackweiler, R.-M., & Schäfer, R. (2020). Grenzen des Wissenstransfers – Grenzen der Innovation im Handlungsfeld geschlechtsbezogener Gewalt. [Limits of Knowledge Transfer – Limits of Innovation in the Field of Gender-Based Violence]. *die Hochschule: Journal für Wissenschaft und Bildung*, 29(2), 71–84. https://doi.org/10.25656/01:24461

Dewe, B., Ferchhoff, W., & Radtke, F.-O. (1992). Das „Professionswissen" von Pädagogen: Ein wissenstheoretischer Rekonstruktionsversuch. [The 'Professional Knowledge' of Educators: A Knowledge Theoretical Reconstruction Attempt]. In B. Dewe, W. Ferchhoff, & F.-O. Radtke (Hrsg.), *Erziehen als Profession. Zur Logik professionellen Handelns in pädagogischen Feldern* (pp. 70–91). Opladen: Leske + Budrich. https://doi.org/10.1007/978-3-663-09988-8

Dewe, B. (2005). Von der Wissenstransferforschung zur Wissenstransformation: Vermittlungsprozesse – Bedeutungsveränderungen. [From Knowledge Transfer Research to Knowledge Transformation: Mediation Processes – Changes in Meaning]. In G. Antos, S. Wichter, & J. Palm (Hrsg.), *Wissenstransfer durch Sprache als gesellschaftliches Problem* (pp. 365–379). Berlin: Lang.

Fixemer, T. (2024). Partizipatives Forschen mit jungen Menschen zu Sexualität, Gewalt und Schutz in der (internationalen) Jugendarbeit: method(olog)ische Reflexionen. [Participatory Research with Young People on Sexuality, Violence, and Protection in (International) Youth Work: Method(olog)ical Reflections]. F*orum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 25(1), Art. 5. https://doi.org/10.17169/fqs-25.1.3998

Gredig, D., Heinsch, M., Amez-Droz, P., Hüttemann, M., Rotzetter, F., & Sommerfeld, P. (2021). Collaborative research and development: a typology of linkages between researchers and practitioners. *European Journal of Social Work*, 24(6), 1066–1082. https://www.tandfonline.com/doi/citedby/10.1080/13691457.2020.1793111?scroll=top&needAccess=true

Grieser, F., Wazlawik, M., Derr, R., Eppinger, S., & Kindler, H. (2023). Wirksamkeit institutioneller Prävention und Intervention bei sexualisierter Gewalt. Adressat*innenperspektiven auf Entwicklung und Implementierung von Schutzkonzepten. [Effectiveness of Institutional Prevention and Intervention in Sexualised Violence. Recipients' Perspectives on the Development and Implementation of Protection Concepts]. *Soziale Passagen 15*, 275-279. https://doi.org/10.1007/s12592-023-00449-5

Gulowski, R. (2022). Sekundärtrauma in der qualitativen Forschung: Traumasensitivität in der Forschung zu sexualisierter Gewalt. [Secondary Trauma in Qualitative Research: Trauma Sensitivity in Research on Sexualised Violence]. *Forum Qualitative Sozialforschung/ Forum: Qualitative Social Research*, 23(1), Art. 18. http://dx.doi.org/10.17169/fqs-23.1.3697

Helfferich, C., Kavemann, B., & Kindler, H. (Hrsg.). (2016). F*orschungsmanual Gewalt. Grundlagen der empirischen Erhebung von Gewalt in Paarbeziehungen und sexualisierter Gewalt*. [Research Manual on Violence: Fundamentals of Empirical Data Collection on Violence in Romantic Relationships and Sexualised Violence] Wiesbaden: Springer.

Henningsen, A., Kampert, M., & Winter, V. (2022). Partizipative Jugendforschung. [Participatory Youth Research] In D. Doll, B. Kavemann, B. Nagel, & A. Etzel (Hrsg.), *Beiträge Zur Forschung zu Geschlechterbeziehungen, Gewalt und privaten Lebensformen. Disziplinäres, Interdisziplinäres und Essays* (pp. 109-126). Opladen: Barbara Budrich.

Hüttemann, M. (2016). Wissensproduktion und Wissensverwendung in Projekten – kooperative Wissensbildung als Alternative zu evidenzbasierter Praxis? [Knowledge Production and Knowledge Utilization in Projects – Cooperative Knowledge Building as an Alternative to Evidence-Based Practice?]. In S. Borrmann & B. Thiessen (Hrsg.), *Wirkungen Sozialer Arbeit: Potentiale und Grenzen der Evidenzbasierung für Profession und Disziplin* (pp. 42–56). Opladen: Barbara Budrich.

Hüttemann, M., Rotzetter, F., Amez-Droz, P., Gredig, D., & Sommerfeld, P. (2016). Kooperation zwischen Akteuren aus Wissenschaft und Praxis. [Cooperation between Actors from Science and Practice.] *neue praxis, Zeitschrift für Sozialarbeit, Sozialpädagogik und Sozialpolitik*, 46(3), 205-220.

Kade, S. (2004). *Alternde Institutionen – Wissenstransfer im Generationenwechsel.* [Aging Institutions – Knowledge Transfer during Generational Transition.] Bad Heilbrunn: Julius Klinkhardt.

Kavemann, B. & Nagel, B. (2018). Erfahrungswissen in der Prävention von sexualisierter Gewalt in Kindheit und Jugend – Qualität lässt sich beschreiben. [Experiential Knowledge in the Prevention of Sexualised Violence in Childhood and Youth – Describing Quality]. *Forum Sexualaufklärung und Familienplanung*, 2/2018, 22-25. Retrieved May, 2, 2024, from https://shop.bzga.de/pdf/13329234.pdf

Krause, N., Gewehr, E., Barbe, H., Merschhemke, M., Mensing, F., Siegel, B., Müller, J.L., Volbert, R., Fromberger, P., Tamm, A., & Pülschen, S. (2024). How to prepare for conversations with children about suspicions of sexual abuse? Evaluation of an interactive virtual reality training for student teachers. *Child Abuse Negl*. https://doi.org/10.1016/j.chiabu.2024.106677

Oestreicher, E. (2014). Die Paar-Probleme – Wie gestaltet sich das Verhältnis zwischen Wissenschaft und Praxis am Beispiel des Transfers professionellen Wissens? [The Couple's Challenges – Exploring the Relationship between Science and Practice through the Transfer of Professional Knowledge?]. In U. Unterkofler & E. Oestreicher (Hrsg.), *Theorie-Praxis-Bezüge in professionellen Feldern. Wissensentwicklung und -verwendung als Herausforderung* (pp. 113-132). Opladen & Toronto: Budrich UniPress.

Poelchau, H.-W., Briken, P., Wazlawik, M., Bauer, U., Fegert, J. M., & Kavemann, B. (2015). Bonner Ethik-Erklärung 1: Empfehlungen für die Forschung zu sexueller Gewalt in pädagogischen Kontexten. Entwickelt im Rahmen der BMBF-Forschungslinie "sexuelle Gewalt gegen Kinder und Jugendliche in pädagogischen Kontexten". [Bonn Ethics Declaration 1: Recommendations for Research on Sexual Violence in Educational Contexts. Developed as part of the BMBF research line "Sexual Violence against Children and Adolescents in Educational Contexts".] *Zeitschrift für Sexualforschung*, 28(2), 153–160. https://doi.org/10.1055/s-0035-1553220

Radtke, F.-O. (2004). Der Eigensinn pädagogischer Professionalität jenseits von Innovationshoffnungen und Effizienzerwartungen. Übergangene Einsichten aus der Wissensverwendungsforschung für die Organisation der universitären Lehrerbildung. [The Autonomy of Pedagogical Professionalism Beyond Hopes for Innovation and Expectations of Efficiency: Overlooked Insights from Knowledge Utilization Research for the Organization of University Teacher Education.]. In B. Koch-Priewe, F.-U. Kolbe, & J. Wildt (Hrsg.), *Grundlagenforschung und mikrodidaktische Reformansätze zur Lehrerbildung* (pp. 99–149). Bad Heilbrunn: Julius Klinkhardt.

Reinmann, G., & Vohle, F. (2004). Implementation als Designprozess. [Implementation as a Design Process]. In G. Reinmann & H. Mandl (Hrsg.), *Psychologie des Wissensmanagements: Perspektiven, Theorien und Methoden* (pp. 234–247). Göttingen: Hogrefe.

Rieske, T. V., Scambor, E., Wittenzellner, U., Könnecke, B., & Puchart, R. (2018). *Aufdeckungsprozesse männlicher Betroffener von sexualisierter Gewalt in Kindheit und Jugend. Verlaufsmuster und hilfreiche Bedingungen*. [Disclosure Processes of Male Survivors of Child and Adolescent Sexual Abuse: Trajectories and Supportive Conditions.]. Wiesbaden: Springer VS.

Rothe, D. (2014). Research Meets Practice (RMP) – Modell und Praxis einer transdisziplinären Kooperation im Feld der Erwachsenenbildung. [Research Meets Practice (RMP) – Model and Practice of Transdisciplinary Collaboration in the Field of Adult Education.]. In U. Unterkofler & E. Oestreicher (Hrsg.), *Theorie-Praxis-Bezüge in professionellen Feldern. Wissensentwicklung und -verwendung als Herausforderung* (pp. 157-176). Opladen & Toronto: Budrich UniPress.

Rulofs, B., Neeten, M., & Söllinger, A. (2023). Schutz vor interpersonaler und sexualisierter Gewalt im Sport – Forschungsbefunde und sportpolitische Meilensteine im Bereich Prävention, Intervention und Aufarbeitung. [Protection against Interpersonal and Sexualised Violence in Sports – Research Findings and Sport Policy Milestones in Prevention, Intervention, and Resolution.]. *Kindesmisshandlung und -vernachlässigung. Interdisziplinäre Fachzeitschrift für Prävention und Intervention*, 26(1), 44-51.

Schmidt, F., Wazlawik, M, Christmann, B., Lamour, M., & Dekker, A. (2023). Sexualität zwischen Affirmation und Funktionalisierung. Kollektive Orientierungen von Sexualpädagog_innen und Präventionsfachkräften in Bezug auf Sexualität. [Sexuality Between Affirmation and Instrumentalization: Collective Orientations of Sex Educators and Prevention Specialists Regarding Sexuality]. *Zeitschrift für Sozialpädagogik*, 21(2), 147-166.

Schmiedl, F. L. (2023). Relationstheoretische Überlegungen zum Forschungs-Praxis Transfer. [Relational Considerations on Research-Practice Transfer]. *Bildungsforschung*, 2022(2), 1-16. https://doi.org/10.25656/01:25458

Schönecker, L. (2022). Reflexionen zum Behinderungsverständnis. Zur Sprache und Definition der Zielgruppe bei Forschung im Kontext „junger Menschen mit Behinderungen". [Reflections on Understanding Disability: Discussing the Language and Definition of the Target Group in Research Contexts Involving "Young People with Disabilities"]. *neue praxis, Zeitschrift für Sozialarbeit, Sozialpädagogik und Sozialpolitik*, 52(6), 531-539.

Schuster, J., Hugo, J., Bremm, N., Kolleck, N., & Zala-Mezö, E. (2024). *Wissensproduktion, Wissensmobilisierung und Wissenstransfer. Chancen und Grenzen der Entwicklung von Wissenschaft und Praxis.* [Knowledge Production, Knowledge Mobilization, and Knowledge Transfer: Opportunities and Limits in the Development of Science and Practice]. Opladen: Barbara Budrich.

Sehmer, J., Gumz, H., Marks, S., & Thole, W. (2020). Dialog statt Transfer: Dialogische Transformationen von Wissen in der Offenen Kinder- und Jugendarbeit als Herausforderung für Praxis, Forschung und Theorie. [Dialogue instead of Transfer: Dialogic Transformations of Knowledge in Open Child and Youth Work as a Challenge for Practice, Research, and Theory.]. *corax* (3), 1–8.

Stehr, J., Schwerthelm, A., & Wazlawik, M. (2023). Bedarfe queerer junger Menschen im Fokus von partizipativer Forschung und Praxisentwicklung. [Needs of Queer Youth in the Focus of Participatory Research and Practice Development.]. *Kindesmisshandlung und -vernachlässigung. Interdisziplinäre Fachzeitschrift für Prävention und Intervention*, 26(1), 60-67.

Stern, A. & Nathanaili-Penotet J. (2023). Art and Action: What Participatory Action Research with Adult Survivors Must Address. In M. Roth, R. Alfandari, & G. Crous (Hrsg.), *Participatory Research on Child Maltreatment with Children and Adult Survivors (Emerald Studies in Child Centred Practice)* (pp. 229-245). Bingley: Emerald Publishing Limited.

Thole, W., Milbradt, B., Göbel, S., & Rißmann, M. (Hrsg.). (2016). *Kasseler Edition Soziale Arbeit: Bd. 4. Wissen und Reflexion: Der Alltag in Kindertageseinrichtungen im Blick der Professionellen*. [The Everyday Life in Early Childhood Education Facilities Through the Eyes of Professionals]. Wiesbaden: Springer VS.

Vobbe, F., & Kärgel. K. (2022). „Ich hatte öfters das Gefühl, die Interviewpartnerin übernimmt Verantwortung für uns." Die Betroffenheit von Forschenden als forschungsethische Herausforderung in partizipativwissenschaftlichen Kontexten zu sexualisierter Gewalt in Kindheit und Jugend. ["I often felt like the interviewee was taking responsibility for us." The Implication of Researchers as a Research Ethical Challenge in Participatory Scientific Contexts on Childhood and Adolescent Sexual Abuse.] In D. Doll, B. Kavemann, B. Nagel, & A. Etzel (Hrsg.), *Beiträge Zur Forschung Zu Geschlechterbeziehungen, Gewalt und Privaten Lebensformen* (pp. 99-108). Opladen: Barbara Budrich.

Wazlawik, M., & Christmann, B. (2018). Professionalisierung und Prävention. [Professionalisation and Prevention]. In A. Retkowski, A. Treibel, & E. Tuider (2018). *Handbuch Sexualisierte Gewalt und pädagogische Kontexte. Theorie, Forschung, Praxis* (pp. 534-542). Weinheim: Beltz Juventa.

Wazlawik, M., Henningsen, A., Dekker, A., Voß, H.-J., & Retkowski, A. (Hrsg.). (2019). *Sexuelle Gewalt und Pädagogik: Bd. 3. Sexuelle Gewalt in pädagogischen Kontexten. Aktuelle Forschungen und Reflexionen.* [Sexual Violence and Pedagogy: Vol. 3. Sexual Violence in Educational Contexts. Current Research and Reflections.]. Wiesbaden: Springer VS. https://doi.org/10.1007/978-3-658-23236-8

Wazlawik, M., Christmann, B., Böhm, M., & Dekker, A. (Hrsg.). (2020). *Sexuelle Gewalt und Pädagogik: Bd. 5. Perspektiven auf sexualisierte Gewalt. Einsichten aus Forschung und Praxis*. [Sexual Violence and Pedagogy: Vol. 5. Perspectives on Sexualised Violence. Insights from Research and Practice.]. Wiesbaden: Springer VS.

Wolff, M., Schröer, W., & Fegert, J. (Hrsg.). (2017). *Schutzkonzepte in Theorie und Praxis: Ein beteiligungsorientiertes Werkbuch*. [Prevention Concepts in Theory and Practice: A Participatory Workbook.]. Weinheim: Beltz Juventa.

World Health Organization (2023). *WHO framework for meaningful engagement of people living with noncommunicable diseases, and mental health and neurological conditions*. Geneva: World Health Organization. Retrieved July, 15, 2024, from https://iris.who.int/bitstream/handle/10665/367340/9789240073074-eng.pdf?sequence=1

Authors

Britta Buschmann is a research associate on the BMBF meta-project "Protection against sexualised violence in educational contexts and care – Accompanying research on transfer and implementation". Her research interests include topics related to sexualised violence, international adoption, flight and migration.
Contact: britta.buschmann@fu-berlin.de

Prof. Dr. Ulrike Urban-Stahl is Professor of Social Work (Sozialpädagogik) at Freie Universität Berlin. Her areas of expertise include child and youth welfare, child protection, and violence in educational institutions and residential care. She is the principal investigator of the BMBF meta-project "Protection against sexualised violence in educational contexts and care – Accompanying research on transfer and implementation."
Contact: ulrike.urban-stahl@fu-berlin.de

Anja Borchert is a research associate on the BMBF meta-project "Protection against sexualised violence in educational contexts and care – Accompanying research on transfer and implementation". She previously worked as a social worker in the field of child protection, with a particular focus on the prevention of sexualised violence.
Contact: anja.borchert@fu-berlin.de

Citation

Buschmann, B., Borchert, A., & Urban-Stahl, U. (2024). Knowledge transfer for the prevention of sexualised violence, *FORUM sexuality education and family planning: information service of the Federal Centre for Health Education (BZgA), 2*, 29–36. https://doi.org/10.17623/BZgA_SRH:forum_2024-2_en_art_prevent-sexu-violence

Perspectives on hormonal contraception among young adults in the European Region

Erica Selznick, Leonidas Galeridis, Kristien Michielsen

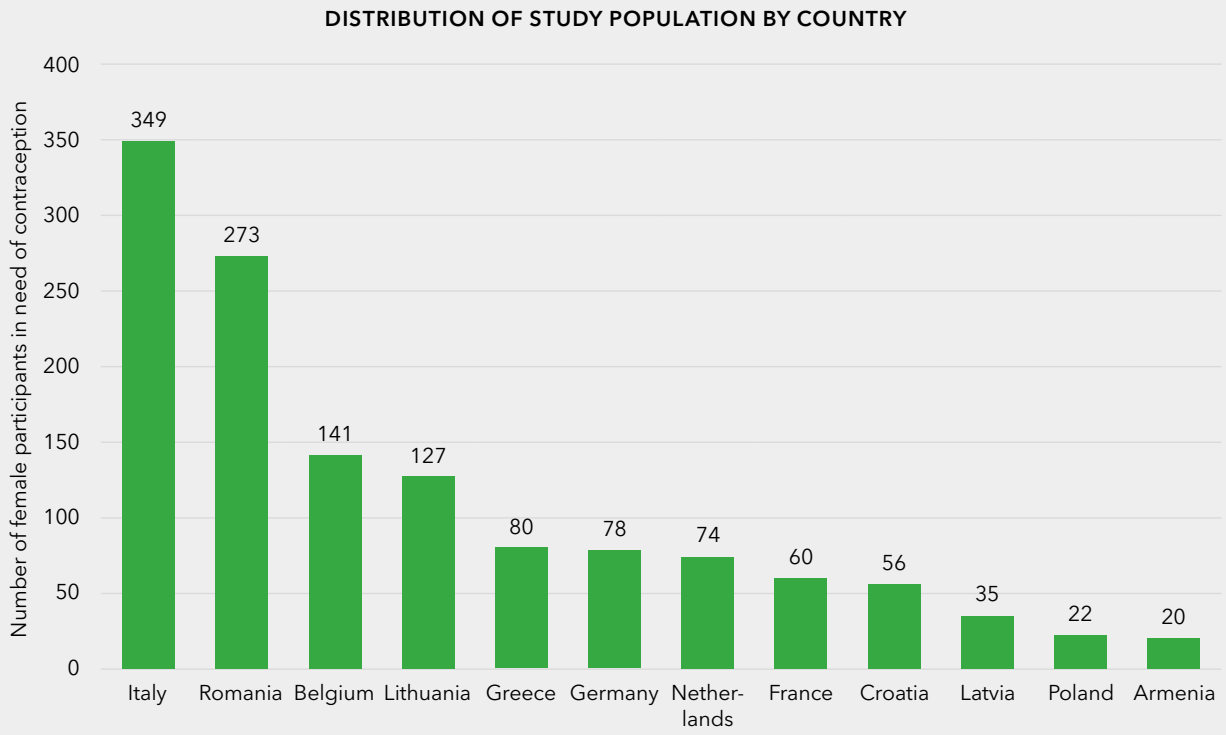
In 2022 the European Parliamentary Forum for Sexual and Reproductive Rights (EPF) conducted a study on knowledge, attitudes and practices regarding contraception among young adults in the European region. Through an online survey using convenience sampling, data were collected among 2,603 young adults aged 18 to 30. This article presents a secondary analysis of these data focusing on young adults' use of and perspectives on hormonal contraception.

Contraceptive use varies widely across the European continent (Dereuddre, Van de Putte & Bracke, 2016). Patterns of contraceptive use reflect policy variations which are more favourable to modern contraception access in Northern and Western Europe than Eastern Europe (EPF, 2024). These differences described in the 2024 Contraception Policy Atlas developed by EPF are particularly striking for young people as only 30% of countries in the region "cover contraceptives in the national health systems for young people." Young people face several barriers to accessing contraception, including financial limitations, social taboos and confidentiality issues (International Planned Parenthood Federation, 2012; Parliamentary Assembly, 2020). Additionally, while young people tend to need the most information, they often access information that is only partial or non-evidence-based and fails to provide them with a comprehensive understanding of their contraceptive options, and where and how to access services (International Planned Parenthood Federation, 2012).

In recent years exaggerated risks and a general unease about interference with natural bodily functions have lessened women's interest in hormonal contraception. Repeated pill scares in Europe following rare cardiovascular adverse events and social media discussions about hormonal effects on mental health, libido and fertility have fuelled public mistrust and hesitancy towards hormonal contraception (Foran, 2019). Some have labelled this phenomenon as "hormonophobia," or "hormonal scepticism" due to a systematic "overestimation of health risks" associated with hormonal contraception (Le Guen et al., 2021).

It is important to understand current patterns of hormonal utilization among young people living in the European region in order to reduce inequities in contraceptive choices and utilization. This secondary analysis aims to describe hormonal contraceptive utilization and associated factors among young adults and the extent to which hormonal hesitancy informs their contraceptive decisions.

FIGURE 1



Sourced from Selznick (2023)

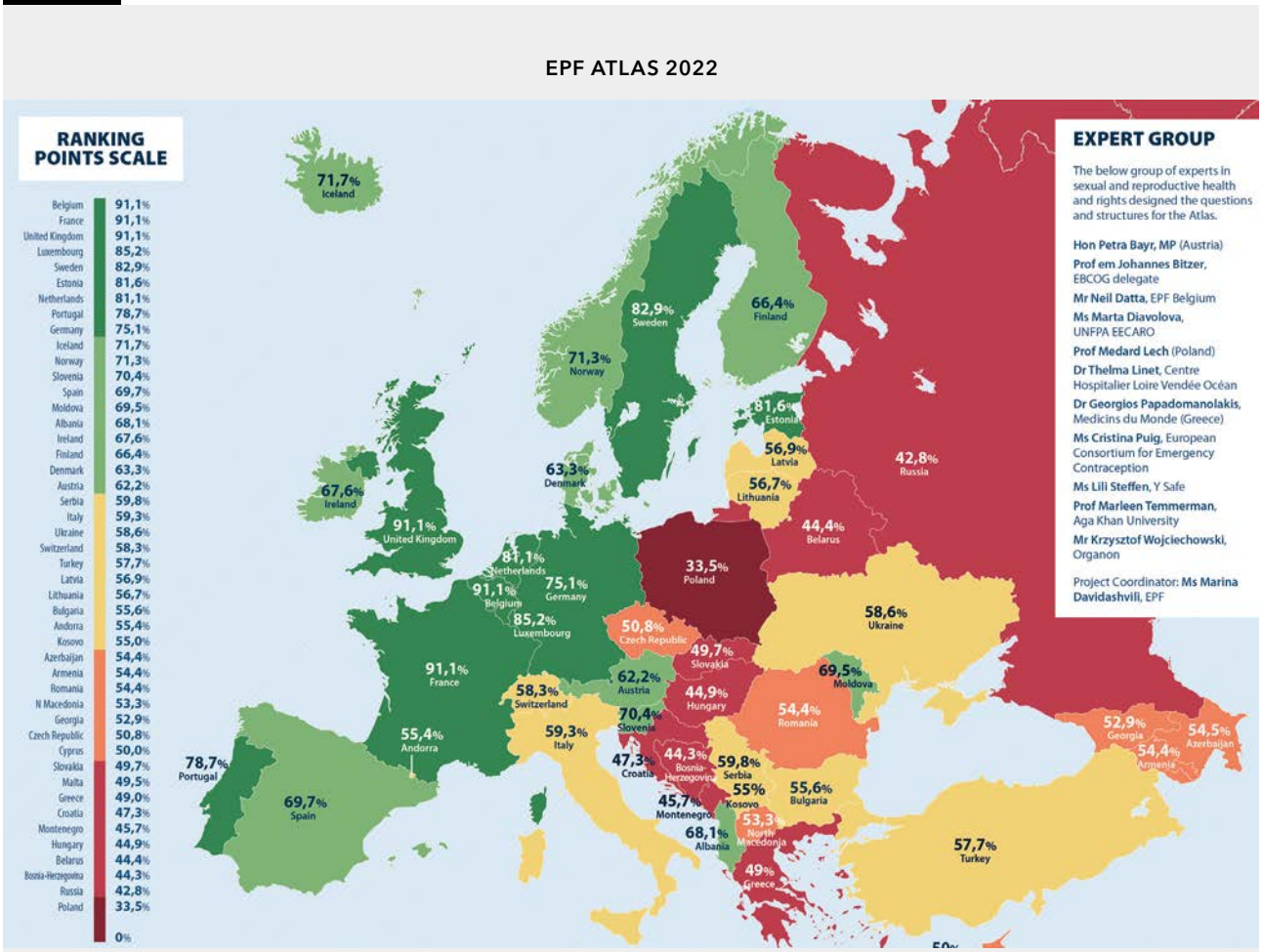
Methods

This study draws on the EPF study "Contraceptive Use and Awareness Among Young People in the European Region", an online cross-sectional survey conducted in July and August 2022 in the European Region (Michielsen, Farje De la Torre & Selznick, 2022). It is a secondary analysis of the collected data, done in the framework of a master thesis written by the first author for a Master of Science in Public Health at the Johns Hopkins Bloomberg School of Public Health (Selznick, 2023).

The study sample included respondents between the ages of 18 and 30 who were living in one of the countries of the European region. Respondents were recruited via convenience sampling, which involved the EPF compiling a list of contacts from each European country to disseminate the survey to the relevant groups and contacts, including organizations, researchers, community leaders, doctors, and activists who either worked with young people, focused on family planning, or had a large audience or network of 18 to 30-year-olds in Europe. A total of 2,603 respondents completed the survey, which was available in 13 languages. The questionnaire solicited information about the respondents' country of residence, their socio-demographic background (sex, age, education, occupation, economic status and religion) and their knowledge, attitudes and use of contraception.

We restricted analysis to countries that had at least 30 respondents who were female at birth and selected a subsample of those who were in need of contraception at the time of the survey. Participants in need of contraception were identified as being female at birth, in current heterosexual or bisexual

FIGURE 2



Sourced from EPF (2022)

partnerships, non-pregnant and not trying to become pregnant at the time of the survey, and did not have fertility related reasons as their explanation for not using contraception. Our analytical sample included 1,315 respondents, ranging from 20 respondents in Armenia to 349 respondents in Italy, as seen in Figure 1.

We considered three outcome measures: knowledge of hormonal methods, current contraceptive use, and hormonal contraception hesitancy. Knowledge of hormonal methods was defined as a numerical variable (0 to 6) based on the number of hormonal methods the respondent knew, in terms of "what it looks like" and/or "how it is used." Current contraceptive use was defined as a three-category variable: non-use, hormonal method use (pills, implants, patch, vaginal ring, injectables and intrauterine devices), and other method use (diaphragms, male condoms, female condoms, withdrawal, male sterilization, female sterilization and fertility awareness). This categorization assumes that most intrauterine devices are hormonal (intrauterine systems, IUS) rather than copper IUDs, as IUS are more common among younger women. Hormone hesitancy was a binary variable combining non-users of contraception who reported they "don't want to use hormones'' or are "scared of side effects" and con-

traceptive users who chose their method because they wanted one that was hormone-free.

We examined age, education, occupation, socio-economic status, religion and region of residence as correlates of hormonal contraceptive knowledge, use, and hesitancy. Region was defined according to the EPF atlas categories of contraceptive policy access at the time of the survey (EPF, 2022) from most favourable, green coloured countries, to most unfavourable, red coloured countries, as illustrated in Figure 2 below.

The analysis began with a description of the sample characteristics. Next, we examined the mean number of known hormonal contraceptives by socio-demographic characteristics and tested for differences using bivariate linear regression. Contraceptive use status was also examined by socio-demographic characteristics and differences tested for using Pearson's chi-squared test. We further investigated factors associated with hormonal method use among all women in need of contraception and among contraceptive users using multivariate logistic regressions. The classification of IUDs as hormonal methods may lead to misclassification, especially in Eastern Europe where a greater proportion of women use copper IUDs that are less costly than IUS. For this reason, a sensitivity analysis was conducted by reclassifying all IUDs into non hormonal methods to examine how IUD classification changed our conclusions. The results remained the same. Finally,

TABLE 1

SOCIO-DEMOGRAPHICS OF THE STUDY SAMPLE

		N	% of total sample
Region	Most favourable	353	26.8
	Moderately favourable	511	38.9
	Less favourable	293	22.3
	Least favourable	158	12.0
Age	18-24	712	54.1
	25-30	603	45.9
Education	Primary or secondary education	158	12.1
	Advanced technical training	58	4.4
	College or university	1092	83.5
Main occupation	Employed (full or part time)	582	44.3
	Self-employed	53	4.0
	Student	589	44.8
	Looking for a job	62	4.7
	Other/no response	29	2.2
Financial situation	Very difficult/difficult	223	17.0
	Neither difficult nor easy	462	35.1
	Relatively easy or very easy	630	47.9
Religion	Religious and currently practicing	56	4.3
	Religious but not practicing	328	24.9
	Not religious	886	67.4
	No response	45	3.4

Sourced from Selznick (2023)

we explored sociodemographic factors associated with hormonal contraceptive hesitancy, testing for differences using Pearson's chi-squared test and subsequently conducting a multivariate logistic regression model. Ethical approval for secondary data analysis (ONZ-2022-0489) was obtained from the Ethical Committee of Ghent University Hospital. Participants had to approve an informed consent form before starting the survey.

Results

The characteristics of the study sample are presented in Table 1. A large proportion of respondents (58%) resided in three countries, Italy, Romania and Belgium. This represented a range of contraceptive access conditions, which are shown in yellow, orange and dark green. While 26.8% of respondents lived in favourable contraceptive access countries (green), 38.9% resided in moderately favourable contraceptive access countries (yellow), 22.3% lived in less favourable contraceptive access countries (orange), and 12% lived in the least favourable access countries (red). Half (54.1%) of the respondents were between 18 and 24, the majority had a higher level of education (83.5% attended or had graduated from a college or university), 44.8% were still students, and 44.3% were in employment. Almost half (47.9%) reported that they found it relatively easy or very easy to cover their basic needs (food, housing) while 17.0% found that their financial situation was difficult or very difficult.

Firstly, we assessed the respondents' knowledge of hormonal contraceptive methods. Altogether,

TABLE 2

MEAN NUMBER OF HORMONAL METHODS KNOWN BY WOMEN'S CHARACTERISTICS

		Mean number of hormonal methods known	P value
Region	Most favourable	3.44	<.001
	Moderately favourable	3.00	
	Less favourable	2.59	
	Least favourable	1.94	
Age	18-24	2.95	.287
	25-30	2.85	
Education	Primary or secondary education	2.99	.753
	Advanced technical training	2.81	
	College or university	2.90	
Main occupation	Employed (full or part time)	2.89	.032
	Self-employed	2.42	
	Student	2.99	
	Looking for a job	2.53	
Financial situation	Very difficult or difficult	2.90	.004
	Neither difficult nor easy	2.70	
	Relatively easy or very easy	3.05	
Religion	Religious and currently practicing	2.86	.179
	Religious but not practicing	2.77	
	Not religious	2.96	

Sourced from Selznick (2023)

TABLE 3

DISTRIBUTION OF CONTRACEPTIVE USE STATUS BY WOMEN'S SOCIODEMOGRAPHIC CHARACTERISTICS

		% non-use	% barrier and traditional methods	% hormonal methods	P value
Region	Most favourable	9.9	27.8	62.3	< .001
	Moderately favourable	14.5	41.9	43.6	
	Less favourable	25.3	56.0	18.8	
	Least favourable	27.2	55.7	17.1	
Age	18-24	16.4	44.9	38.6	.259
	25-30	18.1	40.5	41.5	
Education	Primary or secondary education	15.8	43.0	41.1	.715
	Advanced technical training	15.5	36.2	48.3	
	College or university	17.6	43.0	39.4	
Main occupation	Employed (full or part time)	19.6	38.1	42.3	.016
	Self-employed	20.8	49.1	30.2	
	Student	13.9	46.7	39.4	
	Looking for a job	22.6	45.2	32.3	
Financial situation	Very difficult	19.3	48.4	32.3	0.001
	Neither difficult nor easy	21.2	40.5	38.3	
	Relatively easy or very easy	13.5	42.7	43.8	
Religion	Religious and currently practicing	25.0	26.8	48.2	.121
	Religious but not practicing	15.9	45.4	38.7	
	Not religious	17.2	43.1	39.7	

Sourced from Selznick (2023)

respondents knew about half of the six types of hormonal contraceptive. Knowledge about hormonal contraceptives varied by sociodemographic characteristics (Table 2). More specifically, the average number of hormonal methods respondents knew about was highest among respondents living in favourable contraceptive policy countries compared with countries with a less favourable policy climate, among students and people who are in employment as compared with unemployed respondents, and among respondents from advantaged socioeconomic backgrounds compared with those with a less advantaged economic background.

Secondly, we mapped the use of hormonal contraceptive methods. Altogether, 43.3% of respondents in need of contraception were using other methods, 39.9% were using hormonal methods, and 16.9% were not using any form of contraception at the time of the survey.

The use of hormonal contraception was highest in countries with the most favourable (62.3%) and with moderately favourable (43.6%) policies. Within the countries with the most favourable policy situations, the majority of respondents used hormonal contraception (62.3%). Barrier and traditional methods were most commonly used in countries with less favourable (56%) or the least favourable policies (55.7%)

Respondents who were self-employed, looking for a job or in a difficult financial situation were less likely to use hormonal contraception.

TABLE 4

FACTORS ASSOCIATED WITH HORMONAL CONTRACEPTIVE USE STATUS BY WOMEN'S SOCIODEMOGRAPHIC CHARACTERISTICS

		All women in need		Contraceptive users	
		% OR hormonal use	P value	% OR hormonal use	P value
Region	Most favourable	1	0.000	1	0.000
	Moderately favourable	0.44		0.43	
	Less favourable	0.13		0.14	
	Least favourable	0.12		0.13	
Age	18-24	1	0.894	1	0.700
	25-30	0.98		0.94	
Education	Primary or secondary education	1	0.179	1	0.310
	Advanced technical training	1.44		1.40	
	College or university	0.86		0.88	
Main occupation	Employed (full or part time)	1	0.399	1	0.296
	Self-employed	0.58		0.59	
	Student	0.90		0.78	
	Looking for a job	0.91		0.89	
Financial situation	Very difficult	1	0.447	1	0.183
	Neither difficult nor easy	1.24		1.46	
	Reltively easy or very easy	1.26		1.26	
Religion	Religious and currently practicing	1	0.369	1	0.091
	Religious but not practicing	0.83		0.50	
	Not religious	0.72		0.46	

Sourced from Selznick (2023)

In multivariate analysis, it was only the contraceptive policy environment that remained significant, showing lower odds of hormonal contraception in countries with a less favourable family planning policy environment.

Hormone Hesitancy

A quarter of respondents in need of contraception (25.3%) were classified as having hormonal contraceptive hesitancy, based on their decision not to use contraception because they "didn't want to use hormones" (n=100), were "scared of side effects" (n=60), or because they chose other methods to avoid hormones (n=213). Altogether, side effects represented 18% of the reasons for contraceptive hesitancy.

Hormonal hesitancy varied from 6.7% among hormonal method users to 31.6% among traditional method users, reaching 53.1% among non-users. Hesitancy was higher among the oldest age group, women with the highest level of education, and women who were self-employed. These patterns were mostly driven by differences in hesitancy levels among contraceptive users, while no sociodemographic differences in hesitancy were observed among non-users. More specifically, we found higher levels of hesitancy among contraceptive users living

TABLE 5

SOCIODEMOGRAPHIC FACTORS ASSOCIATED WITH HORMONAL HESITANCY AMONG USERS AND NON-USERS OF HORMONAL METHODS

		All women in need				Non-users				Users			
		% hesitancy	p	aOR	p	% hesitancy	p	aOR	p	% hesitancy	p	aOR	p
Total		25.3				53.1				19.6			
Region	Most favourable	34.6	0.000	1	0.002	65.7	0.141	1	0.086	31.1	<0.001	1	0.0001
	Moderately favourable	20.6		0.55		54.1		0.69		14.9		0.46	
	Less favourable	23.6		0.72		54.1		0.69		13.2		0.45	
	Least favourable	23.4		0.51		39.5		0.29		17.4		0.42	
Age	18-24	20.8	<0.001	1	0.035	49.6	0.271	1	0.548	15.1	<0.001	1	0.03
	25-30	30.7		1.42		56.9		1.26		24.9		1.57	
Education	Primary and Secondary education	16.5	0.012	1	0.149	40.0	0.290	1	0.507	12.0	0.018	1	0.24
	Advanced technical training	20.7		1.23		66.7		2.39		12.2		0.99	
	College or university	27.0		1.58		54.2		1.66		21.2		1.55	
Main occupation	Employed (full or part time)	27.8	0.030	1	0.664	51.8	0.269	1	0.590	22.0	0.129	1	0.79
	Self-employed	35.9		1.40		81.8		2.88		23.8		1.20	
	Student	21.9		0.92		51.2		0.87		17.2		1.09	
	Looking for a job	22.6		0.89		57.1		1.28		12.5		0.72	
Financial situation	Very difficult	24.7	0.951	1	0.241	58.1	0.625	1	0.272	16.7	0.260	1	0.89
	Neither difficult nor easy	25.8		1.09		54.1		0.75		18.1		1.08	
	Relatively easy or very easy	25.2		0.84		49.4		0.51		21.5		0.99	
Religion	Currently practicing	21.4	0.177	1	0.665	64.3	0.704	1	0.740	7.1	0.016	1	0.17
	Religion but not practicing	22.3		1.1		53.9		0.78		16.3		2.62	
	No Religion	27.1		1.2		52.6		0.66		21.8		3.02	

Sourced from Selznick (2023)

in the countries with the most favourable contraceptive policies, among older women, and among highly educated women. Hesitancy was also higher among non-religious women.

In multivariate analysis, it was only the policy environment that remained significant, with greater hesitancy in countries with a more favourable policy environment.

Discussion

This study showed that there are wide variations in the use of contraception in general, and hormonal contraception in particular, across Europe. Regional disparities correlate with policies supporting or restricting access to contraception with greater levels of awareness and use in the most favourable contraceptive policy settings. Within-country dispari-

ties were also identified, since young people of the lowest socioeconomic status feel less knowledgeable about contraceptives and are less likely to use hormonal contraceptives than more affluent populations.

One in four respondents in need of contraception and over half of non-users express concerns about hormonal contraception. While hesitancy correlates with lower levels of use at the individual level, we also found greater levels of hesitancy in countries with the most favourable contraceptive policies and which have the highest levels of knowledge and usage of hormonal contraceptive methods. Hesitancy is also higher among women of a higher socioeconomic status. While misinformation and concerns about side effects are often cited as primary reasons for contraceptive hesitancy, we found that hormonal sceptics feel better informed about hormonal contraception than others and only 18% directly cite side effects as their main reason for not using hormonal methods. Research highlights the role social networks and influencers play in enabling the spread of misinformation contributing to hormonal hesitancy, which can explain why hesitancy predominantly exists among groups who have greater access to and an increased awareness of contraception (Svahn et al., 2021). Respondents with greater access to information through social media and other media forums are more likely to discuss their contraceptive decision with their peers, including having discussions about the side effects and alternative options (Merz et al., 2021; Kofinas et al., 2014).

Given the critical role of contraception in reducing unintended pregnancies among young people and promoting sexual health, these results call for more investment in proper information on contraception across Europe so that women can make informed choices. This is particularly relevant seeing that social media is increasingly promoting natural family planning methods, highlighting negative anecdotes about hormonal contraception, and often providing misleading and misguided information (Schneider-Kamp & Takhar, 2023). Societal shifts in medical authority, including increased individual responsibility, heightened distrust of providers, and opposition to the medicalization of women's health, reinforce these messages. These shifts need to be acknowledged and accommodated in research and policy (Schneider-Kamp & Takhar, 2023). Given that young adults are often the targeted demographic group of these messages, efforts should be made to address these concerns while disseminating factual, accurate information about contraception. This should be accompanied by easy access to affordable modern contraception for young adults throughout Europe that helps them make informed contraceptive decisions.

This study has several limitations. The most important limitation is the use of convenience sampling to select participants. This is likely to introduce selection bias and limit the generalizability of the findings. Although the numbers of respondents are well distributed across regions, the sample population has a higher level of education, a higher socioeconomic status, and a higher employment rate than the general population of young people living in Europe (International Labour Organization, 2022; Eurostat, 2022). As such, it is likely that knowledge and use of hormonal methods are overestimated and social disparities under-estimated. On the other hand, as contraceptive hesitancy seems to be greater among more affluent populations, we may have overestimated this phenomenon. Secondly, the EPF study was not specifically designed to explore hormonal hesitancy, leading to an imperfect composite measure and limited information about the reasons for hesitancy, which may differ by region and socioeconomic status. Future research should expand on these exploratory findings using mixed-method approaches to better characterize the contours and reasons for hormonal hesitancy, who is susceptible to it and how it influences contraceptive decisions. This information is needed to inform decision making aids as well as counselling approaches to respond to a person's concerns, preferences and needs with respect to contraception.

References

Contraception Policy Atlas Europe (2022). European Parliamentary Forum for Sexual and Reproductive Rights. https://www.epfweb.org/sites/default/files/2022-03/CCeptionInfoA3_EN%202022%20MAR2%20LoRes%20%281%29.pdf

Contraception Policy Atlas Europe (2024). European Parliamentary Forum for Sexual and Reproductive Rights. https://www.epfweb.org/sites/default/files/2024-02/CCInfoEU_A3_EN_2024_FEB12.pdf

Dereuddre, R., Van de Putte, B., & Bracke, P. (2016). Ready, willing, and able: Contraceptive use patterns across Europe. *European Journal of Population, 32*(4), 543-573. https://doi.org/10.1007/s10680-016-9378-0

Eurostat. (2022, February). *Young people – social inclusion*. https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Young_people_-_social_inclusion&oldid=526294

Eurostat. (2022, May 24). *41% of young adults hold a tertiary degree*. https://ec.europa.eu/eurostat/en/web/products-eurostat-news/-/ddn-20220524-2

Foran, T. (2019). Contraception and the media: Lessons past, present and future. *The European Journal of Contraception & Reproductive Health Care, 24*(1), 80-82. https://doi.org/10.1080/13625187.2018.1563067

International Labour Organization. (2022, August 11). Recovery in youth employment is still lagging, says ILO. https://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_853078/lang--en/index.htm

International Planned Parenthood Federation (2012). *Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia*. https://eeca.unfpa.org/sites/default/files/pub-pdf/Rep_Keyfactorsinflcontractusein7ctries_Dec2012.pdf

Kofinas, J. D., Varrey, A., Sapra, K. J., Kanj, R. V., Chervenak, F. A., & Asfaw, T. (2014). Adjunctive social media for more effective contraceptive counseling: A randomized controlled trial. *Obstetrics and Gynecology (New York. 1953), 123*(4), 763-770. https://doi.org/10.1097/AOG.0000000000000172

Le Guen, M., Schantz, C., Régnier-Loilier, A., & de La Rochebrochard, E. (2021). Reasons for rejecting hormonal contraception in western countries: A systematic review. *Social Science & Medicine, 284*, 114247. https://doi.org/10.1016/j.socscimed.2021.114247

Merz, A. A., Gutiérrez-Sacristán, A., Bartz, D., Williams, N. E., Ojo, A., Schaefer, K. M., Huang, M., Li, C. Y., Sandoval, R. S., Ye, S., Cathcart, A. M., Starosta, A., & Avillach, P. (2021). Population attitudes toward contraceptive methods over time on a social media platform. *American Journal of Obstetrics and Gynecology, 224*(6), 597.e1-597.e14. https://doi.org/10.1016/j.ajog.2020.11.042

Michielsen, K., Farje De la Torre, F., & Selznick, E. (2022). *Contraceptive use and awareness among young people in the European region*. European Parliamentary Forum for Sexual and Reproductive Rights. https://www.epfweb.org/sites/default/files/2022-10/CC%20Awareness-Report_final.pdf

Parliamentary Assembly (2020). *Empowering women: Promoting access to contraception in Europe* (Resolution No. 2331). https://pace.coe.int/en/files/28675/html

Schneider-Kamp, A., & Takhar, J. (2023). Interrogating the pill: Rising distrust and the reshaping of health risk perceptions in the social media age. Social Science & Medicine (1982), 331, 116081. https://doi.org/10.1016/j.socscimed.2023.116081

Selznick, Erica (2023). *Perspectives on Hormonal Contraception: An Analysis Among Young Adults in the European Region. A secondary analysis of Contraceptive use and awareness among young people in the European region.* (Unpublished master's thesis). Johns Hopkins Bloomberg School of Public Health.

Svahn, S., Niemeyer Hultstrand, J., Tydén, T., & Ekstrand Ragnar, M. (2021). Contraception use and attitudes: Women's concerns regarding hormonal contraception and copper intrauterine devices. *The European Journal of Contraception & Reproductive Health Care, 26*(6), 473-478. https://doi.org/10.1080/13625187.2021.1975267

Authors

Erica Selznick, Centre for Population, Family and Health, Department of Sociology, Faculty of Social Sciences, University of Antwerp. Selznick has a Master of Science in Public Health and a Bachelor of Arts in Public Health. She is a sexual and reproductive health researcher focusing primarily on contraception and pleasure-based approaches in sexuality education and health care services.

Leonidas Galeridis, European Parliamentary Forum for Sexual and Reproductive Rights. Galeridis holds a Bachelor's Degree in Philosophy and History of Science from the University of Athens, and a Master's Degree in International Relations from the University of Strasbourg. He actively engages in advocacy efforts, supporting both national actors and members of the European Parliament working on SRHR, analyses policy developments, and conducts research on SRHR policies across Europe, with a focus on HPV prevention, contraception, and fertility treatments.

Kristien Michielsen, Institute for Family and Sexuality Studies, Department of Neurosciences, Faculty of Medicine, KU Leuven. Prof. Michielsen has a Master's Degree in Political and Social Sciences and a PhD in Social Health Sciences. She has been doing interdisciplinary research on adolescent sexual and reproductive health since 2006, with a specific focus on sexuality education. She worked on this study for the EPF as an independent consultant.
contact: Kristien.Michielsen@kuleuven.be

Citation

Selznick, E., Galeridis, L., & Michielsen, K. (2024). Perspectives on hormonal contraception among young adults in the European Region, *FORUM sexuality education and family planning: information service of the Federal Centre for Health Education (BZgA), 2*, 37–47. https://doi.org/10.17623/BZgA_SRH:forum_2024-2_en_art_hormonal-contraception-eu

Insights into the Swiss LGBTIQ+ Panel: key findings

Tabea Hässler, Léïla Eisner

A few years ago we noticed the lack of data about the situation of lesbian, gay, bisexual, trans, intersex and queer (LGBTIQ+) people in Switzerland. This was something we wanted to change and that prompted us to set up the Swiss LGBTIQ+ Panel in 2019. This research project is dedicated to understanding the experiences, challenges and aspirations of LGBTIQ+ people in Switzerland.

Of central importance is the fact that the longitudinal nature of this study makes it possible to see how changes in the legal and social climate affect LGBTIQ+ people over time. Significant effort was also put into including the various subgroups of the LGBTIQ+ community, as well as participants from all regions of Switzerland. The findings are used by researchers, LGBTIQ+ organizations and institutional stakeholders, providing insights into coming out, discrimination, social inclusion and health through annual surveys. This paper presents the key findings from the 2023 annual survey – the fifth wave of the Swiss LGBTIQ+ Panel (for the whole report, see Eisner & Hässler, 2024). The topics covered include coming out, conversion therapy, discrimination, hate crimes and health.

The 2023 annual report included data collected from January 2023 to August 2023. In order to address the specific challenges faced by different subgroups within the LGBTIQ+ community, tailored versions of the questionnaire were designed for sexual minorities (e.g. gay, lesbian, bisexual, pansexual or asexual individuals) and gender minorities (e.g. trans, non-binary or intersex individuals). Interested cisgender endosex heterosexual (hereafter cis-heterosexual) individuals were also invited to participate. It is important to note that individuals can belong to both sexual and gender minority groups. To minimize the time required to finish the survey, participants completed only one version of the questionnaire. All versions were available in German, French, Italian and English. Former participants were recontacted via email, and new participants were informed through posts, articles, newsletters, and chats from LGBTIQ+ and other organizations. Importantly, the sample represents a wide range of sexual orientations, gender identities, sex characteristics, age groups, educational levels, and regions of Switzerland. Although the aim was to encompass diverse subpopulations within the LGBTIQ+ community across Switzerland and to be sensitive to intersecting identities, the data are not representative. Younger individuals, people with higher levels of education and residents of urban areas were over-represented. This report presents descriptive statistics derived from the 2023 survey. Please note that the central aim of this paper is to make the data accessible to the general audience. For this reason, statistics that are available in our published peer-reviewed journal articles are not provided here.

TABLE 1

CHARACTERISTICS OF SURVEY RESPONDENTS

Participants by	*TOTAL*	*HOMO-SEXUAL*	*BI-SEXUAL*	*PAN-SEXUAL*	*HETERO-SEXUAL*	*ASEXUAL*	*OTHER*
Sex. orien. %	*100*	*42.3%*	*18.7%*	*12.3%*	*13.1%*	*5.7%*	*8.0%*
N	*2,812*	*1,190*	*525*	*346*	*367*	*159*	*225*

Participants by	*CIS WOMAN*	*CIS MAN*	*TRANS WOMAN*	*TRANS MAN*	*NON-BINARY*	*OTHER*
Gender %	*39.8%*	*33.4%*	*4.3%*	*3.8%*	*15.0%*	*3.6%*
N	*1,120*	*940*	*121*	*108*	*423*	*100*

Participants by	*INTERSEX*	*ENDOSEX (NOT INTERSEX)*
Intersex %	*1.0%*	*99.0%*
N	*28*	*2,784*

Participants by	*Under 20*	*20-29*	*30-39*	*40-49*	*50-59*	*Over 60*
Age group %	*8.3%*	*40.0%*	*24.8%*	*12.4%*	*8.3%*	*6.3%*
N	*232*	*1,124*	*698*	*347*	*232*	*177*

Participants by	*GERMAN*	*FRENCH*	*ITALIAN*	*ROMANSH*	*BILINGUAL*
Geo area %	*65.9%*	*27.6%*	*2.4%*	*0.5%*	*3.5%*
N	*1,854*	*777*	*68*	*15*	*95*

Participants by	*NO UNI*	*UNI DEGREE*	*OTHER*
Education %	*38.5%*	*56.0 %*	*5.4%*
N	*1,082*	*1,575*	*153*

Participants by	*ATHEIST*	*CATHOLIC*	*PROTESTANT*	*JEWISH*	*MUSLIM*	*BUDDHIST*	*OTHER*
Religion %	*66.0%*	*11.3%*	*12.5%*	*0.8%*	*0.5%*	*1.1%*	*7.8%*
N	*1,855*	*317*	*352*	*22*	*14*	*30*	*220*

Note: Percentages have been rounded and may not add up to 100%.
Source: Adapted from Eisner and Hässler (2024)

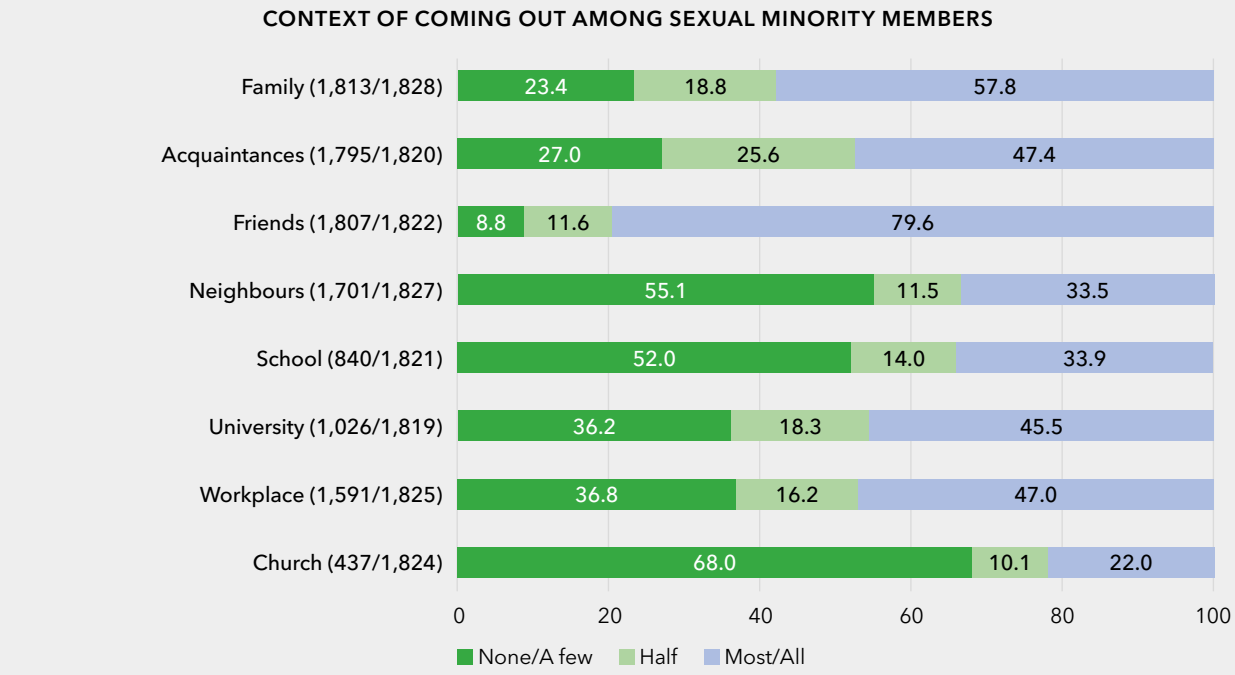
Participants

A total of 2,812 people were included in the 2023 annual report: 1,825 filled out the sexual minority version of the questionnaire, 648 the gender minority version, and 339 the cis-heterosexual version. People from all Swiss Cantons participated in the survey, although respondents from Zurich were over-represented. Table 1 below shows a summary of the participants' sexual orientation, gender identity, intersex status, age group, geographical area, education and religion.

Results of the 2023 Survey

The following sections of this paper present the findings on people's coming out, their exposure to

FIGURE 1



Data in percent
Source: Adapted from Eisner and Hässler (2024)

conversion therapies, experienced discrimination, hate crimes and interactions with the police, and respondents' self-reported health.

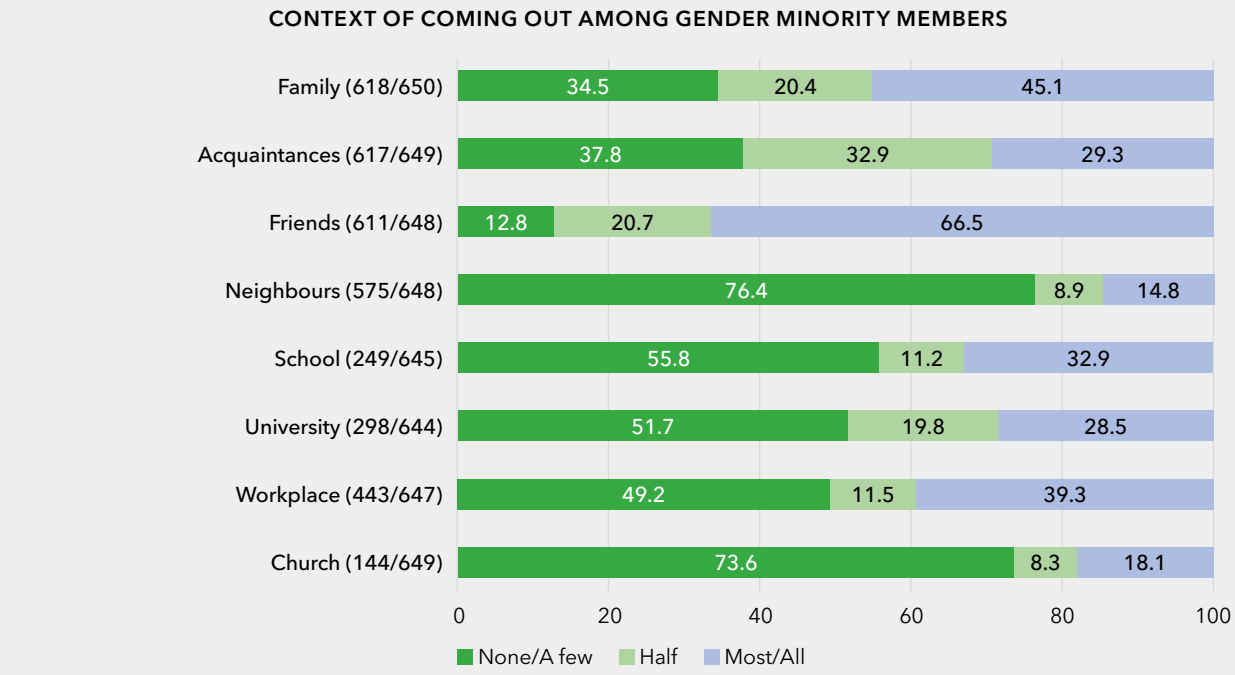
Context of coming out

First of all, survey respondents were asked in which contexts they were open about their sexual or gender identity and to how many people they had come out. Importantly, one's sexual orientation and/or gender identity might not always be relevant and people might not feel the need to come out. However, this measure still provides a valid estimate of how openly people are able to talk about their identity and current relationships/activities. The answers were grouped into three categories, depending on the amount of people respondents had come out to: (1) None or a few people, (2) Approximately half of the people, and (3) Most/all people. The results are shown separately for sexual minority (see Figure 1) and gender minority members (see Figure 2).

It is important to bear in mind that respondents could also choose that a context was not applicable to them (e.g. if they were not attending a school). Therefore, the valid number of responses varies between contexts. The number in the brackets represents the total number of participants answering the question.

As in previous years, participants were most open about their sexual orientation towards their friends and families (see Figure 1 below). Less than half of the respondents to whom the categories acquaintances, university and workplace were applicable had come out to most/all people. Furthermore, most participants did not (or only very selectively) reveal their sexual orientation in the school context (52.0%) and to their neighbours (55.1%). Finally, two thirds (68.0%) of the respondents to whom the category church/religious organization was applicable had not come out in this context.

FIGURE 2



Data in percent
Source: Adapted from Eisner and Hässler (2024)

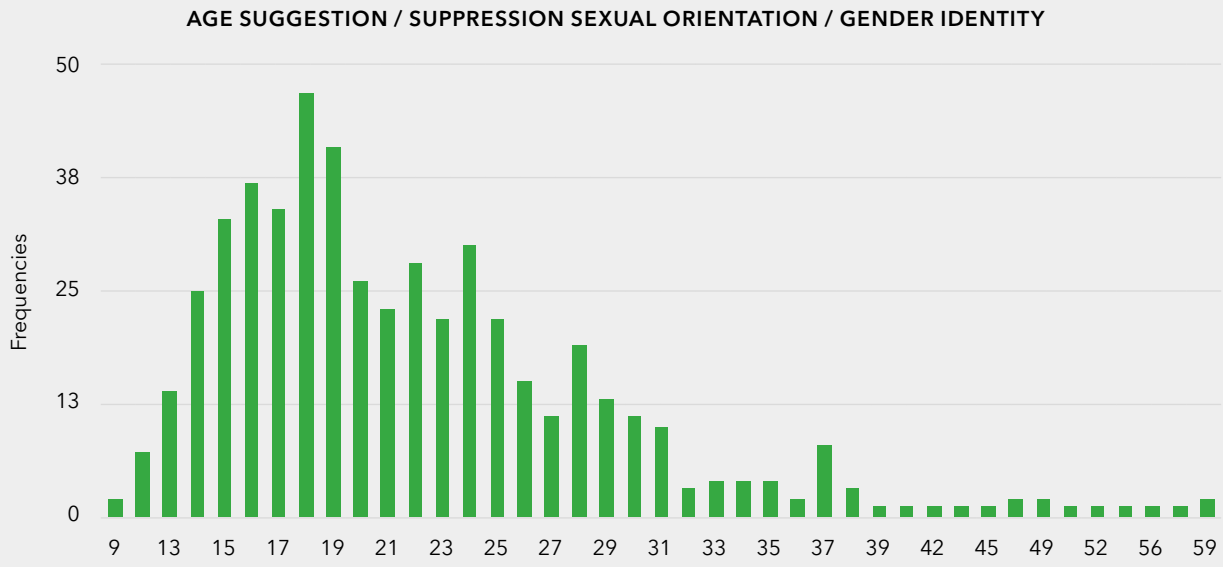
Members of gender minorities (see Figure 2 below) were on average less likely to reveal their gender identity than sexual minority members were to reveal their sexual orientation. Approximately two thirds (66.5%) of respondents had come out to most/all their friends. About half (45.1%) of the gender minority respondents had come out to most/all family members. In workplace, university, school and church contexts as well as towards their neighbours, gender minorities were particularly guarded: between half and two thirds of respondents revealed their gender identity to (almost) no one.

Exposure to so-called "Conversion Therapies"

Research indicates the benefits when LGBTIQ+ people feel they do not need to conceal their identity, but instead can live their lives authentically. Yet, the decision to disclose their identity is significantly affected by the societal climate, proximal climate, and the reactions of those surrounding them (Hässler et al., in preparation). Moreover, LGBTIQ+ people might not always feel safe to disclose and may even be pushed to change or suppress their sexual orientation and/or gender identity.

The term "conversion therapy" describes any attempt to change a person's sexual orientation, gender identity or expression, or any component of these. Importantly, these "conversion therapy" practices are not "therapies" and can do serious long-term damage. They are often conducted by laypersons (such as religious leaders) without any medical or psychological training. The scientific evidence relating to these so-called "conversion therapies" and their harm is clear: attraction to the same gender or multiple genders, gender nonconformity, and identification as a sexual and/or gender minority are not illnesses and do not need treatment (see factsheet on "Conversion Therapies", Hässler & Eisner, 2023a). Many psychological and medical societies,

FIGURE 3



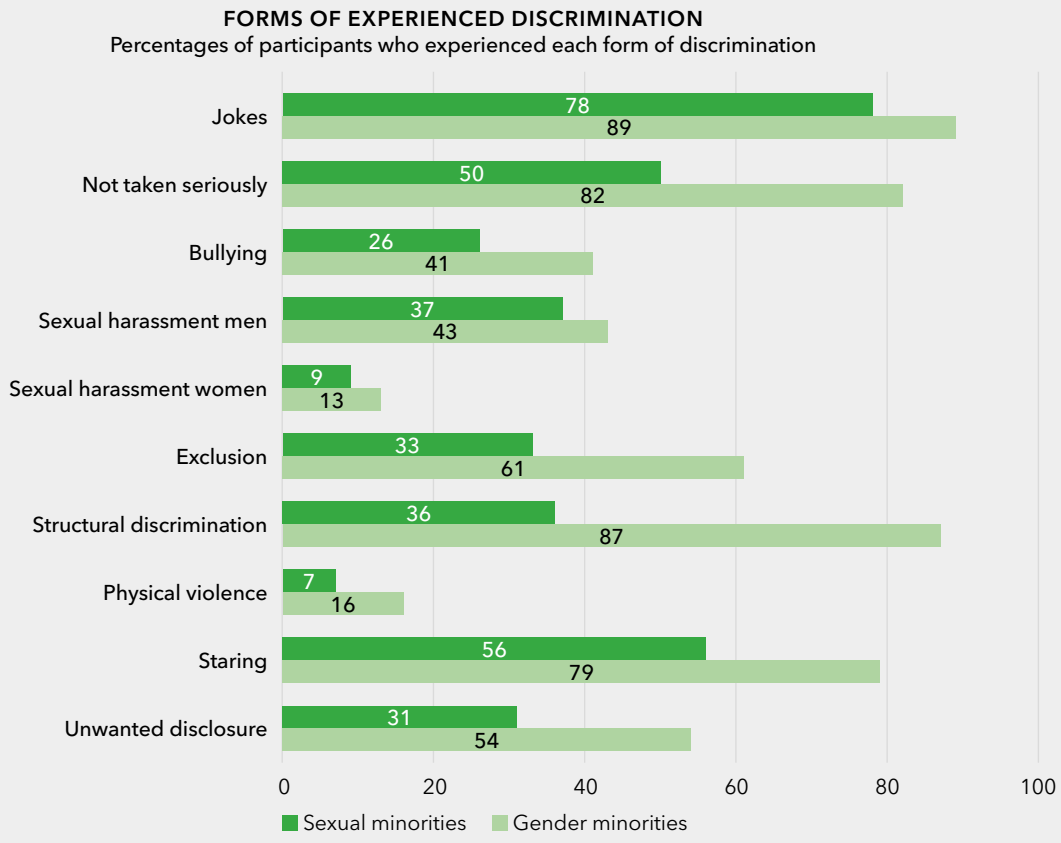
Source: Adapted from Eisner and Hässler (2024)

including the Swiss Psychological Association, have therefore clearly distanced themselves from "conversion therapies" and are in favour of a ban. While "conversion therapies" are illegal in Germany, their prohibition in Switzerland at both the regional (partly already done, partly rejected, partly ongoing) and the national level is currently under discussion.

Due to the limited amount of in-depth data on this issue, questions about "conversion therapies" were included in the 2023 survey. Participants were asked if they had experienced any attempts to alter or conceal their sexual orientation or gender identity. The findings from the survey show that 9.5% of the sexual minority members and 15.5% of gender minority members reported having participated in efforts to change or suppress their sexual orientation and/or gender identity. Figure 3 illustrates the ages at which individuals reported the experience of being offered suggestions aimed at changing or suppressing their sexual orientation and/or gender identity, or when they participated in such efforts. The results indicate that most of these attempts occurred before the age of 20, a time when LGBTIQ+ individuals are particularly vulnerable because they have often not yet come out publicly or have only come out in a very limited way. Indeed, a large European study found that on average people realize that they are members of a sexual minority at the age of 14.8 years. On average, they first come out 3.9 years later, at 18.5 years (Layland et al., 2023). As a result, they lack a support network from the LGBTIQ+ community and other allies.

Participants who reported efforts to change or suppress their sexual orientation and/or gender identity were asked in a follow-up question to specify when this occurred. They were also given the option of providing additional context about the circumstances. Details of these responses are provided below. The contexts mentioned (see example quotes below) included various religious institutions (such as evangelical churches, the Catholic church, free churches and Scientology), educational settings (including sex education and religious teaching), therapy settings (psychiatrists), medical settings (involving doctors and osteopaths), and family settings (parents, siblings and grandparents). Below

FIGURE 4



Data in percent
Source: Adapted from Eisner and Hässler (2024)

are some of the answers provided by the survey participants:

"Several times! But the traumatic moments were in the fall of 2017 when I participated in a 'Torrents of Life' [Evangelical group based in Geneva] style course… but under another name that I don't remember! And a discussion with my pastor in fall 2020 where he suggested I 'keep praying' for my sexual orientation to change!"

"In sex education class we had a very Christian, orthodox teacher who introduced us to a woman who claimed to have been a lesbian previously and told us how she managed to no longer be a lesbian. (approx. 2013)"

"Two phases: 1.) My efforts: a special year of prayer between 15 and 16. It didn't bring the desired result, but a much better one: the realization that I'm gay and want to make the best of it. 2.) When I was around 18, my parents wanted clarity and sent me to a psychiatrist. He tried – gently – to get me on the heterosexual path. He was loyal to the Pope, which I didn't know during the treatment."

"2008. My mother wanted me to see an osteopath who wanted to get me to listen to music to 'calm me down' and get out of homosexuality."

Experienced Discrimination

A large body of research indicates that in addition to the daily upsets experienced by everyone,

LGBTIQ+ people face discrimination and structural inequalities due to their sexual orientation, gender identity, and/or sex characteristics (i.e. minority stressors; Meyer, 2003). To assess the prevalence of LGBTIQ+-specific discrimination, both sexual and gender minority members were asked to indicate how often they had experienced different types of discrimination due to their LGBTIQ+ identity in the past 12 months (see Figure 4). The answers were grouped into two categories: (1) Yes, experienced discrimination, and (2) No, experienced no discrimination. Most members of both sexual and gender minorities reported having been exposed to jokes and being stared at in public spaces. Furthermore, more than one-third of sexual minority (37.3%) and gender minority (42.6%) members reported having experienced sexual harassment by men. Additionally, a large majority of gender minority members reported structural discrimination (86.6%), that their gender identity was not taken seriously (81.8%), and that they were socially excluded because of their identity (61.0%). Significantly, 16.0% of gender minority members and 7.4% of sexual minority members reported being targets of physical violence within the last year. As was the case in previous years, gender minority members are very often the target of discrimination, which stands in stark contrast to the lack of protection against acts of discrimination on the grounds of a person's gender identity.

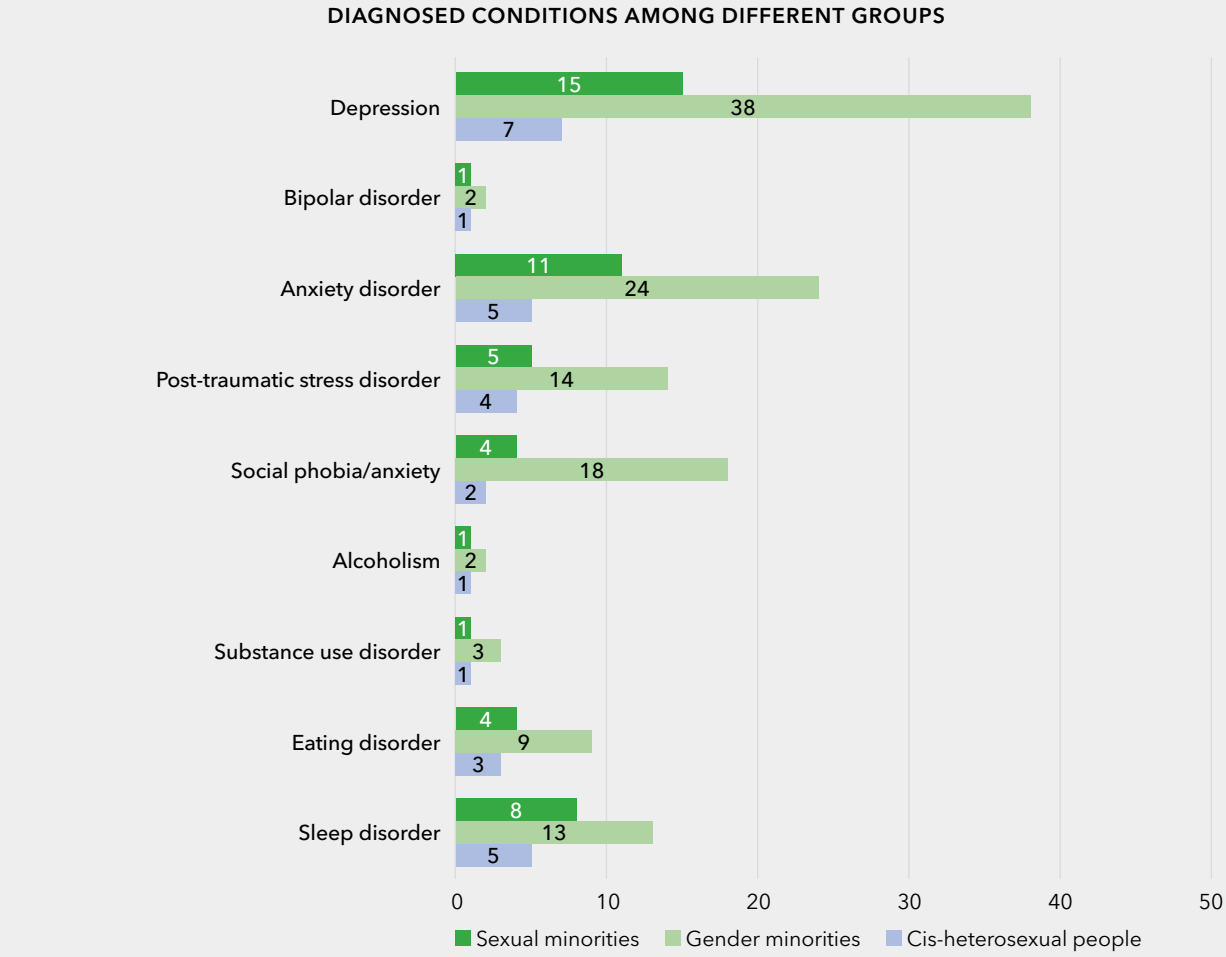
Hate Crimes and Interactions with the Police

Another central theme of the 2023 annual survey was the experiences of hate crimes among sexual and gender minority members. There is currently no systematic assessment of hate crimes against LGBTIQ+ people in Switzerland. For this reason, participants were asked to indicate whether they had ever experienced a hate crime based on their sexual orientation, gender identity, and/or intersex status. For sexual minority members, 10.7% indicated that they had personally been the target of a hate crime, with an additional 11.8% being unsure and 77.6% reporting having not faced such incidents. Among those who had experienced a hate crime only 26.4% reported the crime to the police. The results were even more pronounced when it came to gender minority members. 17.7% reported having experienced a hate crime, 21.8% were unsure, and 60.5% had not faced such a situation. Similarly, among those who had encountered hate crimes only 22.1% reported it to the police. The reasons behind the decision not to report the crime were multifaceted.

A prevalent theme was the lack of trust in law enforcement and the pervasive fear of facing further discrimination. For example, one participant stated that they weren't "treated well by the police," while another said, "Threats to my life and physical violence were dismissed when I was younger; I don't trust them [the police] with the discrimination I face on top today." Similarly, someone else stated, "I don't think the police take threats of sexual assault against women and trans people seriously." Other participants expressed skepticism about the effectiveness of reporting the crime, citing the absence of pertinent statistics or legal protections against discrimination based on gender identity. "There is no distinction in law around hate crimes for trans people. It wasn't worth going through the trouble of reporting [it] if all they could face was a fine." Finally, some participants revealed that they had not even considered reporting the hate crime because they were in a state of panic: "I was in a panic; it didn't occur to me. I had to quickly seek shelter with my partner." Others considered the crime not serious enough: "It was insults, mockery, and twice intimidation (by two men). I did not dare. It wasn't 'serious enough.'" These narratives shed light on the complex dynamics surrounding the (non-)reporting of hate crimes, underscoring the need for enhanced trust-building, increased sensitization among police forces, and a more supportive environment for those who have faced such traumatic experiences. One of the aims of the survey was to investigate participants' perceptions of the police in more detail and thus shed light on the complex relationship between the law enforcement system and the LGBTIQ+ community.

For example, participants were asked how likely it was that they "would…hide their sexual orientation or gender identity in interactions with the police due to fear of discrimination?" on a scale of 1 (does not apply at all) to 7 (fully applies). The responses revealed that sexual minority members were rela-

FIGURE 5



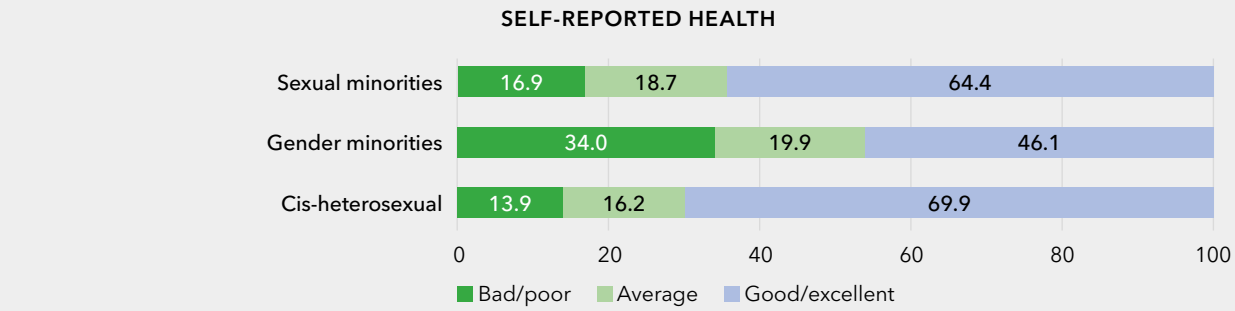
Data in percent
Source: Adapted from Eisner and Hässler (2024)

tively neutral on this matter (M = 3.6), while gender minority members (M = 5.1) were more hesitant to be open about their gender identity during interactions with the police, fearing potential discrimination. Participants were also asked whether they perceived that the police treat LGBTIQ+ individuals with less respect than cis-heterosexual people on a scale of 1 (strongly disagree) to 7 (strongly agree). The findings suggest that both cis-heterosexual (M = 4.2) and sexual minority participants (M = 4.0) were neutral in their perceptions, indicating that sexual minority members perceive the Swiss police as relatively trustworthy. On the other hand, gender minority members (M = 5.0) felt that, to some extent, the police treat LGBTQ+ community members with less respect than cis-heterosexual individuals.

Self-reported Health

The final theme of the 2023 survey was that of participants' health. The participants were asked about various health conditions diagnosed by a healthcare provider. The results, displayed in Figure 5, reveal the proportion of participants reporting each condition, categorized by sexual minority, gender minority, and cis-heterosexual groups. LGBTIQ+ participants, particularly those who identify as

FIGURE 6



Data in percent
Source: Adapted from Eisner and Hässler (2024)

trans, non-binary, or intersex (i.e. gender minority members), are more likely to have been diagnosed with various conditions. This trend is especially pronounced for conditions like depression, anxiety disorders and social phobia. For example, gender minority participants were five times as likely and sexual minority participants were twice as likely to report depression compared with cis-heterosexual participants. Importantly, the data also suggests differences amongst sexual minority members: bisexual and pansexual individuals experience poorer health compared with lesbian women and gay men.

Participants were asked to rate their health over the past 12 months. The answers were grouped into three categories: (1) Bad or poor health, (2) Neither bad nor good health, and (3) Good or excellent health. As in past years, the results displayed in Figure 6 reveal a health gap – one in three gender minority members (34.0%), one in six sexual minority members (19.6%), and one in seven cis-heterosexual participants (13.9%) reported "poor health". These results thus reveal significant health disparities between LGBTIQ+ and cis-heterosexual individuals. However, it is interesting to note that these gaps are significantly wider among gender minority members, while sexual minority members and cis-heterosexual individuals only showed minor differences. This raises the question as to which factors contribute to these health gaps.

Conclusion

In conclusion, the data, gathered from a large sample of LGBTIQ+ and cis-heterosexual individuals across all Cantons in Switzerland, underscore that LGBTIQ+ individuals do not fully disclose their identities in all contexts. Furthermore, some LGBTIQ+ people are still exposed to suggestions to change or to suppress their identities, including efforts to conform to heterosexual and/or cisgender norms, especially in religious, medical and educational settings. There is robust scientific evidence that so-called "conversion therapies" cannot alter individuals' sexual orientation and/or gender identity but rather have harmful effects on LGBTIQ+ individuals (for more detailed information see our fact sheet on "conversion therapies" available in English, German, French and Italian, Hässler & Eisner, 2023a). Leading psychological associations – such as the Swiss Professional Association for Applied Psychology and the German Society of Psychology – emphasize that these practices violate ethical guidelines and advocate for their prohibition. While Germany has already implemented such bans, Switzerland is still debating whether to impose a nationwide prohibition of conversion therapies. It is important to note that gender minority members are especially vulnerable.

Many LGBTIQ+ participants have encountered discrimination based on their sexual orientation and/or gender identity in the past year. These experiences

ranged from subtle instances like jokes to more overt forms such as harassment and physical violence. Again, it is important to note that gender minority members are especially vulnerable. This highlights the critical need for legislative action, seeing that existing anti-discrimination laws in Switzerland only safeguard against discrimination based on sexual orientation and do not include protections for gender identity. Consequently, our data reveal that gender minority members exhibit lower levels of trust in the police and are less inclined to disclose their gender minority identity to law enforcement agencies compared with sexual minority and cis-heterosexual participants. This reluctance may stem from the belief that the police cannot (due to the legal situation) help or will not help, coupled with the fear of encountering further discrimination.

Finally, the data (Eisner & Hässler, 2024) and the results of an LGBT study on behalf of the Federal Office of Public Health in Switzerland (Krüger et al., 2022) reveal health disparities between cis-heterosexual and LGBTIQ+ individuals. Within the LGBTIQ+ community disparities also emerge, with our and other research showing that bisexual and pansexual individuals are more vulnerable compared with lesbian women and gay men. Furthermore, health disparities are particularly pronounced among gender minority members, such as trans, non-binary, and intersex people. Additionally, early surgeries on intersex children continue to be performed in Switzerland, even when they are medically unnecessary and irreversible. Despite warnings from various medical associations and international bodies – including the American Academy of Family Physicians, Human Rights Watch, Physicians for Human Rights, the United Nations, and the World Health Organization – against non-consensual medical interventions and recommendations for deferring unnecessary surgeries until the child can participate in decision-making, Switzerland has not banned medically unnecessary interventions on intersex children (for more details see our fact sheet on prohibition of non-consensual medical treatment of intersex children available in English, German, French, and Italian, Hässler & Eisner, 2023b). This practice violates their autonomy and physical integrity and has been banned in Germany.

A substantial body of research indicates that the health gap among LGBTIQ+ people can be attributed to exposure to structural inequalities and discrimination based on sexual orientation, gender identity, and/or sex characteristics. Despite legal advancements such as marriage equality and easier gender changes in official documents, structural inequalities, marginalization, and discrimination against gender and sexual minorities – known as minority stressors – persist in Switzerland as highlighted by our data. Furthermore, there is a lack of legislation prohibiting non-consensual medical interventions on intersex people and conversion therapies. Gender minority members are also not protected by anti-discrimination laws. These minority stressors are widely recognized as the primary factors contributing to the health gap among LGBTIQ+ individuals (Frost & Meyer, 2023; Hinton et al., 2022). Research increasingly shows that individuals who experience discrimination based on their LGBTIQ+ identity are more likely to suffer from depression and anxiety, conditions that were notably prevalent among our LGBTIQ+ participants, alongside various other physical health issues. Furthermore, not only minority stress but also the lack of social safety can contribute to health inequalities among sexual and gender minorities. Social safety encompasses "social connection, social inclusion, social protection, social recognition, and social acceptance" (Diamond & Alley, 2022).

Importantly, individual and institutional support and safety cues can help mitigate the detrimental effects of discrimination and thus potentially narrow the health gap. Therefore, healthcare providers and institutions need to provide tailored support to LGBTIQ+ individuals. However, data indicate that many health practitioners have little to no training in the specific needs of LGBTIQ+ people (Dullius et al., 2019). Furthermore, many forms still adhere to binary gender classifications, reflecting a limited awareness of gender minority individuals. Similarly, women are often asked about their male partners and men about their female partners, disregarding the reality that not everyone is in a heterosexual relationship or that bi- and pansexual people may have partners of different genders. Unsurprisingly, our previous survey indicated that 20.0% of the sex-

ual minority participants and 57.1% of the gender minority participants had experienced discrimination in hospitals within the last 12 months (Eisner & Hässler, 2021). This creates an environment in which LGBTIQ+ people may not feel safe disclosing their identity to medical staff or may even refrain from visiting a doctor. Implementing simple steps could demonstrate LGBTIQ+ awareness and foster a welcoming atmosphere, such as asking how individuals prefer to be addressed (e.g., Mr., Mrs., or using neutral terms with their first and last name), inquiring about relationship status without assuming the gender of their partner, and providing brochures specifically tailored for LGBTIQ+ people, all of which would signal awareness. It is also of utmost importance to train healthcare professionals in LGBTIQ+ issues during their vocational education, and to ensure that unconscious bias is also addressed. This would ensure that health services are accessible to all individuals, regardless of their sexual orientation, gender identity, and sex characteristics.

Future Directions of the Swiss LGBTIQ+ Panel

A central goal of the Swiss LGBTIQ+ Panel is not only to enhance academic understanding of LGBTIQ+ issues but also to empower policymakers, organizations and the general population to make informed decisions that foster a more inclusive and equitable society in Switzerland and beyond. Moving forward, we intend to prioritize health-related behaviours and outcomes, specifically addressing the unique needs of LGBTIQ+ individuals and their families in end-of-life and palliative care, as well as the needs of LGBTIQ+ adolescents. To achieve this we have gathered both survey and biological data, including cortisol and cortisone values (see Eisner et al., 2024). Our collaboration with healthcare professionals from the Psychiatric University Hospital Zurich, the palliative care unit at CHUV in Lausanne, and international researchers aims to integrate our expertise in LGBTIQ+ issues with medical knowledge. We anticipate that this collaboration will provide valuable insights for scientists, healthcare practitioners, LGBTIQ+ associations and the general public.

If readers want to know more about our research work, we invite them to visit our website (www.swiss-lgbtiq-panel.ch) or check out our social media accounts. Here you can learn more about our fact sheets (e.g., on medical interventions on intersex people or so-called "conversion therapies"), our published and ongoing research, interviews, workshops, and the talks we have given to the media, companies, institutions, universities, and at international conferences, and much more.

References

Diamond, L. M., & Alley, J. (2022). Rethinking minority stress: A social safety perspective on the health effects of stigma in sexually-diverse and gender-diverse populations. *Neuroscience & Biobehavioral Reviews, 138*, 104720. https://doi.org/10.1016/j.neubiorev.2022.104720

Dullius, W. R., Martins, L. B., & Cesnik, V. M. (2019). *Systematic review on health care professionals' competencies in the care of LGBT+ individuals*. Estudos de Psicologia (Campinas), 36, e180171. https://doi.org/10.1590/1982-0275201936e180171

Eisner, L., Fischer, S., Juster, R., & Hässler, T. (2024). *Can a referendum get under the skin? The effects of the Swiss marriage equality referendum on self-reported and biological stress among LGBTIQ+ and cis-heterosexual people*. Proceedings of the National Academy of Sciences. https://doi.org/10.1073/pnas.2400582121

Eisner, L. & Hässler, T. (2021). *Swiss LGBTIQ+ Panel – 2021 Summary Report*. https://doi.org/10.31234/osf.io/dq4eg

Eisner, L. & Hässler, T. (2024). *Swiss LGBTIQ+ Panel – 2023 Summary Report*. https://doi.org/10.31234/osf.io/5tz6u

Frost, D. M., & Meyer, I. H. (2023). Minority stress theory: Application, critique, and continued relevance. *Current Opinion in Psychology, 51*, 101579. https://doi.org/10.1016/j.copsyc.2023.101579

Hässler, T. & Eisner, L. (2023a). *The Facts About "Conversion Therapy" – What Science Tells Us*. Retrieved from https://swiss-lgbtiq-panel.ch/wp-content/uploads/2022/02/fact-sheet_konversionstherapie_en.pdf

Hässler, T. & Eisner, L. (2023b). *Prohibition of Non-Consensual Medical Treatment of Intersex Children*. Retrieved from https://swiss-lgbtiq-panel.ch/wp-content/uploads/2023/12/factsheet_intersex_EN-C.pdf

Hässler, T., Pasek, M., Eisner, L., Osin, E., M., Noor, M., Visintin, E. P., George, O., Hugues, J. C., Van Laar, C., Otten, S., Ummak, E., Cook, J., Rengers, J., & Sebben, S. (in preparation). *Charting course through stormy waters: selective disclosure among LGB+ individuals across relationship domains and geographic contexts*.

Hinton, J. D., De la Piedad Garcia, X., Kaufmann, L. M., Koc, Y., & Anderson, J. R. (2022). A systematic and meta-analytic review of identity centrality among LGBTQ groups: An assessment of psychosocial correlates. *The Journal of Sex Research, 59*(5), 568-586. https://doi.org/10.1080/00224499.2021.1967849

Krüger, P., Pfister, A., Eder, M., & Mikolasek, M. (2022). *Health of LGBT people in Switzerland: Summary of the final report*. Retrieved from https://www.bag.admin.ch/bag/en/home/strategie-und-politik/nationale-gesundheitsstrategien/gesundheitliche-chancengleichheit/forschung-zu-gesundheitlicher-chancengleichheit/gesundheit-von-lgbt-personen.html

Layland, E. K., Bränström, R., Murchison, G. R., & Pachankis, J. E. (2023). Kept in the closet: Structural stigma and the timing of sexual minority developmental milestones across 28 European countries. *Journal of Youth and Adolescence, 52*(10), 2012-2030. https://doi.org/10.1007/s10964-023-01818-2

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674. https://doi.org/10.1037/0033-2909.129.5.674

Authors

Dr Tabea Hässler, PhD, is a senior lecturer at the Institute of Social Psychology at the University of Zurich. Hässler's research focuses on responses to inequalities among members of diverse advantaged and disadvantaged groups (e.g. in the LGBTIQ+, gender and ethnic context) with a particular focus on the situation of LGBTIQ+ individuals in Switzerland and beyond. Hässler's work is influenced by research stays in and visits to several countries and various collaborations with academics from around the globe. One of the central aims of her work is to promote social justice within and beyond academia.
Contact: tabea.haessler@uzh.ch

Dr Léïla Eisner, PhD, is a senior researcher at the Institute of Social Psychology at the University of Zurich and co-leader of the Swiss LGBTIQ+ Panel. Eisner's research interest broadly involves intergroup relations and discrimination. A major focus of Eisner's research lies in the interplay between social change processes and norm (mis)perceptions in various situations, such as in the LGBTIQ+, gender, and environmental contexts.
Contact: leila.eisner2@uzh.ch

Citation

Hässler, T., & Eisner, L. (2024). Insights into the Swiss LGBTIQ+ Panel: key findings, *FORUM sexuality education and family planning: information service of the Federal Centre for Health Education (BZgA), 2*, 48–59. https://doi.org/10.17623/BZgA_SRH:forum_2024-2_en_art_LGBTIQ-ch

Insights from the Austrian LGBTIQ+ health report 2022

Johanna Pfabigan, Sylvia Gaiswinkler

This article discusses the Austrian LGBTIQ+ Health Report 2022, exploring healthcare experiences among sexual and gender minorities (SGMs). It reveals the challenges and disparities within the healthcare system, highlighting discrimination and mental health concerns. The conclusion emphasizes inclusive healthcare practices, stressing the importance of respecting the dignity and rights of all individuals, irrespective of sexual orientation or gender identity.

Introduction

Despite the growing recognition of sexual and gender minorities (SGMs) in society, certain marginalized communities still face significant barriers to accessing quality healthcare services. In the LGBTIQ+ Health Report 2022 (Gaiswinkler et al., 2023), we examined healthcare provision for lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ+)[1] individuals in Austria, aiming to uncover insights and address disparities within the healthcare landscape. This article summarizes key findings from the report, shedding light on the health and healthcare needs of SGMs. While our focus extends beyond sexual health, it is important to recognize that sexual health itself encompasses more than just physical functions and activities. Emotions, relationships and sexual identity are also crucial aspects. Gender identity and sex characteristics, like sexual orientation, are integral parts of an individual's sexual identity and thus of their overall well-being (Öffentliches Gesundheitsportal Österreich, 2021).

Recent literature underlines the stigmatization and discrimination frequently experienced by SGMs with respect to healthcare services, resulting in disparities in access, quality, and the availability of such services (Medina-Martínez et al., 2021; Zeeman et al., 2019). Discrimination mainly stems from heteronormative concepts and can manifest itself as stress, internalized stigmatization or victimization, which can have detrimental effects on SGMs' health (Zeeman et al., 2019).

The LGBTIQ+ Health Report 2022 covers the health status and discriminatory experiences of SGMs as well as health care and health-promoting factors (Gaiswinkler et al., 2023). Framed from a public health perspective, the report combines socioeconomic health determinants with a literature review and, most crucially, the results of a survey carried out with SGMs. An expert group supported the entire process.

Methodology

To collect first-time information on the health situation of SGMs in Austria we used a mixed-methods design incorporating both quantitative and qualitative

1 Although LGBTIQ+ is used in the title of the report, SGM is the more inclusive term.

TABLE 1

SAMPLE OF THE LGBTIQ+ HEALTH SURVEY

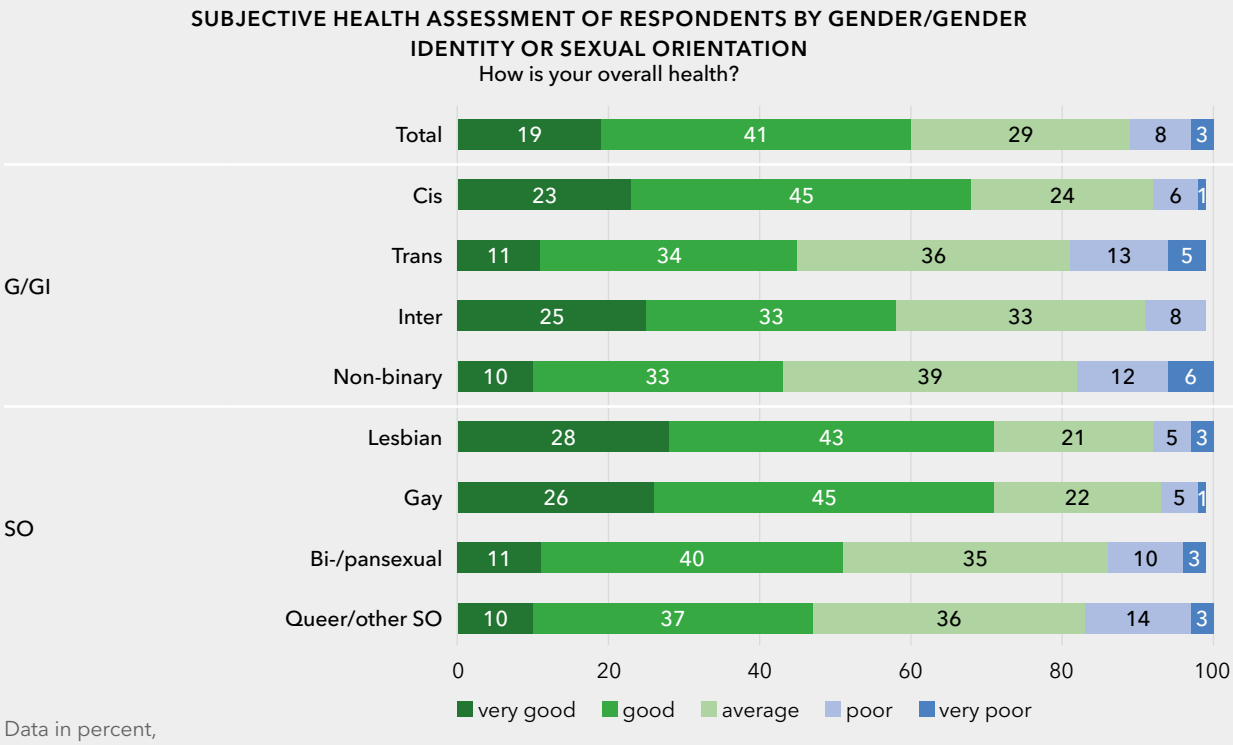
		n	%
Total		1.047	100
Gender identity (GI)	trans	195	19
	inter*	12	1
	non-binary	165	16
	cis	675	65
Sexual orientation (SO)	lesbian	227	22
	gay	278	26
	bi-/pansexual (polysexualities)	312	29
	queer/other	167	21
	heterosexual	18	2
Age in years	15–19	130	12
	20–29	408	39
	30–44	338	32
	45+	171	16
Highest educational attainment	no academic degree	491	47
	academic degree	548	52
Citizenship	Austrian	930	89
	foreign	117	11
Residential region	rural (up to 5,000 inhabitants)	114	14
	semi-urban (up to 500,000 inhabitants)	306	29
	urban (>500,000 inhabitants)	562	54
Employment status	employed	651	62
	in education/training	276	26
	not in education, employment or training	119	11
Income quartile	up to €1,500	368	35
	up to €2,000	176	17
	up to €3,000	259	25
	over €3,000	91	9
	no personal income	123	12

Source: Gaiswinkler et al. (2023); Totals may not add up to 100% due to rounding

approaches. After reviewing the literature, the survey questionnaire was developed in collaboration with an external research institute (Foresight; formerly SORA) and supported by an expert group. To facilitate the comparability of the results, some of the questions in the LGBTIQ+ survey were aligned with the Austrian Health Interview Survey (ATHIS). The data (n=1,047 SGM respondents) were collected between June and September 2022. As the SGM population in Austria is not known, this sample may not be representative. Table 1 lists the respondents' characteristics.

In September and October 2022 qualitative interviews were conducted via Zoom with 10 participants to explore hindering and facilitating factors for SGMs within the Austrian healthcare system.

FIGURE 1



Data in percent,
Source: Gaiswinkler et al. (2023); Totals may not add up to 100% due to rounding

Methodological note on gender identity and sexual orientation

Participants could provide multiple responses for their gender identity. For simplification, we condensed these responses into four groups: "trans" for those identifying as a trans woman, trans man, transgender, or expressing a trans identity in the free-text field; "inter*" for those identifying as intersex woman, intersex man, or inter*/intersex; "non-binary" for those identifying as non-binary, genderqueer, or using the free-text option without selecting intersex or transspecific categories; and "cis" for individuals identifying exclusively as binary female or male.

For sexual orientation, participants could not provide multiple responses, but 2% used the open-text field for more detailed descriptions. It is important to note that self-identifications hold personal significance and individual definitions may vary.

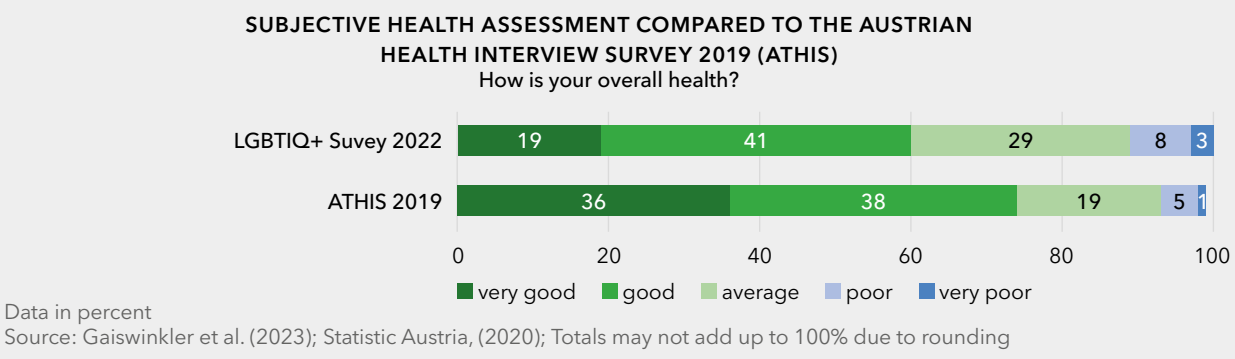
Findings

Self-perceived health status

When asked about their self-perceived health status, specifically, "How would you describe your overall health?", 60% of the participants responded with good/very good, while slightly less than a third rated it as average, and 11% rated it as poor/very poor (see Figure 1). Trans and non-binary individuals tended to rate their health status lower than the average. When analyzed by sexual orientation, individuals who identify as bi-/pansexual or queer/other SO were particularly affected by poor health: 13% of bi-/pansexual individuals and 17% of queer individuals rated their health as poor/very poor.

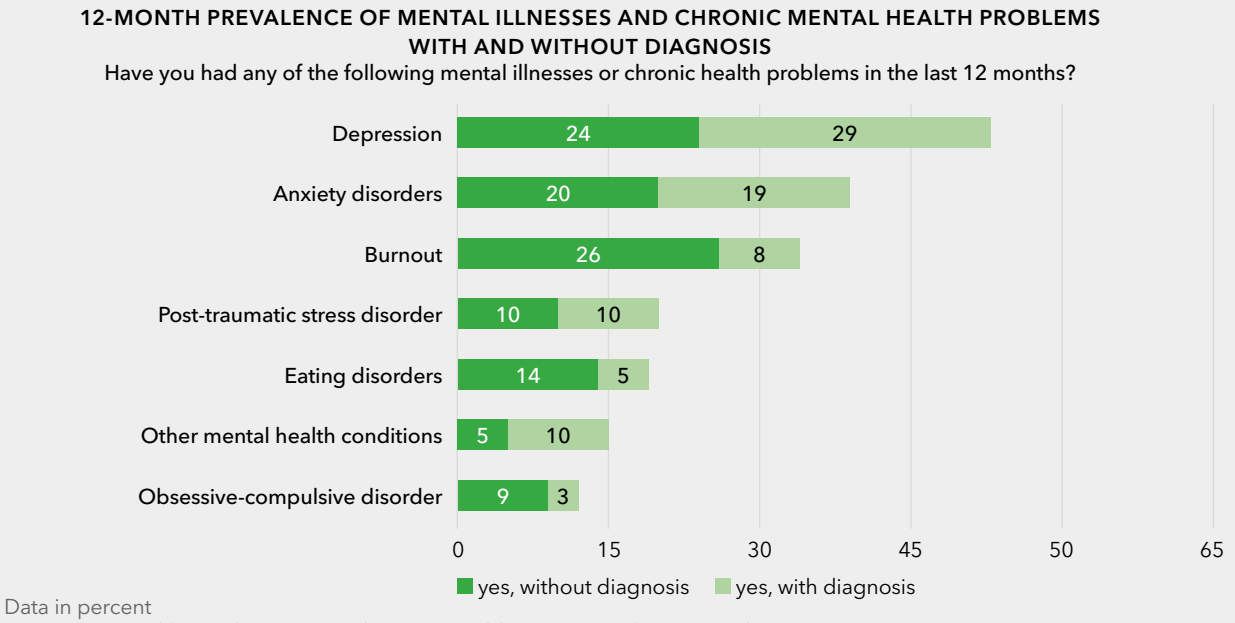
Figure 2 compares our results with data from the Austrian Health Interview Survey. Not as many participants in the LGBTIQ+ survey rated their health positively (60% good/very good) as the Austrian

FIGURE 2



Data in percent
Source: Gaiswinkler et al. (2023); Statistic Austria, (2020); Totals may not add up to 100% due to rounding

FIGURE 3



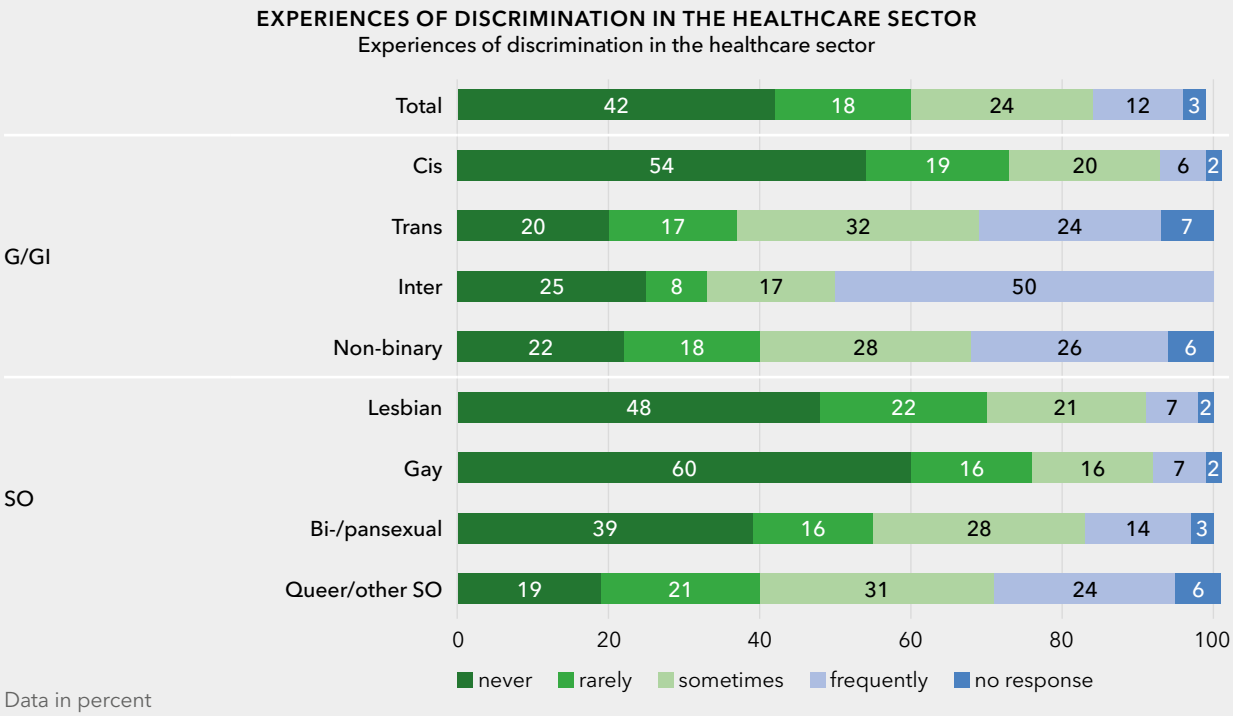
Data in percent
Source: Gaiswinkler et al. (2023); Totals may not add up to 100% due to rounding

population as a whole (74% good/very good). This indicates a potential disparity in self-perceived health status among SGM individuals compared to the general population.

Mental health

As shown in Figure 3, 53% of the participants had experienced depression, a prevalent mental health issue within the community. This figure reaches three-quarters among those aged 15 to 19 (30% with a diagnosis). Over one-third of all participants disclosed struggling with anxiety disorders, with 20% having a diagnosis. Thirty-four percent reported experiencing burnout, a phenomenon that dramatically affects general well-being although it is not classified as a distinct ICD-10 disease. One in five of the respondents revealed that they had suffered from post-traumatic stress disorder. Nearly

FIGURE 4



Data in percent
Source: Gaiswinkler et al. (2023); Totals may not add up to 100% due to rounding

20% of all respondents reported that they had experienced having eating disorders. This applied to 39% of those aged 15 to 19, with 9% having a diagnosis. Twelve percent of all respondents suffered from an obsessive-compulsive disorder, and 15% disclosed other mental health conditions or chronic health problems, including autism spectrum disorder and attention deficit hyperactivity disorder. These figures underscore the burden of psychological distress among SGMs.

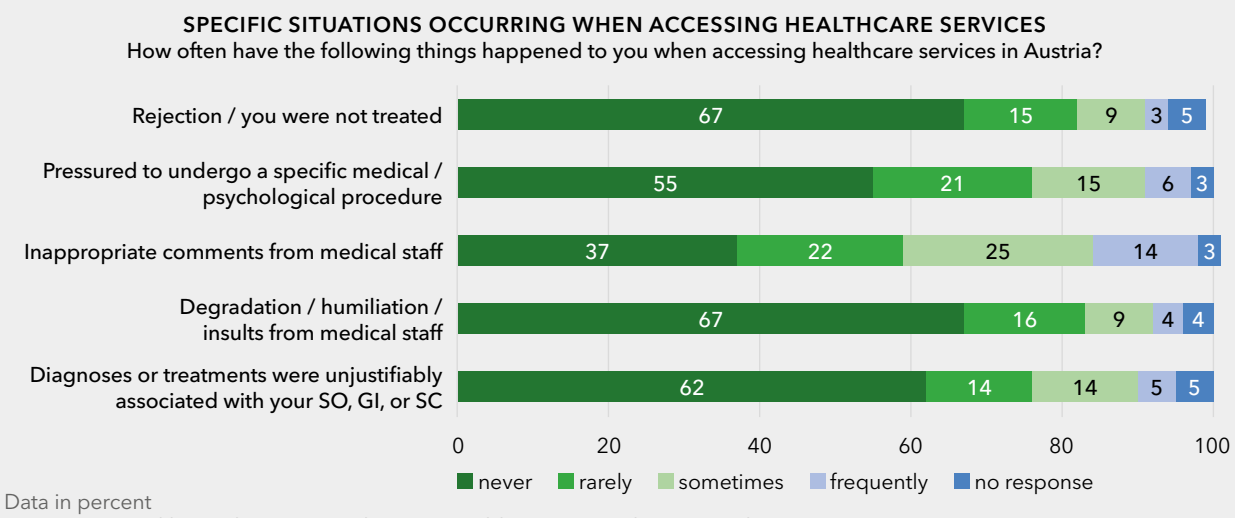
The link between minority stress experienced by SGMs and its adverse effects on mental health is well documented in the literature (Pellicane & Ciesla, 2022; Silveri et al., 2022). Minority stress encapsulates the strains and adversities resulting from stigma and discrimination, significantly impacting the mental health of SGMs. Elevated risks of depression and suicide associated with such stressors are particularly highlighted in the minority stress model (Pellicane & Ciesla, 2022).

Four items relating to suicidal behaviour were included. Two-thirds of participants admitted to having contemplated taking their own lives, with 40% confessing to having formulated plans for suicide and 14% to having attempted suicide. Forty-four percent disclosed engaging in self-harming behaviours. Reliable comparative data for suicide attempts in Austria are missing. While the official suicide rate stands at approximately 0.014%, undocumented cases are significantly higher (BMSGPK, 2022).

Discrimination experiences

Experiences of discrimination have multifaceted repercussions for affected individuals. Those who encounter discrimination are subjected to varying degrees of acute and chronic social stressors within a social hierarchy which can detrimentally affect their health (Allen, 2019). In addition, discrimination can lead to a deterioration in health status as access to resources in various life domains is significantly restricted due to discriminatory practices (Allen, 2019).

FIGURE 5



Data in percent
Source: Gaiswinkler et al. (2023); Totals may not add up to 100% due to rounding

We surveyed experiences of discrimination by asking the question: "When you think about the past two years, have you felt discriminated against in the following areas, regardless of whether it was due to your sexual orientation, gender identity, sex characteristics, or other characteristics?" Respondents reported experiencing discrimination in the areas of housing (19%), employment or when looking for a job (32%), education (29%), access to services (22%), contact with public authorities (22%), and online platforms or social media (54%).[2] Figure 4 shows the responses with respect to the healthcare system. More than half (54%) of the respondents reported feeling discriminated against at least occasionally in the healthcare sector in the past two years, with 12% indicating frequent experiences of discrimination during this period.

As Figure 4 illustrates, in the healthcare sector distinct groups are affected by discrimination to varying degrees. We observed similar patterns in other areas of life (see Gaiswinkler et al. (2023)). The data underscore that non-cis individuals experience high rates of discrimination. When analyzed by sexual orientation, this trend is notable among participants who do not identify as lesbian or gay.

We also inquired about the frequency of certain situations occurring when accessing healthcare services (see Figure 5).

One-third of respondents reported being denied treatment or rejected when accessing health care, 41% stated they had been pressured to undergo specific medical or psychological procedures against their will, 29% recounted experiences of humiliation and/or degradation, and 60% endured inappropriate comments from healthcare professionals.

About one-third disclosed instances in which diagnoses or treatments were unjustifiably linked to their gender identity, sexual orientation, or variations in sex characteristics (SC). These issues were also highlighted in individual interviews. For instance, one participant shared a humiliating encounter with a psychiatrist who was supposed to provide an assessment for their transition. The power imbalance and lack of alternatives in the region made the experience particularly distressing. Others described

2 These percentages include the response categories 'frequently' and 'sometimes'.

the burden of having to emotionally prepare for every medical appointment to be able to deal with potential inappropriate remarks.

Given the prevalence of discriminatory experiences described, it is important to consider their potential impact on participants' subsequent healthcare-seeking behaviours, particularly in terms of avoidance. Twenty-nine percent admitted to avoiding specialist physicians despite having health issues. One in four had avoided their general practitioner, while one in five had avoided psychosocial support services.

Finally, we would like to touch briefly on satisfaction with the healthcare system in Austria. Slightly more than half of all respondents were somewhat or very satisfied with the healthcare system while 16% were somewhat or very dissatisfied.

Interview-based perspectives on inclusive healthcare practice

We would like to underscore recommendations for healthcare providers stemming from insights gathered in the interviews. Many of the respondents expressed a desire for inclusive forms allowing them to specify their preferred salutation, be it Mr, Ms, gender-neutral, or their chosen name. Interviewees also emphasized that queer symbolism, when used discreetly, such as a Pride flag, could communicate a welcoming atmosphere for SGMs and have a profound impact on their well-being when accessing healthcare services. Several participants stressed the importance of healthcare professionals being sensitized to the needs, circumstances and realities of SGMs and voiced a desire to be taken seriously by medical staff. At a structural level, interviewees recognized the challenges of finding time within the existing system. Support from health insurance providers and an increase in the number of healthcare professionals could alleviate some of this strain.

Conclusion: Promoting inclusive healthcare for SGM individuals

The health and well-being of SGMs are shaped by a myriad of factors, including social, cultural, and institutional contexts. Until recently there has been a notable lack of data on the healthcare experiences of SGMs in Austria. Our survey sheds light on the various challenges and disparities they face within the healthcare system in Austria.

Despite limitations, such as the lack of a representative sample due to the unknown population of SGMs in Austria, our findings reveal significant insights into their health status and experiences.

In terms of their mental health, a substantial proportion of respondents reported experiencing depression, anxiety and suicidal thoughts. Discrimination within the healthcare system was a pervasive issue, with reports of treatment being denied, pressure to undergo specific procedures, and humiliation. Such experiences contribute to a lack of trust in and avoidance of healthcare services, further exacerbating health disparities.

However, amidst these challenges lie opportunities for improvement. Recommendations stemming from the interviews emphasize the importance of inclusive practices within healthcare settings. Suggestions included providing inclusive forms for patient registration, incorporating subtle queer symbolism to create a welcoming environment, and sensitizing healthcare professionals to the needs of SGMs. Ultimately, fostering a culture of respect, understanding, and inclusivity within healthcare settings is essential for ensuring the health and well-being of SGMs.

In conclusion, our report highlights the pressing need for targeted interventions and policy changes to address the disparities and discrimination faced by SGMs within the healthcare system. By implementing inclusive practices and structural reforms, we could create a healthcare environment that preserves the dignity and rights of all individuals, regardless of their gender identity, sexual orientation or sex characteristics.

Acknowledgements

We would like to thank our co-authors Richard Pentz, Lukas Teufl and Roman Winkler for their invaluable

contribution to the LGBTIQ+ Health Report and for their productive collaboration. Our gratitude also goes to the group of experts who made significant contributions to the LGBTIQ+ Health Report 2022: Advice Center Courage, Queer Base, TransX, Venib – Association for Non-Binary People, HOSI Salzburg, and VIMÖ – Association of Intersex People Austria and the Universities of Applied Sciences Vorarlberg and Technikum Wien, the Competence Group for Sexual and Gender Diversity at the Austrian Society for Public Health, and Gender Medicine & Diversity at the Medical University of Innsbruck.

Literature

Allen, E. (2019). Perceived discrimination and health: Paradigms and prospects. *Sociology Compass, 13*(8), e12720. https://doi.org/10.1111/soc4.12720

BMSGPK. (2022). *Suizid und Suizidprävention in Österreich* (BMSGPK, Ed.). Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz.

Gaiswinkler, S., Pfabigan, J., Pentz, R., Teufl, L., & Winkler, R. (2023). *LGBTIQ+-Gesundheitsbericht 2022*.

Medina-Martínez, J., Saus-Ortega, C., Sánchez-Lorente, M. M., Sosa-Palanca, E. M., García-Martínez, P., & Mármol-López, M. I. (2021). Health Inequities in LGBT People and Nursing Interventions to Reduce Them: A Systematic Review. *International Journal of Environmental Research and Public Health, 18*(22), 11801. https://www.mdpi.com/1660-4601/18/22/11801

Öffentliches Gesundheitsportal Österreich. (2021). *Sexuelle Gesundheit & sexuelle Orientierung*. Retrieved 29.01.2024 from https://www.gesundheit.gv.at/leben/sexualitaet/sex/sexuelle-gesundheit-sexuelle-orientierung.html

Pellicane, M. J., & Ciesla, J. A. (2022). Associations between minority stress, depression, and suicidal ideation and attempts in transgender and gender diverse (TGD) individuals: Systematic review and meta-analysis. *Clinical Psychology Review, 91*, 102113. https://doi.org/10.1016/j.cpr.2021.102113

Silveri, G., Schimmenti, S., Prina, E., Gios, L., Mirandola, M., Converti, M., Fiorillo, A., Pinna, F., Ventriglio, A., Galeazzi, G. M., Sherriff, N., Zeeman, L., & Amaddeo, F. (2022). Barriers in care pathways and unmet mental health needs in LGBTIQ + communities. *International Review of Psychiatry, 34*(3-4), 215-229. https://doi.org/10.1080/09540261.2022.2075256

Statistik Austria. (2020). *Österreichische Gesundheitsbefragung 2019. Hauptergebnisse des Austrian Health Survey (ATHIS) und methodische Dokumentation*. Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz (BMSGPK) https://www.statistik.at/fileadmin/publications/Oesterreichische-Gesundheitsbefragung2019_Hauptergebnisse.pdf

Zeeman, L., Sherriff, N., Browne, K., McGlynn, N., Mirandola, M., Gios, L., Davis, R., Sanchez-Lambert, J., Aujean, S., Pinto, N., Farinella, F., Donisi, V., Niedźwiedzka-Stadnik, M., Rosińska, M., Pierson, A., & Amaddeo, F. (2019). A review of lesbian, gay, bisexual, trans and intersex (LGBTI) health and healthcare inequalities. *European Journal of Public Health, 29*(5), 974-980. https://doi.org/10.1093/eurpub/cky226

Authors

Johanna Pfabigan, MSc, Health Expert, Department for Health Professions and Long Term Care, Coordination Unit for Women's and Gender Health
Contact: johanna.pfabigan@goeg.at

Sylvia Gaiswinkler, MA, Senior Health Expert, Department for Health, Society and Equity, Coordination Unit for Women's and Gender Health
Contact: sylvia.gaiswinkler@goeg.at

Citation

Pfabigan, J., & Gaiswinkler, S. (2024). Insights from the Austrian LGBTIQ+ health report 2022, *FORUM sexuality education and family planning: information service of the Federal Centre for Health Education (BZgA), 2*, 60–67. https://doi.org/10.17623/BZgA_SRH:forum_2024-2_en_LGBTIQ-at

Infothek

» Brochures

» Projects

» Studies

BROCHURES

Sexual Health Assessment of Practices and Experiences (SHAPE)

As part of the CoTSIS study (Cognitive testing of a survey instrument to assess sexual practices, behaviours, and health-related outcomes, 2021 to 2022), the World Health Organization (WHO) conducted research in 19 countries to develop a short and generally accessible survey instrument to assess sexual health practices and behaviours. The aim was to achieve better comparability of studies in this field with a 'global standard instrument'.

The resulting SHAPE questionnaire (Sexual Health Assessment of Practices and Experiences) contains a series of questions on the above-mentioned topics that are generally relevant and understandable. The questionnaire is a combination of modules that can be adapted to regional and cultural conditions. The aim is to improve the ability of researchers to collect and compare relevant data on sexual health practices in different countries. The 64-page publication contains information on the development of the modules as well as suggestions for customisation and implementation.

Questionnaire:
https://iris.who.int/bitstream/handle/10665/375232/9789240085909-eng.pdf?sequence=1

CoTSIS study:
https://doi.org/10.1186/s12978-021-01301-w

The role of artificial intelligence in sexual and reproductive health and rights

This technical brief provides an overview of the landscape surrounding the use of AI in Sexual and Reproductive Health and Rights (SRHR), and highlights the related risks, implications and policy considerations. Considering the rapidly evolving nature of AI, this brief seeks to provide clarity in understanding how AI is being applied in SRHR and flag key issues to ensure AI is used effectively, inclusively, sustainably and with due consideration for human rights. This document targets implementers, policymakers, technology developers, funding agencies and researchers working at the intersection of AI and SRHR and aims to facilitate joint understanding among these stakeholders.

More information:
World Health Organization (Hg.) 2024: The role of artificial intelligence in sexual and reproductive health and rights: technical brief
ISBN 978-92-4-009070-5 (electronic version)
ISBN 978-92-4-009071-2 (print version)

Download:
https://iris.who.int/bitstream/handle/10665/376294/9789240090705-eng.pdf?sequence=1

PROJECTS

ONEDU

ONE stands for collaboration and networking; EDU stands for education for all. Lynn Huber, anthropologist and midwife, and Patricia Frei, filmmaker and midwife, founded ONEDU as an online educational platform to empower people in 2019. The website contains free video courses on birth preparation for midwives (Midwife Refugee Kit) and for migrant women (Migrant Birth Kit). This course is available in 16 languages.

Contact:
https://de.onedu.org/

Tabu Kamu

The Turkish-language educational website "Tabu Kamu" provides practical information about sexuality, sexual health and relationships. The aim is to enable people to make healthy decisions about their bodies, sexuality and relationships in a culturally sensitive manner. On the website the different internal and external voices that young people hear when it comes to sexual questions are represented in cartoon characters: "Tabu" stands for customs and traditions, "Emu" for feelings, "Fufu" for passion, "Ku" represents logic, "Ibu" the influence of peers, and "Kamu" public gossip. The website recommends consciously listening to the different voices, weighing them up and only then making your own decision. A team of 26 people works on the website, most of whom are volunteers.

Contact:
http://www.tabukamu.com/

STUDIES

Reproductive geopolitics

How do women decide to have a child and what influences do society, institutions, NGOs etc. have on this decision? Access to reproductive healthcare and reproductive technologies becomes geopolitical when states, international organisations or transnational corporations assign different values to bodies to reproduce. By doing so, they govern the production of the future national body. This project argues that while in the past the territorial management of populations was explicitly framed as population politics, in the present the governance of reproduction takes place more implicitly through regimes of healthcare, migration and sexual politics. Policies in these regimes continue to manage populations in a territorial fashion, but they do not officially pursue population control. Our project seeks to make these largely unnoticed population politics more explicit.

More information:
https://reproductivegeopolitics.ch/

Contact:
mLAB
Institute of Geography
Universität Bern
Hallerstrasse 12
3012 Bern
SWITZERLAND
Unit for Social and Cultural Geography
carolin.schurr@unibe.ch

EMIS 2024

On 18 February 2024 the EMIS study (European Men-who-have-sex-with-men and Trans People Internet Survey) was launched for the third time in 50 European countries. The survey on health and well-being, which is being conducted by Maastricht University, the Robert Koch Institute and Deutsche

Aidshilfe (DAH), is aimed at both gay and bisexual men and, for the first time, specifically at trans women and non-binary people who have sex with men.

The online questionnaire was available in 35 languages and open until mid-April 2024. The first results of the data analysis are expected by the end of the year.

More information:
https://www.emis-project.eu/

UNESCO Global Status Report Sexuality Education

Comprehensive sexuality education (CSE) is central to children and young people's well-being, equipping them with the knowledge and skills they need to make healthy and responsible choices in their lives. How has school-based sexuality education developed internationally and what cultural, social and political factors promote the use of sexuality education? A UNESCO report provides an overview of the status of school-based sexuality education worldwide. It aims to help ensure that all students have age-appropriate access to quality sexuality education throughout their school years.

More information:
UNESCO (2021). The journey towards comprehensive sexuality education. Global status report. Published in 2021 by the United Nations Educational, Scientific and Cultural Organization (UNESCO) Available: https://doi.org/10.54675/NFEK1277

European Contraception Policy Atlas 2023

Access to contraception should be a key concern of governments in empowering citizens to plan their families and lives. Yet the Contraception Atlas – a map that has rated 46 countries throughout geographical Europe on access to modern contraception since 2017 – continues to reveal a very uneven picture across Europe and a widening divide between Eastern and Western Europe.

The findings show that for many European countries ensuring that people have choice over their reproductive lives is not a priority. Now in its fourth edition, the Atlas tracks government policies on access to contraceptive supplies, family planning counselling and online information.

More information:
https://www.epfweb.org/node/89

Patients' and health care providers' perspectives of sexual and reproductive health services for people with disability: a scoping review protocol

The objective of this review that began in 2022 is to summarize the nature and focus of research that has been conducted into patients' and health care providers' perspectives of sexual and reproductive health access for people with disability. The review will be conducted in accordance with JBI methodology (JBI is a global organisation promoting and supporting evidence-based decisions that improve health and health service delivery; https://jbi.global/about-jbi). A search strategy has been developed for MEDLINE, Embase, CINAHL and gray literature. After de-duplication, results will be independently screened against the inclusion criteria by 2 reviewers. There will be no geographical limitations, but non-English-language publications will be excluded. Only literature published after the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) came into effect will be included. Charting tools will be used for data extraction, and results will be presented in descriptive, diagrammatic and tabular formats.

More information:
https://journals.lww.com/jbisrir/fulltext/2023/02000/patients__and_health_care_providers__perspectives.11.aspx

Young People's RSE Poll 2022

A survey of 1,002 young people aged 16-17 in England carried out by Censuswide between 2 and 13 December 2022, and commissioned by the Sex Education Forum, reveals broken promises in relationships and sex education, which leave young people unprepared for modern challenges.

Three years after the Government introduced statutory RSE (Relationships and Sex Education), only 40% of young people rate their lessons as 'good' or 'very good'. Meanwhile, nearly one in five (18%) still say their in-school RSE is bad or very bad. Students report that they do not learn enough about today's most pressing issues, including pornography (58%), LGBTQ+-relevant information (54%), and healthy relationships (54%). While 44% of respondents agreed that what they learned in RSE had helped them and 42% said the content felt relevant to them, over a quarter still felt lessons were neither relevant (26%) nor helpful (27%).

More information:
https://www.sexeducationforum.org.uk/resources/evidence/young-peoples-rse-poll-2022

National strategic roadmap for sexual health 2021-2024

The National Sexual Health Strategy (Stratégie Nationale de Santé Sexuelle, SNSS) pursues a comprehensive and positive approach to improving sexual and reproductive health in France. The aim of the SNSS is to integrate sexual and reproductive health into general health policy. Priorities are promoting lifelong health and prevention in all areas of life; tackling social and regional inequalities in access to health care; and improving the quality of healthcare.

More information:
https://sante.gouv.fr/IMG/pdf/feuille_de_route_sante_sexuelle_2021-2024_16122021_eng-gb_final.pdf

Domestic violence and sexually assaultive behaviour in the Netherlands

In order to obtain a clear picture of the extent and development of cases of sexual harassment and sexual violence in the Netherlands, quantitative studies are regularly carried out. These are also intended to provide information about the effectiveness of prevention policies. The PHGSG (Prevalentiemonitor Huiselijk Geweld en Seksueel Grensoverschrijdend gedrag) was held for the first time in 2020 and again in 2022. 24,000 people over the age of 16 were surveyed using an online questionnaire. The study focuses on offline/online sexual intimidation, physical sexual violence and sexual transgression.

More information:
https://longreads.cbs.nl/phgsg-2022/samenvatting/

Health of students in Germany: current results of the HBSC study

Children and young people at German schools largely rate their health as good. However, almost all of them do not exercise enough and the health situation very much depends on wealth, age and gender. These are some of the results of the nationwide HBSC study (Health Behaviour in School-aged Children), which was presented in March 2024.

The HBSC study is an international study involving 51 countries and was developed in collaboration with the World Health Organization (WHO). Representative surveys are conducted in schools every four years. The current data for Germany was collected by a research association led by the Technical University of Munich (TUM) and the University Medical Center Halle.

The scientists investigated questions relating to physical activity, bullying, cyberbullying, mental well-being, health literacy and health inequalities. 6,475 students aged 11 to 15 from all over Germany took part in the most recent survey conducted in 2022. The results were published in the Journal of Health Monitoring.

More information:
https://www.rki.de/DE/Content/Gesundheitsmonitoring/JoHM/2024/JHealthMonit_Inhalt_24_1.html

Project "Isala" and the female microbiome

A multidisciplinary team of microbiologists, bioinformaticians, bioengineers, gynaecologists and general practitioners in Belgium (University of Antwerp) is researching the female microbiome within the framework of the "Isala" project (ongoing since 2019). A cooperation with sister institutes in Peru and Switzerland is planned. 4,684 women provided their personal information through extensive questionnaires and more than 3,300 women donated vaginal swabs. Using these data and swabs, the vaginal microbiome of women in Flanders was mapped and influencing factors were identified. Microbiome research can help develop alternative strategies for the use of antibiotics. The role of the microbiome in infections, urinary tract infections, sexually transmitted diseases, fertility and healthy pregnancy will also be the subject of this research.

More information:
https://isala.be/en/

Imprint

FORUM Sexuality Education and Family Planning
A Publication Series published by Bundeszentrale
für gesundheitliche Aufklärung (BZgA)
[Federal Centre for Health Education (BZgA)]

Acting Director:
Dr. Johannes Nießen
Maarweg 149–161
50825 Köln
Telephone +49 221 8992-0

https://www.sexualaufklaerung.de/forschung/publikationsreihe-forum

https://www.sexualaufklaerung.de/en/english/forum/forum-sexuality-education-and-family-planning

Bibliographical information of the German National Library – CIP Entry for the German issue
FORUM Sexualaufklärung und Familienplanung [FORUM Sexuality Education and Family Planning]. Informationsdienst der Bundeszentrale für gesundheitliche Aufklärung [Information Service of the Federal Centre for Health Education (BZgA)], Abteilung S – Sexualaufklärung, Verhütung und Familienplanung [Department of Sexuality Education, Contraception and Family Planning] – Köln: BZgA
Entry after 1996,I
ISSN 2192-2152 (German issues)

Concept:
Abteilung S – Sexualaufklärung, Verhütung
und Familienplanung [Department of Sexuality Education, Contraception and Family Planning], BZgA

Managing editors:
Angelika Hessling, Dr. Sara Scharmanski, BZgA

Copyediting and revision:
JoannaN.Translations, Oberhaching

Text:
FORUM Sexualaufklärung und Familienplanung /
FORUM Sexuality Education and Family Planning
Heike Lauer
Anton-Burger-Weg 95
60599 Frankfurt
Telephone +49 69 682036
heike-lauer@t-online.de

Design & Layout Concept:
Kühn Medienkonzept & Design GmbH,
Ruppichteroth, Köln

Typesetting & Layout:
Uwe Otte, Brühl

Version:
PDF-Version (EN) 1.0
published online November 2024

Citation:
International Studies (2024). *FORUM sexuality education and family planning: information service of the Federal Centre for Health Education (BZgA), 2*. https://doi.org/10.17623/BZgA_SRH:forum_2024-2_InternatStudies

NEWSLETTER SEXUALITY EDUCATION, CONTRACEPTION AND FAMILY PLANNING

Stay informed – subscribe to the newsletter!
The newsletter provides information on research projects and -results and new publications in this field.

https://www.sexualaufklaerung.de/ueber-das-portal/service-und-kontakt/newsletter-bestellen

WWW.SEXUALAUFKLAERUNG.DE/FORSCHUNG/PUBLIKATIONSREIHE-FORUM

With more than 50 editions, more than 1,500 articles and around 500 keywords, FORUM Sexualaufklärung und Fami-lienplanung [Sexuality Education and Family Planning] is one of the largest full-text resources in German covering the subject of sexuality education and family planning.

English-language issues available at:
https://www.sexualaufklaerung.de/en/english/forum/forum-sexuality-education-and-family-planning

BZgA Bundeszentrale für gesundheitliche Aufklärung

ISSN 2192-2152