Voluntary termination of pregnancy & contraceptive methods among juveniles

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MINISTRY
OF HEALTH
AND CONSUMERS AFFAIRS

Plan de Calidad para el Sistema Nacional de Salud

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Executive summary

This Report intends to provide responses to the concern about voluntary termination of pregnancy (VTP) among juveniles. The Ministry of Health and Consumers through the National Health System's Quality Agency –The Observatory on Women's Health– has carried out processing of data on VTP, checking of surveys and existing research in our country on the subject and has also commissioned a specific qualitative study. The latter conducted by CIMOP (Spanish initials for Communication, Image and Public Opinion) has gathered information on sexual conducts, resorting to VTP and usage of contraceptive methods among juveniles of ages between 14 and 24, from different Autonomous Communities, social classes and countries of origin, as well as from parents, educators and healthcare providers.

From results yielded by the report it emerges that Spanish VTE rates are still among the lowest in the EU countries and if currently available information is anything to go by (considering notification of VTP's evolution since a Register was put into effect in 1987, and the evolution of VTPs effected abroad, before and after legalization, it cannot be asserted that VTPs are rising among Spanish women. Rather, VTP's increase would be more likely due to the mounting recording and to the rising population of young inmigrants with diverse cultural situations and access to social services.

A change in young people's sexual and contraceptive usage conducts is also noticeable. They widely express having engaged in coital intercourse earlier and do it more frequently, in conditions not always safe from the unwanted pregnancies' prevention standpoint and of sexually transmitted diseases. Although in the European context they are the ones to use male prophylactics most, it is detected that a decrease in use might be taking place and gradually being replaced by emergency contraception. All this within a framework of unchanged gender inequality, as girls still withstand pressure to engage in early coital intercourse, show limited capacity for negotiation over use of prophylactics and are the ones to assume responsibily for emergency contraception and its potential consequences, and whenever VTP is involved.

Hence, collaboration among all administrations concerned is called for, with the express purpose of improving information on sexuality and reproduction and young people's access to contraceptives, keeping in mind that the approach must be a gender and multicultural one in order to avoid inequities.

1. Nature and purpose of the present report

The present report tries to give answers to the concern arising from pregnancy termination's figures among young people, released at the end of 2004 and related to VTP notified to the register during 2003, which reflected an increase in number for early ages.

Then the question arose «How come there has been a constant rise in VTP in the last ten years in our country particularly among women under 25 when there is more information about contraception methods and increased access to their benefits?

To answer this question the Ministry of Health and Consumers through the National Health System's Quality Agency –The Observatory on Women's Health, has carried out processing of VTP data, checking of surveys and existing research in our country on the subject and has also commissioned a specific qualitative study.

The latter, conducted by CIMOP, has gathered information on sexual conducts, resorting to VTP and usage of contraceptive methods among juveniles of ages between 14 and 24 from different Autonomous Communities and social classes.

Fourteen discussion groups with native juveniles and 10 with young immigrants were conducted and 5 individual interviews to women having had unwanted pregnancies (four terminated and a full term one) were held. In addition, 5 discussion groups with native parents were conducted, 3 with immigrant parents, 2 with education system's professionals and 24 individual interviews with healthcare providers and teaching professionals were held bearing in mind their informative and formative role in these subjects.

Since this report is aimed at giving response to the question raised above, its focus is on VTPs. For the sole purpose of better understanding them and their prevention, are the other aspects of reproductive health and sexuality in juveniles, approached. However, they are not considered to be irrelevant. Quite the opposite, as when a woman or a couple decide to terminate a pregnancy, it stands as obvious that the promotion of health initiatives that start with information and emotional-sexual education and go on to adequate access and correct use of contraceptives, has failed.

This report is within the reflexive and action framework of International Organizations. During the Special Session of the United Nations' General Assembly, held in June 1999, Governments agreed on that

«healthcare systems must train and equip healthcare providers and take whatsoever other measures to ensure that abortions be safe and accessible». Along these lines, the World Health Organization, in its role of advisor to nation-states regarding the provision of quality services, has issued a document entitled «No Risk Abortion: Technical and Policy Guide for Healthcare Systems».

Also international professional networks, such as the «International Planned Parenthood Federation» representing 151 national organizations, working in 183 countries, have raised the need to prevent unwanted pregnancies and approach voluntary termination of pregnancy as a public health issue because of its repercussions on women's health, and as far as quality and accessibility of healthcare services are concerned.

In what concerns juveniles, the World Health Organization has launched an European strategy on «Adolescents Sexual and Reproductive Health», which includes providing them with information and education on sexuality and reproduction, helping them develop the necessary skills to handle this matter in a responsible and satisfactory manner and giving them access to the suitable services to reduce both unwanted pregnancies and sexually transmitted infections.

On the other hand, in the European Parliament Resolution's on «Health and Rights in Terms of Sexuality and Reproduction» (2001/2128) the Commission are exhorted to take into account the youngs' opinions on sexual and reproductive health as well as their rights in this domaine, and are advised to consider the said opinions as important aspects in the follow-up of the White Paper for a fresh impulse to European Youngs.

The Ministry of Health and Consumers considers that sexual and reproductive health in general, and in particular that of juveniles are essential components of individual and collective health. It also considers that access to contraceptives, both safe and of proven efficacity as well as adequate information on their use in accordance with personal needs and preferences, contributes to the improvement of individual, family and society's sexual and reproductive health.

Alongside Human Rights and Health International Organizations, the Ministry of Health and Consumers considers that the best, health authorities can do to face VTP is establish sexual and reproductive health policies to make the different contraceptive options easier, as well as provide accessible services that ensure that VTP are performed under quality conditions for users.

Along the same lines, the Ministry of Health and Consumers considers that promotion of an adequate reproductive and sexual health, with a special regard for the affective aspect, is an essential component of gender equality policies.

2. VTP rates in spain

After legalization of VTP by Organic Act 9/1985 of 5 July 1985, a Ministry of Health and Consumers' Decree of 16 June 1986, made notification of voluntary terminations of pregnancy, compulsory through official form. Thus, the Ministry's first statistics date from 1987 and gather 16,766 notified VTP from 29 centres.

Close inspection of VTP registered statistics reveals a slightly increasing trend in all age segments up to 1992 followed by an apparent standstill stretching over to 1997 and a seeming upturn mostly in youngest women until 2002. From that year onwards the overall figures come to a relative halt then splitting into 2 diverging groups (20 to 24 and under 19 years of age) though a close watch should be kept on figures over the next years to see whether this trend stabilizes (Table 1 and Graph 1).

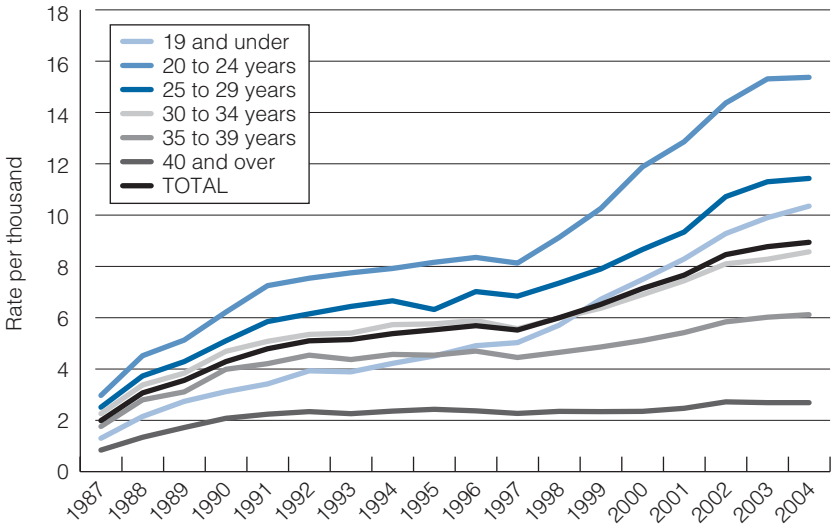
Table 1. VTP Rates (per thousand) by ages groups. Spain 1990-2004

AGE	1990	1995	2000	2002	2004
< 20	3.12	4.51	7.49	9.28	10.35
20-24	6.22	8.16	11.88	14.37	15.37
25-29	5.1	6.32	8.66	10.72	11.43
30-34	4.69	5.76	6.9	8.1	8.57
35-39	3.99	4.54	5.11	5.84	6.12
> 40	2.08	2.43	2.35	2.72	2.69
TOTAL*	**4.29**	**5.53**	**7.14**	**8.46**	**8.94**

Source: Ministry of Health and Consumers. VTP Register.

* Women between ages 15-44.

Graph 1. Evolution of VTP rates in accordance to age. Spain1987-2004



Source: Ministry of Health and Consumers. VTP Register 2004.

3. VTP in other countries

Since VTP is a worldwide phenomenon, it is advisable to know what the situation is in neighbouring countries with similar laws, records and welfare provisions when it comes to considering the situation in Spain. Nevertheless comparisons and their interpretations should be cautious bearing in mind the diversity of existing approaches and cultural differences. According to some comparative studies, it seems that once laws are enacted in some countries in order to regularize attention to VTP and these are registered, there is at first a steady rate increase until they reach a ceiling where they stabilize. This happened for instance in the United States and in the UK where they seem to be decreasing slightly at present after having doubled or tripled present rates in Spain.

Internationally, two aspects shown in the graph 2 below are worth mentioning:

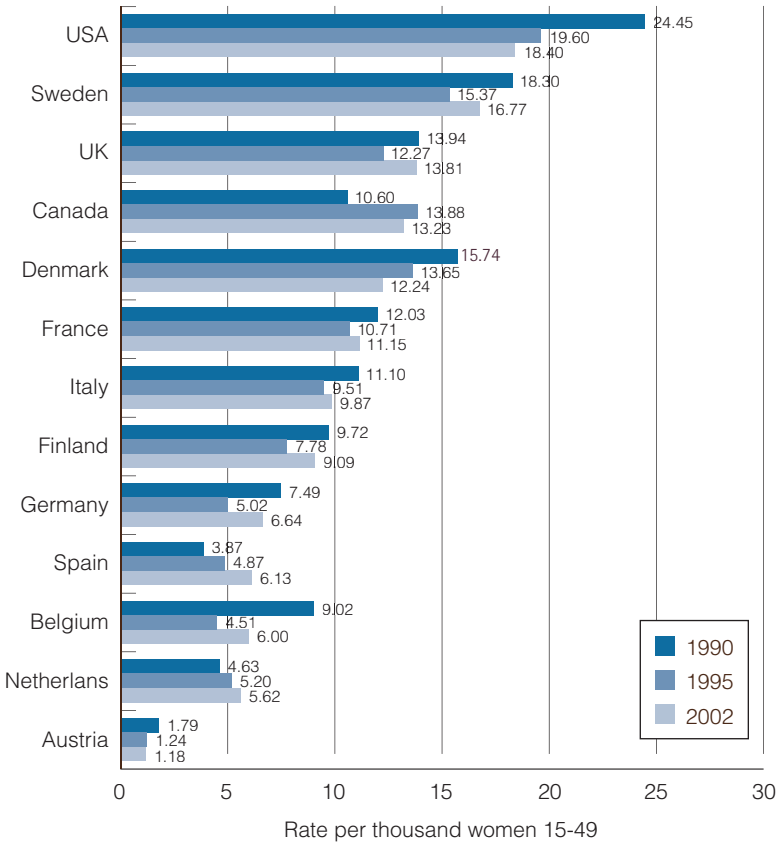
1) In Spain, rates seem to be still rising while in other countries they seem to be decreasing slightly.

2) Spanish rates are still the lowest if compared with those of other EU countries and others like the U. S. and Canada.

In order to correctly interpret these data, one must bear in mind on the one hand when VTPs started to be registered in Spain and extent of reporting evolution in the first years, and on the other, the fact that legalization in our country took place later than in most of the other countries (Sweden in 1937; United Kingdom in 1967). Customs and culturally determining factors, together with the existence or absence of family planning policies would partly explain these differences, as is the case of Romania where rates above 50 per thousand were reached in 2002.

Also, in countries where a decrease is detected, it does not seem to be important in absolute terms and presents fluctuations over time. One should also bear in mind that a decrease in the number of VTPs, especially when associated to policies that hinder its practice in public services, does not necessarily mean a lessening of their numbers, but just that they are not being registered or are being performed in inadequate conditions, with an increased risk for the users' health and lives. In such cases, VTPs become a public health issue and a source of gender and income inequity.

Graph 2. Abortion frequency in some European countries, Canada and USA



Within the EU15 VTP is yet to be legalized in Ireland, Luxembourg and Portugal. 1990 graphic representation corresponds to 1992 for Belgium; likewise 1995 shows 1994 data for Greece; 2002 graph shows 1997 for France and The Netherlands, 1999 for Albania, Italy and USA, 2000 for Austria, Canada and Spain and 2001 for Belgium and Denmark. Germany includes FRG and the former GDR.

Databases used: Eurostat, United Nations for several years. Also www.insee.fr for France, www.statistics.gov.uk for United Kingdom, www.ssd.scb.se for Sweden. INE y Ministerio de Sanidad y Consumo for Spain. For USA and Canada, United Nation's demographi year books. Also USA www.cdc.gov and www.census.gov and for Canada also www.bcstats.gov.bc.ca.

Likewise, existing difficulties must be acknowledged for comparing rates in different countries without going deep into political and social circumstances which might explain detected changes and that might range from amendments to laws as was the case in Germany after reunification, to changes in records, social climate or provision of services in those countries. As shown in the tables below, variations in the coverage afforded by laws are substantial. Hence, we must take this international information as it is: one more element for reflection over the complexity of the phenomenon we are dealing with (Ruiz, 2005).

Table 2. Legal regulation of abortion in various countries, in terms of restrictiveness (1997)

	more restrictive ←				→ more open
COUNTRIES	Only to save the woman's life	Also due to physical health problems	Also due to mental health problems	Also due to socio-economical reasons	No restrictions imposed on reason but on gestation stage
Ireland	✔				
Poland	✔	✔			
Northern Ireland	✔	✔	✔		
Portugal	✔	✔	✔		
Switzerland	✔	✔	✔		
Spain	✔	✔	✔		
Finland	✔	✔	✔	✔	
United Kingdom	✔	✔	✔	✔	
Italy	✔	✔	✔	✔	✔
Greece	✔	✔	✔	✔	✔
France	✔	✔	✔	✔	✔
Germany	✔	✔	✔	✔	✔
Austria	✔	✔	✔	✔	✔
The Netherlands	✔	✔	✔	✔	✔
Belgium	✔	✔	✔	✔	✔
Sweden	✔	✔	✔	✔	✔
Norway	✔	✔	✔	✔	✔
Denmark	✔	✔	✔	✔	✔
Russia	✔	✔	✔	✔	✔
Romania	✔	✔	✔	✔	✔
Hungary	✔	✔	✔	✔	✔
Yugoslavia	✔	✔	✔	✔	✔
Cuba	✔	✔	✔	✔	✔
Canada	✔	✔	✔	✔	✔
USA	✔	✔	✔	✔	✔

Fuente: A. Rahman, I. Katzive y Henshaw. «A global review of laws on Induced abortion 1985-1997», in *Family Planning Perspectives,* vol. 24, number 2, June 1998.

Table 3. Abortion Regulation in different world regions in terms of restrictiveness (1997)

	more restrictive ←				→ more open
REGIONS	Only to save the woman's life	Also due to physical health problems	Also due to mental health problems	Also due to socio-economic considerations	No restrictions imposed on reason but on gestation stage
25% of world population: 54 African countries, Asia, America and only Ireland in Europe	✔				
10% of world population: 25 African countries, Asia, America and only Poland in Europe	✔	✔			
4% of world population: 20 African countries, Asia, Americas and, in Europe: Northern Ireland, Switzerland, Portugal and Spain	✔	✔	✔		
20% of world population: 6 Asia countries, Africa and, in Europa: Finlandia y Great Britain	✔	✔	✔	✔	
41% of world population: 49 countries: 29 from Europe, 6 from Asia, and 4 from the Americas	✔	✔	✔	✔	✔

Fuente: A. Rahman, I. Katzive y Henshaw. «A global review of laws on Induced abortion 1985-1997», in *Family Planning Perspectives,* vol. 24, number 2, June 1998.

4. VTP register

When frequency of any health phenomenon is analysed it is crucial to know the source of information where data come from. More precisely: which aspects of the phenomenon it depicts, how reliable it is and what the coverage is with respect to the former. Validity of statistics will largely depend on all this and therefore so will the validity of the analysis of a situation based on the said statistics.

The register started to operate after enactment of a Ministry of Health and Consumers' Decree on June 16, 1986 which established the obligation to notify voluntary terminations of pregnancy. Progressive improvement in the quality of the recording and its territorial coverage (Catalonia was included in 1990) shows a progressive increase in the number of notifying centres with the subsequent and progressive increase of the number of notified VTPs.

- 29 centres in 1987 from which 16,766 were notified.
- 102 centres in 1995 from which 49,367 were notified.
- 133 centres in 2004 from which 84,985 were notified.

Various studies included in a meta-analysed revision of the subject (Ruiz, 2005) state that, due to the habitual initial difficulties that all registers encounter and to the limited territorial coverage at the beginning of the reporting, under-recording of VTPs in the first years might be between 30 and 70% of cases.

In the study carried out by the Ministry of Health and Consumers to evaluate registering quality in 1990 (its fourth year in operation) estimated unregistered VTP cases that year, reached 18,500, i.e. 33% of actually practised VTPs which were estimated to be 55,577. This would mean a real rate of VTPs in 1990 of 6.5 per thousand and not 4.3 per thousand as statistics reflect (Rodríguez, 1994).

Studies carried out in France and Italy show similar levels of under-recording (Ruiz, 2005).

The rise in number of notifying centres no doubt shows an improvement in VTP registering and a better territorial coverage. It also probably shows a real rise in centres providing VTPs, which would mean better accessibility. On the other hand, these facts cast a doubt on to what extent VTPs have risen, or if it is their notification which has, or if both phenomenons have occurred in parallel.

5. VTP among Spanish women

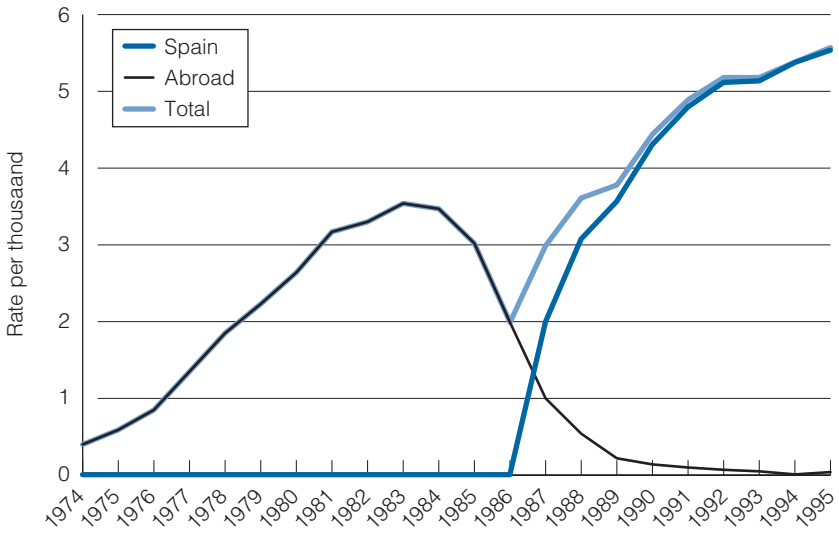
When analysing real evolution of VTP among «Spanish women» not only must notified cases be taken into account, since an official register exists but also those that went undeclared, more importantly before records were set up and during the first years of functioning, and, also VTPs performed on Spanish women in other countries.

VTP is common practice when it comes to fertility control in all societies and at all times in History and occurs be it permitted, legalized or forbidden. Forty six millions of VTPs per year are estimated to be performed, around half of which in unsafe conditions, especially in countries where they have not yet been legalized or where accessibility to adequate services does not exist. According to international human rights and healthcare organizations, the best governments can do concerning VTPs is establish sexual and reproductive health policies that promote effective contraception and provide quality services designed to ensure that VTPs are performed in conditions of accessibility for users (WHO, 2003).

In Spain, just as in every other country in the world, VTPs have always been performed. Before the Legalization Act, they were carried out clandestinely putting women's health and lives in serious danger. Some women travelled to countries where healthcare systems provided these services, England and Holland mostly. So in years prior to democracy (1974-1978) around 38,000 women voluntarily terminated their pregnancy in England and some more than 220,000 did it in Holland or England in the years previous to legalization in Spain (1974-1986).

After enacting of the Law, VTP records in those countries show a sharp and progressive fall of the number of Spanish women registered, dropping to only 328 in 1995 (it should be pointed out that most of those women were young). This fall is closely related to the increase of registered cases in Spain, therefore the total of cases in those countries added to the ones in Spain shows a similar trend. In other words, application of the law in Spain did not increase VTPs further than was expected from what was already happening. What it really did was supress the need for women to travel abroad as shown in graph 3 (Peiró, 2001).

Graph 3. Evolution of VTPs performed abroad and in Spain



6. VTP in Spain

As previously stated, when analysing VTPs, it is important to separate all that concerns Spanish women —and that means including events that took place before and after legalization, both in and outside Spain– from the analysis of the phenomenon of VTP in Spain using the information provided by the register —and that includes both Spanish citizens and citizens from other countries, bearing in mind that in both cases we will only be considering part of reality. The visible part reflected by what was notified and registered.

Furthermore, if we analyze the VTP phenomenon in Spain from data in the register, the fact is that among variables reflected, the user's country of origin is not mentioned. There are thus important constraints when it comes to know what really is happening with these groups of women. Women who, at least upon arrival in Spain are more vulnerable since they usually have less information on contraception and greater difficulties to gain access to this type of healthcare facility.

Apart from women from other countries residing in Spain, part of recorded VTPs pertain to non-resident foreign women (2,496 in 2004). As we have just seen, when part of the women who need to have an abortion cannot have one in their country, they travel to other places where they can be provided with that service, just as Spaniards used to do before the law was passed.

Since Spanish VTP register does not include the variable «country of origin» on its notification bulletin, it is only possible to obtain such information by means of detailed reports, some clinic statistics or from Autonomous Communities' records that do include it, as is the case of the Madrid Community.

It is a well known fact that over the last few years in Spain there has been an important and steady increase of the foreign population (European Community and Non-EC) with a central presence in birthrate and fertility. Based on INE's (National Institute of Statistics) provisional data for 2005, 15% of births (nearly 70,000) were from immigrant mothers and more than half of the total were from women coming from the four countries that appear on Table 4.

This higher reproductive activity translates, on the one hand, into different positions regarding sexual relations, contraception and equal opportunities for men and women in different cultures. And also probably into the fact that many of the newcomers find it difficult to gain access to

Table 4. Distribution of women and births by country of origin

COUNTRY OF ORIGIN	% from among inmigrant women	% from among birth of inmigrants
Ecuador	15	14.2
Morocco	10	20.8
Colombia	9	7.1
Romania	8	9.8
TOTAL	32	51.9

the National Health System's reproductive healthcare services. It is only logical to assume that such a reproductive activity entails not only an increased number of births but also of unplanned and unwanted pregnancies and therefore of VTPs.

On the other hand, even though residing in Spain gives them right to benefit from family planning, the use of it will greatly depend on cultural, economical and geographical accessibilty. It is worth mentioning here that if the decrease of the annual birth rate from foreign mothers since 2002 is anything to go by, it could be said that these women more and more resemble Spanish women in this sense, and that this could be due to the fact that little by little they are gaining better access to contraception and becoming better able to decide on their maternity.

To have the country of origin datum is essential to correctly analyze the situation and properly direct preventing measures taking into account particular circumstances and specific needs of each group of users in order to improve efficacity.

7. Users' countries of origin

Spain, as has already been mentioned, has undergone an important socio-demographic transformation over the last 10 years with an increase since the mid-90s of incoming population from other countries that according to INE has gone from half a million foreigners in 1995 (among which the estimated economical immigration hardly reached 200,000) to more than 3.69 million in 2005, that is an 8.4% of the population (among which more than 2.5 million are supposed to represent economic immigration). In this flow, fertile women hold an important place as they already exceeded one million in 2005.

Although it is true at present that it is hardly possible to know exactly the frequency of VTPs among immigrants as VTP records do not hold this information, there exist some studies effected in various areas in Spain that account, though partially, for the change in the socio-demographic and cultural profile of the VTP phenomenon.

In a study carried out between 1998 and 2002 in the Northern area of Almeria province (Barroso, 2005) the percentage of immigrants out of the total performed VTPs was 52.7%, with 25% corresponding to minors of ages 15 to 19 and 60.6% to the age group between 20 to 24 years. Likewise, VTP growth data in the various Andalousian Healthcare Districts are directly related to the presence of immigrants.

A study by Madrid Dator (1) Clinic on procedures performed shows a progessive rise in the proportion of non-Spanish users from year 1994 to 2005 (from 11 to 45%), which reached 22% among women under 25 years of age in 1999 and 35% in 2005.

Data from the *Epidemiologic Bulletin of the Madrid Community,* in 2004 (2), revealed that half of notified VTPs corresponded to non-Spanish women in accordance with the following distribution by ages:

(1) Dator Clinic, 2006.

(2) *Boletín Epidemiológico de la Comunidad de Madrid,* Num. 3. Vol. II. March 2005.

Table 5. VTP in the Community of Madrid by country of origin and age

AGE	Spain (n)	Another country (n)	Total (n)	% another country/total
< 20	1,011	685	1,696	40.4
20-24	1,796	2,281	4,077	55.9
25-29	1,613	2,407	4,027	59.9
30-34	1,354	1,750	3,104	56.4
35-30	1,061	957	2,018	47.4
40-44	489	292	781	37.4
> 45	35	11	46	23.9
TOTAL	**7,359**	**8,383**	**15,742**	**53.3**

Source: *BECM,* no. 3, vol. II, March 2005.

A different study (3) undertaken on data gathered from 15.000 questionnaires supplied by 12 private clinics in 5 Autonomous Communities reveals that 49% of VTPs performed in the said clinics was to non-spanish women.

Evidence from these studies seems to determine that between 40 and 50% of VTP performed in Spain correspond to non-Spanish women with an important representation of women under 25 years of age among them.

Extrapolating this information to the whole of the immigrant population in Spain in order to make an estimate of VTP rates among native population (4) and taking into account over-recording in 1990, it

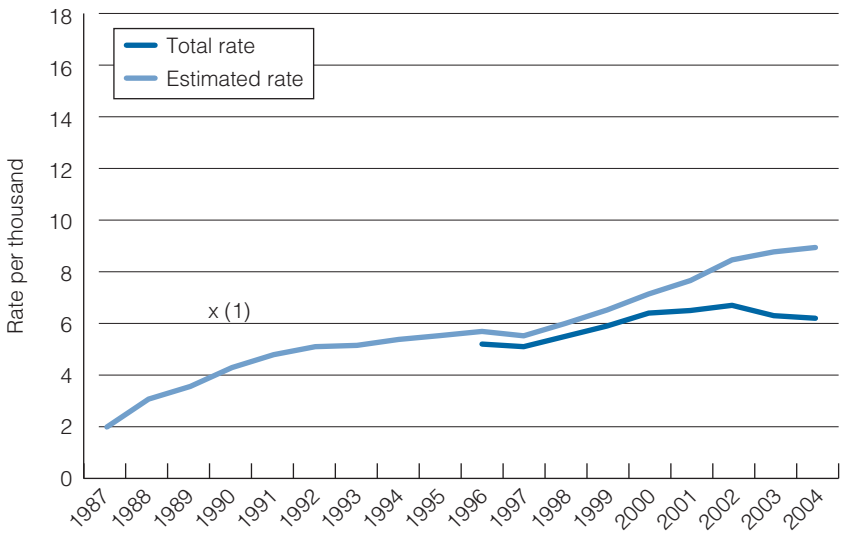
(3) *El País,* 28 December 2005.

(4) With the purpose of reflecting immigration effects on VTP rates, corrected rates have been issued for Spain as a whole. To this end specific VTP rates by age were calculated for immigrants in the Community of Madrid (only «country of origin factor» available data); these specific rates were assumed to be the same for the whole of the immigrant population in Spain (and constant in time) and were applied to this fertile age population. That is how estimated VTP were obtained for immigrant population, and, subtracting from the total, those attributable to native population.It is on them that estimated rates were calculated.

This estimate presents two relevant limiting factors: 1) when obtaining specific rates, the denominator (municipal register's foreign population records) might be under-represented,

might be said that total VTP rates among Spanish women over the studied period would have remained at around 6 per thousand. Thus the recent increase would be principally related to the change in composition of Spanish society that now includes various collectivities, that modify, temporarily at least, statistics (Graph 4).

Graph 4. Evolution of total VTP rate and native population estimated rate. Spain1987-2004



(1) Rodríguez Blas, C., *Gac Sanit* 1994; 8: 63-70.

According to these estimates and bearing in mind the limiting factors encountered, women immigrants' VTP rates would be considerably higher than those of Spanish women (up to 30 per thousand). In under 24 VTPs, two-thirds of the rate increases occurred between 1996 and 2004 would bear

with which rates would be over-estimated; 2) if women immigrants' total population did not present the same profile as Madrid immigrants with regard to the country of origin, reproductive habits, socio-economical and work situation –and therefore VTP rates– this estimate would change. At any rate, and as long as the variable «country or origin» is not included in VTPs Protocol, it is an approach that may help us understand rates evolution.

relation with the increase in young immigrant population. These estimates would strengthen the hypothesis that relates difficulties encountered by women immigrants to gain access to adequate contraceptive methods and to reproductive and sexual healthcare services.

But the numerical factor is not the only influence, as, due to reasons related to religious and cultural factors among others, women coming from certain countries are more fertile than others, and hence yield higher birth and VTP rates than expected with regard to their numerical presence. A good example are women from Romania, a country with one of the highest VTP rates in Europe and that transfer their situation outside their country. On the contrary, Colombian women's presence is below their populational weight.

According to the qualitative study conducted by CIMOP, unwanted pregnancies in some young South Americans might be related to their integration process in Spanish society. This process might entail the addition of the country of origin's society and culture risks to those of the Spanish society, not having yet developed skills for the responsible and positive management of the said risks. On the one hand, family culture of origin prescribes a large number of children as a model of socio-personal fulfillment. On the other, in Spain, more personalized vital objectives and a young sexuality dissociated from reproductive objectives prevail. The «courtship» culture existing in the country of origin generates the belief in the knowledge of, and the confidence in the other, that remains in Spain but with a much shorter «courtship». This can give a false impression of security and of not needing the use of prophylactics, with an increased risk of pregnancy or infection.

This study also reveals that a situation of inequality affecting girls exists in these groups, as they see themselves under boys' pressure to engage in sexual intercourse using no prophylactics or other contraceptive methods. Also, some of them seek to get pregnant as having children would come as a way to establish lasting bonds. But often, if pregnancy occurs, it prompts the couple's breakup and sometimes its termination.

In another qualitative study (Llacer, 2006), interviewed healthcare staff pointed to timetables as one of immigrant women's difficulties to gain access to family planning consultations. These women often find employment in domestic service, care to dependent persons or in restaurant service, that coincide in time with consultations or find it difficult to obtain permission to attend them. Other circumstances listed as related to unwanted pregnancies and VTPs, were their partners' refusal to use prophylactics, disorientation as to optimal contraceptive methods to be used, lack of partner, or if existing, lack of co-responsibility with regard to pregnancy, and, in some wome n mixed up in prostitution, false

expectations that pregnancy might help them quit. Also situations of sexual violence were mentioned, either within the family or from the partner, as a more complex problem to be detected than the most extreme of rape.

8. Other socio-demographic features of VTPs in Spain

With regard to the socio-economical traits of women that use this service, we can only count on marital status and education level variables, the only ones to be likewise included in both the VTP register and in the populational census.

This allows calculation of those populational rates which enable correct assessment of changes over time. Since censuses are conducted every 10 years and each subsequent municipal register does not include these variables, their updated data cannot thus be submitted. Therefore, populational rates have been calculated from data in the latest available censuses (1991 and 2001) and from information gathered in the VTP register for the two previously mentioned variables.

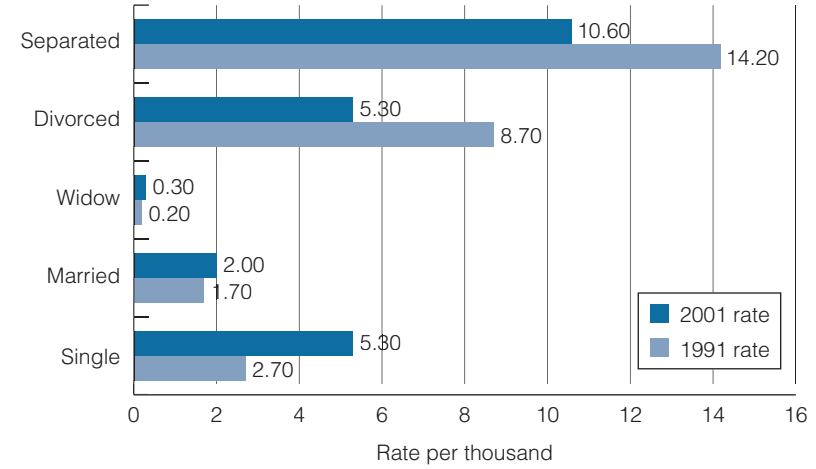
Where marital status is concerned, the highest VTP rates come from users declaring to be separated or divorced. With regard to 1991, this group's VTPs have gone down while rising among unmarried women.

As regards education level, though for the period under study the highest rate is that of groups with a higher level of education, an increase in the 2001 rate corresponding to women with lower education levels has been detected.

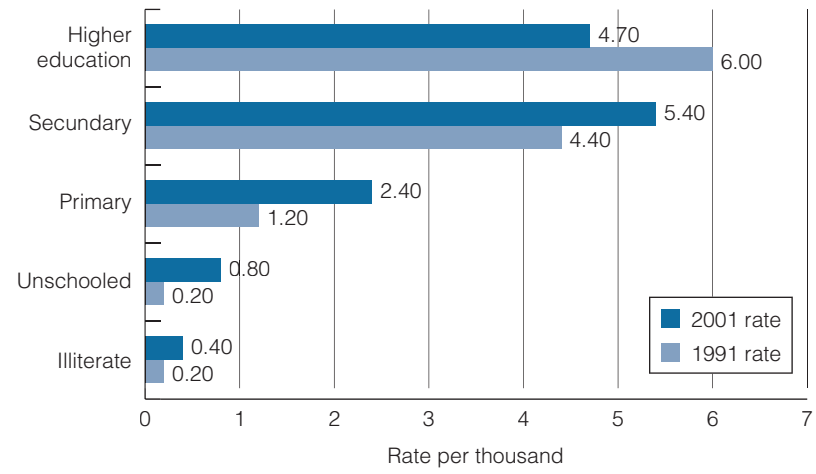
The only group showing a decrease in VTP has been higher education users, namely middle and upper-middle classes, a majority of whose members usually access University and higher education. The highest rate in 2001 was registered in users with secondary education (Graphics 5 and 6).

Qualitative information may help us to better understand these changes that might be due to variations in the working and social composition of youth residing in Spain and to the different positionning of young people and their families in front of unwanted pregnancy situations and their repercussions on their lives.

Graph 5. **Performance of VTPs in accordance to marital status. Spain 1991 & 2001**



Graph 6. **Performance of VTPs in accordance to level of education. Spain 1991 & 2001**



9. Changes in sexuality-related cultures

Changes in the way of experiencing sexuality occur in all groups of juveniles. Among young female immigrants the change takes place between existing cultures in societies and social groups of origin and the ones they must and are able to develop in Spain. In Spanish women, the main change occurs among cultures and behaviours of generations brought up in the fear of HIV-AIDS in the late 80s and early 90s and certain emergent cultures in which sexuality takes the role of the school of life and in which fear to HIV-AIDS has significantly decreased. The main consequences of those changes in relation with the risk of unplanned pregnancy and subsequent TP is that heterosexual coital relations have become widespread and start earlier.

The evolution of answers to the question about «having had coital intercourse» between 1990 and 2002 (Graphic 7) may be observed in the WHO international schoolchildren survey (Ministry of Health HBSC 2004). The main conclusion that arises is that along these 12 years there has been a significant change in their sexual behaviour, chiefly among female teenagers who show a more precocious start of coital intercourse.

In 2002 results, within the 17-18 years old group, boys declare having started at 14.61 on average and girls at 15.89 whilst among the youngest, at 14.33 and 15.83 respectively. Results gathered in «Informes de la Juventud en España» (IJE) The Youth in Spain Report YSR (Table 6) confirm these trends, although having applied different methods on different age groups data may not coincide exactly.

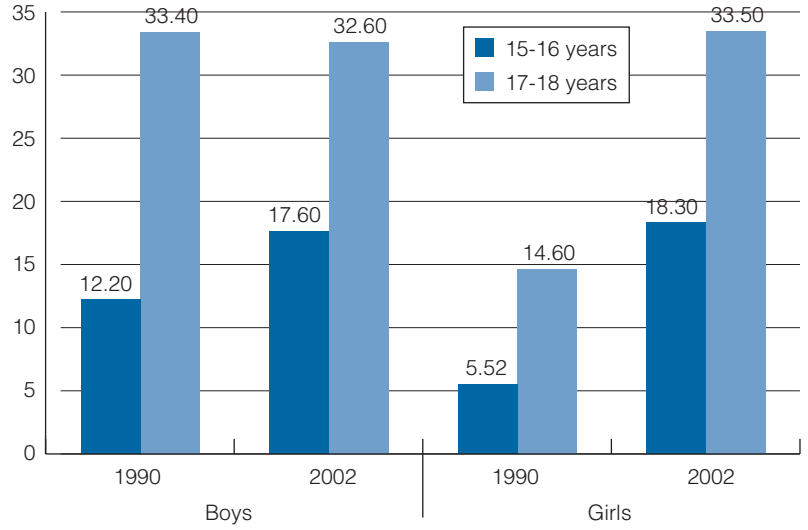
In the same survey, when comparing countries participating in 2002, what stands out is the difference in percentages of juveniles declaring coital sexual relations at 15. These different percentages apply both to frequency and to numbers of boys and girls. In Spain's case, aspects to be pointed out are that frequency is below average and that differences between boys and girls are small (Graph 8).

Starting age seems to have moved forward as other conducts related to health do lilewise (for instance cigarettes and alcohol consumption) and boys' and girls' practices have levelled off.

Something worth pointing out here is that answers given may well be gender biased, as may be the case when surveying on sex habits.

This earlier initiation might entail a higher exposure to risks as lacking sufficient information and being less able to responsibly manage them at

Graph 7. Different age boys and girls (%) that admit engaged in coital sexual relations



Source: Ministry of Health and Consumers-HBSC 1990 and 2002 for Spain.

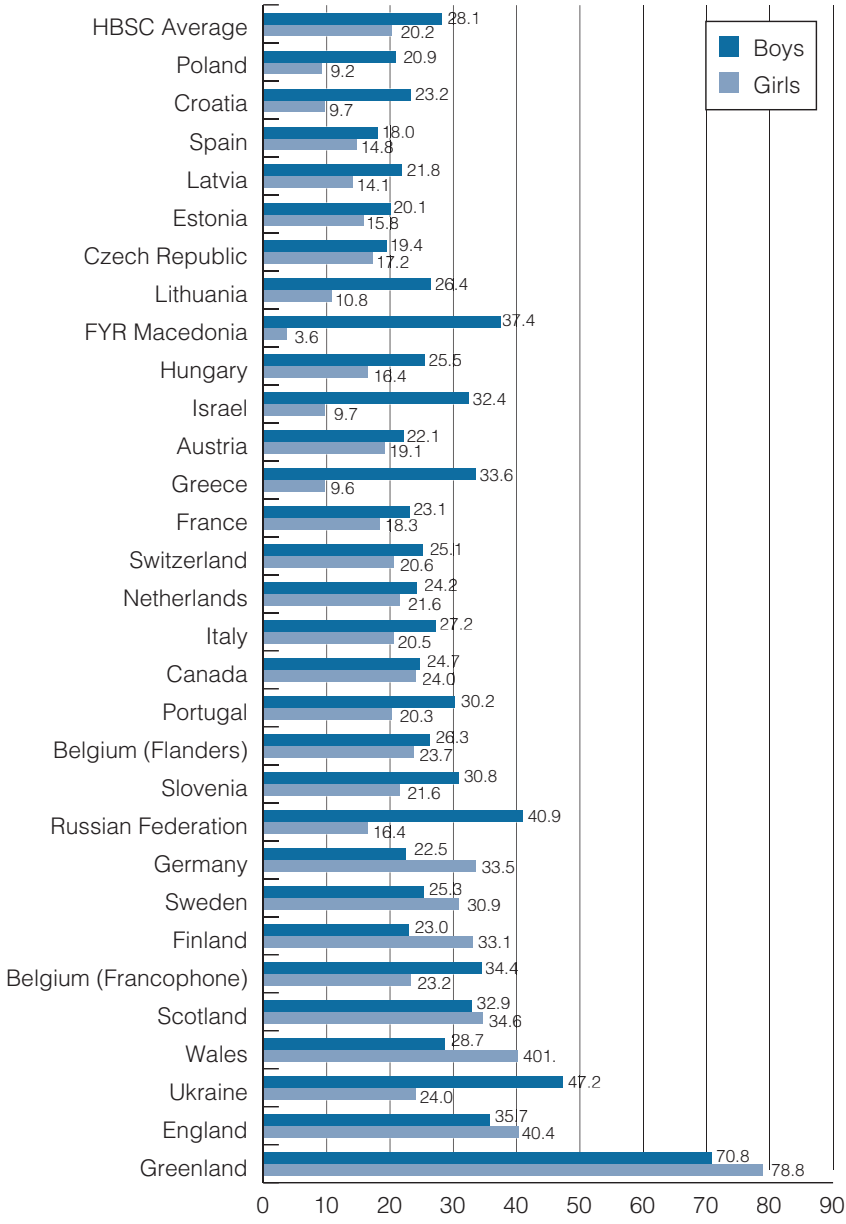
Table 6. First sexual experience average age evolution

	IJE(YSR)-1996	IJE(YSR)-2000	IJE(YSR)-2004
Girls	18 years and 8 months	18 years and 4 months	18 years
Boys	17 years and 7 months	17 years and 4 months	17 years and 4 months

Source: INFORME JUVENTUD EN ESPAÑA 1996, 2000 y 2004. Base: Persons having had relations among the 15-29 years.

that age are facts. While at more adult ages and with better information sexual intercourse may encompass a number of attitudes apart from coitus itself, at an earlier age the trend appears to point at copulation. This pressure towards coitus seems to be largely promoted by the media environment surrounding juveniles (films, comics, etc.) (CIMOP, 2005).

Graph 8. **Graph 8: Boys and girls (%) that admit having experimented in coital sexual relations**



Source: HBSC-2002 Data for Spain.

10. Usage of contraceptive methods

All available qualitative and quantitative information suggests that during the 90s the use of diverse contraceptive methods has seen a progressive increase among juveniles. **Male prophylactic** is the method par excellence and **emergency contraception** is the one on the rise. Other methods like the pill, the coil, the diaphragm or the patches are associated to more adult ages, with well established couple relations, or to women who have already had children, situations, all of them perceived as far-off by most juveniles.

Both male and female juveniles say that **male prophylactic** is the most accessible method, though it may be having accessibility problems in certain environments, partly because of the economic cost it entails and also because a certain sector of young people declares being «embarrased» when asking for it, as 25% of them responded in the survey conducted in 2003 among juveniles in Seville. (Real, 2003).

The rest of methods require planning, gynecological check-ups; in other words, a certain degree of healthcare control that discourages present juvenile generations from their use. While among more adult generations gynecological consultation is well established and consolidated, it does not seem to work that way in present juvenile generations. That is why only a minority of young women, broadly speaking only those who have a more stable partner, resort to that kind of contraceptives.

Male prophylactics present some deterrents usually associated to certain beliefs related to pleasure, discomfort of use or to other aspects. On the contrary, most deterrents associated with the rest of contraceptive methods are related to aspects of importance for young women: aesthetics and health. For a wide sector of juveniles represented in the qualitative study discussion groups (CIMOP, 2005) **hormonal methods («the pill»)** «are fattening», «make you look ugly», «are bad for your figure», «have side effects», «can produce cancer» or «produce infertility» if their use is continued. Such beliefs cast a negative picture of the said methods discouraging their use among a vast majority of girls.

In the frame of evolution of the usage of prophylactics, some qualitative studies (Conde, 2004; CIMOP, 2005) have detected a certain relaxation of the discursive «norm» that encourages users to «always» wear prophylactic in the course of intimate relations involving some kind of risk. Although it is true that there is no complete correlation between discourse

and behaviour, it is also true that discourse comes to, somehow, represent what happens in the reality of behaviour.

Also some survey results point at the need to reinforce information and education on correct use of contraceptive methods. In the one conducted in Seville (Real, 2003) a 26.4% of youngsters declared having used contraceptive practices of dubious efficacity in the course of their coital relations, such as vaginal washing or withdrawal. Likewise, 31% of those polled declared to often use prophylactics but not on all occasions and 17.7% (14% of boys and 21.6% of girls) expressed their belief in the fact that prophylactics are effective even if put on after penetration.

Something similar is expressed in Callejas's article (2005) where it is reported that 12% of youngs between 14 and 18 years of age who declared having had sexual intercourse with penetration, had resorted at least once to «withdrawal».

Along this line, a national survey carried out by «el Consejo de la Juventud» (Council of the Youth) among youngsters between 13 and 29 (Hernán, 2002) revealed that between 27 and 46.5% would have expressed «not having used condom in none of their three last sexual relations with penetration». One Dátor Clinic (5) study in women having undergone VTP, shows that 42% of foreign women polled and 22% of the Spanish ones affirm that their partners force them to have sexual intercourse without prophylactic.

In spite of these data, it is young people in our country who, in the international sphere, most use prophylactics

According to the international survey on schoolchildren (HBSC-2002) 80% said they had used condom in their latest sexual encounter, the highest percentage among partipating countries. It should be said however that the youngest children (15-16 years) again according to the same survey, present less safe conducts (10% used no method whatsoever in their latest intercourse, 10.4% «withdrew» and 2.6% were not sure about the method employed) (see Table 7 and graphic 9).

From INJUVE data, it follows that just one-third of juveniles that use prophylactics when having coital sex, find that protection against sexually transmitted diseases (STDs) especially regarding HIV/AIDS is a good reason to use it.

Although girls seem to be slightly more sentisive to unwanted pregnancy prevention, they do not show the same attitude when it comes to infections, despite their greater vulnerability (Table 8 and Graph 10).

(5) *El País,* May 2, 2005.

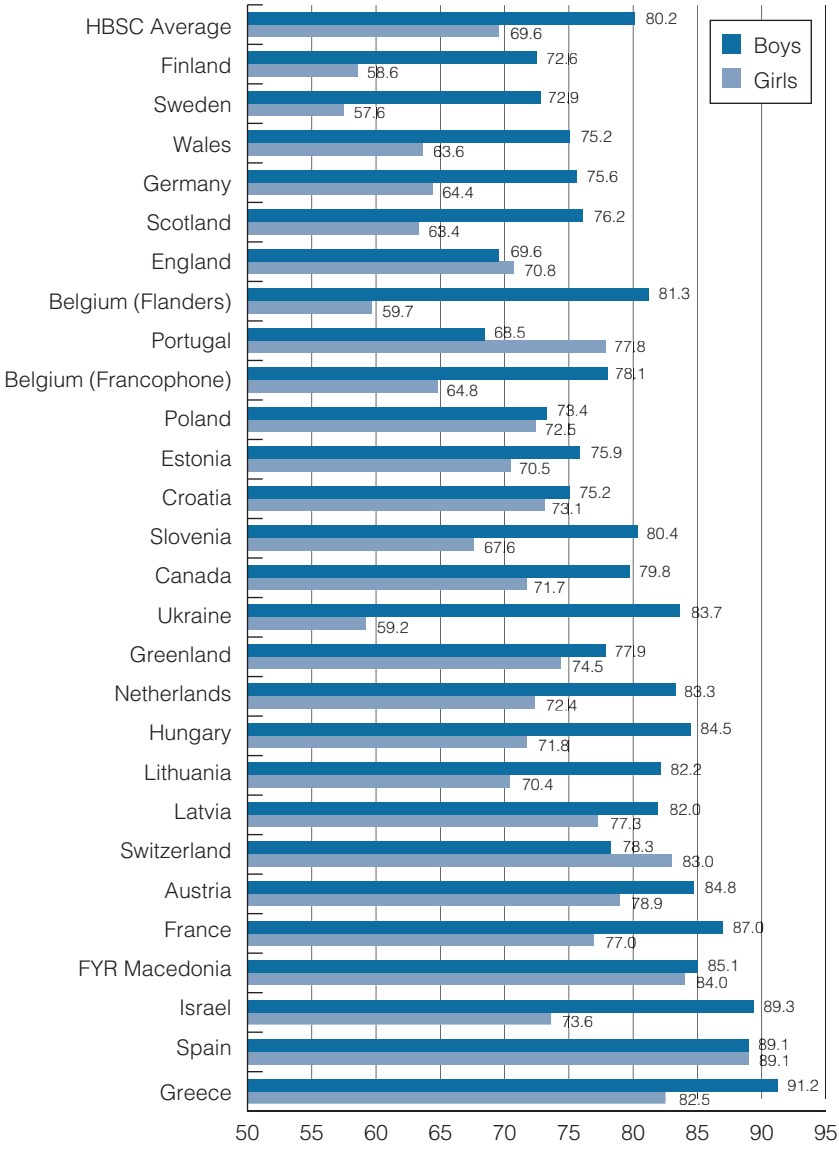
Table 7. Declared conduct referring to latest sexual encounter

		Boys		Girls	
		15-16 N = 269 %	17-18 N = 567 %	15-16 N = 255 %	17-18 N = 620 %
Average starting age in sexual coital relations		14.33	15.83	14.61	15.89
Used prophylactic	Yes	78.8	84.1	82.0	84.2
	No	16.4	14.3	12.5	15.3
	N.C.	4.8	1.6	5.5	0.5
Used contraceptive pills	Yes	5.2	9.2	11.4	14.8
	No	62.1	64.6	64.7	61.3
	N.C.	32.7	26.3	23.9	23.9
Withdrew	Yes	10.4	11.6	14.5	15.2
	No	57.2	62.1	60.0	59.4
	N.C.	32.3	26.3	25.5	25.5
Used «other methods»	Yes	5.9	2.1	3.9	2.4
	No	60.6	69.5	67.8	68.7
	N.C.	33.5	28.4	28.2	28.9
Not sure about contraceptive method use	Yes	2.6	0.5	0.0	0.0
	No	59.1	78.3	68.6	81.6
	N.C.	38.3	21.2	31.4	18.4
Did not use contraceptive method	Yes	10.0	5.5	4.3	3.9
	No	87.7	94.2	92.9	95.8
	N.C.	2.2	0.4	2.7	0.3

Source: HBSC-2002 Data for Spain.

Summarizing, as regards frequency of male prophylactis usage, some aspects should be improved. Above all because, on the one hand there are still youngsters who do not use them or do not do it properly and, on the other, because there seems to be a certain tendency towards relaxation regarding their use, probably due to a decreased perception of infectious diseases transmission risks, actually HIV/AIDS. It also reveals problems

Graph 9. Usage condom (%) in the last coital sexual relation by 15-year-old boys and girls



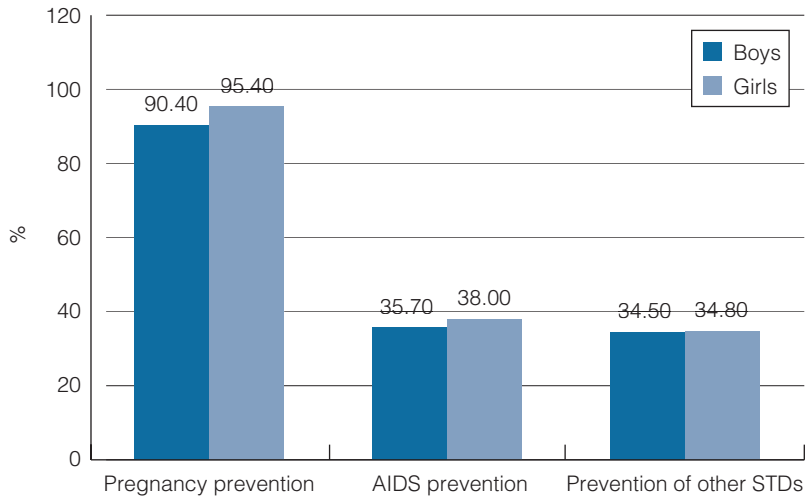
Source: HBSC-2002 Data for Spain

Table 8. Reasons to have use condom in latest encounter (%)

	IJE-2000	IJE-2002	IJE-2004
Prevent pregnancy	93	95.4	93
Protect themsel-ves from AIDS	43	45.1	34.8
Protect th. from other STD	35	43.2	31.9

Source: INJUVE 2000-2004. Base: Persons having used prophylactics.

Graph 10. Reasons to use condoms (%)



Source: INJUVE, 2004.

connected with boys' involvement and co-responsibility and even coercive attitudes upon girls for the non-use of condoms.

It should not be forgotten either that the presence and dominance of the rule for the use of condom may in itself be an incitation factor for transgression, as playing with risk is a material feature of youth.

Emergency contraception (EC) is the method that seems to be used more and more frequently: 100,000 new units a year until reaching 500,000

in 2005 (Table 9). This method appears to play a double role as, on the one hand it might reinforce the reason for not using prophylactic, and on the other, it seems to be highly effective at preventing unwanted pregnancies.

Table 9. Evolution of emergency contraceptives sales (thousand of units) at pharmacies and hospitals. 2001-2005

	Pharmacies	Hospitals	Total	Usage Rates*
2001	144.3	15.9	160.2	18
2002	299.6	39.5	309.1	34
2003	317	76.7	393.7	43
2004	366	118.4	484.4	51
2005**	399	107	506	53

Source: IMS (Internacional Marketing Studies). Data of pharmacies account for a representative panel of 95% of the said shops. *Rate per thousand women aged 15-45. The total amount of sales **for 2005 was considered until August (available figures).

In the absence of unified and general data on EC, some part data may help know the users' profile. So, for instance, assessment data on EC in Andalusia (6) (period 2001-2005) yield an age profile in which 67% of users are below 25 years of age (35.2% below 20 and 31.5% aged 20-24); Catalonia (7) data (period October 2004-October 2005) show a similar profile with 63% of users below 25 (4.2% under 16, 30.3% aged 16-19 years and 28.5% between 20-24) and as per Asturias (8) Emergency Contraception Register (period July-December 2005) 60% of users were below 25 (28% under 20 and 31.3 % between 20-24 years of age).

Also in the qualitative study (CIMOP, 2005) polled professionals point out that most of «the day after pill» users are below 30 years of age, and that

(6) Consejería de Salud, Servicio Andaluz de Salud: Informe sobre Anticoncepción de Emergencia, Andalucía 2001-2005.

(7) Generalitat de Cataluña (www.gencat.net).

(8) SESPA, Subdirección de Atención Primaria: Evaluación de la dispensación de la contracepción post-coital, julio-diciembre 2005.

older users opt for other kinds of contraceptive methods (pills, hormonal treatments or coils (IUD), mostly).

Which means that, according to available data, it could be said that around 63% of EC is used by juveniles. From this information and the data furnished be IMS (International Marketing Studies) on distribution of the said emergency methods among pharmacies and hospitals of the different Autonomous Communities, results the next table where estimated EC usage rates among juveniles together with VTP rates per AC are shown together (Table 10).

Both VTP (between 4.68 and 17.34 per thousand) and EC usage (between 43 and 161 per thousand) range widely. These differences are supposed to be related to factors depending on healthcare administrations as well as to differences in conducts and sexual practices in each place. They are related, partly, to the existence of sexual and reproductive healthcare programmes for juveniles, offering global and gender approaches and basic services, mainly sexual information and education and, partly too, to economical, geographical and cultural accessibility to these specific VTP and EC services in each Autonomous Community.

When interpreting data represented on the table above, it should be taken into account that used register (IMS) only reflects sales to hospitals and pharmacies' offices data and that other EC distribution channels may have been overlooked, for instance direct purchases from healthcare administrations, as occurs in Andalusia. That is why the above data should be interpreted with caution and bearing in mind that disclosing them serves the only purpose of helping to reflect on the possible improvement of the quality of sexual and reproductive health services provided to male and female youngs.

Finally, with the available information we are unable to split EC total usage into young users' countries of origin, but judging by interviews held with professional providers of the service, immigrants' presence would still be very limited in all the above figures (CIMOP, 2005). Also and based on Dator Clinic data, only 36% of immigrants having had a VTP in 2004 claimed to use an effective contraceptive (54% of Spaniards) which signals objectives for priority action.

Table 10. Emergency contracepcion (EC) and Volontary Termination of Pregnancy (VTP) Usage in juveniles aged 15-24 per AACC (2004)

	WOMEN aged 15-24	VTP in WOMEN aged 15-24	EC estimated WOMEN aged 15-24	Rate per thousand VTP	Rate per thousand EC
NATIONAL TOTAL	**2,601,461**	**33,386**	**305,361**	**12.83**	**117.38**
Andalusia	527,259	7,393	22,720	14.02	43.09
Aragón	66,113	940	8,343	14.22	126.19
Asturias	56,986	744	7,643	13.06	134.12
Balearic Islands	57,396	999	7,792	17.41	135.76
Canary Islands	127,338	1,292	20,583	10.15	161.64
Cantabrian Com.	32,048	179	2,779	5.59	86.71
Castile-La Mancha	113,929	937	12,970	8.22	112.26
Castile and León	137,154	1,248	20,209	9.10	147.35
Catalonia	378,127	6,221	48,904	16.45	129.33
Valencian C.	274,685	3,458	42,395	12.59	154.34
Extremadura	70,073	533	7,065	7.61	100.82
Galicia	159,442	978	22,013	6.13	138.06
Madrid	346,747	6,013	50,691	17.34	146.19
Murcia	86,804	1,265	10,929	14.57	125.90
Navarre	31,229	242	1,902	7.75	60.90
Basque Country	109,733	708	15,040	6.45	137.96
Rioja	16,353	189	2,158	11.56	131.96
Ceuta and Melilla	10,045	47	1,402	4.68	139.57

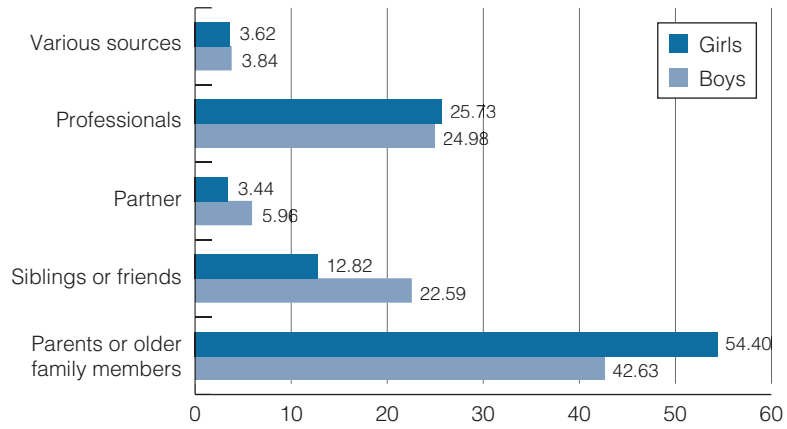
Source: Own results fom INE (NIS National Institute of Statistics) (Census, 2001), Ministry of Health and Consumers (VTP) and International Marketing Studies (Emergency Contraceptives 2004) This last data refer to Chemist'Shops and Hospitals.

11. Information of sexuality and contraceptive methods

According to (MSC) Survey on Sexual Habits, young people's expectations as regards sources of information about sexuality and contraception matters, do not match actual information received.

Among preferred sources, family and female professionals from healthcare and educational spheres are ranked below peers who most usually play the informing role.

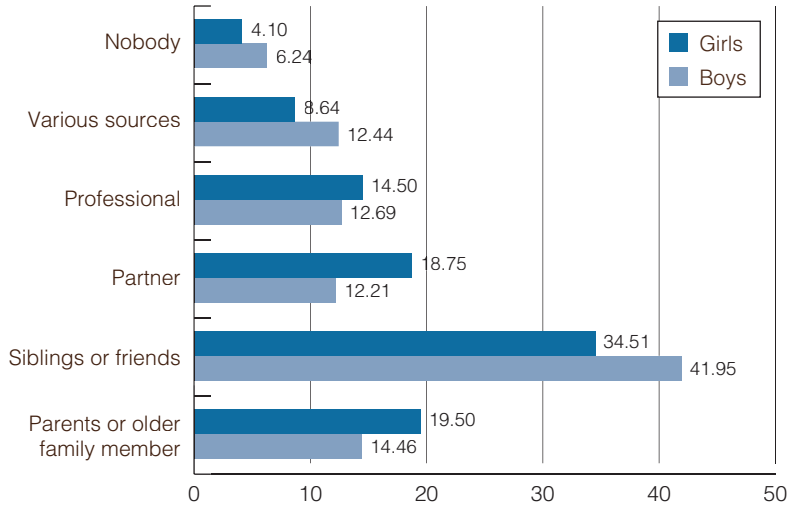
Graph 11. Prefered information sources for young aged 18-29



As regards differences between girls and boys, the former seem to prefer and use more, professional and family sources and above all they claim to talk more about these subjects with their mothers.

From interviews to youngsters, healthcare and education professionals and parents (CIMOP, 2005) we can conclude that neither sexual or reproductive nor contraceptive information are integrated in youngsters' lives or experiences. This happens in all groups regardless of nationality or culture.

Graph 12. Main information sources for young aged 18-29



Information they get is often superficial, based mainly on conversations they hold with their peers, and on what they read in magazines or watch on television.

Not only do these sources inform but transmit experiences and allow comparison, all of which is key at this age. They also prescribe patterns of behaviour and convey and consolidate beliefs, either correct or erroneous. Male prophylactics use is a good example of this; although there is a great deal of information about these products, a significant number of youngs would not be able to use them correctly. Or also, the belief that there is no risk of pregnancy when having coital sex for the first time. Sexual patterns that pervade media prioritize pleasure and coitus as if they were equivalent.

A further result of the said qualitative study is the notion that the role adults are playing at the moment to prevent unwanted pregnancies and sexually transmitted diseases is insufficient.

Within the family environment, sexuality is one of the less discussed or brought up topics. In the best of cases it is done to commend the use of prophylactics, failing to provide further information or to take a more active or educational role in what concerns the living of sexuality. This only adds to reinforcing of coital relations, leaving aside other essential dimensions. Within the family sphere and especially girls admit to being

more at ease with their mothers when it comes to talking about these topics, than with their fathers.

The education system's role in this domaine appears to be considerably weakened. As expressed throughout the referred research, sexual-affective education has practically vanished from the education system. But not only is the situation alarming because of the quantitave plummeting of these contents but because the prevailing approach, limited to anatomy and biology aspects, presents marked deficiencies. Though this kind of knowledge is central to the understanding of genitalia and reproductive system's functionning it has proved insufficient to help youngsters understand the sexual-affective world.

With respect to the healthcare system, young girls, let alone boys, do not seem to perceive it as an accessible space where to get information and counselling on reproductive and sexual healh. Although in some cases healthcare providers cooperate with education centres giving talks on this kind of subject, they are usually oriented to the prevailing anatomical-biological aspects and also this type of punctual activity is sensed as insufficient and of limited effectiveness.

Broadly speaking and when dealing with what is sexual-affective, it could be said that the existing approach reinforces to a larger extent the negative aspects rather than the positives ones. Preventing risks and avoiding problems are more discussed topics than how to live what is sexual-affective in a more diverse, complex, responsible and pleasurable way.

Furthermore, efforts for promotion and education on gender equality seem to be insufficient and so does determined support for equality in the education system's programmes on sexual-affective education and control of the picture conveyed by publicity and media.

12. Equality-based sexual-afective relations

A process of change is observed in those stereotypes and most traditional gender clichés that ascribe the activity and sex worlds to the male, and a more passive role and a practice of sex more associated to the affective world, to the female. In girls more than in boys, and in upper classes more than in middle and lower-middle classes, a change in the said stereotypes is taking shape into a more egalitarian, more active line among girls and incorporating more affective elements among boys. There are other social sectors though, where behaviours prescribed by the most traditional stereotypes are still in force and where girls are less able to decide freely on when and how to have sex (CIMOP, 2005).

From the viewpoint of sexual and reproductive health policies to be adopted by health administrations or other, it is crucial that equality-based relations, shared responsibility and mutual respect are promoted when it comes to making decisions on the type of relations and contraceptive use. These policies' objectives and proceedings shall avoid inequalities in what concerns use of contraceptive and VTP services and shall take into account that decisions on what is financed and how, will have repercussions on young people's health.

13. Juvenils' thinking on sexual and reproductive health

The qualitative study conducted by CIMOP points at some aspects material to understanding of data and to devising work hypothesis that would allow deeper knowledge of these issues and improvement of possible interventions.

The way to live sexuality juveniles nowadays develop is far from traditional procreative purposes and closer to experiencing it as a school of life, in which the most important issue is to build oneself, to forge a bond of affection with the other and set up a framework of confidence and of personal and shared responsibilty. This complete set of transformations points at what could be called the emerging of a new model of relationships and sexual-affective behaviours, a fresh approach to and experience of sexuality in young generations which would translate into a wide and diverse series of dimensions (reproduction imagery, beliefs on sexuality, personal development and couple relation establishment projects, etc.).

Some studies (Marquet, 2004) have underlined the existence in various societies of a certain «recreational sexuality» whose practice falls within the context of pleasure time. In our country, Bimbela refers to the concept of «ludic» sexuality (very close to the «recreational» concept) when trying to explain discrepancies between what is said and what is done in terms of prevention measures on the part of youngs.

However, according to Conde, this depiction of juvenile sexuality as «recreational» proves insufficient to explain the collection of consecutive phenomena that becomes apparent in this domaine. What this author advocates is that the most strictly «ludic» or «recreational» experience in sexuality would arise at the initial moments of the latter, among the most adolescent ages. However at these same ages and especially in the more adult ones, from 17-18 onwards, sexuality would accomplish a wider and more complex function as an identity-provider and school of life function in the broadest sense of the expression.

In other words, the sexual-affective world, the development of sexual relations, holds a decisive position in the array of conditions that define and characterize youth; in how they are able to grow, in how they can evolve into adult and responsible individuals, build their sexuality and shape at the same time a personal project that can materialize in many diverse ways. Sexuality thus appears as an intimate and fenced-in space, a space of their

own where they can express and learn to know themselves and «the others», in which adult guidance and advice are admitted but that each of them has to explore, with their own errors, failures and successes.

Juvenile discourses expressed in that research, point therefore at the existence of a new model, a new experience of the young sexuality marked by a series of generational characteristics of their own

Procreation appears linked to the development of a new imagery where the existence of the so called «artificial techniques» for assisted reproduction holds a prominent place and so does a parallel belief in an increased difficulty to have children in the course of «natural» sexual intercourse.

Nowadays the youth coexists with a plurality of conceptions of sexuality and procreation. In contrast with the traditional patriarchal conception, heterosexual and institutional, present evolution shows different forms of exercise of sexuality – and not only heterosexuality – and exercise of procreation, in an environment of more diverse relationships among women and men and with more plural family reference models.

A sensation of fragility and precariousness also seem to be present in the midst of affective relations, to which former generations' experiences of divorces and separations might have contributed. In addition, educational and social models would reinforce each individual's notion of the «I» to the detriment of the «we».

In this context, discourses on VTP show a «secularization» and «normalization» of this problem, far from moral and ideological-political debates.

In general, youngsters show a pragmatic approval of VTP, even in sectors that reject it on a more theoretical and moral principles level. They take it as a personal decision, of assessment according to each woman's situation, far from any kind of moral or more general social charge. Reflections on the woman's situation itself weigh more in their decision than any consideration on the «conceived and as yet unborn».

They all place the decision of practising a VTP as a continuation of emergency contraceptives, as a «last resort» in case of errors or failure of the latter. But this normalization and dedramatization of VTP does not entirely eliminate either the social stigma or the sensation of guilt and personal grief.

14. Conclusions

1. According to available information from the VTP register and from other sources it cannot be said that VTPs are increasing among Spanish women. If evolution of notifications of VTP since the register was put into effect in 1987, and evolution of VTPs performed outside Spain before and after legalization, is anything to go by, it should rather be said that VTP rates for Spanish women would have hardly varied since legalization.
2. Available data reveal that increase of VTP in Spain is due, on the one hand, to the increase of notifications to the register thanks to the improvement of its coverage and the transformation of clandestine VTPs and VTPs performed abroad, into recorded ones. And on the other, to the rising of immigrant population, to a greater fertility of young immigrant women and probably too, to the fact that the latter have a higher number of unplanned and unwanted pregnancies than Spanish women.
3. Emergency contraception (EC) is the method that seems to be used more and more frequently. Based on available data it can be said that around 63% of EC is used by women under 30 years of age. Through the available information the country of origin of the users remains unknown but according to interviewed professionals providing these services the number of immigrants resorting to EC would be very limited. Also, based on data supplied by a specialized clinic, among immigrants having had a VTP in 2004, only 36% declared using an effective contraceptive method (versus 54% of Spaniards)
4. Information on policies and sexual and reproductive health services for juveniles offered by the NHS (National Health System), on the satisfaction over the said facilities expressed both by Spanish and immigrant juveniles, as well as young people's opinions on accessibility and effectiveness of the said services is scant. As a matter of fact, existing health opinion polls do not incorporate sexual health aspects and the polls on juveniles' conducts do not include aspects regarding health services.
5. Juveniles' sexual behaviour patterns are changing. Nowadays's youngs declare engaging in coital sex more frequently and more precociously, and not always do it in safe conditions both from the unwanted pregnancies' and the sexually transmitted diseases' pre-

vention points of view. Although in the European context they are supposed to be those who use male prophylactic the most, discourses justifying decrease in its use and its replacement by emergency contraception has been detected.

6. The present situation seems to be maintaining to a great extent gender inequalities in what concerns sexual and reproductive health, especially in lower socio-economical layers. Girls are still experiencing pressure to induce them to engage in precocious and coital sex, present limited capacity to negotiate use of prophylactic and must assume responsibility for and possible consequences of emergency contraception and sometimes VTP.
7. Juveniles need more and better information on sexual and reproductive health, coming from more qualified informers bearing educational responsibilities towards them, especially parents and healthcare and teaching professionals duly trained in sexuality with a global and gender approach. To prove effective, this information should incorporate further dimensions beyond the simply biological one, in particular the rapprochements that juveniles initiate towards the worlds of affective and sexual relations.

15. Suggestions

The Ministry of Health and Consumers faced with the above conclusions intends to implement the following proceedings:

1. Include in the *NHS 2007 Quality Plan* a variability analysis for services attending to juveniles' sexual and reproductive health within the NHS. The said analysis will allow formulation of specific proposals intending improvement
2. Revise, with AACC, the VTP's system of information, that, after twenty years of functionning, needs adapting to new social realities and better knowledge on aspects material to devising effective prevention actions, especially the country of origin of users.
3. Analyse the needs and difficulties of young immigrants for accessing sexual and reproductive health services (for instance timetables, knowledge on available resources, language, cultural acceptability, administrative aspects, etc.) for the purpose of designing adequate proceedings and include them in the *NHS Quality Plan* and, if needed, in the *National Plan for Social Inclusion*.
4. Conduct a survey on sexual and reproductive health in order to know what the needs are in terms of information and attention and what the opinions on accessibility and on existing resources' effectiveness in this field, especially those oriented to the population under 30 years of age.
5. Analyse healthcare providers' ways to approach sexual and reproductive health, especially primary care staff's, to provide juveniles with adequate care, and design together with Autonomous Communities and local administrations, the necessary formative actions.
6. Develop information and sexual education strategies for correct use of contraceptives, usign the most effective channels and messages for juveniles, incorporating the participation of groups of youngs and in cooperation with the Ministry of Education, The Institute of Youth, Women's Institute, Autonomous Communities and local Administrations.
7. Develop tools and campaigns to promote shared responsibility between girls and boys in sexual-affective relations to prevent unwanted pregnancies, in cooperation with the Ministry of Education, The Institute of Youth, Women's Institute, Autonomous Communities and local Administrations.

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The present report tries to give answers to the concern arising from pregnancy termination's figures among young people, released at the end of 2004 and related to voluntary termination of pregnancy (VTP) notified to the register during 2003, which reflected an increase in number for early ages.

The Observatory on Women's Health on the National Health System's Quality Agency of the Ministry of Health and Consumers Affairs has making that report for the sole purpose of better understanding them and their prevention, are the other aspects of reproductive health and sexuality in juveniles, approached.

This report is within the reflexive and action framework of International Organizations. The Ministry of Health and Consumers considers that sexual and reproductive health in general, and in particular that of juveniles are essential components of individual and collective health. It also considers that access to contraceptives, both safe and of proven efficacy as well as adequate information on their use in accordance with personal needs and preferences, contributes to the improvement of individual, family and society's sexual and reproductive health.

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