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International Master of Science in Social Work

SEXUALITY EDUCATION IN SWEDEN

**A study based on research and young people's service providers in
Gothenburg**

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ABSTRACT

The study was conducted in Sweden to reflect on the country's adolescent sexuality education and the youth service providers' experiences. **Method:** 5 interviews were held, 1 individual and 4 group interviews. Groups were made up of 3 people in two of the groups and 2 people in the other two groups. Data used was primary from (informants) and secondary (researches made in Sweden about the subject area). **Results:** Empirical findings show that sexuality education in Sweden has long been provided targeting school pupils. Most frequently taught subjects include factual information about growth and development, reproductive systems, empowerment through such skills as (refusal, negotiation of condom use, how to terminate a relationship etc), STIs including HIV and teenage pregnancy to mention but a few. It is teachers and school counsellors who discuss sexuality issues and often they would invite guests from youth clinics and other organisations such as RFSU i.e. the Swedish Association for sexuality education and The Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights (commonly known as RFSL in Swedish). RFSU is much more invited. The Swedish government has Adolescent Sexual Reproductive Health policies and has also established youth clinics which have qualified staff to deal with young people's psychological, sexuality and other related problems. Finally, the report shows that some factors contribute to the rise in the number of STIs among youth in Sweden and it is the service providers' desire to reverse this problem.

Key words: adolescents, sexual reproductive health, sexuality education, STIs prevention, empowerment, self efficacy,

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1. INTRODUCTION

1.1 The structure of the degree report

This thesis sought to reflect on how sexuality education is conducted in Sweden. The report starts with the reason why I chose to write about this subject area, general overview of youth sexuality and HIV/AIDS, followed by background of sexual reproductive health education in Sweden, research aims and research questions, research on sexuality in Sweden, theoretical concepts and definition of words thereafter a presentation of my own research findings including results and analysis, reflections will be brought in linking findings to Sub Saharan African countries (with special reference to Botswana and Swaziland) and ending with recommendations.

1.2 Choice of subject

I have decided to write about sexuality education in Sweden because Sub-Saharan Africa (the region I'm coming from) is more heavily affected by HIV/AIDS among youth than any other region of the world. I used Botswana and Swaziland as examples in this paper because they are among countries in this region hardest hit. The response to HIV/AIDS was expanded in many different directions to include education, prevention, treatment and care. I was working for one of the organisations called Botswana Christian AIDS Intervention Programme (BOCAIP) as a youth programme officer. It is churches' initiative to mitigate the spread of HIV and dealing with its psychosocial effects among individuals, families and communities. It has a lot of programmes and among them was a youth programme which aims to contribute to the reduction of HIV/AIDS, STIs and teenage pregnancy amongst young people aged 12-29 in the south eastern part of the country. The age 12-29 years was adopted because it is an age bracket that defines a young person according to Botswana's National Youth Policy. My interest is to acquire some of the health promotion skills as being used by professionals in Sweden, especially social workers in the area of youth & sexual health as I am also one.

1.3 Aims and objectives of the study

The study aims at finding out the content of sexual reproductive health education in Sweden. This will include reflections on the type of information that young people access. Since Sweden has a relatively lower prevalence rate of HIV/AIDS and teenage pregnancies compared to other countries as per the international standards, the study will get to find out furthermore on how and where youth access to the needed information.

1.4 Research questions

My research questions are as follows:

1. How is the sexual reproductive health information and education provided in Sweden?
2. What kind of topics are provided and by whom?
3. Youth clinics' service providers and teachers' work experiences concerning youth and sexual health

Words such as adolescent, sexual health, sexuality education and sexual rights have been defined in details under the theory chapter (i.e. chapter 4).

2. YOUTH & HEALTH – Some Facts

2.1 Youth Sexual Health and HIV/AIDS

Change is taken as everyday part of life. It might be positive or negative depending on how people term it to be. In the past, such words as sexual desire, sexual well-being and sexuality in general were a taboo. Today people are freer to talk about sexual and reproductive health. In many countries there is also access to information; for example through mass media or other sources and therefore it becomes increasingly important to offer education about love relations and sexuality. Young people all around the world are at risk for a broad range of health problems (WHO, 2005). Among these problems are early sexual debut, unwanted pregnancies, unsafe abortion, pregnancy related complications, Sexually Transmitted Infections (STIs) and HIV/AIDS. Youth are especially vulnerable to these problems because they are more likely to engage in unplanned and unprotected sex. They also engage in sexual activity with multiple partners and they might have limited awareness of sexually transmitted infections prevention (ibid).

Millions of people around the world are living with HIV and AIDS. In 2007, reported cases of men, women and children who lost their lives was 2.1 million and 33.2 million people around the world as living with HIV (www.avert.org). UNAIDS and WHO estimates show that in 2007 alone, 2.5 million people were newly infected with HIV (ibid). Some governments around the world make efforts to fight the spread of HIV especially among young people. Young people are at persistent risk for HIV infection as UN (2007) reported that young people account for over half of all new infections each year. Africa is mostly affected in comparison with other continents.

In giving an example of the above, according to the most recent estimates, 17.1% of Botswana's 1.7 million people are HIV positive and hardest hit are young people and women (ACHAP, 2006). The Ministry of Health Botswana report (2005) indicates that 33.4% and 30.6% youth aged 15-19years and 20-24yrs respectively have contracted HIV. In Swaziland the figure indicates that approximately one in four (26%) of people aged 15-49years are infected (www.unaids.org). One can say like in other societies this is the most economically productive segment of the population. Some of the key factors thought to exacerbate the spread of HIV/AIDS among youth in Sub-Saharan African countries include concurrent sexual partners, gender imbalances in matters related to sexuality, alcohol abuse, high levels of poverty, and high prevalence of STIs related to HIV transmission.

2.2 The STIs and HIV scene in Sweden

From an international comparative perspective, the prevalence of HIV in Sweden is low. By the end of 2006, Swedish authorities had reported a cumulative total of 7477 HIV cases, 2095 of the infected individuals had developed AIDS, including 1317 that had died (www.euro.who.int). The same webpage reported that 71% of all HIV cases have been among men. In 2006, the country reported 377 new cases, 58 new AIDS cases and 10 AIDS deaths. Of the cumulative HIV cases, 44% were reported to have

been transmitted heterosexually, 38% by men having sex with men and 14% by injecting drug use (ibid). Most cases of heterosexual transmission are found among non-Swedish migrants and most people in this group are thought to have acquired HIV prior to their immigration to Sweden (Herlitz & Steel, 2000).

We can also take a look at the HIV and STIs scene in Sweden for the year 2007. 252 new cases of HIV cases were reported during the first half of 2007 and were considered to be the highest figure since reporting began (Blaxhult, 2007). By the end of the year the number reported to be HIV positive was 541 and the number has not been this high since the mid 1980s when it became possible to diagnose HIV infections (Arneborn & Blaxhult, 2008). Unlike in 2006, the year 2007 reported cases for HIV in Sweden were 8014 in total and about 4500 people were reported as still alive and living in Sweden (ibid).

In the early stages of the epidemic, there was particular concern about the spread of infection among men who have sex with men, and among intravenous drug abusers. National Institute of Public Health (2001) reported that many in this category have modified their sexual behaviour as a result of the HIV-epidemic and HIV has fallen significantly among them. HIV has not spread significantly among young people in Sweden. I would say it's not a youth problem in comparison of other countries hardest hit. The mean age of HIV diagnosis is 35-36 years. Herlitz & Steel (2000) said 8 persons aged 15-24 years are infected every year. In Sweden current figures report 62 cases in the age category 15-24 years: 42 women and 20 men (Tötterman & Rahman, 2002). However, chlamydia, gonorrhoea, syphilis and condyloma are on the increase among young people. They are most common for women aged 15-24 years and males 20-24 years as is reflected in statistics (www.smittskyddsinstitutet.se).

Women and adolescent girls in Sub-Saharan African countries e.g. Botswana, Swaziland have higher HIV figures than their male counterparts like in Sweden even though the Swedish figures are very low. Sexual and reproductive ill health is one of the most common causes of illness and death among girls aged 15 and above in developing countries (www.sweden.gov.se). Lower HIV figures do not mean the behaviour of Swedish youngsters is free of risk, as shown by the high prevalence of e.g. chlamydia and the numbers of abortion. National Institute of Public Health has as a result emphasised the need for targeting young people with education for the prevention of both STIs including HIV and unwanted pregnancies.

2.3 Provision of Sexuality education and information in general

Different countries have vast ways of providing sexual and reproductive health education, information and services. One question is who provides these services, how and the results thereafter. There are many efforts aimed at providing sexual and reproductive health information and services to the youth by a number of organisations. These organisations include government ministries, youth clinics, and non-governmental organisations. Several community based organisations and churches in addition may have different youth based programs.

For example in Botswana and Swaziland there are many efforts aimed at providing sexual and reproductive health information and services to the youth by a number of organisations. These organisations include government ministries, libraries, and non-

governmental organisations. Several community based organisations and churches have different youth based programs. That a lot of information is being provided is very clear. What is clearer still is that the youth continue to be the most highly infected group. Statistics as shown above show that HIV/AIDS infection rate is rife among the youth. It is assumed or believed that the youth are made vulnerable to infection by lack of correct information on sexuality and relationships, risk taking attitudes and behaviour as documented by various studies undertaken by researchers in the country. Sexuality education is new in the two countries and was mainly introduced because of the spread of HIV; and a lot still has to be done.

2.4 Background of Sexual and Reproductive Health education in Sweden

States have become organising focus of the social sphere, for the sake of moral uniformity, economic well being, national security or hygiene and health. Like Weeks (2000) has mentioned, states can become more involved with sex lives of individuals, providing the rationale for techniques of moral and legal management, detailed intervention into private lives and scientific exploration of the subject of sex. He further said that the actual practice of the state varies enormously, depending on a variety of historical factors and contingencies.

Sweden is the country which has the long history of sexuality education in the world. Government's emphasis is that the goal of good sexual health is for all persons to have equal opportunities, rights and conditions to enable them to accept and have a positive attitude to their sexuality, and to decide over their own bodies. The country shares the same common belief that high quality information and comprehensive sexuality education can equip young people with the attitudes, knowledge and skills they need to make informed choices now and in the future; enhance their independence and self-esteem; and help them to experience their sexuality and relationships as positive and pleasurable (IPPF European Network, 2007) In order to ensure effective sexual reproductive health and rights, the government has chosen to focus on certain strategic areas. These strategic areas as enshrined in the Swedish's International Policy on sexual and reproductive health and right (2006) include among the others: empowerment of women and girls to shape society and their own lives, the health and rights of young women and young men, safe and legal abortions, HIV/AIDS and STIs, education and dialogue about sexuality and reproductive, education system where all girls and boys receive education which will impact on sexual reproductive health rights.

2.4.1 Sexuality education in Swedish schools

"I dream of the day when every new born child is welcome, when men and women are equal and when sexuality is an expression of intimacy, joy and tenderness (www.rfsu.org)".

The above were words from Elise Ottesen-Jensen, known as Ottar, who in the 1920s according to (www.rfsu.org) created a considerable stir when she travelled around Sweden. She founded the Swedish Association for sexual education in 1933. This organisation played a major role in reforming contraceptive and abortion laws and introducing sexual education in the public schools in Sweden. However, more people are recognised for having played a major role in the establishment of sexuality

education in Sweden. For example; Knut Wicksell was reported to be one of the first people in Sweden to plead for sexuality education in a modern sense according to Centerwall (1996). He also said Karolina Widerström was an early pioneer and also the first female doctor in the field of sexuality education.

Voluntary sexuality education was introduced in 1942 into elementary schools, and in 1954 a sexuality education lesson was aired on the radio for the first time (Wellings and Parker, 2006). In 1945 the first official teachers' manual for education appeared according to Centerwall (1996) with partial revisions in 1949, 1956, 1965, 1966 and 1977. Parker and Wellings write that in 1955, Sweden became the first European country to establish compulsory sexuality education in all schools. Sexuality education is provided by schools and non governmental organisations. It is included as a part of the general health objectives for public health work.

The aim of sexuality education is to support and prepare young people for a responsible sexual life by many countries. The methods used and messages conveyed to youth depend from one country to another. Sweden's SRHR policy includes a number of different issues which are all interlinked, for example; efforts to fight HIV and AIDS and other STIs. The build up of educational systems, health services and legal frameworks are mentioned to be important conditions for successful SRHR policies (International Policy on reproductive health and rights, 2006). SRHR policy is implemented in various ways and through different channels. The Swedish sexuality education conveys facts about sexual and reproductive health such as anatomy, sexual functions, sexual orientations, STIs, HIV/AIDS, abortion, relationships and contraceptives etc.

The country belongs to the sexual supportive culture. It accepts sexuality as a deep and significant human value during the whole life and is best able to promote sexual and reproductive health and rights (Lennér, 1998). The Swedish organisation or way of dealing with sex and relationships education has been seen as unique in an international perspective according to Lindell (1995). She says it is distinguished from others in so far as the education is compulsory throughout the nine-year schooling. Sexuality education is considered to be well integrated even though the quality varies a lot between different schools in Sweden (Lennér, 1998). Lennér has indicated that about 50% of the sexuality education programmes at schools has a very good quality.

At present the Swedish government is reported to be the only government that has adopted a national policy for international work with sex and reproductive health and rights (www.sweden.gov.se/mfa). The Swedish view is that sexual and reproductive health is a matter of democracy, equity, equality and sustainable economic development not health only. Each and everybody's rights are an absolute prerequisite and are one of the strategically important areas of SRHR policy. The emphasis is on the ability to decide over their lives.

2.4.2 Youth Clinics in Sweden

Youth clinics were also opened in the 1970s as a complement to sexuality education in schools. As Policy Programme for Sweden's youth centres (2000-2002) state, many of the centres during that period were based on collaboration between maternity care and social services. The focus was on prevention of undesired pregnancies and to

maintain reproductive health for girls and women in particular (ibid). Changes in STIs and HIV panorama in the 1980's led to their testing and prevention becoming an integrated activity at youth clinics. Boys and young men as well became a target group to a greater extent than before according to Policy Programme for Sweden's youth centres (2000-2002). Today the number of special youth clinics is about 240 in Sweden and together with schools; these have been found to be very efficient in reaching out young people about sexuality education.

2.4.3 Other sources of sexuality information and education

Young people despite schools and youth clinics are exposed to other forces in their efforts to gain answers to questions of sexuality and the details of intimate relationships. Centerwall (1996) reported that most young people would rather mention their friends as an important source of information in terms of sexuality and personal relationships. He also emphasises that parents have a limited role in sexuality education. Young people place their hopes in someone from outside the family and experience themselves to be free and independent. For his part, Reimer (1995) asserts that what is notable among youth in present day Sweden is an entertainment orientation. His emphasis is that young people meet friends in the process of amusing themselves and that's when they can talk about questions of relationships and sexuality.

However, parents and teachers today generally accept that children should be given honest answers from an early age about where they come from (Lennèr, 1990). Swedish children get honest answers according to Lennèr and the questions they ask about sexuality develop in the age 3 – 5 years. It is children's right to get honest answers and this is how Swedish sexuality education is today. Day care staff is also prepared to answer the children's questions about sexuality matters according to Lennèr (1990).

There are some researchers who acknowledge the impact of media to adolescents concerning sexuality and relationships. Forsberg (2000) asserts that internet makes a notable change with respect to knowledge and array of information found in it. However, a few studies have been conducted regarding the impact that the media has. Edgardh (2001) reported that no studies have been published in Sweden and thus it is difficult to evaluate the influence of media on adolescents' sexual behaviour.

3. EARLIER STUDIES

Swedish authorities have adopted Sexual Reproductive Health Rights as part of health for all programmes. Society's task has been provision of prevention, care and support so that everyone has an opportunity to obtain sexual and reproductive health fulfilment (Centerwall, 1996). Education in the area of sexuality and human relationships has been there for the past decades with researchers interested in it. With the AIDS epidemic, sexual behaviour in the general population and in specific groups has become a prominent field of research. It is notable that this is not a new area of study in Sweden. This has even been mentioned by Edgardh (2001) trying to show that adolescent sexuality has an impressive number of studies in Sweden. Two reports have been published covering the field of adolescent sexuality, reproductive health issues, and society's interventions and legislation in Sweden (ibid). Forsberg published a review that summarised the research up to year 1999 and another study by Danielsson and other researchers in 2003 on teenage sexual and reproductive behaviour. It is important to note that the review published by Forsberg was done on behalf of the Swedish National Institute of Public Health.

The above are not the only studies done on the subject matter. A lot of researchers have shown interest in the area. Centerwall has in 1996 used reference materials by Skolverket (Sweden's National Agency for Education). He provided an overview of how education in the arena of sexuality and human relationships works today and to suggest guidelines for how it will develop and be practised in the future. Other studies have been conducted and published in Swedish language. The studies which I have looked into written in English language looked at different areas since sexuality is a broad issue that can be sub-divided into various parts. For instance, some have focused on the evaluation of sexuality education intervention, adolescents' reproductive behaviour, evaluation of STD Prevention programmes and young people's knowledge and attitudes towards STIs just to mention a few. In some of these studies, researchers have highlighted some information on sex education in Sweden.

Other most important sources of information which need to be mentioned are the internet, Swedish government web pages with statistics and policies. They have relevant information about sexuality education in Sweden which has been used throughout the writing process of this paper. There is a wealth of information about sexuality education and sexual health studies which I read from the internet written in English. I selected what I considered relevant and related to this study. Among some of the studies that have been conducted before include the following: **sexual debut in Sweden**. The median age at sexual debut is taken to be 17years and according to researchers on this subject, intercourse seem to take place earlier in the relationship than in the past, and the wish for more sexual experience had increased. The study was done by Klanger et al (1993). Forsberg (2005) in the recent study has found out that sexual debut has been stable for the last years at 16-17 years with some differences here and there. In the same study she said 24% of young people had not had their sexual debut yet at 19 years.

Teenage girls somewhat make their debut later than boys. Some studies reported that there is a larger variation in age depending on whether the young person live in the country side or is from higher social classes. However, another study by Håggström

(2005) said more teenage boys from the working class have had their sexual debut somewhat earlier. Boys from immigrant families had in mean their sexual debut earlier than Swedish boys. Among girls from immigrant families, their sexual debut is later than Swedish girls.

Ekstrand et al (2005) have in turn studied **risk taking behaviours**. They have had focused group interviews with 17year old Swedish girls. In drawing their conclusion from their results they indicated that risk taking behaviours such as negligence in contraceptive use and intercourse under the influence of alcohol were suggested as main reasons behind the increasing numbers of abortion among Swedish teenagers. Liberal attitudes towards casual sex were expressed and girls were perceived as more obliged than boys in taking responsibility for contraceptive compliance and avoidance of pregnancy.

Prevention and contraceptive use

Condom use is reported as the most frequent method of contraception for sexually active youth, followed by the dual use of condoms and contraceptive pills only. These findings were from yet another study that was aimed at identifying and reporting cross-national patterns in contraceptive use among sexually active adolescents by Godeau et al (2002). However, Larsson et al (2007) said the fact that young men appear less inclined to use contraception is disturbing, and must be addressed in sexual education and individual counselling to promote a better sexual health for adolescents. They investigated self reported sexual experiences on abortions, STIs, use of contraception and possible influencing factors on contraceptive use among Swedish high school students.

Recent studies about **sexuality education** written in English could not be found. The study that I found which was conducted by Edgardh (2001) reported that during 1990s, schools have suffered budget cut backs in Sweden because it was a period of economic stagnation. She said sexual and reproductive health problems are on the increase among young people despite sexual education in schools, widespread youth clinics and family planning services that are free of charge. In addition Edgardh (2002) reported that sexual education is taught less. Håggström (2005) study found that young people have a strong need and wish to discuss questions about sexuality, living together and love. They had also expressed that they want knowledge about everything connected to sexuality and love. 20% had indicated that they want to know about STIs. Some said they would like to know much about relationships, sexual techniques and contraceptives. The study was published in Swedish.

Relationships

I have had help in translation of some studies about youth and relationships published in Swedish and later made a summary. One is Boström (2007) who reported that half of young people interviewed stated that it is important to have an established relationship when sexual intercourses are involved. This was girls' opinion. Only 5% however wait until they are married or share the same home. It is important to note that Sweden is a secularized country and marriage is not necessary to have sex. The youth period is also very long in Sweden. Mean age at first birth is 30years and people would have been involved in different relationships before that. Another study was done by Forsberg (2005) who found that the general tolerance of having sex for

one night (“one night stand”) is strong among young people, especially boys compared with girls. Girls expect more of feelings, love etc not only sex.

Young people’s opinions about gender differences related to sexuality. Differences which have been noticed were: boys want more sexuality and its more tolerant attitudes towards boys sexual behaviours; girls feelings are more involved; girls are more shy related to sexuality; it is easier for boys to get sexual satisfaction; more boys have positive experiences from their first intercourse; girls are more involved in stable sexual relationships, but its only 1/3 of boys who would do the same; and girls need to think about sexual respectability more than boys.

4. THEORETICAL FRAMEWORK

Theory is acknowledged by Rubin & Babbie (2001) as it plays an important role in social work research, as it does in social work practice. This can not be denied. Without theory, it might be clueless in designing your study. Gilbert (1993) said different theories bring different aspects of the world into view and this is why we need them.

For this study, social cognitive theory (self efficacy in particular) and empowerment theory were used to outline the frame of action for Swedish sexuality education. The two theories will be explained later before being applied in the results, findings, analysis and reflections section. Below I will define the four words: adolescence, sexuality education, sexual health and sexual rights as they are used in this paper.

4.1 Definition of words

Provision of these working definitions has no been easy because there were various meanings given by different authors. I have therefore used some definitions of international repute and this paper was written based on those.

Adolescence was seen as “years following rapid physical and cognitive changes of puberty marked by a time of adjusting to and consolidating these transformations into a revised sense of identity (Kroger, 2000:48)”

Definition of **sexual health**, sexual health and reproductive rights (SRHR), reproductive health and reproductive rights are based on existing international agreements. Sexual health has been defined to as “quality of life and personal relations, counselling and health care (Swedish International Policy on sexual and reproductive health and rights, 2006:3)”.

The same policy further defines **sexual rights** as the right to decide by all people over their own bodies. All young people have the right to comprehensive sexual and reproductive health information, education and services. Wellings and Parker (2006) argue that the information and education can make young people to be active citizens, to have pleasure and confidence in their sexuality, and to be able to make their own informed choices.

One may wonder what **sexuality education** is. From The Safe Project (2007), the term sexuality education involves “disseminating general and technical information,

facts and issues which create awareness and provide young people with the essential knowledge and training in communication and decision making skills they need to determine and enjoy sexuality both physically and emotionally, individually as well as in relationships". The argument is that the education should be adapted to target group's age and stage of development.

Like it was said earlier on, self efficacy (which comes from social cognitive theory), empowerment and prevention work (related to sexual and reproductive health) were used to provide a framework or lens for viewing sexuality education in this paper. What prompted the use of these theories in this study is the reason that they have been most widely applied in health behaviour research. I also take it that sexuality education is part of health promotion where people are given knowledge, means, and social entitlements to exercise increased control over their own development and the conditions that affect their lives. In addition to this, it is also a way of influencing health behaviour. Empowerment and self efficacy aim to change behaviour, they are good fit for prevention based sexuality education programs e.g. prevention of teenage pregnancy by preventing sexual involvement or increasing condom use, STIs and HIV prevention programs.

I have used these theories to explain how sexuality education works at both the individual and societal levels. Ill health has serious consequences both at the individual and societal levels. For example; an individual can be at risk of psychosocial problems, physical manifestation and shortened life span while for society as a whole major costs can be incurred for care and treatment to mention a few. It is the combined impact of these consequences and a lot more which ultimately justifies the use of extensive efforts to prevent ill-health. It can be prevention of STIs, HIV or unwanted pregnancies.

4.2 Social cognitive theory

This theory was originally called Social learning theory. Its proponent is Albert Bandura. It was renamed because Bandura saw motivation factors and self regulatory mechanisms as contributing to a person's behaviour rather than just environmental factors (www.musikingum.edu). The theory has dominated the field of health promotion according to (Naidoo & Wills, 2005) as it helps understand how to motivate and maintain behaviour change. Bandura has described how his theory can be applied to the study of health behaviours in a couple of recent publications. A list of his main behavioural predictors include: self efficacy, outcome expectancies, goals and socio structural factors.

Rosenstock and associates (1998) explain self -efficacy as conviction about one's ability to carry out the recommended action. This explanation is not so much different from the theory's founder who defined the same term as "beliefs in one's capabilities to organise and execute the course of action required to produce given attainments (Bandura 1997:3)". Bandura has made "outcome expectancies (the expected outcome of a specific behaviour) and self efficacy (perceived ability to perform behaviour) two of the most central concepts of this theory (Aarø et al, no date: 46).

It reflects actors' beliefs about whether they think they can perform a given activity. Kashima & Lewis (1993) further pointed out that when people lack a sense of self-

efficacy, they do not manage situations effectively even though they know what to do and possess the requisite skills. A common belief is that self-inefficacious thinking creates discrepancies between knowledge and action. This theory attempts to predict behaviours when youth's volitional control over their behaviours is questionable. It also provides explicit guidelines on how to enable people to exercise some influence over how they live their lives.

According to Bandura (1997), a vast amount of social learning occurs among peers. He further said in his book that learning occurs among peers because of similarities in age and experiences where there is provision of most informative points of reference for comparative efficacy appraisal and verification.

4.3 Empowerment

This is important due to the nature of the work that service providers are doing. The word empowerment is frequently used with many different meanings ascribed. The word empowerment represents a concept for which there are neither synonyms nor a consistent definition (Stein, 1997). For his part, Rappaport (1984:2) pointed out that "it is difficult to frame positive definitions of empowerment, because it has components that are both psychological and political". One can say it takes on a different form in different people and contexts. Empowerment is about "helping clients to gain power of decision and action over their own lives by reducing the effect of personal or social blocks to exercising existing power (Payne, 2005:295)". This theory emphasis is in helping people to overcome barriers to self-fulfilment within existing social structures. It can be by developing their confidence, self-esteem, assertiveness, knowledge, skills and expectations. For the sake of this study, this definition will be adopted and used the way it is.

Empowerment is an integral part of WHO definition of health promotion. Information and the skills to use this information to effect change are central to empowerment from WHO's view. Naidoo and Wills (2005) said empowerment can be done through education. Education for empowerment was said to include a number of different stages e.g. creating awareness, increasing knowledge, changing attitudes and motivating people to continue their behaviour or to adopt an innovation.

An important feature of empowerment is that a person, individually or collectively actively takes charge of the situation (Werkö, 2008). She further illustrates that empowerment involves the empowered person developing confidence and belief in his or her own capacities and capability to influence. In turn that person can be said s/he can actively take charge of situations and have control of decisions that impact their lives. What is considered important with empowerment is people's autonomy in making decisions about their life and their power to choose from among several behaviours.

4.4 Prevention work

Young people's right to information and education is embodied in several international treaties and conventions. Several international agreements documenting this right include the "Convention on the Elimination of All Forms of violence against Women (CEDAW), the convention on the rights of the child (CRC), the International

Covenant on Economic, Social and Cultural Rights (ICESCR) and the ICPD programme on action (IPPF European Network, 2007:16)”. This is an indication that the provision of information on sexual reproductive health to young people has been advocated for as a core element in issues of population growth and development at the international and national levels with an effort to prevent ill health.

Naidoo & Wills (2005) have argued that key to health improvement is education. They even said it is the process of communicating, informing and educating individuals and communities that make people gain control over their health. Health literacy or “know how” as is called by the above authors include knowledge, personal skills and education concerning the determinants of health as well as risk factors and behaviours and the use of health care systems. These are part of preventive work needed by young people so that they won’t pick up a good deal of misinformation late in their development. Bandura (1997) argued that socially oriented efforts at sex education are thwarted by sectors of the society that lobby actively for maintaining a veil of silence regarding protective sexual practices in the belief that such information will promote indiscriminate sexuality.

Information, education and communication (IEC) form the basis of successful HIV/AIDS prevention programmes. Broad based education work is believed to be powerful to change risky behaviours and reduce the number of new HIV infections (www.gtz.de). For its part, UNFPA said the role of IEC in prevention must be viewed systematically through a gender lens if appropriate responses are to be made in national policies and programmes (www.unfpa.org). It further highlighted that gender responsive education can help to address HIV/AIDS through some of the following:

- “Promoting access to education for all: Formal, non formal and informal educations have a major role to play in changing attitudes and behaviours that are sustaining the gender inequalities that contribute to the spread of HIV. Schools, workplaces, literacy classes, health centres, media and all other places of learning have the potential to address the spread of HIV/AIDS by promoting gender equality
- Making policy and strategies to reduce the spread of HIV/AIDS and mitigate its impact into HIV/AIDS national action plans, Education for All National Plans, and national agendas promoting gender equality and empowerment
- Mainstreaming gender in the education system. Gender mainstreaming is defined as considering the impact of gender norms in an integrated and inclusive way. Gender affects education in terms of who accesses education; who delivers it (the extent of a patriarchal leadership model within the school structures); and how it brings about change in the learner’s life
- Ensuring that education policies and programmes address gender based discrimination, exploitation and violence, including in the school itself. Schools and education establishments are workplaces that need to ensure the safety of their staff, learners and patrons, be they male or female.
- Developing workplace policies for education within Ministries of Education which are compliant with the International Labour Organisation’s code of practice on HIV/AIDS and the world of work (ibid)”.

This shows that gender plays a vital role in educational systems and it is should to be mainstreamed so that it effectively addresses HIV/AIDS issues. From the above, rights to sexual and reproductive health services and sexuality education, gender, empowerment and self efficacy are key tools in the struggle for a healthier and more

equitable society. One key word which was agreed upon at the UN conferences in Kairo and Beijing was women empowerment. The global consensus is that women's autonomy and ability to make and influence their decisions and choices in all spheres including reproductive lives should be strengthened. One needs not to forget openness on sexuality because it is also seen as the point of entry of health promotion and prevention.

5. RESEARCH METHODS

5.1 Qualitative study

I have used two different methods to collect data for this report and answer the research questions. These were mostly: 1) Swedish studies and documents on prevention of STIs, HIV/AIDS, sexuality education and youth sexual health. The researcher wanted to get an understanding and perspectives about the sexual reproductive health education, information and services on the already written documents.

2) Interview schedule

Face to face in-depth interviews with the interviewees based on interview schedule were used. Demographic details of interviewees were collected, for example, their age, sex, educational level. This method is characterised by "flexibility and the discovery of meaning, rather than standardization, or a concern to compare through constraining replies by a set interview schedule (May, 2001:125)".

Respondents were allowed to talk about their beliefs, perceptions and work experiences about sexuality related issues. A qualitative approach was adopted to collect and analyse data. The study's focus was not on quantity but in quality and production of data. This was done by enabling the interviewees to answer questions using their own frame of reference (May, 2001). The researcher had formulated the questions herself.

Interview schedule for the study was open ended. According to Newell (1996), a distinction has to be made between an interview guide and an interview schedule. She said "a schedule contains set questions in a predetermined order adhered to in each interview (p.97)". In this study questions were asked using the exact wording and order of the questions to the interviewees. Interviews were recorded by pen and also audio taped with the information transcribed immediately after each interview. The average interview lasted for 11/4hr but the interviews varied from 11/4 to 11/2hr depending on the respondents. The dates for interviews ranged from March 28th until April 7th 2008.

The interviewer had no previous personal contacts with the interviewees and performed all the interviews herself. There were 5 interviews conducted, 1 individual and 4 group interviews. 3 of the interviews were conducted at the respondents' workplaces, 1 at a coffee shop and the last one at the place where I was placed for fieldwork. The interview schedule contained 34 questions on the following subjects: (1) staffs' work experience, (2) collaborative efforts, (3) methods employed, (4) topics for sexuality education, (5) impact and (6) challenges and future prospects in sexuality education. All questions were used for clinic staff and the following were

excluded for teachers (school staff) as they were not applicable to the nature of their work: Questions 9, 10, 11, 23, 26, and 27 (see appendix).

3) Other sources of information

Some other information was collected from the Centre for Infectious Diseases Control in Gothenburg. It was a way of deepening my understanding of STIs, HIV/AIDS prevalence and control in Sweden. Two nurses and a coordinator for HIV projects in the city were interviewed. Some of the information is presented in the study as well. Apart from these visits, I have also visited PG Väst project during my field placement period where they shared about HIV/AIDS prevalence rate in the country.

5.2 Sampling

The sampling method used to find key informants was purposive. According to Grinnell (2001), this method is characterised by the use of one's own judgement in selecting a sample. With this method, as a researcher you do not require the existence of some sort of sample frame, or no sampling frame is readily available (May, 2001). In using purposive sampling, the procedure was to make a selection of respondents from service providers both males and females. The basis for selecting such a sample was that it could yield considerable data particularly for my qualitative research studies. In addition to that, the researcher wanted to save time and effort by identifying interested individuals. An attempt was to construct a picture of how sexual reproductive health education has been implemented. The purposive sampling is one of the non probability sampling strategies.

The study population was predominantly the adolescents' sexual reproductive health service providers and/ or educators in a school as well as youth clinics. These are the only people who could be used as key informants in an attempt to construct a picture of how information and education are being provided. Furthermore, they have worked extensively under adolescent sexual reproductive health services provision. I got details of interviewees from my fieldwork supervisor because of the limited contacts I have had in Sweden as a student from abroad. The interviews were conducted with 1 male teacher and 2 female school nurses (at school) and 3 female social workers, 1 male social worker, 2 female gynaecologists, 1 female nurse and 1 female midwife. I managed to interview them because of their volunteerism and the availability.

5.3 Method of analysis

Since the purpose of the qualitative research interview has been "depicted as the description and interpretation of themes in the subjects' lived world (Kvale, 1996:187)", my work was to do as such. The transcripts of the interview were categorised and analysed out of common themes found in interviews. I used a tape recorder and note book to capture information from the respondents. This information was transcribed, analysed by trying to follow Kvale's approaches to interview analysis. These are meaning condensation, meaning categorisation, and meaning structuring through narratives and meaning interpretation (Kvale, 1996). I chose statements that seemed important to the study because it was impossible to note exactly everything that was said. Some of those statements were used in the results and analysis chapter as a way of quotations. Since the interview was in English,

transcription was also made in the same language. The tape recorder was mainly used to get fully words of interviewees by playing it time and again before transcribing. Thereafter, I made a summary for each interview, matched the same answers which respondents gave (meaning categorisation) and interpretation of those answers. Meaning structuring could not be done because of time frame and this is why the researcher had to do meaning interpretation.

5.4 Reliability and validity

During the studies, I intended not to come up with conclusions that people like or conclusions that suit my personal preferences but was to consider measurement validity. Throughout the study, attempts were made to minimise biases and errors by ensuring that the study can be repeated with the same results. This is why I have recorded research methods and procedures so that they can be checked and repeated by those interested in this area of study. Since validity is defined as measuring the right concept by Gilbert (1993), I have interviewed staff in clinics and teachers to get perspective of my subject and for research questions to be answered. I was increasing validity because these are people who are charged with responsibility of providing sexuality education.

Reliability on the other hand is explained as showing consistency from one measurement to the next (Gilbert, 1993). He continued to say that a study can be said to be reliable if similar results would be obtained by others using the same questions and the same sampling procedure (page 96). Descriptions of sampling and analysis have been reported and the way I went about the study shows that it is valid and reliable. Also the way of questioning was the same for all groups except for the school where some questions which were seen not to be applicable to them were left out. Those questions have already been talked about above, see pages 13-14.

5.5 Generalizability

This study was done on a small scale with a few respondents or informants having been used to answer the questions because of lack of resources. Time was limited and in view of these, it can not be generalised to a large population. One can not say the views and opinions of service providers as well as the teachers are representative of all such professionals in the country. After the in-depth interviews, I could understand how sexuality education is but I could not carry all I have learnt from the specific to the general. Generalizability is all about the extent to which the study can be used to inform us about persons, places, or events that were not studied (Grinnell, 2001). Sample generalizability can not be made with this study because as was said before, it was a tiny sample that was actually interviewed rather than the entire population of teachers, nurses and social workers also called counsellors.

5.6 Ethical considerations

Ethical issues related to social research are important. In my study serious thought about them were considered. Throughout all the study, some ethical considerations were raised. The main issue was to protect respondents' integrity and anonymity. The names of the interviewed in the study were coded with YCf for females interviewed in youth clinics and YCm for males. SCf means females in schools and SCm is for

males. In some cases symbols were used to indicate missing words and omitted words were replaced with /aam/, while ... means a short break.

In addition to this, it was of importance to also inform them in advance that their participation is voluntary and that they could break the interview at anytime. I also thoroughly informed the key informants about the purpose of the study. This was done in writing (consent letter, see appendix II) to the youth centres to ask for access and also by making verbal clarifications during interview sessions. As a researcher I also assured them that the tape recorded material will be destroyed soon after use. Those who didn't want to be recorded were told to indicate that.

5.7 Limitations of the study

1. The use of a tape recorder might have made respondents somehow nervous and more reluctant to share information. In addition to that, they can behave differently from what they would have done in the absence of the tape recorder. Tape recorder may bias answers from respondents if they know that their voices are being recorded and their anonymity is not completely preserved. However, it is claimed to be necessary for the credibility of qualitative interviewing (Patton, 1990).
2. On the onset, the intention was to conduct face to face interviews with individuals in schools and youth clinics. However, respondents preferred to be interviewed as a team. Respondents might have attempted to present themselves (or their opinions) in a socially desirable manner as a group. They might have professed views they do not actually hold or deny behaviours or feelings that they believe might be met with disapproval. The respondents who preferred to be interviewed as a team stated the reason that their English was not perfect and wanted the company of colleagues.
3. Interviewing more than two people did not bring as much information as I would have expected. There were some interruptions from others as someone would be answering and that ended up making that particular person to loose track and not say what s/he intended to say. At all times my role was to let them give each other a chance.
4. A fourth limitation was related to studying of research literature and some other important documents about sexuality education in Sweden with no Swedish language skills. A lot of Swedish reports in this field are regrettably not translated into English language.

6. RESULTS AND ANALYSIS

6.1 Goals of schools and clinics with regards to youth sexual health

The overall objective for youth clinics is promotion of physical and mental health, to empower young people in the development of their identity so that they can deal with their sexuality in order to prevent unwanted pregnancies, STIs and HIV. This has been said by all interviewees in clinics and they share the same objective apparently.

YCf: We at clinics are aimed at promotion of sexual health and STIs free youth. Then we also are more into reinforcement of identity among teenagers by giving them education in groups or talking to them on an individual basis. The third thing is we are into the promotion of sexual health between young people, both males and females. Our clinic was the first (i.e. the one in Gamledstaden) in the 1985 to be opened and most of the youth clinics have started about 1990s. It was working with the hospital and focusing on provision of contraceptives. But it now focuses on young person as a whole including males. We work according to our policy.

There is only one policy that guides all youth clinics commonly known as Ungdomsmottagningar in Sweden and respondents said their work is guided by it. The objective is not so much different with the schools with regard to sexuality education. Schools are also focusing on promotion of health among students or pupils by providing them with factual information.

SCm: Our general goal in school is to offer education to students in different subjects, to best equip them to be able to go to universities. In Sweden high schools are meant to give them skills for the courses they would like to take later. But concerning sexuality, our aim is to empower young people in the school with sexuality education so that they can live healthy. Also so that they can make better decisions.

With the schools, it is the same with the youth clinics because the teachers have said SCf: *the school's mission is as formulated in the Swedish Education Act, the National Curriculum, The UN Convention on the Rights of the Child and the General Advice for after school recreation Centres.*

The overall reason why sexuality education is provided as was derived from the interviews is to encourage wellness and healthy lifestyles. In addition to this, the interventions as seen by others who advocate for this kind of education is the grounds that it “enhance wellness while it also aims to ameliorate problems, provide opportunities for participants to develop knowledge and skills, and engage professionals as collaborators instead of authoritative experts (Perkins & Zimmerman, 1995:570)”. Youth clinics and schools in Sweden share the goal of empowering youngsters so that as individuals, they can have situation-specific perceived control as the authors above might call it. Education also involves work to prevent abortions, unplanned pregnancies and STIs with the belief that youngsters will have a healthy way of thinking about life. The idea is that by providing education that gives knowledge and self esteem, the individual will be able to understand his/her own will and thus have the ability to say “yes” or “no” in sexual matters (Centerwall, 1996).

According to Bandura (1997), the ability by adolescents to forsake risky activities or become chronically enmeshed in them is determined in large part by the interplay of personal competencies, self regulatory capabilities and the nature of the prevailing social influences in their lives. Youth clinics and schools are put in place to help young people guard against risky activities. They do this through reinforcing self efficacy because according to Bandura as is stated above, management of risky activities rest partly on a firm sense of self efficacy. It is the teachers, nurses, social workers and other professionals' determination to work towards achieving their organisations' goals. From the responses, they use their capabilities with intentions to heighten young people's personal competencies. Adolescents who are insecure in their efficacy are said to be less able to curtail involvement in for instance drugs, unprotected sexual activity to mention a few than are those who have a strong sense of self regulatory efficacy (Bandura, 1997). Therefore, schools and youth clinics aim at enforcing and empowering youth to have strong self efficacy.

6.2 How are information and education about sexuality and prevention provided?

Both service providers at youth clinics and teachers said they try to heighten pupils and out of school youth's control and self determination. They do this through (1) group education, (2) individual counselling (and sometimes group) and (3) condom campaigns.

6.2.1 Group education

YCM: We reach out to youth in schools and this is easy for us because we find them there already rather than going out to look for them in other places. This is the only place where we find them. And it is good because when they finish school they know about us already. We don't follow them around when they finish school; they visit us because they know.

Education in the arena of sexuality and personal relationships developed in Sweden over several decades. It has also become so widely accepted in school education. Schools were reported from interviewees as advantageous places for health promotion because every child and teenager visits school in Sweden. It has become clear that schools are the most common place where children can be easily reached and be offered a form of education that lies significantly closer to the actual life of young people. The Independent School Reform made it possible for families to send their children to any school (www.sweden.se). The law states that children have equal right to education regardless of gender, ethnic or political background, and economic status of their family.

Health promotion in Sweden has been a crucial issue and one would say the country observes right of education as it is one of the principals of human rights. Children and adolescents have been targeted as key to future prevention of ill health. However, the teachers who were interviewed said there are pupils or students whose parents don't allow them to participate in sexuality education lessons.

SCf: General public's opinion towards the work we are doing is good. Parents can't do anything to stop sex education..... But, with parents with immigrant

background, I have received telephone calls with some parents talking with me and saying that if you are coming to class to talk about this.... I want my daughter or my son not to attend your session when you are talking about sexuality issues.

Teachers further said they can not be objectional to these parents because their children have been exempted from certain activities or instructions which are compulsory in Swedish schools. This exemption came about as an expansion of the original rule according to The local Sweden's news in English (2008), to allow students to skip otherwise obligatory lessons, such as sexuality education under special circumstances. The original rule came about in 1969 to allow students of different faiths to skip Christian religious instruction, which was compulsory in Swedish schools at that time. Allowance to skip sexuality education came about in 1996. Immigrant parents' exceptions are on the basis of different cultures and religion making their children not to participate in sexuality education lessons according to teachers and clinic staff reports.

The country provides multidisciplinary personnel and resources needed to foster the health of youth. In youth clinics there are social workers, nurses, gynaecologists, psychologists, general practitioners and venereologists. Schools have counsellors and according to the one I interviewed, her role is to give special support to pupils' general health, lifestyle and psychosocial problems as a complement to teachers. Provision of multidisciplinary personnel and resources e.g. contraceptives shows a serious commitment by the country to fostering the health of its youth. The move also helps in doing the job effectively by the professionals concerned.

In schools planning of education in sexuality and personal relationships is management's responsibility. Authority may be delegated to specific teachers and they often collaborate with the youth clinics. The youth clinics arrange study visits for young people. Since a young person's sexual and development does not exist in a vacuum, apart from schools and the youth clinics there are also some other organisations that they network with for effective delivery of services. It is in the 8th grade that the youth clinics arrange study visits. They call these conversation groups and they said they try to promote healthy lifestyles, address the social nature of health behaviour and equip pupils with the means to exercise control over habits that can jeopardise their health.

Education is conducted in different ways in different areas or schools with clinics. This may probably be explained by the level of competence of the educators and the interaction between educators and pupils. For instance staff in one clinic said they provide information to students in the 8th grade but in another it is with the 9th grade. Variance in the quality between schools in Sweden has been associated with different factors. These range from embarrassment, the argument by teachers proving that they have enough problems fulfilling their basic academic mission and placing responsibility on certain teachers. Centerwall (1996) argued that all teachers should be informed of the content of the education provided and support it. He further said that it can benefit the entire school if education in the arena becomes a matter for all teachers. I share the same sentiments with him and I also believe that this can be possible if teachers are adequately equipped for the role. The education can also include salutogenesis perspective. According to Lennèr (1998) salutogenic means

educating also about the positive aspects of sexuality and love, not only problems and negative consequences.

6.2.2 Individual counselling

After discussions in groups, pupils can visit school counsellors as a follow up on discussion or for special psychological support. Individual cases differ and counsellors in some cases may make referrals to school nurses and further on to the youth clinics. They said sometimes they conduct group counselling among teenagers to strengthen their self esteem, working on gender equality and some life skills.

SCm: The nurse and I give students information in a group. It is after these group discussions that individuals may make follow ups. It might be with students who want to learn more as a way of empowering them.

This was a response on the question of how individual adolescents are given information. Teachers, nurses and social workers/counsellors said they also provide education even on one to one basis. The idea is that knowledge will transform into boosting self esteem and the individual to understand his or her own will. This they said they do because sometimes when pupils or students are in groups they can not openly talk about their own personal problems.

SCf: you know individual counselling is important as a source of sexuality information. Personal sexual issues can not be discussed in an environment not conducive and so we can see them one by one in our rooms.

In addition to the above, the school nurses believe that by so doing they give students a feeling of security and respect for anonymity and integrity. According to Lennè (1990), ethics is the basic part of sexuality education. The interviewees said they have a professional obligation to secrecy. One of them said:

YCf: even the parents are not supposed to be informed about the visit,....it is on some cases that I can call a parent and tell him or her about the situation, for example a young person who is suicidal because I must do that

The gynaecologists asserted that they like their work because their clients are girls and are interested in empowering them on how to negotiate condom use. It is not only that, but they said they also talk about the structure or anatomy of the female sex organ. I can explain this effort by saying it is part of prevention work as has been called for by international organisations. By raising young girls self consciousness, that might translate into self confidence and self respect thus marking the beginning of their own empowerment. UN (2007) reported that empowerment begins with self and that when an individual is empowered, they know what is happening to them and they use their knowledge for their good and for the good of others. Both staff in clinics and school takes into consideration gender quality, women empowerment and male involvement into consideration in their health promotion.

6.2.3 Condom campaigns & other activities

YCf: Aamm..... we normally have condom days every spring and summer. Then we use pamphlets to advertise our activity. With this we try to relay message about the importance of condom use. We do it in a funny way so that it can be entertainment as well as information dissemination at the same time.

Respondents said as health workers they must make people more aware of their responsibility to use condoms in the sexual acts. They said condoms protect both contractions of infections as well as pregnancy. Students are taught how to correctly use them and can get them for free in school and at youth clinics if they are under 20years according to interviews.

Apart from condom campaigns, the schools have other activities and projects as part of information and education about HIV prevention. An informant said *SCf: we have had an HIV/AIDS commemoration last year December in the school and we invited different organisations to talk about different topics.* The respondent however raised a complaint about lack of resources for HIV/AIDS and other health related problems. She said:

SCf: we are allocated 3000sek for each subject in the school every year and it is too little. It is difficult HIV groups and organisations are well funded by the government compared to us.....

6.3 Methods employed for gender mainstreaming

SCf: Working with young people is great because they are active; they ask a lot of questions because they are eager to learn. It is both boys and girls who are in schools.....some have relationships.

It has become evident from the interviews that pupils and students on both sexes are reached as schools are open for children of all sexes in Sweden. They asserted that adolescents need guidance more than any other stage because the adolescent stage is so vulnerable and filled with secrets. Much emphasis is on topics that will help them avoid risky behaviours that would endanger their lives according to informants. Outreach activity is deemed to be important as the clinic activity from the clinic staff views. Policy Programme for youth centre's (2000-2002) marked clinics to be responsible for visits by school classes, information in schools and being a complement to teaching in schools on sexuality and interpersonal relations.

Respondents in school said they do offer education and is complemented mostly by youth clinic staff. In terms of people who seek assistance both medical and psychosocial, females were reported to visit midwives more often than males do.

SCm: I think also girls have more access, more natural to talk about sexuality but men are not open, they don't do that. It's not natural for men to talk about their penis. Women can go and have it checked; men can do that only when there is a problem not in a preventive way and may be that's why we have more girls coming. Men when they have a problem don't like to talk about it.

One other reason might be because boys come to collect condoms and we don't register them. But girls need prescription from midwives or doctors.....

The division of the social world into male and female categories means that they are both socialised in very different ways. Following Helman (2000) view, they are educated to have different expectations of life and to develop emotionally and intellectually in particular ways. She said in the face of suffering and pain men are usually expected to have an unemotional language of distress; to be stoical and uncomplaining. This stoicism may be counterproductive to health, as from the response it shows from interviewees; some boys in Sweden may ignore early symptoms of serious disease.

Several aspects of male gender culture can be said to contribute to men's ill health or the risk of such ill health developing. A set of guidelines both explicit and implicit acquired from infancy onwards tell individuals how to perceive, think and act as either a male or female member of society. Respondent from school said this has a negative impact for males in general though it varies from one person to another.

SCf: Males don't come and this is why sometimes they end up committing suicide. They don't like to talk about their problems compared to females.

Even though there are lower numbers of males visiting counsellors or medical personnel, respondents said efforts are done to encourage them. There is open house or what they sometimes call "drop in centre" where they are allowed to visit without appointments. Days differ for both boys and girls so that they can be free to visit clinics. In addition to this, discussions are sometimes conducted in groups with members of the same sex. In so doing, they aim to strengthen pupils' self esteem and their sense of having their own identity. The above was said by clinic staff who said it was the best means they could use to attract more males to utilise their services as much as females do.

Staff recruitment has also been associated with ways of mainstreaming gender equality in services utilisation for young males and females. One respondent said;

YCM: Also the fact that we have males shows staff has gender balance. There is a mixed group in our working place. Almost five men and that shows to youth that its both boys and girls to be served, this is unusual with any other practice.

This, one can say can be a motivating factor for individuals who feel safe with professional of the same sex as them or somebody of the opposite sex. Even in the school, there are males working hand in hand with both counsellors and school nurses to offer psychosocial support. Apart from gender balance, staff competence also plays a major role. With respect to sexuality it has been explicitly indicated that those working at youth clinics should have the competence to respond to questions relating to sexuality in a non-moralizing way and that they are open for discussions regarding sexuality. Therefore, Sweden can be commended for this effort as compared to African countries e.g. some of the countries I referred to earlier in chapter 1 where some organisations use volunteers to offer sexuality education and other sexual health related services. They are not professional trained on counselling but are only offered the basics.

Central to sexuality education in recent years in Sweden has been the issue of equality between men and women. At schools, boys and girls should be treated equally, and traditional attitudes to gender roles should be counteracted and questioned (Centerwall, 1996). Staff in one of the clinics has said attempts have been made to give special, separate kinds of support to boys and girls apart from open houses.

YCf: with girls for example I can help them to realise that they have a right to say “yes” or “no” in sexual contexts and to develop the ability to do so. The same with boys, we can discuss with them the same, for example, how important it is to respect each other in a relationship.

Sweden has initiated projects designed to improve sex education for boys so that they could have accurate information about HIV/AIDS- related issues, and positive, healthy sex practices. According to Centerwall (1999), Swedish initiative to involve men in sexual and reproductive health services has included mentors who talk to young Swedish boys regarding their problems and intimate matters. The target groups were military personnel, teachers, nurses and midwives, ministers, coaches and other key persons caring for young men. I would say what the youth clinics are doing is part of promoting gender equality by involving boys in sexual health issues. By so doing, they can develop high self efficacy and knowledge which are seen to be important in health promotion according to Bandura. Knowledge is prerequisite for rational behaviour. National Institute of Public Health (2001) is also supportive of dissemination of knowledge since they believe it helps establish behaviour early. It is not only young people who should have knowledge but school personnel also need access to good reference material which has gender perspective (ibid) in order to give correct information. The institute also is of an opinion that behaviour as is it established early can follow a person through life and later be difficult to change. For that reason, young people are in many respects the strategically most important group to reach.

6.4 Topics mostly discussed in sexuality education

Teachers, nurses and social workers interviewed said that they teach youth how to exercise self protective control over sexual situations. Topics that educators from clinics discuss with pupils sounded the same from the interviews. This has been proved by the respondents working in different clinics.

SCm: Topics sometimes depend on what the teachers in schools would like us to talk about. We present different topics and some of them are condom use, HIV/AIDS and STIs, taking care of oneself, how the body of both boys and girls looks like, body and soul, food, how to say “no”, gender issues, homosexuality, masturbation and many more. The most important messages that we underlie is taking care of oneself or responsibility so that they can lead healthy lives. The most important thing is to have control over their lives.

Pupils receive essential factual information about high risk sexual behaviour and protective measures. This is enhancing perceived efficacy and skills in managing sexuality. All topics are discussed irrespective of their sensitivity as was said during the interviews. In a document by Ministry of foreign affairs (no date), they stated that youth is a time of quest when one has not yet adopted hard and fast behavioural habits

and is therefore likely to be relatively amenable to influence. They believe it's in youth too that people develop their inner compass which affects their health later in life. This is why sexuality education has been deemed crucially important to reduce young people's risk of becoming infected with HIV. Respondents said in Sweden there is no taboo subject when dealing with sexuality issues because the society is quite open. It is on rare cases that some youngsters would feel embarrassed among their peers when for instance the discussion is about homosexuality. It is those who are not sure of their sexual identity who feels ashamed because some of their peers laugh at them. This one can also see as an advantage for sexuality education openness to discussion by young people in Sweden

SCm: We educate topics such as how to deal with conflicts regarding sexual activities/terminating a relationship, abortion, teenage pregnancy, STIs, condom use and many more. Getting youth to talk openly about them is not a problem. We have observed that.....eeeh, if you feel shy to talk about these issues youth don't talk but by being open you give them an avenue where they can freely talk. Homosexuality in a group when boys are not sure about their sexuality yet can be a challenge. Boys sometimes can feel a bit tensed because they are more likely to be teased. It can be a taboo subject.

Most common themes cut across individual subjects; this was indicated by the answers given by respondent. Topics are well discussed without embarrassment. With roughly half of all HIV-infected individuals becoming infected before the age 25 worldwide, Sweden's interest is educating individuals on topics that they will have to make decisions at the end of the day. According to Sweden's Ministry of foreign affairs (no date), of the 15 000 people who become infected daily worldwide, 7000 are aged between 10 and 24. Therefore, children and adolescents in Sweden are given priority from a perspective of the rights of the child with the aim of reducing the spread of HIV. Information and education are important in influencing individuals towards behaviour that reduces the rate of transmission according to the National Institute of Public Health (2001). All are included in the education irrespective of gender because Sweden is interested in promoting gender equality in the area of health promotion as well. Both boys and girls are treated as equals because UNFPA says that is what forms the basis of successful HIV/AIDS prevention programmes. I would say that the country is considerate of gender responsive education as part of ill health prevention efforts.

Themes that touch on sexuality and personal relationships are ultimately concerned with identity, self esteem and empowerment (Centerwall, 1996). Message that I got from interviews is that the provision of information is in such a way that it will concern each and everyone. Discussions are conducted to give space for everyone to be able to recognise themselves. For instance at the school they have said,

SCm: our messages are supposed to be applicable to all students. We know that even in the same class students can be different in development, maturity. Some have had sex before and others no.....

Showing tolerance and openness allows everyone to speak. They also take into consideration mutual listening, having sensitivity to a young person's own reality, so that messages that are to be conveyed reach each person. These were responses to the

question that sought to find out the best practices that respond effectively to the needs of adolescent boys and girls of different ages and ethnicity. Centerwall (1996) reported that creating structure and security while also representing certain moral values is important.

All the facts a young person need in order to live a sexual life are part of individuation process. Respect to individual differences can help adolescents feel good about themselves, and their bodies, remain healthy, and build positive, equitable, loving relationships. By so doing, certain health problems can be prevented among them.

6.5 Service providers' experiences with regard to youth sexual health

All the interviewees had more than 5 years of work experience. The years ranged from 5- 20 years. They have had different experiences in youth work. The informants were aged between 30-55 years. All worked full time and had finished university and other institutes' education on different disciplines. The following were mentioned as some of their experiences working with young people:

6.5.1 Anxiety disorder

In the school, there are anxiety disorders which were reported to be a main concern. Disorders are brought about by factors such as societal expectations, peer pressure and individuals' sexual lives. These disorders were reported by school nurse because she meets most of the students who voluntarily come for individual counselling and she said some can be referred by the teachers.

SCf: You know society sets goals for them that are so high and when they can't meet them, they become stressed. Some want to be Madonnas for example.

SCm: And also, you know the pupils today they go to work. A lot of our students have some work in the evenings and weekends and they have to study at the same time. Many of pupils are stressed because of their studies, work.....

Poor interpersonal skills, coupled with negative thought processes, can create difficulties for adolescents negotiating changing relationships, searching for autonomy while trying to fit it, and simultaneously trying to succeed in a competitive academic and social environment (Burns et al, 2002). One of the primary aims of teachers and counsellors through individual counselling is to reduce known and modifiable anxiety risk factors as it was said during the interviews. The respondents at the school said they also impart good problem solving and social skills, high self esteem and a sense of control and positive expectations for the future. What they do is to raise the awareness of individual identity, strengthen the feeling of self worth, and increase the ability to handle interpersonal relation all of which are vital in promotion of health among youth. It is empowerment so that they can have control and not be controlled by circumstances.

6.5.2 Changing of partners

One other thing experienced by both school and youth clinic staff is the changing of partners as is shown by the below statement from one of the interviews. To quote one

respondent from the school, he said it contributes largely to their anxiety because sometimes they invest a lot in those relationships.

SCm: and sexual relations. They have their own sex lives and cause stress too when relationships don't work out.

Studies have shown that changing of partners is common among youngsters in Sweden. A series of love affairs before marriage, what can be termed serial monogamy can cause depression according to my interviews. Lennèr (1998) stated that young persons of both sexes in Sweden have had in mean 5 partners before they start a serious living together relationship or a marriage. In their study Herlitz and Ramstedt (2005) have found out its common to have three or more sexual partners in Sweden during one year. It is not only serial monogamy which service providers have commented on, they said they also have experienced that teenagers have the problem of “one night stand” and what sometimes is called “fuck buddies” common among youth. Their main concern is that their efforts are being reversed by these behaviours thus leading to STIs. This has been reported by Edgardh (2001) saying despite the Swedish tradition of a liberal and supportive approach towards adolescent sexual relations and the network of youth health centres, teenage abortion, HIV/AIDS rates and Chlamydia infections are rising steeply in Sweden.

6.5.3 Non use of condoms

The school as well as the clinics have further more experienced non use of condoms by young people. Certain factors that they have attributed to avoidance of condoms during sexual intercourse include the use of alcohol, the belief that sexual intercourse doesn't feel natural, belief that one's partner will think I'm not faithful and feelings of shyness and difficulty in discussions of condom use. The use of alcohol seems to be playing a major role and has been reported by Tydén (1996) too in sexual behaviour among high school students' study. Tydén has said alcohol plays a significant role in impairing judgement. Some youth don't practise safer sex despite the fact that they know what they should do as was said by clinic staff interviewed. Young people know a lot about STIs and preventative methods but have difficulty in applying their knowledge in practice (Jarlbros & Persson, 1990). Jarlbros & Persson have reported this from their youth clinic study too.

All of the clinics staff in my interviews exemplified non use of condoms because young people think they are protected when the girl is on the pill. They indicated that young people are only concerned about pregnancy not any other risk. This behaviour that they have observed encourages them (staff at clinics) to put more emphasis on showing youngsters how to discuss condom use. The use of skill based programmes, including self efficacy training has been suggested as the staff believes that they help them improve and/or increase communication with their sexual partner about condom use. Tydén (1996) recommends that girls or young women taking oral contraceptives should not tell their partner at the beginning of a new relationship. Tydén in one of the studies found out from some young men to be problematic to use a condom if the girl said she was on the pill. Clinic staff indicated that this is hazardous and shows that some youngsters have a sense of invulnerability to HIV, believing that it can not happen to them.

6.5.4 Skyrocketing incidences of STIs

One other important point to mention in the threat posed by the non use of condoms is STIs. Service providers have raised concern on rising numbers of STIs among youth. They have associated rising numbers with non use of condoms.

One of the respondents said, YCf:STIs are topping in our clinic. Every time we ask ourselves do we need anything else, do we need to talk about something different or what? Chlamydia is increasing 25% more compared to 2006 in this clinic. We are not happy about these numbers.

The prevalence rate of STIs is increasing each year in the country generally according to all informants. They said it is high among adolescents and young adults who are sexually active. According to information acquired from interviews in the Centre for Infectious Diseases Control in Gothenburg, the Västra Götaland region has had increases in STIs in years 2006-2007 from 2989 for women to 3677 and 2314 to 2853 for men. People affected are mostly youngsters and they associated the figures with changes in sexual behaviour. The major increase is noticed among young people aged between 15 and 24 years (www.smittskyddsinstitutet.se). The increase has been noted every year since 1997 according to information from the office in Gothenburg.

One respondent said YCf: I think we have had 40% increase in HIV/AIDS the whole of Sweden and almost 80% in Chlamydia. I think these numbers are true if I am not mistaken.

All of them have said STIs indicate risky behaviour and hence a vulnerability to the spread of HIV/AIDS and sexuality education should be given continuously. The respondents not only talked about the epidemiological consequences but also personal results that can be brought about by increases of STIs. It is through empowerment that young people can achieve power to effect change. This can be done by continuous normalisation of sexuality in the context of adolescent development, promoting values of respect and responsibility, and encouraging communication in relationships (Heasley & Crane, 2003). By doing this, young people are empowered in the process and can be in a position to make sound decisions.

However, some laws have been put in place to fight the spread of infectious diseases in the country called **The (Swedish) Law of Communicable Diseases Act** for example. In the Nordic countries (Sweden, Denmark, Norway, Finland, and Iceland), specific laws about sexually transmitted infections were introduced between the First and Second World Wars (Moi, 2001). The Communicable Diseases Act of 1988 “embodies and reinforces the notion that the protection of society takes precedence over the freedom of individuals (Danzinger, 1998)”. HIV/AIDS, since 1985, and Chlamydia, since 1988, are amongst about fifty other infections that have to be notified in Sweden (Christianson, 2006). This law permits registration of infected people, as well as compulsory partner notification and tracing. Once diagnosed with HIV, people are required by law to inform current and future sexual partners about their infection and adopt safer sex behaviours, such as obligatory condom use (www.regeringen.se). On July 1, 2004, a few minor changes in the law were made. This includes the duty of physicians to warn or inform sexual partners of a patient infected with HIV, if the

patient fails to do so. Isolation of the HIV positive person could be considered if the person engages in behaviour which is risky for others, only when other solutions are tried and found to be less successful (www.regeringen.se). Respondents believe this law to be good because it partly contributes to controlling HIV spread even though it is time consuming.

YCf: Yes we have traced partners before, of those people who had STIs. They had to conform because they are bound by the law to do that. But, it takes time to trace partners because sometimes they change addresses. If someone has an STI we ask them how many partners you had, do you have phone numbers so that we call them.....

The Communicable Diseases Act is not the only thing that was put in place as a basis for preventive work. Some other initiatives that formed part of prevention were provisions of the Health and Medical Services Act and the public health policy of the National Institute of Public Health with respect to HIV and STIs, as well as within the framework of various regional or local programmes (National Institute of Public Health, 2001). There are also medical and social laws that govern work for health care workers for example Föräldrabalken (Parent Law).

The National Institute of Public Health has one of its objectives being to give young people equal opportunities to develop healthy sexuality. It has also underlined 6 principles deemed to be important for prevention of STIs/HIV in Sweden. These are: right to knowledge that enables individuals to avoid infections; self determination encompassing added chance to make conscious choices with respect to sexual risk-taking; voluntariness and respect of individuals' integrity within the framework of applicable laws e.g. the Communicable Diseases Act; responsibility meaning individuals have to protect themselves against infections and for those who know they are infected with STI/HIV have a responsibility not to transmit the disease to others; treatment, relief and psychosocial support for those who have become infected; and participation and influence to have much say as possible in the work of STIs/HIV prevention (National Public Health Institute 2001: 31-32).

6.5.5 Fall in frequency of HIV/AIDS campaigns

Since the 1980s, the frequency and targeting of HIV/AIDS prevention campaigns has been modified in Sweden according to interviews. The campaigns used to be massive and have now reduced also leading to people feeling at ease with contracting the disease. The campaign was initiated by the AIDS Commission to prevent HIV in general public. At that time approximately 1500 cases of HIV had been documented in Sweden according to Hertliz and Steel (2000).

SCm: When we first heard about HIV/ADS in the 1980s in Sweden, there were many campaigns it was a big issue and everyone talked about it. But now no one is talking about it. And people were afraid of it. It is really changing.....(sigh).

Hertliz and Steel (2000) have verified this in their study. The two have said since 1987, the HIV/AIDS campaigns have changed. Prevention efforts are currently directed towards adolescents, immigrants from endemic countries, men who have sex with men, and HIV infected persons and their relatives. Interviewees felt that this is

not enough because the general public is left out. Their main concern is that other groups especially adults also have to be included because sometimes they can talk and share with their children about methods of prevention and information dispelling myths. They agreed that sometimes discussion in the family is important for the development of normative sexual behaviour. In the same study by Hertliz and Steel, they indicated that engagements in discussions concerning HIV/AIDS with family, friends and sexual partners was at its peak in 1987 and decreased in 1997. Christianson et al (2007) are also of the opinion that lack of adult supervision makes youth vulnerable. This they have discovered in their study conducted on HIV-positive youth in Sweden. The findings from Christianson et al (2007) said lack of supervision from parents is one of the mechanisms that may help in understanding why and how young people are at risk of contracting STIs including HIV.

6.5.6 Other contributing factors to Swedish sexuality patterns

A lot of factors have been seen to be influencing Swedish sexuality. Economic expansion had a huge impact on better living and social conditions, which led to the re-examination and change of the interpretation of sexual norms and patterns surrounding interpersonal relationships and sexual behaviour (Forsberg, 2001). Sexuality in the 2000's is said to be greatly influenced by the transition from the industrial society to the information society. Forsberg uses the example of the easy accessibility of pornography to anyone who would like to access this type of material, whereas in the early 1990's, adolescents most likely satisfied their sexual curiosity by ordering undergarments via mail order catalogues. Yet today, adolescents have a wide range of social information regarding sexuality, and the mass media expands upon this from television shows, newspaper articles to "girl's magazines and hardcore pornographic films (Forsberg, 2001: 18)". Swedish sexuality has also been influenced by other cultures, either by immigration of foreigners, which leads to multi-ethnic schools and neighbourhoods, or the emigration and travelling of Swedes (Forsberg, 2001).

Travelling abroad has also been mentioned by informants. They said it also has contribution to the spread of STIs and HIV among young Swedes. *SCm: In Sweden people travel a lot. For example I know of one girl who was in Australia and she met Swedes guys, and she thought she was safe with them. She didn't know their sexual life.....we are not safe we have to protect yourself.*

SCf: The elderly people also travel to other places for instance here in Sweden they like going to Thailand and they bring with them young girls. So it is a challenge really...

As part of prevention strategy, National Institute of Public Health (2001) has posited that an increasing number of people travel abroad and it targets foreign travellers for STI/HIV – prevention. The institute further iterated that in recent years a large proportion of Swedes who have contracted STI/HIV heterosexually were infected abroad. Special measures have been put in place for "immigrants with poor basic education and for those who have arrived in Sweden in recent years from countries with inadequate education about sexual matters, including information about HIV/AIDS and STIs (National Institute of Public Health, 2001:30)".

Of the trends noted in the 1996 "Sex in Sweden" study, Forsberg (2001) identifies two main contradictory trends. Firstly, several signs indicate that Swedish adolescents' attitudes are becoming more open and permissive. This is reflected towards a more permissive stance regarding sex outside of relationships and a greater acceptance of homosexuality and bisexuality. However, a contradictory trend is reflected by a more conservative view regarding sexuality, highlighted by the sex roles attributed to certain groups, demonstrated in the "later coitarche [first penetrative sexual experience] among girls than boys in some areas of the country (Forsberg, 2001: 19)".

6.6 Monitoring and evaluation (M&E)

It has been evident that there are different tools and systems used by youth clinics and the school to monitor their work. These varied from weekly meetings, statistics, feedback slips from clients and evaluation forms for pupils. The most common tool that the respondents iterated to be used is monthly statistics which they submit to the youth centre managers and with the school they said they keep it for their record. However, the respondents could not give the exact figures for teenage pregnancies, STIs, and other cases. One respondent said:

YCM: we have statistics and we compile it for our boss. But we don't know what he does with it. May be he gives to politicians and say this is what we have, we are not involved with that.

Informants said monitoring is part of prevention work because it helps them deal with personal change, and to teach adolescents how to exercise self protective control over sexual situations. However, they all showed concern about the rising numbers of STIs and said if they were politicians with power they would give the following factors priority;

YCF: if I was a politician, my priorities will be to advocate for more money for the youth clinics so that they could improve,

YCF:also in service training for teachers is needed

YCF:open discussions in the society, more campaigns and free condoms for everyone in Sweden. When we first heard about HIV/AIDS in Sweden there were many campaigns.....

The above were some of the concerns raised by youth clinic staff and at the school they feel students don't take sexuality education lessons seriously. As a result they said the politicians can influence change and make it like other ordinary subjects.

SCM: students feel it's not important sometimes because they do not have certificates and grades for sexuality education. And I think it should be in ordinary education system. They feel you are not paid for reading for this; they don't get marks like with other educational courses.

If empowerment of young people to make sound decisions, reinforcement of identity, promotion of sexual health and "STIs free" youth are the principal aims of youth clinics and the school then monitoring and evaluation are important. It is through

M&E that programmes can be improved, professionals can assess their health improvement role in an organisation. Naidoo & Wills (2005) asserted that how professional interpret their health improvement role will depend on many factors including their professional training, their role in the organisation, their personal experience, interests and social and political perspective. STIs, HIV/AIDS, abortion, teenage pregnancy and other health related problems are governments' concerns. Measuring such illness or disease trends places a premium on data analysis and statistics. M&E thus embodies ideas about why and how health can be improved. Information, education and communication (IEC) is one of the key policy areas on SRHR of young people in Europe and IPPF Europe network has recommended that the implementation of sexuality education should be monitored and evaluated.

6.7 Future prospects

Respondents said the following can help shape the future of sexuality education in Sweden. One said; *SCf:empower teachers because they get tired, no money in schools. Give them money for sexuality education.* The respondent believed that availing money for schools can help in providing the education in an effective manner.

Another respondent from school felt that; *SCm: The problem is in big schools like this, teachers have so many classes and how they do the education is different for each class. So it is better if the education is provided to each class in the school the same way.* The respondent was of a view that if there are special teachers who are assigned the task of giving sexuality education to all classes it can be better. He felt that there would not be variations in all schools.

The last opinion which was shared by all informants from youth clinics was that there should be *“special teachers who can do sexuality education without being embarrassed or ashamed because discussions on love-life can touch on one’s personal experiences.*

The respondents believe that the above can help sexuality education in the long run. Provision of information alone is unlikely to change behaviour and I am of the opinion that some of the above can form the basis of much health promotion. However, all efforts should be young people centred so that individuals can have a say in how their health is to be promoted and recognizing the value of their perspective. This is what empowerment calls for, supporting them to acquire the skills and confidence to take greater control of their own health.

7. REFLECTIONS AND CONCLUSION

Reflections

Research respondents indicated that in Sweden, most groups consider HIV/AIDS to be a distant threat, present in Africa, Asia, and big cities but not part of their social world. This notion has been shown in a study which concluded that since a few were actually HIV positive in Sweden, people did not worry about contracting the disease (Christianson, et. al, 2007). Most people thought that “ordinary” people with “bad luck”, excluding themselves, could be at risk of contracting HIV/AIDS. Therefore, sexuality education needs to be continued even after completion of schools. Unlike other forms of education, sexuality education and personal relationships is different in that it follows young people’s development (Centerwall, 1996). Continuation of the education can be helpful because in growing up, youngsters constantly process and integrate information in accordance with their level of development. It is for this reason that education in this arena be continuous.

From my experience working with young people, knowledge and attitudes regarding safer sex is not sufficient if the individual behaviour does not support this. This has often been termed by academics and professionals in related fields as the knowledge – attitude – behaviour (KAB) gap. The increasing cases of STIs among the youth in Sweden are a problem because we are in a global era of HIV/AIDS. There is a high risk of HIV/AIDS increases in the future, and recent media reports are already reporting this, confirmed by interviews with professionals in the field i.e. staff from Centre for Infectious Disease Control and PG Väst. National Institute of Public Health (2001) posited that knowledge is a prerequisite for rational behaviour but attitudes to what is appropriate in a given behaviour are very important.

Why adolescents?

Sweden unlike some of the countries targets adolescents because it is taken as a period of teachable moment. Lennèr (1997) sees the adolescence stage characterised by high motivation to learn and that earlier knowledge lasts in all contexts including sexuality. A number of factors hinder provision of sexuality education in for instance some of the African countries being Botswana and Swaziland as examples. Difficulties reported as hindering adolescents’ sexuality education include the belief by parents that their children are too young to receive such education, the embarrassment felt when talking about the subject, and the belief that it may encourage promiscuity (www.poptline.org). A WHO study has shown that education in sexuality does not lead to young people becoming sexually active. The idea underlying Swedish sexuality education is that a positive view on sexuality leads to greater self esteem and to the capacity to have control over one’s own sexual life (Centerwall, 1996). It is an important part of self efficacy and empowerment.

In Sweden, there is an openness and shared vision among many people towards sexuality and Lennèr (1997:1) expressed this as a “most humanistic way to promote sexual and reproductive wellbeing, health and rights”. Social tolerance has been concerned with responsibility for the sexual health of young people. Talking about empowerment is meaningless if the context in which young people find themselves in is not appropriate. Of the most importance also is a source of information and kind of

information that is given if young people are to have high sense of self efficacy, be empowered and have control of decisions concerning their live.

The mean age for sexual debut in Sweden is 17 for both boys and girls but 15 or 16 in other European countries (Lennèr, 1997). Adolescents in the two African countries cited above for instance become active at an early age and many of them have multiple partners. This early sexual initiation implies that education on sexuality should target youths when they are younger like Sweden does. According to Meekers & Ahmed (2000), education in Botswana should start no later than grade 6 or standard 1 and preferably earlier. Studies in Botswana by Moahi and Lekau (2005) have found that young people gather a great deal of SRH information and knowledge from sources that may not necessarily be reliable. Botswana and Swaziland's net result is that teenagers are getting pregnant at higher rates than in other societies that address the informational, attitudinal, and interpersonal aspects of sexual development openly and provide ready access to contraceptive services. In the case of Swaziland, drop outs at both primary and secondary school levels are high. There are also high rates of early marriage and child bearing and it has been reported that most deliveries in the country's hospitals are among teenage girls (www.ungei.org). Increasing number of girls become involved in commercial sex work sometimes in these countries.

Young people need information about 'the birds and the bees' facts, in plain and simple terms and at a level they will understand (Bandura, 1997). Bandura asserted that the psychosocial profile of teenagers who engage in unprotected intercourse includes a low sense of efficacy to exercise self protective control in sexual involvements.

Enablement equips young people with the personal resources to select and structure their environments in ways that set successful course for their lives. Bandura says the success with which the risks and challenges of adolescence are managed depends, in no smaller measure, on the strength of personal efficacy built up through prior mastery experiences. In Sweden adolescents are taught how to manage their sexuality long before they are ready to take on the functions of parenthood. The efforts toward education and access to birth control are working. In a study conducted by Darrouch et al (2002), Sweden proved to have lower teenage pregnancies and low percentage of women aged 20-24 who had a child before age 20. The country was compared to Canada, Great Britain, France and US. Sweden had 7, France 9, Canada 20 while Great Britain and US had 31 and 49 respectively. It shows that when teenagers are instructed through mastery modelling about how to exercise control over their sexual lives, they are much less vulnerable to enlistment in teenage pregnancy. This is not the only study proving how Europe yields their lower rates of negative outcomes and high rates of positive outcomes from adolescents' behaviour. Kelly & McGee (2003) have indicated that teens in Europe have fewer sexual partners during their teen years than their American peers. Countries where sex education is accepted, in combination with family planning services, have the lowest rate of teenage pregnancies and abortion on demand (Ruusuvaara, in Christianson, 2006).

With the increased knowledge, the age for sexual debut seems to rise for both boys and girls. Not only that but, birth of the first child rise to an age where both parents have had time to study, and learn and begin to work. This might hopefully create a better setting for mature parenthood and thus give the next generation a healthier and

happier childhood. By so doing, countries can globally mend problems and prevent future ones.

Conclusion

In Sweden, most efforts to prevent adverse results of early sexual activity centre on educating adolescents about sexual matters and contraceptive use, especially providing the sexual active ones with contraceptive services. Sexuality education is specifically designed to effect behavioural changes and the ability to effect situational changes. A situational change is possible with education and greater decision making power on health related and other matters. Work is done on the basis of a holistic view of young people. Adolescents' sexual reproductive health rights are taken seriously. They include issues on relationships that do not allow girls' consent, sexual expression, and pleasure. The reason for taking these rights seriously being that they may result in unwanted and physically dangerous pregnancies, increasing the risk of abortion, transmission of STIs, greatly increasing the risk of HIV infection and of cervical cancer. Girls are often unable to insist on the use of condoms or to practice birth control, and are accused of promiscuity if they do (Stein, 1997). The country now makes pupils gain skills and resources that lead to personal development. They intend to improve their self concept and personal interaction skills. Greater control over one's life is seen to be important. The power to make decisions and control one's life is the key to empowerment. Sexuality education utilises principles of social cognitive and empowerment theories and emphasise communication, negotiation and problem solving skills. They also provide information and skills development to reduce exposure to STIs, HIV and pregnancy among sexually active adolescents.

The country sees youth as assets rather than problems. Adolescents get inundated with messages aimed at helping them avoid unhealthy behaviours. The reality is that some groups for example teenagers do not experience as many negative consequences as teens in other countries in Africa and the United States. However, some researchers like Christianson have listed factors like family values, traditions, religion, economic standards, and environmental milieu as influential to young people's sexual decision making. These influence how young people act. This is true because Sweden wants to increase access to sexual and reproductive health care and ensure that such care is available and economically reasonable for everyone.

The reputation of Sweden's openness and freedom with regard to sexuality is not reflected in an "increase in permissiveness but rather the ability to make informed and responsible decisions regarding sexuality (Hertliz & Steel, 2000:889)". The country has no culture that has indigenous sex and health education discourse that are reinforced through the language of taboos and proverbs. Adolescents as a result are open to discuss all issues with clinic staff and their teachers. There are no clashes between sex education with traditional sex education and practices. In Botswana and Swaziland for example; HIV/AIDS prevention strategy shows high levels of public information and messages to Abstain, Be faithful and use Condoms (ABC). However, ABC discourse alone is ineffective when it conflicts with traditional sex education and practices. The process of empowerment has a back up in Sweden because of how people view sexuality in the country. The Swedish government had implemented mandatory sex education in all public schools and the education starts in primary schools with basic information concerning reproduction.

As the children advance to secondary they receive age appropriate information concerning contraception, STIs and HIV. Early education regarding sexuality has probably also contributed to the low prevalence of HIV. The education is provided by professionals and more emphasis is on universal access to high quality service with basic infrastructure and health facilities. These professionals have been seen to be the most efficient way to reach young people. In quoting Lennèr (1997) in her presentation, she said “professionals illustrate a holistic work, where both the body, emotional and the social situation including young people’s social network are considered”.

In addition to competent staff, equity and gender equality issues are fundamental to health service delivery. In clinics they have devised some means of promoting equality in the utilisation of services. One way is recruitment of both males and females to allow for freedom by young people to discuss openly with whoever they would choose to help them. There are mentors for young males also.

Efforts to get young people to adopt health practices that prevent STIs, unwanted pregnancies and abortions should be guided by the knowledge of what makes sexuality education effective in promoting preventive action. In my opinion teachers, social workers and other professionals involved in sexuality education should continually raise efficacy of youngsters worldwide. Sexuality education prompts increasing adoption of safer sex practices when perceived efficacy is raised, but decreasing adoption when perceived efficacy is lowered according to Bandura’s theory. By so doing, they can be able to exert personal control and therefore reducing the STIs incidences among youngsters. Bandura (1997) pointed out that people need enough knowledge of potential dangers to warrant action, and do not have to be scared out their wits to act. The point is belief in one’s personal efficacy to carry out the activities and belief in the efficacy of the self protective activities to detect incipient problems are uniformly good predictors. Young people need tools needed to exercise personal control over their health habits and this might help fight youth’s ill health which is a concern all over the world.

8. RECOMMENDATIONS FOR THE FUTURE

1. Provision of more professionals in clinics can be helpful because in schools teachers are not adequately equipped with training to seriously undertake sexuality education. Like other professionals, they may devote a major share of their efforts to the activities on which they are evaluated rather than education on sexuality. It is important for increased staff including social workers for they can help reduce rises in the number of lifetime partners, increased casual sex events, “fuck-buddy” relationships, and sexual intercourse outside stable relations common among young people.

2. Further research need to be done on young women’s perceptions towards “morning after pill” and condom use. The introduction of the new emergency “morning after” contraceptive pill for women is believed might lead to a reduction in young people’s unwillingness to use condoms. This possible explanation is a hypothesis that should be tested in further research.

3. Global need of sexuality education and youth centres because they have a holistic view of young people and their problem formulation not only medical but also social as well as psychological kind. These two are mostly needed in this era of HIV where young people are mostly affected worldwide.

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APPENDIX I

Interview Schedule

Demographic background

Age -----

Sex -----

Educational level ----- and Profession -----

Years of working experience -----

Work Experience

1. What is the organisation's goal and objectives?
2. Describe the responsibilities you are charged with in this organisation
3. How do you feel in being a service provider/teacher?
4. What are your experiences working with youth? Positive and complications
5. How is the general public's opinion towards sexuality education that you are doing?
 - How are parents' opinions and attitudes towards the education?
 - What about different groupings of parents (e.g. immigrants, homosexuals, single parents)?

Collaboration

6. Do you have any partnership? With which organisations (both locally and internationally)
7. What are your opinions about this partnership? How do you experience the cooperation?
 - Strengths and weaknesses
 - What needs improvement?
8. Any suggestions with regard to the organisations collaborative efforts.

Methods employed

9. How does the organisation reach out to youth in this part of the city?
10. Is there a gender balance in utilisation of services? Comments
11. How do you mainstream gender equality in sexual reproductive health services and education?
12. What are the best practices that respond effectively to the needs of adolescents?
 - For boys and girls
 - Different ages
 - Ethnicity
13. How do you get youth to talk openly during discussions especially for sensitive topics?

Topics

14. What topics do you usually address in general?
 - With what key messages that you underline?
 - Which are the most important topics?
15. How much time do you give for lessons/discussions about sexuality?
16. Who provides information dissemination?
17. Does gender play a role in being an educator? Comment
18. Which topics are taken as taboo? AND how do you deal with them?
19. To what extent do youth use contraceptives?
20. What are the main reasons among youth for avoiding contraceptives during sexual intercourse?
21. Are you focusing on some specific contraceptives? Which ones and why
22. How is the situation of youth and multiple partners?

23. Have you traced partners? Law of communicable infections

Impact issues

24. Would you say the organisation is achieving its goal? How

- Any impact on the work you are doing

25. What monitoring and evaluation tools and systems are used in here?

26. Give if possible statistics of STIs, teenage pregnancy and HIV/AIDS for the past years in your organisation

27. What do the numbers signify?

28. Does information and knowledge to young people get transformed into positive and healthy behaviour? Comment

29. What brings increase in both STIs and HIV in Sweden for the past years?

Reasons

30. What are youth's perceptions towards knowledge related to SRH and HIV/AIDS information services?

Challenges/ Future prospects

31. What are your most important challenges nowadays concerning sexuality education in Sweden?

32. What are your major concerns about sexuality education in the future?

33. Are there any needs to be considered in this area?

34. If you were a politician with power, what would be your priorities in the sexual and reproductive health field?

THANK YOU!

APPENDIX II – Letter of consent

My name is Bonolo Kelefang, a student at Gothenburg University (Department of Social work). I'm currently studying International Master of Science in Social Work and one of the requirements is to write a degree report in any area of social life in Sweden area. I have decided to write about youth and sexuality. The reason being that it's the area I'm working on back home. My country of origin is Botswana and working as a youth officer. I worked for an organisation that rendered sexual and reproductive health services to youth. Therefore, it will be my pleasure to conduct my research within your organisation and that involves interviewing some staff members.

The following is a presentation of how we will use the data collected in the interview.

The research project is a part of our education in the International Masters program in Social Work at the University of Gothenburg, Sweden. In order to insure that our project meets the ethical requirements for good research we promise to adhere to the following principles:

- Interviewees in the project will be given information about the purpose of the project.
- Interviewees have the right to decide whether he or she will participate in the project, even after the interview has been concluded.
- The collected data will be handled confidentially and will be kept in such a way that no unauthorized person can view or access it.

The interview will be recorded as this makes it easier for us to document what is said during the interview and also helps us in the continuing work with the project. In our analyze some data may be changed so that no interviewee will be recognized. After finishing the project the data will be destroyed. The data we collect will only be used in this project. It will be 1 1/2 hr interview.

You have the right to decline answering any questions, or terminate the interview without giving an explanation.

You are welcome to contact me or my supervisor in case you have any questions (E-mail addresses below).

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